
The Health of California's School Children: A Case of State Malpractice

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February 2009



Children's Advocacy Institute



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CAI strives to educate policymakers about the needs of children—about their needs for economic security, adequate nutrition, health care, education, quality child care, and protection from abuse, neglect, and injury. CAI's goal is to ensure that children's interests are represented effectively whenever and wherever government makes policy and budget decisions.

Author's Acknowledgments

I would like to thank Professor Howard Taras, M.D., of the University of California, San Diego for his assistance in preparing the Survey of California School Nurses, Administrators and Others.

I would also like to thank Liana Gefter, MD, for reviewing the Survey of California School Nurses, Administrators and Others, and for drafting Appendix C, Medical Analysis of Report, discussing why school nurses are medically necessary.

Finally, I'm grateful to Professor Bob Fellmeth, Elisa Weichel and Christina Riehl of the University of San Diego School of Law's Children's Advocacy Institute for their invaluable input and assistance.

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Published by the Children's Advocacy Institute
of the University of San Diego School of Law.

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Overview

There is a crisis affecting children in California — lack of adequate health care. Far too many California children do not have access to medical care at all. Many other children have inadequate access. In an era of economic uncertainty, more and more children find themselves without the most basic medical care.

While the educational setting is the one place where almost all California children come together, the vast majority of California's schools do not provide healthcare services that are sufficient to meet their pupils' needs. While schools are not ideally the "medical home" for children, and while access to pediatric care is the paramount part of health assurance, the school nurse is an important element for public health, basic administration, and detection for referral to physicians and hospitals. In terms of the school nurse element of child health care, California lags behind the rest of the nation. Few California schools meet the recommended ratio of one nurse to every seven-hundred-fifty (750) mainstreamed students. Given the current budget pressures facing California schools, and the lack of priority given to healthcare by many administrations, the number of schools providing appropriate healthcare services is surely decreasing.

Cash-strapped school administrations often cut into student health provision to make ends meet. There are consequences of doing so, however, including loss of funding based on performance-measures; adequate provision of school healthcare services correlates with higher attendance rates and better academic performance. Thus, sacrificing school healthcare services has unintended consequences.

Given the pressure on school districts and the low priority generally given to student healthcare services, a state-mandated solution is necessary. Thus, in addition to analyzing the current state of school nursing in California, this report suggests a legislative solution to the current crisis.



1 The Healthcare Needs of California's Children

1.1 Health Issues Faced by California's Children

The healthcare needs of American children are increasing in both number and complexity. For example, the number of children with disabilities covered by the *Individuals with Disabilities Education Act* (IDEA) has steadily increased since the inception of the program in 1974.¹ Currently, almost 14% of students in the United States have covered conditions, up from 8.3% in the 1976–77 school year, an increase of 5.7%.² The change in California has been much more dramatic: between the 1990–1991 school year and the 2003–04 school year, the number of children covered by IDEA increased by 44%.³

Even if special needs children are taken out of the equation, the healthcare needs of children remain significant. The most common health issue faced by children — maintaining a healthy diet and staying physically fit — reaches an overwhelming majority of California children.⁴ Approximately one-quarter of the students in the California school system are overweight.⁵ Almost 40% are considered unfit.⁶ Less than a 25% are fit enough to pass the state's physical fitness tests.⁷

The second most common health issue faced by California's school children — asthma — reaches fewer students, but is no less significant in terms of its effect. Asthma attacks are frequent, difficult to prevent, disruptive to the lives of sufferers, and, sometimes deadly.⁸ Asthma is becoming increasingly prevalent in the lives of California's children. In 2006, 14% of American children under age 18 had been *diagnosed* with asthma at some point in their childhood.⁹ In California, school-age children are *currently* suffering from the disease at a rate of about one in ten.¹⁰

In spite of the obvious increasing healthcare needs of children, far too little has been done to provide access to competent care, with many children suffering under the burden of an unmet health need. California does little by way of direct service provision and not enough to guarantee insurance coverage for all effected children. The minimum level of income needed for survival (excluding proactive healthcare) is twice the Federal Poverty Line (FPL).¹¹ Thus, poor and near poor families¹² who do not have private insurance or governmental assistance cannot afford healthcare for their children. In one recent year, 763,000 California children were medically uncovered at a given point in time; 1.1 million were uncovered at some point over the 12-month period.¹³

1.2 Healthcare Coverage for Low Income Children

1.2.1 Types of Coverage for Low Income Children

1.2.1.1 Private Coverage of Low Income Children

One of the reasons for the gap in coverage is the decline in employment-based coverage for children.¹⁴ Less than 35% of low-wage firms offer coverage to their employees.¹⁵ Additionally, premiums are increasing, preventing many families who would otherwise take private coverage from doing so. This problem is particularly acute in California, which experienced an 8.3% increase in premiums during 2007 compared to a 6.1% increase nationally.¹⁶ Thus, fewer families have

insurance coverage offered to them, and many that do cannot afford private coverage for their children.

1.2.1.2 Federal Programs for Low Income Children

While many middle-class and affluent children are covered by private insurance, poor and near poor children rely on coverage from federal/ state programs. The federal government channels assistance through the states by two main programs: Medicaid and the State Children's Health Insurance Program (SCHIP). The programs do not cover all children in need and do not provide complete coverage for enrolled children.

1.2.1.2.1 Medi-Cal

Medicaid is a medical assistance program authorized by Title XIX of the Social Security Act.¹⁷ It provides health coverage for individuals and families with low incomes and resources.¹⁸ Medi-Cal is the name of the Medicaid program administered by the State of California through the California State Department of Health Care Services and the Centers for Medicare and Medicaid Services (CMS).¹⁹

1.2.1.2.2 SCHIP (Healthy Families)

SCHIP was enacted in 1997 to address the growing problem of children without health insurance.²⁰ In California, the SCHIP-funded program is entitled Healthy Families.²¹ The program was the largest expansion of health insurance coverage for children since the enactment of Medicaid three decades before.²² Nevertheless, the program does not cover all uninsured or underinsured children, but instead addresses the needs of "targeted low-income children" who are at or below 200% of the FPL (i.e. "near poor") or whose family has an income 50% higher than the state's Medicaid threshold.²³ It is jointly financed by federal and state governments, with administration of the program left to the states.²⁴ States can charge premiums, require co-payments and limit benefits.²⁵ So even children who are "covered" by the program have something less than full health insurance.²⁶ Additionally, state funding is capped, which can lead to budget shortfalls and forced reduction of rolls and/or benefits.²⁷

1.2.2 Utilization of Health Insurance for Children

A survey by the Kaiser Commission on Medicaid and the Uninsured revealed that there are ongoing gaps in healthcare coverage of children.²⁸ The issue becomes more acute the further one moves down the class line.

In 2005–06, for *all children* ages 0–18²⁹:

- 50% were covered by an employer
- 6% were covered by individual insurance
- 30% were covered by Medicaid/other public insurance
- 14% were uninsured

For those children that were *near poor*.³⁰

- 31% were covered by an employer

5% were covered by individual insurance
44% were covered by Medicaid/other public insurance
20% were uninsured

For children who were *poor* during the same period:³¹

13% were covered by an employer
4% were covered by individual insurance
60% were covered by Medicaid/other public insurance
23% were uninsured

1.3 The Lingering Problem of Uninsured and Underinsured Children

In 2005, there were over 763,000 uninsured low-income children in the state of California.³² California is the 9th worst state in the nation in terms of provision of public healthcare to this vulnerable group.³³ The problem is two-fold: lack of enrollment of children eligible for governmental programs and dropping of previously covered children from governmental programs.³⁴

The effect of the lack of insurance is evident. Children cease to have access to routine care and increasingly rely on emergency care.³⁵ This costs the state more in the long-run and damages the health of the effected children.³⁶ Lack of regular examinations leads to less early detection and timely treatment. Approximately 12% of uninsured children reported that they had not had contact with a doctor or other health care provider for *more than two years*.³⁷ For children covered by public programs, the rate was 4%.³⁸ For children covered by private insurance, the rate was 2%.³⁹ Thus, lack of insurance coverage matters with respect to access to healthcare and to the cost to both the individual and to the state.

2 Addressing the Healthcare Crisis through the Schools

2.1 Reaching California's Children

School-age children make up between 20–25% of the population of the state of California.⁴⁰ In 2006, there were approximately 6.9 million school-age children in the state of California.⁴¹ California's 9,863 schools served over 6.4 million of them.⁴² While schools are not ideally the “medical home” for children, and while access to pediatric care is the paramount part of health assurance, the school nurse is an important element for public health, basic administration, and detection for referral to physicians and hospitals.

Within the past decade, for example, there have been several school-based outbreaks, including the recalcitrant outbreak of tuberculosis at La Quinta High School during the mid-90s⁴³ and the more recent outbreak of measles in San Diego during January and February 2008.⁴⁴ In the San Diego incident, the “index” patient (i.e. patient zero) was an unvaccinated 7-year-old boy who had visited Europe with his family.⁴⁵ His parents sent him to school after he had exhibited symptoms, but before the onset of a rash.⁴⁶ He thus exposed everyone he came into contact with — including both insured and uninsured children — to the virus. And the children he came into contact with in turn came into contact with many others once they left the school grounds.

In addition to the potential to check outbreaks of communicable diseases, improving the health of students has a positive effect on their ability to learn and their performance at school. Thus, addressing children's health issues at their source benefits both the child and society at large in terms of both health and academics.

2.2 The Effect of School Health Services on Students

2.2.1 School Health Services and Student Health

Studies have shown that the provision of school health services has an effect on the overall health of the student, both in and outside the schoolroom, even for students whom are old enough to tend to most of their individual needs. For example, many people assume that older students can competently self-medicate.⁴⁷ This is often not the case.⁴⁸ High school students make frequent errors in the self-administration of medication.⁴⁹ In this context, the school health policy does make a difference: when the school takes a proactive role in student healthcare, students are more likely to get proper medication.⁵⁰

In addition to the obvious improvement in student health, society benefits from in-house treatment. When schools take the most active role possible by founding school based health centers, students are much less likely to visit the emergency room, decreasing the demand on overburdened emergency rooms and decreasing cost to the individual, their insurer (which may be the state), and society.⁵¹

2.2.2 The Effect School Health Services on Attendance and Academic Performance

Obviously, children with health issues such as asthma are likely to miss school.⁵² Understanding the relationship between asthma and attendance is critical because asthma is one of the two most

common health conditions facing American school children⁵³ and it accounts for more absenteeism than any other chronic disease.⁵⁴ It is also related to other hurdles that students face on the road to academic success, including inner-city poverty.⁵⁵ Asthma is a crushing problem for many school districts. Yet when schools address the problem head-on by making efforts to manage student asthma, attendance improves markedly.⁵⁶ Addressing asthma in a proactive fashion goes a long way towards improving student attendance, a prerequisite for academic success.

There are indications that provision of health services may also have a direct, general effect on academic performance. It is known that chronic conditions have a substantial negative effect on student performance.⁵⁷ While there are many conditions that have not been researched, it has been shown that chronic conditions such as diabetes, sickle cell anemia, and epilepsy do have a deleterious effect on student ability to achieve academically.⁵⁸ It is believed that this is because of the correlation between performance and cognitive functions such as attentiveness, which are negatively affected by chronic disease.⁵⁹

2.3 Methods of Providing for Healthcare in the Schools

There are many different methods of providing healthcare to students, but the three most typical are: (1) the comprehensive school-based health center, (2) the “traditional” school nurse, and (3) provision of healthcare services by other school personnel.

2.3.1 The School-Based Health Center

California currently has over 150 school-based health centers (SBHCs),⁶⁰ health clinics that are located directly on school campuses.⁶¹ SBHCs provide a comprehensive range of services equivalent to a primary care clinic, often including dental care.⁶² They are staffed by trained medical professionals including nurses, part-time physicians, and mental health providers.⁶³ Centers are often linked to community health providers, such as clinics and hospitals, which provide services that cannot be provided on site.⁶⁴

While SBHCs would be the ideal solution to providing care directly to California's children, a lack of funding prevents implementation of the SBHC model as the universal solution. Most SBHCs are funded through a combination of state grants and external funding, which is often cut in times of budget shortfalls. Thus, while SBHCs are the best solution and there are some school districts where they are thriving, it is unlikely that enough funding will become available to use them as the primary method implemented to address the healthcare needs of California's school children.

2.3.2 School Nurses

School nursing is a specialized branch of the nursing profession that requires expertise and training on matters related to student health.⁶⁵ The role of the school nurse is both care-based and educational.⁶⁶ Modern school nurses do much more than bandage skinned knees. They serve as the focal point for the well-being of the student body. Ideally, a school nurse will cooperate with school administration and faculty to provide for the needs of the children in his/her care and serve as a point of contact to the larger healthcare and social welfare system.⁶⁷ A complete description of the duties and mission of school nurses can be found at the National Association of School Nursing website.⁶⁸

2.3.3 Other “Trained” Personnel

There are many who feel that the needs of students can be met by individuals who are not licensed to practice of medicine⁶⁹ even though California standards for the training and supervision of such individuals is well below that of other states.⁷⁰ California, like a majority of states, relies on health aides and staff to provide healthcare services to students on a daily basis. In other states, health aides are a supplement, not a substitute, to the care provided by the school nurse; over forty 46% of states require that health aides be under the direct supervision of a school nurse or physician.⁷¹ While California abdicates responsibilities directly to health aides and uses them as a substitute for school nursing, many other states require supervision by certified nursing personnel who use the services of the health aide to supplement the care they provide.

California also allows “trained” faculty and staff to assist students with routine healthcare matters. Reliance on staff members to provide healthcare is misguided, as they are neither adequately trained nor paid to tend to student health needs. Many report they are over-burdened with healthcare duties, particularly when they are asked to administer medications to students, a routine, daily need of many California children.⁷²

An overwhelming majority of schools allow the administration of medication by non-nurses.⁷³ Most schools have written policies governing the administration of medication, but there are often gaps and there is evidence that, absent direct oversight, the written policies are ignored.⁷⁴ Additionally, many staff members have only minimal training in dispensing medication,⁷⁵ and are often not aware of what to do when a child misses a dose, what contraindications or conflicts exist between medications, or even what a specific medication should look like. An anecdote from a survey of school nurses in Iowa demonstrates what happens when a nurse is not present:

“A parent sent medication in a prescription bottle indicating the child should be taking Adderall. The secretary was giving the medication to the child and the nurse happened to be standing there and asked what the child was taking. When she was told Adderall, she grabbed the secretary’s hand and told her ‘Adderall is blue.’ The pill was white. The mother had switched bottles, sending another drug in the Adderall bottle.”⁷⁶

School faculty and staff are even more ineffective during a true emergency. As the mother of Phillip Hernandez knows, the results can be fatal. Phillip, who had been plagued by asthma since the age of three, was not allowed to keep an inhaler on his person because his school had a written policy that all student medication must be stored in a place inaccessible to other students in order to ensure student safety.⁷⁷ Philip’s nebulizer was “safely” kept under lock and key in the school office under the watchful eye of a school secretary who had been trained to assist Phillip.⁷⁸

On May 13, 1996 Phillip suffered a severe asthma attack and headed to the school office.⁷⁹ In such a high pressure situation, the school secretary was unable to assemble Phillip’s nebulizer.⁸⁰ The nurse assigned to the school was not present as she was across town at another of her assigned schools.⁸¹ The secretary’s only recourse was to dial 911.⁸² By the time the paramedics arrived, it was too late.⁸³

It was only after Phillip’s death that his mother learned of an exception to the school medication policy that would have allowed Phillip to keep his inhaler on his person if he had a written request from his doctor.⁸⁴ She sued the school district,⁸⁵ and several years later a jury awarded her \$9 million for the loss of her child.⁸⁶ She was allowed to recover damages because the

school failed to affirmatively inform her of the exception to the medication policy — not because the school failed to provide adequate assistance to a child known to have severe (and potentially fatal) asthma attacks.⁸⁷

2.4 The School Nurse Solution

It is unlikely that the state of California will provide adequate funding to ensure all schools have a SBHC. Furthermore, reliance on school health aides as a substitute to school nurses is an inadequate solution. Thus, using school nurses to provide healthcare to students is the most practical solution presently available. Yet, few California schools meet the recommended ratio of one full-time, onsite nurse to every seven hundred fifty (750) mainstreamed students.⁸⁸ The reason for this is twofold: (1) administrators who see the value of school health services do not see the value added by a school nurse,⁸⁹ and (2) practical constraints (such as lack of resources) negatively affect the presence of nurses in the California public school system. Nevertheless, where nurses are present, they have a clear positive outcome on student health and school performance. The closer the school comes to meeting the recommended school-nurse-to-student ratio, the better the well-being of the school's children.⁹⁰

2.4.1 School Nurses and Student Health

School nurses ensure that students get proper routine care and are best-equipped to handle emergency situations. They also provide a proactive role in student health. Parents, faculty and staff are often unaware of a child's health problems or fail to identify illnesses (such was the case with the index patient in the San Diego measles outbreak).⁹¹ The presence of a school nurse makes it much more likely that communicable diseases, chronic illness and problems such as teen pregnancy, depression and learning disabilities will be identified and treated.⁹² In terms of both routine care, emergency treatment of a student, and discovery of undiagnosed problems, the presence of a school nurse matters a great deal.

2.4.2 The Effect School Health Services on Attendance and Academic Performance

In addition to meeting otherwise unmet health needs,⁹³ the presence of a full-time on-campus school nurse has both a tangible direct effect on student attendance and performance and an intangible — yet invaluable — impact on student morale.

The presence of a full-time school nurse has a clear direct effect on student attendance.⁹⁴ Where a school nurse is present, students have access to over-the-counter medications and other types of treatment that would otherwise not be provided.⁹⁵ Consequently, fewer students leave school early due to illness or injury.⁹⁶ There is also evidence that school nurses make a difference in school performance. For example, it has been shown that school nurses have a positive effect on the number of students who eventually graduate.⁹⁷

In addition to tangibly improving attendance and academic performance, school nurses provide intangible benefits. School nurses are often more objective and more sympathetic than staff members.⁹⁸ Thus, school nurses provide an outlet to students who would not otherwise seek care and assistance.

3 The State of School Nursing and School Health Services in California

Few California schools have adequate nursing services to provide for the health needs of mainstreamed students.⁹⁹ While Californians often pride themselves as being leaders and innovators, California provides fewer health care-related mandated services for its students than other states. In addition, California school districts often devalue student health services and school nurses. This is compounded by California statutory law, which often works against provision of adequate school health services.

Every six years, the U.S. Department of Health and Human Services' Centers for Disease Control conducts a survey of the fifty states and District of Columbia.¹⁰⁰ This survey addresses many of the aspects of the Allensworth-Kolbe Coordinated School Health Program Model (see Appendix A), including provision of health services.

It is clear that California does not prioritize student health at the same level as other states; in fact, it lags behind in many areas. In contrast, Tennessee, a state with less than 17% of the population of California, and a much lower gross state product, provides one of the most comprehensive school nurse laws in the nation.¹⁰¹ States like Vermont and the District of Columbia have school nurse-to-student ratios at the top end of the scale, whereas California's ratio is near the bottom.¹⁰²

3.1 Student Health Staffing Levels

3.1.1 Student Health Administrator

Unlike many states, California does not *statutorily* mandate that there be an individual responsible for student health for the entire state.¹⁰³ While many states also require that someone be responsible for student health at the district level, California has no such requirement.¹⁰⁴ California is aligned with other states in its lack of mandate of a school-level health administrator; few states require a student health administrator at the school level.¹⁰⁵

Mandated Student Health Administrator

	% of States	California
At State Level	74.5%	N
At District Level	40.0%	N
At School Level	18.0%	N

3.1.2 School Nurse

California, like most states, does not have minimal staffing requirements for school nurses. However, thirteen states and the District of Columbia have taken steps to ensure the presence of a school nurse in the lives of students.¹⁰⁶ This is accomplished via two basic approaches: (1) a minimum of one nurse per school (or district) or (2) a specified minimum nurse-to-student ratio.

Despite the lack of state-mandated requirements, a majority of the nation's schools do have at least some school nurse presence, though it is only part-time.¹⁰⁷

Mandated School Nurse

	% of states	States	California
One full-time nurse per school	12%	Connecticut,* Delaware, DC, Massachusetts, New Jersey, Rhode Island	N
Specified nurse-to-student ratio	14.0%	Alabama, Arkansas, Louisiana, Minnesota, Pennsylvania, Tennessee, West Virginia	N

*Connecticut requires one or more nurses per *school district*, while the other states require one nurse per *school*.

3.1.3 Health Aides

California, like a majority of states, also relies on health aides and staff to provide healthcare to students on a daily basis.¹⁰⁸ Unlike California, over 46% of states require that health aides work under the direct supervision of a school nurse or physician.¹⁰⁹ Thus, California abdicates responsibilities directly to health aides where many other states require their supervision by certified personnel. California is relying on health aides to serve as a *substitute* for care by a school nurse instead of relying on health aides to *supplement* care by a school nurse.

3.2 School Nurse Certification

School nurse certification is one area where California is ahead of most states. California, like a majority of states, requires that a school nurse be an RN.¹¹⁰ However, California goes further than most states in requiring a special school nurse certification.¹¹¹

School Nurse Certification

	% of States	California
LPN required	17.6%	N
RN required	82.4%	Y
SN Certificate required	41.2%	Y

3.3 The Role of the School Nurse in Special Education

Most states require that a school nurse participate in an Individual Education Plan required by IDEA.¹¹² Many states also require school nurse participation in an Individual Health Plan required by IDEA.¹¹³ California does not require the presence of a school nurse in either case.¹¹⁴

Over a third of states also require that a school nurse participate in a Section 504 Plan¹¹⁵ (which ensures that disabled students have access to extracurricular and after-school programs such as athletics, music and clubs).¹¹⁶ California has no such requirement.¹¹⁷

The Role of the School Nurse in Special Education

	% of States	California
Mandatory role in IEP	50.1%	N
Mandatory role in IHP	47.1%	N
Mandatory role in Section 504 Plan	35.3%	N

3.4 Required Services

3.4.1 Provision of Mandated Services

Like a majority of states, California requires that schools identify/refer students who have suffered physical, sexual or emotional abuse.¹¹⁸ A majority of states mandate more services than California: administration of medications (other than self-administration); assistance in enrolling in supplemental food programs (such as WIC); case management for students with disabilities; first aid; and identification and management of chronic conditions.¹¹⁹

Services Mandated by a Majority of States

	% of States	California
Administration of medications	80.0%	N
Assistance in enrolling in Supplemental Food programs such as WIC, food stamps, food banks	54.2%	N
Case management of students with disabilities	50.0%	N
First aid	59.5%	N
Identification or referral for physical, sexual or emotional abuse	80.0%	Y
Identification of or school management of chronic health conditions	57.1%	N
Violence prevention	50.0%	Y

3.4.2 Administration of Medication

While a majority of states require some administration of medications by school personnel, California generally does not.¹²⁰ The recent settlement agreement reached in the case of *K.C., et al. v. Jack O'Connell*, has thrown this area into doubt, as it authorizes, but does not require, the administration of diabetes medication by school employees with training.¹²¹ Thus, schools may allow other staff members to administer insulin but cannot compel them to do so.¹²²

California is more aligned with other states with respect to self-administration of medication. Over 90% of states allow some self-administration,¹²³ and almost 90% allow self-administration of prescription quick-relief inhalers.¹²⁴ A majority of states also allow for self-administration of epinephrine.¹²⁵ Some states allow for self-administration of other medications.¹²⁶ As in other states, California school children may self-administer inhaled asthma medication, if they follow the statutory requirements.¹²⁷ California school children may also self-administer epinephrine or have it administered by school personnel.¹²⁸ A student may take other medications, if he/she has a written statement from a healthcare provider and a parent.¹²⁹

3.5 State Earmarked Funding for Selected Topics

While California does provide some funding for staff development on topics such as cardiopulmonary resuscitation,¹³⁰ there are several areas that a majority of other states fund and California does not: emergency preparedness; first aid; identification of emotional or behavior

disorders; identification of/referral for physical, sexual or emotional abuse; identification of/school-based management of acute illness; identification/treatment of STDS; immunization administration; oral health problems; and teaching self-management of chronic health conditions.¹³¹

State Earmarked Funding for Selected Topics

	% of States	California
Administration of medications	73.5%	Y
Alcohol or drug use treatment	55.3%	Y
Case management for students with chronic health conditions	68.0%	Y
Case management for students with diabetes	58.0%	Y
Emergency preparedness	87.8%	N
Federal laws that protect the privacy of student health information	85.7%	Y
First aid	51.0%	N
Identification of emotional or behavior disorders	64.6%	N
Identification of or referral for physical, sexual or emotional abuse	70.8%	N
Identification of or school-based management of acute illness	74.0%	N
Identification of or school-based management of chronic health conditions	84.0%	Y
Identification or treatment of STDS	50.0%	N
Immunizations	82.0%	N
Infections disease prevention	76.0%	Y
Oral health problems	50.0%	N
Teaching self-management of chronic health conditions	80.0%	N
Tobacco-use cessation	53.1%	Y

4 Importance of a Legislative Solution

California is clearly not a leader when it comes to the provision of school nursing services. There are both practical and legislative reasons for this. While the global nursing shortage makes it more difficult to provide school nurses to all schools, this is a force that acts on all states, including those (like Tennessee) that are proactively addressing student health through comprehensive school nurse legislation.¹³² What is unique to California is the low priority placed on educational spending, which leads to ground-level decisions that are hostile to student health. The current statutory scheme governing student health further undermines the role of school health services in general, with particularly negative effects on school nurses.

4.1 Practical Obstacles

4.1.1 The Low Priority of Educational Spending

While California ranked first in public school enrollment for the 2005–06 school year, it ranked 10th in per capita expenditures for K–12 students.¹³³ Comparatively, California ranked 3rd in per capita expenditures for correctional institutions.¹³⁴ Thus, spending on education is generally not highly ranked in California-state level priorities.

4.1.2 Ground-Level Decisions on Healthcare

In California, the health of school children is left largely in the hands of local officials, many of whom de-prioritize student health.¹³⁵ A survey of California conducted by the Children's Advocacy Institute at the University of San Diego School of Law during the 2007–08 school year (hereinafter "CAI Survey"; see Appendix B) revealed that school administrators place less value on student health than other respondents.¹³⁶ Even those who feel that student health is a priority often believe that healthcare in the schools can be provided by trained staff;¹³⁷ they do not see an investment in school nursing as a value-add for their schools. When faced with scarce resources, schools usually pour their resources into academic programs.¹³⁸ Local level officials see education and healthcare as two disconnected, often disjunctive choices.

4.1.2.1 Healthcare is Not a Priority

4.1.2.1.1 Priority Placed on Student Health and Its Effect

Consistently, the CAI Survey revealed a gap between the opinions of school administration and school nurses and others with respect to the prioritization of student health and healthcare by the district. A slight majority of respondents felt that student health was one of several priorities, but clear differences of opinion existed when examining the prioritization question by role. School board members were the only group that felt health was a high priority. All other groups felt it was one of several priorities, except for district nurse respondents, who often felt that the district was undermining student health.

When asked about the effect of the prioritization of student health, there was a clear difference in perspective based on the role of the respondent in the school system. Principals, school board members, health aides and office support staff viewed the allocation of healthcare

responsibilities as adequate. School nurses viewed the allocation as “not serving” the student bodies. Surprisingly, district-level nurses *and teachers* viewed the allocation of healthcare responsibilities as failing students.

4.1.2.1.2 Staffing for Healthcare

While school principals and administrators felt that the daily allocation of healthcare responsibilities was adequate, they felt that the staffing levels were inadequate. Perhaps this is because they feel they are doing the best with what they have, but they would also like to hire additional personnel if they could afford to. Only health aides and office support staff were most likely to report that staffing levels were adequate. In some respects, these answers might be self-interested because hiring of additional school nurses can mean hiring of fewer health aides and office staff. Surprisingly, 34.1% of health aides, the individuals most likely to be hired in lieu of school nurses, felt the staffing levels were inadequate.

Consistent with their answers to other questions, district nurses tend to be the most cynical group, with a vast majority responding that staffing levels were “inadequate” or “very poor.”

4.1.2.2 Universal Concern with Limits on Resources Available to Care for Students

Even where school administrators felt they were doing an adequate job, they cited resource allocation as a major hurdle. For example, a majority of respondents cited lack of funds as the primary reason that staffing levels were inadequate. This held across all respondent groups, but was most strong among school board and administration, as 72.7% cited lack of funds as the principal reason school health staffing was inadequate. However, there were some individuals, particularly school nurses, district nurses, and teachers who felt that school board values were the primary reason that staffing was inadequate. In addition, a majority of respondents (58.7%) felt that the reporting of injury and illness was adequate, but indicated in a follow-up question that lack of funds was the primary obstacle to providing “adequate services”.¹³⁹

4.2 Current California Law with Respect to School Nursing

One of the reasons that California school districts do not put much emphasis on school nursing is that no federal or state statute either requires or strongly motivates them to do so. The general trend at both levels of government has been to pass legislation that negatively influences school nurse hiring. The emphasis on student self-treatment, performance of healthcare duties by health aides, and external contracting for mandated services has diminished the perceived value of the school nurse.

4.2.1 No Existing Statute

Nothing in federal or state law requires that schools maintain specified levels of health services or that they employ a school nurse. Schools are required to provide nursing services only to students who have been proven eligible under the Individuals with Disabilities Education Act (IDEA). Even in this situation, federal caselaw has established only that nursing services are required *after* a covered individual need has been established.¹⁴⁰ There is no preemptive school nursing services requirement under federal law, not even for special needs students.

Similarly, California law does not require schools to have a school nurse on staff. The California Legislature has stated that it intends for school boards to give “diligent care” to the health of students and requires it to maintain health services adequate for students to learn, but does not mandate the hiring of any health personnel.¹⁴¹ Several California Code sections acknowledge that schools may be without a school nurse.¹⁴² While there are grants that give preference in funding to programs with school nurses, no grants require the presence of a school nurse.¹⁴³ Thus, while the California Legislature sees the value of school nurses, it does not require schools to employ them, nor does it provide a strong enough incentive to hire them.

4.2.2 Statutes that Undermine School Nurses

4.2.2.1 Self-Administration by Students

The trend in both federal and state law is to allow students greater rights to self-treat without supervision by a school nurse. Under federal law, preference is given to states that allow for self-treatment of asthma.¹⁴⁴ Under the California Code, students are expressly allowed to self-administer medication, use inhalers without supervision and auto-inject epinephrine.¹⁴⁵ Both federal and state legislatures show a preference for student self-care of certain conditions.

4.2.2.2 Delegation to Other Faculty and Staff

Faculty members and school staff who are not credentialed may provide healthcare services. At the federal level, the *Head Start* program allows delegation of healthcare services.¹⁴⁶ In California, persons performing “school health” functions more than 50% of their time must be credentialed,¹⁴⁷ however, provision of healthcare services is not strictly limited to those who are credentialed.¹⁴⁸ Non-credentialed individuals may provide services of a predictable nature including catheterization and gastric tube feeding.¹⁴⁹ Non-credentialed individuals may not provide services that would violate California Business and Professions Code section 2052(a), which prevents the practice of medicine without a license, or Section 2725(b)(2), which limits the types of individuals who can administer medications. While performance of healthcare duties by non-credentialed individuals allows schools to meet the technical requirements of state and federal law, it creates a risk of services being provided by individuals who are not fully trained to deal with non-predictable situations or handle the pressure of emergency care — a risk that was all too real for Phillip Hernandez.

4.2.2.3 Performance by Non-Credentialed Nurses

When addressing the type of nursing services a school can provide, the California Legislature allows the provision of services by those not specifically trained for the job. California law explicitly allows for provision of school-based health-care services by a qualified school nurse or a qualified public health nurse.¹⁵⁰ It also allows licensed nurses without a school nurse specialty to provide care under several health-care related sections of the Education Code and the California Code of Regulations.¹⁵¹ Thus, nurses with general training are allowed to provide care in the challenging school-specific context.

4.2.2.4 Outsourcing

Finally, the California Education Code allows schools to outsource their health services. Schools can hire outside physicians and nurses to provide those services that are mandated by law.¹⁵² Thus, even the minimal healthcare services that a school is required to provide can be outsourced.¹⁵³

4.3 Necessity of a Statutory Solution

Absent a change in California statute, many schools will continue to choose to provide student healthcare by non-licensed personnel, who are ill-equipped to deal with the challenging medical needs of today's school children. A physician's analysis of why school nurses are medically necessary is contained in Appendix C.

California needs a comprehensive school health law, with school nurse requirements as a foundation. After surveying the current laws of those states with school nurse provisions, it is recommended that California adopt a statute that includes the following elements:

- A clear requirement for a 1:750 nurse-to-student ratio for mainstreamed students.
- A provision outlining of what types of individuals can be used to satisfy the ratio.
- A provision detailing allowed delegation of care.
- Minimum requirements for health record keeping and reporting.
- A provision allowing care by all school employees in the event of a medical emergency.

A model statute is contained in Appendix D.

Endnotes

¹The *Individuals with Disabilities Education Act* (IDEA) was enacted in 1974 to address the educational needs of children with disabilities (20 U.S.C. § 1400 et seq.).

² National Center for Education and Statistics. *2005 Digest Tables: Table 50. Percentage of Youth Ages 3–21 Served under the Individuals with Disabilities Education Act (IDEA), by Disability: Selected Years, 1976–77 through 2005–06*, available at http://nces.ed.gov/programs/digest/2005menu_tables.asp.

³ National Center for Education and Statistics. *2005 Digest Tables: Table 52. Number and percentage of children served under Individuals with Disabilities Education Act, Part B, by age group and state or jurisdiction: Selected years, 1990–91 through 2005–06*, available at: http://nces.ed.gov/programs/digest/2005menu_tables.asp

⁴ See Sheniz A. Moonie, et al., *Asthma Status and Severity Affects Missed Days of School* 18, 1 JOURNAL OF SCHOOL HEALTH (2006); American Lung Association. *Trends in Asthma Morbidity and Mortality. Epidemiology and Statistics Unit, 2003* NATIONAL HEART, LUNG, AND BLOOD INSTITUTE. GUIDELINES FOR THE DIAGNOSIS AND MANAGEMENT OF ASTHMA: EXPERT PANEL REPORT NO.2 NIH PUBLICATION 97-4051 (July 1997); D.M. Manino, et al., *Surveillance for Asthma—United States, 1960–1995*, Centers for Disease Control and Prevention (1998).

⁵ *California Obesity Prevention Initiative*. CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES AND THE CALIFORNIA DEPARTMENT OF HEALTH, available at www.dhs.ca.gov/cdic/copi/html/problem.htm.

⁶ *Id.*

⁷ *Id.*

⁸ Kevin McCoy, *School Blamed in Boy's Death*, USA TODAY, December 13, 2005 (hereinafter McCoy), available at www.usatoday.com/news/nation/2005-12-13-nurse-hernandez-side_x.htm.

⁹ Barbara Bloom, M.P.A. and Robin A. Cohen, Ph.D. *Summary Health Statistics for U.S. Children: National Health Interview Survey, 2006*. 10: 64 VITAL AND HEALTH STATISTICS. United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics (September 2007).

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¹⁰ Susan H. Babey, Ying-Ying Meng, E. Richard Brown and Theresa A. Hastert, *Nearly Six Million Californians Suffer from Asthma Symptoms or Asthma-like Breathing Problems*, UCLA CENTER FOR HEALTH POLICY RESEARCH, Health Policy Research Brief (October 2006).

¹¹ *California Employer Health Benefits Survey 2007*. CALIFORNIA HEALTHCARE FOUNDATION, available at www.chcf.org.

¹² “Poor” is 100% of the Federal Poverty Line (FPL) or below. “Near Poor” is 100–199% of the FPL.

¹³ UCLA Center for Health Policy Research, Findings from the 2005 California Health Interview Survey (Los Angeles, CA: July 2007) at 62, 65, available at www.healthpolicy.ucla.edu/pubs/files/SHIC_RT_072807.pdf.

¹⁴ California Health Interview Survey (CHIS 2005) results as summarized in: E. Richard Brown, Ph.D., et al., “Section 3: Children’s Insurance Coverage” in *The State of Health Insurance in California*, UCLA CENTER FOR HEALTH POLICY RESEARCH, Health Policy Fact Sheet (July 2007).

¹⁵ *California Employer Health Benefits Survey 2007*. CALIFORNIA HEALTHCARE FOUNDATION, available at <http://www.chcf.org>.

¹⁶ *Id.*

¹⁷ The program description is available at www.cms.hhs.gov/home/medicaid.asp.

¹⁸ *Id.*

¹⁹ The program description is available at www.medi-cal.ca.gov/.

²⁰ The program description is available at www.cms.hhs.gov/home/schip.asp.

²¹ The program description is available at www.healthyfamilies.ca.gov/English/about.html.

²² *Id.*

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ *California: Health Insurance Coverage of Children 0–18, States (2005–2006)*, KAISER COMMISSION ON MEDICAID AND THE UNINSURED (January 2008), available at <http://statehealthfacts.org>.

²⁹ *Id.*

³⁰ *California: Health Insurance Coverage of Children 0–18 Living in Near Poverty (100–199% FPL), States (2005–2006)*, KAISER COMMISSION ON MEDICAID AND THE UNINSURED (January 2008), available at <http://statehealthfacts.org>.

³¹ *California: Health Insurance Coverage of Children 0–18 Living in Poverty (under 100% FPL), States (2005–2006)*, KAISER COMMISSION ON MEDICAID AND THE UNINSURED (January 2008), available at <http://statehealthfacts.org>.

³² *California Health Interview Survey* (CHIS 2005) results as summarized in Shana Alex Lavarreda, E. Richard Brown, Jean Yoon, and Sungching Glenn, *More Than Half of California’s Uninsured Children Eligible for Public Programs But Not Enrolled*, UCLA CENTER FOR HEALTH POLICY RESEARCH, Health Policy Fact Sheet (October 2006).

Seven of ten uninsured children are eligible for Medi-Cal, Healthy Families (SCHIP) or one of the 14 county-based “Healthy Kids” programs. Less than 220,000 children are uninsured and not eligible for public coverage.

³³ California is one of twelve states with a rate of uninsured low income children that is above 21%. See *Health Coverage for Low-Income Children*, KAISER COMMISSION ON MEDICAID AND THE UNINSURED (January 2007), available at www.kff.org/kcmu.

³⁴ See note 32, *supra*.

³⁵ M.E. Rimzsa, R.J. Butler and W.G. Johnson, *Impact Of Medicaid Disenrollment On Health Care Use And Cost*, 119 PEDIATRICS No. 5, e1026–32 (2007).

³⁶ *Id.*

³⁷ Barbara Bloom, M.P.A. and Robin A. Cohen, Ph.D. *Summary Health Statistics for U.S. Children: National Health Interview Survey, 2006*, 10:64 VITAL AND HEALTH STATISTICS. United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics (September 2007).

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ U.S. Census Bureau. STATE AND COUNTY QUICKFACTS, available at <http://quickfacts.census.gov/qfd/states/06000.html>.

⁴¹ U.S. Census Bureau. 2006 AMERICAN COMMUNITY SURVEY, available at <http://factfinder.census.gov/>.

⁴² U.S. Centers for Disease Control and Prevention. COMMON CORE DATA (for the 2005–06 school year), available at <http://nces.ed.gov/ccd/>.

Nationwide, the estimated number of students enrolled in public elementary and secondary schools for the 2007–2008 school year was 49.6 million. *National Center for Education and Statistics, Table 3-1. Public school enrollment in prekindergarten through grade 12, by grade level and region, with projections: Various years, fall 1965–2016*, available at <http://nces.ed.gov/programs/coe/2007/section1/table.asp?tableID=663>.

⁴³ *California School Becomes Notorious for Epidemic of TB*, THE NEW YORK TIMES (July 18, 1994).

⁴⁴ Centers for Disease Control, *Outbreak of Measels — San Diego, California, January–February 2008*. 57 MORBIDITY AND MORTALITY WEEKLY REPORT, 1-4 (February 22, 2008), available at cdc.gov/mmwr/preview/mmwrhtml/mm57e222a1.htm.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *See, e.g.*, 42 U.S.C. § 280g, which entices states to allow self-administration of asthma medication.

⁴⁸ K.M. Buston and S.F. Wood. *Non-Adherence Amongst Adolescents With Asthma: Listening To What They Tell Us About Self-Management*. 17 FAMILY PRACTITIONER, 134–38. ; H. Kyngas And M. Rissanen *Support As A Crucial Predictor Of Good Adherence Of Adolescents With A Chronic Disease*, 10 J CLIN NURS, 767–774 (2001).

⁴⁹ *Id.*

⁵⁰ *See* Lani Wheeler, et. al. *Managing Asthma In Schools: Lessons Learned And Recommendation*, 77 JOURNAL OF SCHOOL HEALTH, 350 (2006).

⁵¹ J.D. Key, et. al. *Reduced Emergency Department Utilization Associated with School-Based Clinic Enrollment*, 30 JOURNAL OF ADOLESCENT HEALTH, 273–8 (2002).

⁵² 45% of children with a chronic illness fall behind in school work, 58% miss school, and 10% miss more than a quarter of the school year. K.M. Thies, *Identifying the Educational Implications of Chronic Illness In School Children*, 69 JOURNAL OF SCHOOL HEALTH, 392–97 (2006). *See also* Howard Taras and Williams Potts-Datema, *Chronic Health Conditions and Student Performance at School*, 75 JOURNAL OF SCHOOL HEALTH, 255 (2004).

⁵³ *See* Sheniz A. Moonie, et al., *Asthma Status and Severity Affects Missed School Days*, JOURNAL OF SCHOOL HEALTH, Vol. 76, No. 1 (Jan. 2006); American Lung Association. *Trends in Asthma Morbidity and Mortality. Epidemiology and Statistics Unit, 2003*, NATIONAL HEART, LUNG, AND BLOOD INSTITUTE. GUIDELINES FOR THE DIAGNOSIS AND MANAGEMENT OF ASTHMA: EXPERT PANEL REPORT NO.2 NIH PUBLICATION 97-4051 (July 1997); D.M. Manino, et al., *Surveillance for Asthma—United States, 1960–1995*, Centers for Disease Control and Prevention (1998).

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ C.D. Erickson, et al., *The Healthy Learner Model For Student Chronic Condition Management Part II: The Asthma Initiative*, 22 JOURNAL OF SCHOOL NURSING, 319–29 (2006).

⁵⁷ Taras and Williams Potts-Datema, *Chronic Health Conditions and Student Performance at School*, *supra* note 52.

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ See <http://www.schoolhealthcenters.org>.

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ See <http://www.nasn.org>.

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ See Appendix B: Survey of California School Nurses, Administrators and Others, *infra* (hereinafter *CAI Survey*).

⁷⁰ See Section 3.1.1.2 for further details.

⁷¹ *Id.*

⁷² James H. Price, et al., *Elementary School Secretaries' Experiences and Perceptions of Administering Prescription Medication*, 73 JOURNAL OF SCHOOL HEALTH, 373 (2003).

⁷³ 76.5% of states have a policy related to who may administer medications to students at school:

74.5% of states allow administration by school nurses;
53.1% of states allow administration by teachers;
45.2% of states allow administration by school health aides; and,
58% of states allow administration by other school staff.

SHPPS: School Health Policies and Programs Study 2006 (hereinafter *SHPPS 2006*), Centers for Disease Control — National Center for Chronic Disease Prevention and Health Promotion, available at www.cdc.gov/HealthyYouth/SHPPS/.

⁷⁴ *CAI Survey*, *supra* note 69. Several respondents indicated that the policy is ignored when school administrators or school nurses are not present.

⁷⁵ 66.7% of states that allow administration by staff other than nurses/physicians have a policy that the administration must be directly delegated by the nurse/physician who has an oversight role.

⁷⁶ Karen B. Farris, et al., *Issues of Medication Administration and Control in Iowa Schools*, JOURNAL OF SCHOOL HEALTH, 73(9):331-7 (2003).

⁷⁷ See *McCoy*, *supra* note 8.

⁷⁸ A nebulizer is a device for treating asthma that is more efficient than an inhaler. It delivers medication in the form of a liquid mist and is commonly used for asthma and other respiratory diseases.

⁷⁹ *McCoy*, *supra* note 8.

⁸⁰ *Id.* Since Phillip's death, the school has launched an aggressive training program to help school personnel deal with severe asthma attacks properly.

⁸¹ *McCoy*, *supra* note 8.

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *McCoy*, *supra* note 8.

⁸⁶ The amount was reduced to \$2.24 million by the trial judge. In an unpublished decision, a California court of appeal upheld the decision (*Gonzalez v. Hanford Elementary School District* (2002) 2002 Cal. App. Unpub. LEXIS 1341, 2002 WL 1033719).

⁸⁷ *Id.* See also the case of Steve Martinez, a fourth grader who suffered an epileptic seizure in 2005. CPR was delayed because no one was adequately supervising the boy. When CPR was finally performed, it was by the playground supervisor who had not had training since the 1960s. *Jury Awards \$7.6M for Playground Seizure*, Associated Press (April 9, 2007).

⁸⁸ The U.S. Department of Health and Human Services has recommended a school nurse-to-student ratio of 1:750 in its Healthy People 2010 goals (i.e., one full-time nurse for every 750 **mainstreamed** students). U.S. Department of Health and Human Services. HEALTHY PEOPLE 2010, 2nd ed.; *With Understanding and Improving Health and Objectives for Improving Health*, (Washington, DC: U.S. Government Printing Office; November 2000), available at www.health.gov/healthypeople.

A "mainstreamed student" is a student who does not have health needs severe enough to be covered by the Individuals with Disabilities Education Act (20 U.S.C. § 1400 et seq.), which requires that schools make accommodations for a student's condition in order to allow the student access to public education. See *Right To Free Appropriate Public Education*, 78A C.J.S. SCHOOLS AND SCHOOL DISTRICTS § 702; *Medical Services in General*, 78A C.J.S. SCHOOLS AND SCHOOL DISTRICTS § 703. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 701 et. seq.) provides similar access to extracurricular activities.

In its survey of school health, the Centers for Disease Control and Prevention defined a "full-time nurse" as a nurse who is on campus for thirty or more hours a week. The study is available at www.cdc.gov/healthyyouth/shpps/index.htm. A narrative summary of the results can be found in Nancy D. Brener, PhD., et al., *Health Services: Results From the School Health Policies and Programs Study 2006*, 77 JOURNAL OF SCHOOL HEALTH 464, 476-77(2007).

Only about one-third of schools have full-time nurses onsite at all times students are present. Many of these schools do not meet the required 1:750 ratio. SHPPS 2006, *supra* note 73. See also Susan K. Telljohaan, et al., *Access to School Health Services: Differences between Full-time and Part-Time School Nurses*, 20 JOURNAL OF SCHOOL HEALTH 176-181 (2004) (finding significant unmet needs in schools with part-time nurses).

⁸⁹ *CAI Survey*, *supra* note 69.

⁹⁰ E.J. Bradley, *Establishing a Research Agenda for School Nursing*, 14 JOURNAL OF SCHOOL NURSING, 4-13 (1998). The study analyzed average values across 47 states.

⁹¹ They also often underestimate the severity of their child's condition. *Wheeler*, *supra* note 50.

⁹² Martha Guttu, et al., *Does the School Nurse-to-Student Ratio Make a Difference?*, 74 JOURNAL OF SCHOOL HEALTH, 6-9 (2001).

⁹³ S.K. Telljohann, et al., *Access to School Health Services: Differences between Full and Part-Time School Nurses*, 20 JOURNAL OF SCHOOL NURSING, 176-81 (2004).

⁹⁴ S.K. Telljohaan, et al., *Effect of Full-Time Versus Part-Time School Nurses on Attendance of Elementary Schools with Asthma*, 20 JOURNAL OF SCHOOL NURSING, 331-34. (2004).

⁹⁵ L. Foster, *Implementing an Over-The-Counter Medication Administration Policy In An Elementary School*, 22 JOURNAL OF SCHOOL NURSING, 108-113 (2006).

⁹⁶ Gay Allen, *The Impact of Elementary School Nurses on Student Attendance*, 19 JOURNAL OF SCHOOL NURSING, 225-31 (2003); L. Wyman, *Comparing the Number of Ill or Injured Students Who Are Released Early From School by School Nursing and Non-nursing Personnel*, 21 JOURNAL OF SCHOOL NURSING, 350-55 (2005).

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⁹⁷ George Fryer and Judith B. Igoe, *A Relationship Between Availability of School Nurses and Child Well-Being*, 11 JOURNAL OF SCHOOL NURSING, 12–18 (1995).

⁹⁸ Studies have shown that teachers have a lower expectation of students with chronic illnesses and thus treat them differently. *See, e.g.,* A.L. Olson, et al., *School Professionals' Perceptions about the Impact of Chronic Illness in the Classroom*, 158 ARCH. PEDIATR. ADOLESC. MED., 53–58 (2004).

⁹⁹ During the 2005–06 school year, fewer than 400 schools employed a full-time nurse. Data from the California Department of Education's Data Quest reporting program, available at <http://dq.cde.ca.gov/dataquest/>.

¹⁰⁰ SHPPS 2006, *supra* note 73.

¹⁰¹ For current figures on the population and gross state products, *see* U.S. Department of Commerce: Bureau of Economic Analysis. *Bear Facts: BEA Regional Fact Sheet* available at www.bea.gov/regional/index.htm. The Tennessee law regarding school nurses can be viewed at www.michie.com/tennessee/. Sections T. C. A. § 49-3-359 and T. C. A. § 68-1-1201 et. seq. address the school nurse program.

While Tennessee has a comprehensive law, the state's actual ratios do not meet the 1:750 recommendation because the mandates are not funded adequately. *Healthy Children Learn Better! School Nurses Make a Difference*, brochure from the National Association of School Nurses, available at www.nasn.org.

¹⁰² The top five states in terms of meeting the school nurse-to-student ratio well exceed it: Vermont's ratio is 1:298; New Hampshire's ratio is 1:376; the District of Columbia's ratio is 1:434; Connecticut's ratio is 1:504; and Delaware's ratio is 1:506 students. In contrast, California ranks 44th with a 1:2,230 school nurse-to-student ratio. Only Ohio, Oregon, Idaho, Oklahoma, North Dakota, Michigan and Utah fare worse. *See Healthy Children Learn Better! School Nurses Make a Difference*, *supra* note 101.

¹⁰³ SHPPS 2006, *supra* note 73. California does employ an administrator to work in the area of school health, but it is not statutorily required to do so.

¹⁰⁴ CAL. EDUC. CODE § 1750 provides that “[t]he county superintendent of schools *may*, with the approval of the county board of education, employ one or more supervisors of health, as supervisors of health” (emphasis added).

¹⁰⁵ SHPPS 2006, *supra* note 73.

¹⁰⁶ *Id.*

¹⁰⁷ Over 86% of schools have a school nurse serving the school either on a part-time or full-time basis (SHPPS 2006, *supra* note 73).

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ CAL. EDUC. CODE §§ 44267.4, 49426, 80050; SHPPS 2006, *supra* note 73.

¹¹¹ CAL. EDUC. CODE §§ 44267.4, 49426, 80050; SHPPS 2006, *supra* note 73.

¹¹² SHPPS 2006, *supra* note 73.

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ *Id.*

¹¹⁶ 34 C.F.R. § 104

¹¹⁷ SHPPS 2006, *supra* note 73.

¹¹⁸ *Id.* *See also* CAL. EDUC. CODE §§ 33319 (health screening), 49403 (communicable disease and immunization requirements), 49405 (smallpox control), and 49406 (examination for tuberculosis).

¹¹⁹ SHPPS 2006, *supra* note 73.

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¹²⁰ SHPPS 2006, *supra* note 73

¹²¹ *K. C., et al., v. Jack O'Connell*, Case No. C-05-4077 MMC, U.S. District Court for the Northern District of California. It is most probable that unlicensed, voluntary school employees with appropriate training should only act in emergency situations pursuant to CAL. BUSINESS AND PROFESSIONS CODE § 2727(d).

¹²² The California Department of Education (CDE) posted a *Legal Advisory on the Right of Students with Diabetes in California's K-12 Public Schools* addressing the matter. It is available at www.cde.ca.gov/lb/he/hn/legaladvisory.asp.

¹²³ SHPPS 2006, *supra* note 73.

¹²⁴ 88% of states allow self-administration for prescription quick-relief inhalers (SHPPS 2006, *supra* note 73).

¹²⁵ 66% of states allow self-administration for epinephrine auto-injectors (SHPPS 2006, *supra* note 73).

¹²⁶ 42% of states allows self-administration for insulin/similar injected medication; 28% of states allow self-administration of other prescribed medications; and 20% of states allow self-administration of OTC medications (SHPPS 2006, *supra* note 73).

¹²⁷ CAL. EDUC. CODE §§ 49423, 49423.1.

¹²⁸ CAL. EDUC. CODE § 49414.

¹²⁹ 5 CCR § 600 et. seq.

¹³⁰ CAL. EDUC. CODE § 49413.

¹³¹ SHPPS 2006, *supra* note 73.

¹³² A global nursing shortage currently exists. Fewer nurses are entering the field at a time when the need for nurses is increasing. Less than 10% of the total number of working nurses is under 30. By 2011 the number of nurses exiting the profession will exceed the number entering. Government and private initiatives to correct the problem are underway, but the existence of the shortage does affect schools in the short-term as they compete with hospitals and private firms who can pay more to hire top-quality nurses. See *Tri-Council for Nursing Policy Statement*, National League for Nursing (2002), available at www.nln.org/aboutnln/news_tricouncil2.htm; M. Johnson, *Choosing Where We're Going By Knowing Where We Are: Results Of The 2002 Membership Survey*, 17(6) NASN NEWSLETTER, 18-19 (November 2002); *Projected Supply, Demand, And Shortages Of Registered Nurses: 2000-2020*, U.S. Department of Health and Human Services, Health Resources and Services Administration (July 2002), available at <ftp://ftp.hrsa.gov/bhpr/nationalcenter/rnproject.pdf>.

¹³³ *Rankings and Estimates: Rankings of the States 2006 and Estimates of School Statistics 2007*, National Education Association Report, available at www.nea.org/research/index.html.

¹³⁴ *Id.*

¹³⁵ In the CAI Survey (Appendix B), several administrators responded to questions with variations of "It is not the responsibility of school's to perform."

¹³⁶ See Appendix B for a complete analysis of the responses.

¹³⁷ Many CAI Survey respondents echoed these sentiments:

"School principal DOES NOT believe in school nursing."

"General attitude on the part of administrators that anyone can safely provide any kind of healthcare to student."

¹³⁸ Many respondents echoed these sentiments:

"We have a superintendent who is focused solely on test scores and told the nursing department that we are not a part of his educational plan."

"Superintendent does not feel nurses are important to his educational plan."

"Our Superintendent has made it clear that he does not see School Nurses as a priority need in our district. He sees education

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as a priority need. He does not see the connection between school health and education.”

¹³⁹ 30.1% of respondents felt that lack of funds was an obstacle to reporting and review of reports.

¹⁴⁰ See, e.g., *Cedar Rapids Community School Dist. v. Garret F. ex. rel. Charlene F.*, 526 U.S. 66 (1999) (holding that continuous nursing services required by a disabled students were “related services” that had to be provided under the Individuals with Disabilities Education Act (IDEA)); *Irving Independent School Dist v. Tatro* (1984) 468 U.S. 883 (holding that school nursing services are not excluded medical services under the IDEA).

¹⁴¹ CAL. EDUC. CODE §§ 49400, 49427.

¹⁴² See, e.g., CAL. ED. CODE § 44955(d)(1)) (acknowledging that some schools will be without school nurses); CAL. ED. CODE § 49414 (allowing for provision of auto-injectors in situations where “the school does not have a school nurse”).

¹⁴³ See, e.g., CAL. EDUC. CODE § 49412 (Tobacco Surtax); § 35294.13 (School Safety Grants); § 33319 (School Health Days).

Similarly, the IDEA does not require the presence of a school nurse on the team assessing the individuals needs even though the notes from the Committee on Labor and Human Resources states that there are situations where a licensed nurse would be necessary (20 U.S.C. § 1401).

¹⁴⁴ 42 U.S.C.S. § 280g (granting preference for states that allow self-treatment of asthma).

¹⁴⁵ CAL. EDUC. CODE §§ 49480, 49423.

¹⁴⁶ 45 C.F.R. § 1304.22 (allowing for administration of medication by “trained staff member(s)” under the Head Start program).

¹⁴⁷ CAL. EDUC. CODE § 44065.

¹⁴⁸ See, e.g., CAL. EDUC. CODE § 49412.5(a)(1)-(2) (allowing individuals with special needs to be assisted by either credentialed individuals or by other trained personnel if under the supervision of a school nurse, licensed physician or certified public health nurse); 5 C.C.R. § 601 (allowing “school nurse or other designated personnel” to assist students with medication if authorized by a physician); CAL. EDUC. CODE § 49414 (allowing specially-trained personnel to use epinephrine auto-injectors); CAL. EDUC. CODE § 49414.5 (allowing other school personnel to volunteer to assist diabetic students in emergencies).

¹⁴⁹ CAL. EDUC. CODE § 49412.5(a)(1)-(2).

¹⁵⁰ CAL. EDUC. CODE § 4423.5(a)(2), 5 C.C.R. § 3051.12.

¹⁵¹ See, e.g., CAL. EDUC. CODE § 49423.5 (allowing certified public health nurses to supervise assistance of individuals with special needs); 25 C.C.R. § 51190.3 (generally allowing nursing services be provided by a “certified public health nurse”).

¹⁵² CAL. EDUC. CODE § 49402; CAL. HEALTH & SAFETY CODE § 101425

¹⁵³ See, e.g., CAL. EDUC. CODE § 49423.5 (allowing outside physicians and nurses to supervise assistance of individuals with special needs), CAL. EDUC. CODE § 49452.5 (allowing mandatory scoliosis testing to be contracted out); CAL. EDUC. CODE § 49413 (allowing CPR training program to be outsourced).

Appendix A: Comprehensive School Health Model

States that acknowledge that student health is an integral part of their educational mission typically focus on health education, physical education, nutrition services, and mental health/social services.¹ While these efforts are important, there are other areas of student health that have been neglected for far too long. A truly comprehensive school health model includes:

1. Health Education;
2. Physical Education;
3. Health Services;
4. Nutrition Services;
5. Mental Health/Social Services;
6. Healthy and Safe School Environment;
7. Health Promotion for Faculty and Staff; and,
8. Family and Community Involvement.²

The focus of the present study is on the third element — Health Services.

In addition to the overly narrow focus by most states, the default operating mode at the local level is to proactively provide only those health services mandated by the state and to provide reactive care when students become ill or injured.³ This does not have to be so. A proactive approach that embraces a holistic approach is possible. Those studies that address proactive approaches to School Health Services take one of three approaches:

- The *Medical Home* Model, which treats the school as an expansion of the child healthcare system. (e.g., School Based Health Centers)
- The *Access* Model, which serves to get children into healthcare outside the school by screening and diagnosis of potential problems. (e.g., screening and referrals)
- The *Add-on* Model, which provides care that essentially duplicates care provided outside the school context.⁴

Irrespective of which model is used, studies suggest that health services school be provided to both students and faculty/staff, including:

- Health education and counseling;
- Screening and referral;
- Care plan development/case plan management;
- Administration of medications;
- Care for acute, chronic and episodic conditions;
- Emergency care;

- Access to community resources; and,
- Outreach to the community.⁵

In addition, it is advisable that nurses or other medical personnel sit on any committee that affects/is affected by student health, such as Section 504 Plans, IEP/IHP Plans, and those affecting student athletes.

Appendix A Endnotes

¹ See *SHPPS: School Health Policies and Programs Study 2006* (hereinafter *SHPPS 2006*), Centers for Disease Control — National Center for Chronic Disease Prevention and Health Promotion, available at www.cdc.gov/HealthyYouth/SHPPS/ for a detailed comparison of school health programs by state as well as selected districts and schools.

² D. Allensworth & Lloyd J. Kolbe *The Comprehensive School Health Program: Exploring an Example Concept*, 57 JOURNAL OF SCHOOL HEALTH, 409 (1987). The Allensworth-Kolbe model has been widely accepted for over 20 years. The CDC supports this model. See *Coordinated School Health Program*, available at <http://www.cdc.gov/healthyyouth/cshp/>.

The California Department of Education also supports this model. See *Building Infrastructure for Coordinated School Health: California's Blueprint*. Available at www.cde.ca.gov/ls/he/cs/present.asp.

³ See, e.g., *A CDC Review of School Laws and Policies Concerning Child & Adolescent Health*, 78 JOURNAL OF SCHOOL HEALTH, 90-94 (2008); “Financing School-Based Health Centers” available at <http://www.healthinschools.org/static/papers/ninestrategies.aspx>; Nancy D. Brener, PhD, et. al. *Health Services: Results from the School Health Policies and Programs Study 2006*, 77 JOURNAL OF SCHOOL HEALTH, 464-85 (2007).

⁴ *Id.*

⁵ *Id.*



Appendix B: Survey of California School Nurses, Administrators and Others

In 2007–08, the University of San Diego School of Law’s Children’s Advocacy Institute conducted an extensive survey of California school nurses, administrators, and others; almost 500 individuals responded.¹

1. Characteristics of Schools and Survey Respondents

1.1. Characteristics of Schools in the Survey

The survey respondents represented schools from different types and sizes of districts spread throughout the state.² Survey respondents represented urban (27.0%), suburban (41.9%) and rural (19.4%) schools. A majority of respondents worked primarily at elementary schools (58.5%), but junior high schools (30.8%) and high schools (28.5%) were also well represented. School enrollment ranged from the mid-teens to several thousand, with an average of 2,600 students.

1.2. Characteristics of the Survey Respondents

Almost 42% of survey respondents were school nurses. School principals and assistant principals accounted for the next largest group of respondents at just over 22%. School board members, school clerical and administrative staff, school health staff and other faculty and staff also responded to the survey.³

2. School Health Policy and Practice

2.1. Health of Students as a District Priority

Respondents were asked to rank the importance of student health to the district choosing from the following options:

1. The school district views the health of students as a very high priority.
2. The school district views the health of students as one of several priorities.
3. The school district is neutral toward student health.
4. Through action or inaction, the school district undermines student health.
5. Do not know/no opinion.

A slight majority of respondents (54.5%) chose the second option. When analyzing the results by role, clear differences of opinion became evident. School Board members were the only group that felt health was a high priority.⁴ All other groups felt it was one of several priorities, except for district nurse respondents, who often felt that the district was undermining student health.

Health of Students as a District Priority (By Type of Respondent)

	School Nurse	Principal/ Assistant Principal	School Board/ Administration	Health Aide/Other Healthcare	District Nurse	Office/ Support Staff	Teacher
High priority	11.3%	26.9%	51.6%	22.0%	0.0%	12.5%	1.8%
One of several priorities	59.3%	60.6%	41.9%	51.2%	28.6%	56.3%	43.6%
Neutral	17.0%	6.7%	3.2%	17.1%	28.6%	0.0%	25.5%
Undermines	13.4%	4.8%	0.0%	4.9%	42.9%	18.8%	23.6%

2.2. Daily Provision of Healthcare

2.2.1. Individuals Providing Healthcare to Students on a Daily Basis

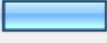




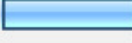




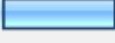
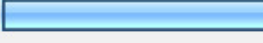


Respondents were asked to identify individuals providing daily care to students. A majority (64.5%) reported that school staff provided such care. Less than a quarter reported that a dedicated, full-time credentialed school nurse provided care. More respondents (27.2%) reported that care was provided by school administration than by a dedicated, full-time credentialed school nurse.

2.2.1.1. Differences Between Schools

High schools reported the provision of care by a “dedicated full-time credentialed school nurse” more frequently than elementary or junior high schools. High schools reported a 39.7% provision rate, whereas elementary schools reported only a 21.2% provision rate and junior high schools reported a 32.9% provision rate.

Elementary schools reported provision of care by “school support staff” more frequently than junior high or high schools; elementary schools reported a 70.1% provision rate, junior highs a 64.3% provision rate and high schools a 56.3% provision rate.

Individuals Providing Healthcare to Students on a Daily Basis (All Respondents)

		Response Percent	Response Count
Dedicated full-time physician		0.0%	0
Dedicated full-time credentialed school nurse		24.7%	112
Dedicated full-time RN		9.1%	41
Dedicated full-time LPN or LVN		5.3%	24
Other dedicated full-time medical personnel(with some formal training/certification)		10.4%	47
Part-time physician		0.9%	4
Part-time credentialed school nurse		31.8%	144
Part-time RN		10.8%	49
Part-time LPN or LVN		2.0%	9
Other Part-time medical personnel(with some formal training/certification)		15.5%	70
External medical service		2.0%	9
School-administration		27.2%	123
School support staff		64.5%	292
Faculty		21.4%	97
Other		22.3%	101
	answered question		453
	skipped question		44

2.2.1.2. Responses Marked “Other”

The survey included an “other” category for this question. A follow-up question allowed respondents to describe other individuals who provided healthcare to students on a daily basis. The results were surprising. Several respondents indicated that classroom aides provided healthcare. One respondent indicated that a plant manager and security personnel provide healthcare to students on a routine basis.

2.2.2. Types of Healthcare Routinely Provided by School Personnel

Very few schools (3.3%) restrict individuals who are not physicians or credentialed school nurses from providing any healthcare at all. At almost all schools, non-nurses are providing some type of routine care for students.

2.2.2.1. First Aid and CPR

As one might expect, trained individuals routinely provide first aid in a vast majority (89.7%) of schools. Even those without training render first aid in over a third of schools (33.9%).

In spite of state funding and support for training in cardiopulmonary resuscitation (CPR),⁵ only a slight majority (54.4%) of schools report individuals other than school nurses provide this type of care. Perhaps the number of individuals trained to provide CPR is higher, but respondents felt they were not performing CPR frequently enough.

2.2.2.2. Assessment of Students and Administration of Care

2.2.2.2.1. Asthma, Allergies and Diabetes

Asthma is the most widespread health issue in American schools.⁶ Almost 15% of school children will be diagnosed with asthma at some point in their lives.⁷ The California Legislature has acknowledged the issue in the California Education Code.⁸

According to survey respondents, a majority of schools (58.9%) allow non-nurses to assess students for asthma and respiratory distress. Two thirds of schools (66.4%) also allow school personnel to administer inhaled medications, which would include asthma medications. It is unclear the extent of training non-nurses have before being allowed to assess and treat asthma. As the case of Phillip Hernandez has shown, merely allowing non-nurses to treat student asthma attacks is not enough to protect student welfare.⁹



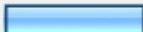





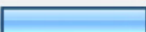

Care of students with diabetes and allergies has also received attention from the media and from the state. In spite of the recent settlement regarding the management of diabetes in schools,¹⁰ a majority of schools still rely on the school nurse to assess and treat students for diabetes-related issues. Similarly, a majority of schools do not provide for non-nurse assessment or treatment of students with severe allergic reactions, even though the issue has received attention from the state legislature.¹¹ While many of these health issues do require the expertise of a school nurse or other certified health practitioner, the absence of school nurses in many schools means that students are often left without any care at all.









2.2.2.2.2. Other Types of Assessment and Care

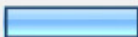









For other types of assessment and care, there was no single health issue that was assessed or treated in a majority of districts. Some schools allowed non-school nurses to administer rectal medications (6.8%) and perform many services traditionally associated with trained and certified healthcare providers, including urinary tract catheterization (15.7%), gastric tube/feeding tubes (16.8%), colostomy/ostomy care (6.3%), airway suctioning (9.8%).


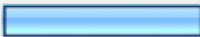









**Types of Routine Care Provided by Individuals
Other than Physicians and Nurses (All Respondents)**

		Response Percent	Response Count
Such individuals are not allowed to provide any healthcare. They are not authorized to provide any of the care listed below.		3.3%	14
First aid (with some training)		89.7%	384
First aid (without some training)		33.9%	145
CPR		54.4%	233
Assessment of student for medications prescribed on an "as needed" basis- Asthma or other respiratory distress		58.9%	252
Assessment of student for medications prescribed on an "as needed" basis- Seizure activity		26.6%	114
Assessment of student for medications prescribed on an "as needed" basis- High blood sugar (diabetes)		39.0%	167
Assessment of student for medications prescribed on an "as needed" basis- Low blood sugar (diabetes)		45.3%	194
Assessment of student for medications prescribed on an "as needed" basis- Pain or distress		35.3%	151
Assessment of student for medications prescribed on an "as needed" basis- Severe allergic reactions		49.3%	211

Assessment of student for medications prescribed on an "as needed" basis- Other symptoms or signs.		30.8%	132
Assessment of student for over-the-counter medications available to students on an "as needed" basis- Pain or distress (e.g., headache, menstrual cramps)		34.6%	148
Assessment of student for over-the-counter medications available to students on an "as needed" basis- Nausea		17.1%	73
Assessment of student for over-the-counter medications available to students on an "as needed" basis- Mild allergic symptoms or cold symptoms		27.8%	119
Assessment of student for over-the-counter medications available to students on an "as needed" basis- Sore throat		20.8%	89
Assessment of student for over-the-counter medications available to students on an "as needed" basis- Skin problems requiring topical cream/lotion (e.g, itchiness, insect bites)		30.8%	132
Assessment of student for over-the-counter medications available to students on an "as needed" basis- Need for sun screen		18.0%	77
Assessment of student for over-the-counter medications available to students on an "as needed" basis- Other		10.5%	45

Administration of over-the-counter medications available to students on an "as needed" basis- Pain or distress (e.g., headache, menstrual cramps)		32.2%	138
Administration of over-the-counter medications available to students on an "as needed" basis- Nausea		16.4%	70
Administration of over-the-counter medications available to students on an "as needed" basis- Mild allergic symptoms or cold symptoms		27.8%	119
Administration of over-the-counter medications available to students on an "as needed" basis- Sore throat		21.3%	91
Administration of over-the-counter medications available to students on an "as needed" basis- Skin problems requiring topical cream/lotion (e.g, itchiness, insect bites)		29.9%	128
Administration of over-the-counter medications available to students on an "as needed" basis- Need for sun screen		18.7%	80
Administration of over-the-counter medications available to students on an "as needed" basis- Other		15.2%	65
Administration of routine or "as needed" medications- Oral medications		61.4%	263
Administration of routine or "as needed" medications- Inhaled medications		66.4%	284
Administration of routine or "as needed" medications- Rectal medications (e.g., Diastat)		6.8%	29

Administration of routine or “as needed” medications- Injection or pump-delivery of non emergency medications (e.g., Insulin)		17.3%	74
Administration of routine or “as needed” medications- Injection of emergency medications (e.g., epinephrine, glucagons)		47.9%	205
Administration of routine or “as needed” medications- Other		22.2%	95
Administration of epinephrine shots		36.2%	155
Medical Procedures- Urinary Tract Catheterization		15.7%	67
Medical Procedures- Gastric tube /feeding tubes		16.8%	72
Medical Procedures- Colostomy or other ostomy care		6.3%	27
Medical Procedures- Assistance with oxygen		6.8%	29
Medical Procedures- Suctioning of airway		9.8%	42
	<i>answered question</i>		428
	<i>skipped question</i>		69

3. The Effect of School Healthcare Policy

3.1. Adequacy of Care

3.1.1. Allocation of Healthcare Responsibilities

Survey respondents were asked to rate the adequacy of the daily allocation of healthcare responsibilities. They were given four choices:

1. The daily allocation of healthcare services excellently serves the needs of our students.
2. The daily allocation of healthcare responsibilities adequately serves the needs of our students.
3. The daily allocation of healthcare responsibilities does not serve the needs of our students.
4. The daily allocation of healthcare responsibilities fails the needs of our students.

A majority of respondents chose the second option.

3.1.1.1. Differences between Urban, Suburban and Rural Districts

Urban districts most frequently indicated that the daily allocation of healthcare responsibilities did not serve the needs of their students (37.5%). Both rural (47.3%) and suburban (39.2%) districts most frequently indicated that the allocation of healthcare responsibilities was adequate to serve the needs of their students.

3.1.1.2. Differences Based on Type of Respondent

There was a clear difference in perspective based on the role of the respondent in the school system. Principals, school board members, health aides and office support staff viewed the allocation of healthcare responsibilities as adequate. School nurses viewed the allocation as “not serving” the student bodies. Surprisingly, district-level nurses *and teachers* viewed the allocation of healthcare responsibilities as failing students.

Adequacy of Daily Allocation of Healthcare Responsibilities (By Type of Respondent)

	School Nurse	Principal/ Assistant Principal	School Board/ Administration	Health Aide/ Other Healthcare	District Nurse	Office/ Support Staff	Teacher
Excellent	12.6%	6.8%	12.9%	17.5%	0.0%	0.0%	3.6%
Adequate	36.3%	49.5%	51.6%	60.0%	14.3%	50.0%	16.4%
Does not serve	43.2%	34.0%	29.0%	17.5%	14.3%	25%	36.4%
Fails	8.4%	8.7%	0.0%	2.5%	71.4%	6.0%	41.8%

3.1.2. Adequacy of Emotional, Mental and Social Health Services

Survey respondents were asked to rate the adequacy of the daily allocation of healthcare responsibilities. They were given four choices:

1. The daily allocation of mental and social services excellently serves the needs of our students.
2. The daily allocation of mental and social services adequately serves the needs of our students.
3. The daily allocation of mental and social services does not serve the needs of our students.
4. The daily allocation of mental and social services fails the needs of our students.

A majority of respondents chose the second option.

3.1.2.1. Differences between Urban, Suburban and Rural Districts

The results were consistent with those for the question on the allocation of healthcare responsibilities. Urban districts most frequently chose that the emotional, mental healthcare provided by the schools was not adequate (40.5%). Rural (43.3%) and suburban (41.1%) districts most frequently chose that services were adequate.

3.1.2.2. Differences based on Type of Respondent

The results based on type of respondent were similar to the results for the daily allocation of healthcare responsibilities. However, district nurses and school teachers were less pessimistic on mental health issues, with a plurality choosing that the services do not serve students adequately rather than choosing that the services fail students.

Adequacy of Emotional, Mental and Social Health Services (By Type of Respondent)

	School Nurse	Principal/ Assistant Principal	School Board/ Administration	Health Aide/ Other Healthcare	District Nurse	Office/ Support Staff	Teacher
Excellent	9.4%	7.7%	16.1%	22.0%	0.0%	6.3%	3.6%
Adequate	44.5%	42.3%	48.4%	48.8%	14.3%	31.3%	30.9%
Does not serve	39.8%	37.5%	25.8%	26.8%	42.9%	25%	38.2%
Fails	6.8%	11.5%	6.5%	2.4%	28.6%	18.8%	27.3%

3.2. Adequacy of Health Service Staffing

3.2.1. Adequacy of Staffing Levels

A majority of respondents (50.3%) felt that staffing levels were inadequate. Less than a third (27.5%) felt staffing was merely “adequate”. Only a few respondents chose the extremes: 9.1% felt that staffing was “excellent” and 13.1% felt that staffing was “very poor.”

3.2.2. Adequacy of Staffing Levels (By Type of Respondent)

While school principals and administrators felt that the daily allocation of healthcare responsibilities was adequate, they felt that the staffing levels were inadequate. Perhaps this is because they feel they are doing the best with what they have, but they would also like to hire additional personnel if they could afford to.

Only health aides and office support staff were most likely to report that staffing levels were adequate. In some respects, these answers might be self-interested because hiring of additional school nurses can mean hiring of fewer health aides and office staff. Surprisingly, 34.1% of health aides, the individuals most likely to be hired in lieu of school nurses, felt the staffing levels were inadequate. Consistent with their answers to other questions, district nurses tend to be the most cynical group, with a vast majority responding that staffing levels were “inadequate” or “very poor.”

Adequacy of Staffing Levels (By Type of Respondent)

	School Nurse	Principal/ Assistant Principal	School Board/ Administration	Health Aide/ Other Healthcare	District Nurse	Office/ Support Staff	Teacher
Excellent	10.5%	5.8%	6.5%	19.5%	0.0%	6.3%	5.5%
Adequate	22.5%	36.5%	32.3%	43.9%	14.3%	37.5%	12.7%
Inadequate	59.2%	45.2%	51.6%	34.1%	42.9%	31.3%	45.5%
Very Poor	8.9%	11.5%	6.5%	2.4%	42.9%	25%	36.4%

3.2.3. Reasons Why Staffing is Inadequate

3.2.3.1. Primary Reason Staffing is Inadequate

A majority of respondents cited lack of funds as the primary reason that staffing levels were inadequate. This held across all respondent groups, but was most strong among school board and administration, as 72.7% cited lack of funds as the principal reason school health staffing was inadequate. Some individuals, particularly school nurses, district nurses, and teachers who felt that School Board values were the primary reason that staffing was inadequate.

Given recent media coverage and scholarly attention to on the global nurse shortage,¹² a surprisingly low number (8.0%) of individuals cited a “shortage of nurses”.

Primary Reason Staffing is Inadequate (By Type of Respondent)

	School Nurse	Principal/ Assistant Principal	School Board/ Administration	Health Aide/ Other Healthcare	District Nurse	Office/ Support Staff	Teacher
Lack of funds	59.6%	64.2%	72.7%	54.8%	57.1%	41.7%	47.2%
Shortage of nurses	6.6%	6.2%	18.2%	6.5%	14.3%	0.0%	9.4%
Low enrollment	2%	6.2%	9.1%	3.2%	0.0%	8.3%	0.0%
School Board	21.2%	4.9%	0.0%	6.5%	28.6%	16.7%	22.6%
Other	6.0%	2.5%	0.0%	3.2%	0.0%	8.3%	0.0%
Adequate	4.6%	12.3%	0.0%	12.9%	0.0%	8.3%	7.5%

3.2.3.2. Additional Reasons Staffing is Inadequate

When asked to cite additional reasons why staffing is inadequate, a majority (64.7%) cited the lack of funds or budgeting issues. Some respondents vented their frustration in the open-ended follow-up question:

“MAA and LEA MediCal...has helped fund critically needed services. This funding is being threatened with no replacement funding. This will be devastating to health services.”

“None of our nursing time is funded from the general budget. Two years ago, the school board decided to remove the one full-time nurse manager salary from the general budget and put her time into "soft money" (i.e., grants). Now there is no nursing time in the general budget and the grants are not being renewed due to a change in administration.”

Over a third of respondents (34.8%) cited the school board's values. Almost a third (30.3%) chose the shortage of nurses, a problem exacerbated by low salaries offered to school nurses. According to survey respondents:

“The salaries are not competitive with what nurses can make outside the school district.”

“[Nurses] registered in California have a higher income than school nurses are offered. We have difficulty recruiting and retaining staff because of the low salary offered. The rule of supply and demand comes into play here...”

“Salaries are inadequate to attract experienced, certificated nurses - the only ones we get are totally green (I was.) Also, the student/nurse ratio, until this year was 5500/1. This year there was an additional position, which reduced it to 3500/1. As soon as we get staff, they leave due to the inability to handle all that needs to be done. A second problem is the salary. I cannot support myself on the present salary levels, which are commensurate with the teachers' [salaries].... I had a choice — either own a car or pay the rent — what kind of salary is that??? Over half of staff are single parents and salaries are totally inadequate for the responsibility involved. I've been here three years and am totally burned out, and am leaving as soon as I find another job.”

With respect to the opinion of the school board, individual respondents often felt that student healthcare was not a priority, or that the district decision makers did not really understand what was necessary to adequately care for students. Respondents indicated that:

“We have a superintendent who is focused solely on test scores and told the nursing department that we are not a part of his educational plan.”

“Superintendent does not feel nurses are important to his educational plan.”

“Our Superintendent has made it clear that he does not see School Nurses as a priority need in our district. He sees education as a priority need. He does not see the connection between school health and education. At my school site we are adequately staffed. This is a rare occurrence. I have worked at many different school sites in this district and this is the first time I have felt that I have been adequately staffed in the nurse's office.”

“District is in Program Improvement. Everything having to do with anything not directly

related to getting the district out of program improvement is frowned upon.”

“[The] [p]rincipal, school staff and board members are not aware of what happens in [the] health office. [The] [p]rincipal does not want to be involved and only becomes involved when there is a complaint or problem. [The] [s]taff on site have no idea what [the] school nurse/health office staff do on a daily basis despite repeated advice and are so overwhelmed with their own workloads they do not have time to become involved. They think we only see "traffic" which is only a small portion of our responsibility. They refuse or resist to work in Health Office and want a nurse or aide in the health office so they don't have the responsibility but don't have or won't take the time to speak out to administration or board members. [The] [p]rincipal [is] too busy dealing with other issues on campus.”

“I have an office assistant, however the selection of staff was not mine. I do not feel that this staff member shares the same level of commitment to the health needs of the students as I do.”

3.2.3.3. “Other Reasons” Why Staffing is Inadequate

The staffing shortfall questions were followed by an open-ended question that allowed respondents to cite additional reasons why school staffing was inadequate. Respondents cited a lack of state involvement and focus on the increasing number of children with special needs.

“[There is a] [l]ack of state direction (required vs. recommended) regarding quantity and quality of care.”

“Increasing need for professional services in diabetic care”

“Increase in chronic illnesses in the student population like diabetes, seizures, asthma.”

“The staff we have great staff and all doing a good job, but the need exceeds what we can provide based on the large numbers of needy children. They have many complex social needs which exceed the capabilities of any school to provide but which seriously impact the students' ability to learn. We need another full-time nurse, more counselors, more tutors and more police on campus. We also could use our own clinic and more after school programs and academic support for those in need.”

“The acuity of health problems is going up as more medically fragile children are saved. Their needs are more complex and the school district finds it less costly to keep the children in the district. However, the staffing needs to increase to meet these children's needs.”

“This year School X has several medically fragile students enrolled. Our School Nurse is a consummate professional and is scrambling to do her best to handle the serious and complex issues that accompany an insulin dependent diabetic kindergartener and a 5th grader who is a wheelchair bound hemophiliac. The School Nurse is assigned to two elementary schools and coincidentally, there is another insulin dependent diabetic at the other site. Both diabetics require daily blood monitoring. It is helpful that her health tech. assists with these issues one day a week in her absence at our site and she has also trained one of the consenting Instructional Aides to perform this task. However, The School Nurse is having to travel back and forth between both sites most days in order to monitor and stabilize various medical challenges. I believe we urgently require an additional day of nursing time at School X. Technology and miraculous medical innovations make it possible

for children with very serious health challenges to be able to attend public schools and that is a very positive thing for our school to have these children in attendance. However, School X desperately needs additional nursing support to guarantee the safety and welfare of these students with special needs.”

4. Negative Outcomes Caused by Lack of a School Nurse

4.1. Negative Outcomes to Date

Almost a third of respondents (29.9%) reported that there were “no negative effect on student health, however, the figure is much lower as several respondents later chose to report specific negative outcomes.

The most frequent negative outcome was stress on staff (46.4%). A significant number of respondents also reported that students were absent (41.1%) and/or underachieving (37.9%). Almost a third of respondents (31.0%) reported that 911 were called in situations that would have been treatable at the school if proper staff were available.

Unfortunately, respondents indicated that severe negative outcomes like the death of Phillip Hernandez had occurred at their school: 40 respondents reported adverse health effect from lack of care, 3 reported permanent injury that might not have happened had proper care been rendered at school and 6 reported fatalities that may have been avoided through adequate staffing.

4.1.1.Differences Based on Type of School

Urban schools and high schools were most likely to resort to 911 calls. Urban respondents reported more frequent resort to emergency care/911 services (45%) than rural (25.8%) or suburban (29.7%) respondents. High school respondents also report 911 calls more frequently (35.5%) than did elementary (28.3%) or junior high (27.8%) school respondents.

High school respondents most frequently report no negative outcomes (56.3%).¹³ For high schools reporting negative outcomes, the most frequently reported outcome was student absence (43.5%).

4.1.2.Differences Based on Type of Respondent

Principals (40.8%) and health aides (45.0%) were most likely to report no negative health outcomes.

School nurses, district nurses, office staff and teachers reported student absence and performance issues. In a follow-up question, respondents indicated that they felt there was a correlation between absence and performance:

“[For most of today’s children] [n]urse services are paramount to students achieving their full academic potential.”

“High rates of absenteeism with no one checking up on kids.”

“Lower API scores/AYP results from too many students missing too many classes due to unresolved or even bogus health issues.”

Surprisingly, district nurses (85.7%) and school teachers (44.4%) were more concerned with staff distraction than office and support staff (37.5%) were. Perhaps it is because they feel under-trained, over-burdened and fear accountability if they make a mistake. Other respondents indicated a general state of confusion as to what staff is allowed to do. Many nurses echoed this sentiment and added that staff broke the rules when not supervised.

“Our campus is large. Teachers are often first responders and must be trained in first aid, epipen, seizure safety and diabetes reactions. Teachers should administer emergency meds, like epipens instead of waiting for the ‘nurse’ to arrive.”

“Staff Members do not want to provide healthcare to individuals because it is time consuming and they do not feel it should be their responsibility. They fear sometimes that they might do something wrong. The School District does not require them to be trained for health services, yet expects them to care for students' health in the absence of the School Nurse or health clerk.”

“Policies on OTCs¹⁴ are all over the place from never allow without a parental or doctor note to pretty much anyone can assess and give to a child.”

“Staff break the rules when the nurse isn't present.”

“Some staff break this rule when the nurse is not present.”

“I feel the answer I put is so only when the school health assistants are given proper training yearly and work under the supervision of a certificated school nurse WHO IS PRESENT at the facility where these individuals are assessing, administering, etc.”

4.1.3. “Other” Negative Outcomes

The negative outcome question was followed by an open-ended question that allowed respondents to report additional negative outcomes. Respondents reported that 911 was called needlessly, that appropriate care was delayed, or that inappropriate care was rendered.

Called 911 Instead of Providing Appropriate Care

“Call 911 needlessly.”

“UAP's have called 911 unnecessarily.”¹⁵

Appropriate Care was Delayed

“Obvious lack of ‘true’ care that made students wait until parents could be reached to take them to medical assistance, up to 3 hours at times.”

“Child became ill with a fever. There was no nurse to administer Tylenol or Motrin and the parent could not be reached. The child suffered for hours before a parent finally was able to come to the school.”

Inappropriate Care

“Children with fractures and one child with viral meningitis were sent back to class without parent being notified.”

“Injured student was inappropriately cared for due to lack of assessment at the scene. (Encouraged to walk to health office after a head injury with LOC, another student returned to P.E. prematurely causing further injury”

“Children sent home for pink eye when not necessary. Inhalers used inappropriately. There was a medication error with a diabetic student.”

“Dr. orders for a diabetic student were not followed unless the nurse was present.”

“Diabetic students with low blood glucose under-perform in class because UAP do not understand the complexities of diabetes. Staff has gone to the union because they were fearful of child with complex medical needs in their class. “









Additional Insightful Responses





“There are probably outcomes that I will never hear of because they are lost in the shuffle esp. at the high schools!”

“We are reactive instead of proactive. I mainly deal with the current crisis, with little time for follow-up.”

“Hospitalization, medication error, litigation.”

Negative Outcomes Caused by Lack of a School Nurse (All Respondents)

No- There have not been any negative effect on student health.		29.9%	134
Yes- Student was sent outside of school for health services that could have been provided by trained personnel onsite.		18.3%	82
Yes-Student went to emergency care/911 was called.		31.0%	139
Yes-Student suffered adverse health effects/injury was worsened by lack of immediate care.		8.9%	40
Yes-Student was permanently and severely impacted by lack of immediate care. (e.g. became disabled, lost major function, etc.)		0.7%	3
Yes- Student fatality that might have been prevented by immediate care by trained personnel.		1.3%	6
Yes- Many students have been absent from school for apparent illness, without a nurse to investigate the validity and work with students' parent and doctor to increase attendance.		41.1%	184
Yes- Many students have been underachieving relative to their academic potential, possibly from health-related problems (such as: sleep disorders, poor sleep, depression, attention-related problems, violence in the home, intermittent pain, nutrition-related, other undiagnosed issues), because staff could not refer this student to a school nurse with time to assess the		37.9%	170

situation and intervene.			
Yes- Medical orders from doctors have been misinterpreted or left unquestioned because no medical personnel was there to detect the problem. This has caused school to overspend on resources in some cases or underserve a student's needs in other cases.		16.1%	72
Yes- Staff members (teachers, front-office secretaries) have been stressed or otherwise distracted from their other functions (teaching, school administration) because of fear or time-consuming issues related to caring for health-related issues, in the absence of a school nurse.		46.4%	208
Yes- Other		3.3%	15
Do not know/no opinion		6.0%	27
	answered question		448
	skipped question		49

Negative Outcomes Caused by Lack of a School Nurse (By Type of Respondent)

	School Nurse	Principal/ Assistant Principal	School Board/ Administration	Health Aide/ Other Healthcare	District Nurse	Office/ Support Staff	Teacher
None	26.2%	40.8%	33.3%	45.0%	0.0%	31.3%	14.8%
Student sent outside	23.6%	4.8%	60.0%	10.0%	57.1%	25.0%	13.0%
Emergency/911 call	3.9%	27.2%	40.0%	22.5%	71.4%	37.5%	29.6%
Adverse health effect/worsened injury	11.0%	4.9%	13.3%	2.5%	28.6%	12.5%	3.7%
Permanent/severe impact	0.5%	0.0%	6.7%	0.0%	0.0%	0.0%	0.0%
Fatality	2.6%	0.0%	3.3%	0.0%	0.0%	0.0%	0.0%
Absent without investigation	49.2%	29.4%	36.7%	25.0%	85.7%	43.8%	40.7%
Underachieving	45.5%	26.2%	33.3%	22.5%	85.7%	25.0%	44.4%
Medical orders not followed	24.6%	3.9%	16.7%	7.5%	71.4%	0.0%	11.1%
Staff distracted, etc.	57.6%	32.0%	50.0%	27.5%	85.7%	37.5%	44.4%

4.2. Potential for Serious Negative Outcome

When asked whether the provision of healthcare in their school was likely to lead to “a serious adverse outcome, given time”, a majority of respondents (56.5%) answered in the affirmative. School nurses, district nurses and teachers felt a serious adverse outcome was more likely than not. Principals, administration, health aides, and office support staff reported that a serious adverse outcome was not likely. However, almost half of school board respondents (48.1%) did feel a serious adverse response was likely. Thus, while respondents’ choices were shaped by their roles, principals, administrators and health aides were not as positively slanted toward the status quo as one might expect.

Potential for Serious Negative Outcome (By Type of Respondent)

	School Nurse	Principal/ Assistant Principal	School Board/ Administration	Health Aide/ Other Healthcare	District Nurse	Office/ Support Staff	Teacher
Likely to be adverse	65.9%	40.2%	48.1%	47.4%	71.4%	42.9%	66.7%
Not likely to be adverse	34.1%	59.8%	51.9%	52.6%	28.6%	57.1%	33.3%

5. Provision of Services Beyond State Mandates and Emergencies

In order to gauge whether schools were doing only the bare minimum, respondents were asked whether their school provided any screening services beyond the state mandated, how the schools handled immunization reporting, and whether schools kept injury and illness reports.

5.1. Health Screening

5.1.1. Health Screening Beyond Mandate

A significant percentage of schools (45.4%) provide dental screenings to students. While schools are required to perform basic hearing and vision tests, over a quarter of schools (26.1%) provide enhanced screening that goes beyond this mandate. Few schools provided any other type of health screening to their students.

5.1.2. Health Screening Services

5.1.2.1. Adequacy of Health Screening Services

Almost half of respondents (49.4%) felt that the health screening at their school was adequate to serve student needs. Over a quarter of respondents (27.6%) felt that the health screening was not serving the needs of the students. Few respondents felt that health screening was excellent (7.1%) or a complete failure (8.6%). Only a few respondents (2.6%) felt that it was not the responsibilities of schools to screen.

Surprisingly, district nurses and teachers were the most pessimistic group. Over a third of teachers (35.7%) felt that the health screening failed the needs of students. Perhaps this is because teachers see the direct impact of vision, hearing, and other health issues on the abilities of students to learn.

Adequacy of Health Screening (By Type of Respondent)

	School Nurse	Principal/ Assistant Principal	School Board/ Administration	Health Aide/ Other Healthcare	District Nurse	Office/ Support Staff	Teacher
Excellent	8.8%	2.9%	16.7%	15.4%	0.0%	0.0%	0.0%
Adequate	50.8%	55.9%	50.0%	56.4%	42.9%	42.9%	26.2%
Does not serve	30.4%	27.5%	23.3%	15.4%	28.6%	28.6%	26.2%
Fails	6.1%	3.9%	3.3%	2.6%	28.6%	14.3%	35.7%
Not the responsibility of schools	1.7%	3.9%	3.3%	0.0%	28.6%	0.0%	7.1%

5.1.2.2. Obstacles to Adequate Health Screening Services

Even though most respondents felt that screening was adequate, a significant percentage (44.5%) felt that resource problems were the primary driver of inadequate screening.¹⁶ Several respondents indicated that the problem was not one of screening, but one of follow-up with parents.

They felt that additional personnel would ensure that parents took the issue seriously and provided the child with health services.

5.2. Immunization

5.2.1. Responsibility for Immunization Recordkeeping and Compliance

School nurses share immunization responsibilities with health aides and school secretaries. About a third (33.9%) of schools reported that immunization compliance was largely the responsibility of school secretarial or administrative support staff. Over a quarter (26.0%) of schools place responsibility in the hands of school nurses, however, slightly more schools (29.6%) assign the duty to a health aide.

5.2.2. Adequacy of School Immunization Screening Services

A majority of respondents (55.6%) feel that immunization screening services are adequate to serve the needs of students. Consistent with answers provided to other survey questions, many respondents, including those that did not feel service provision was inadequate, felt that lack of funds were the primary obstacle to providing adequate services.¹⁷

5.3. Illness and Injury Reporting

5.3.1. School Reporting Requirements

There is no majority pattern with respect to school reporting and review. Almost a third of respondents (32.8%) reported that their schools filed and reviewed injury and illness reports. A significant number of schools either do not file reports (23.9%) or do not review the reports regularly (23.1%).

5.3.2. Adequacy of School Reporting Requirements

A majority of respondents (58.7%) felt that the reporting was adequate. Consistent with answers provided to other survey questions, many respondents, including those that did not feel service provision was inadequate, felt that lack of funds were the primary obstacle to providing adequate services.¹⁸

Appendix B Endnotes

¹ There were a total of 497 respondents. Some of the questions could be skipped and will have a total response count of less than 497.

² Analysis of self-reported zip codes revealed a spread of schools throughout the state.

³ The exact response rates are as follows:

School Nurse	41.9%
Other Health Personnel	8.3%
Principal/ Assistant Principal	22.4%
School Board Member/ Administrator	6.5%
School Secretary/ Administrative Staff	3.4%
Other Staff	13.1%

⁴ For a thorough analysis of the perception of California school board members and other district leaders, *see* California School Boards Association, *Providing School Health Services in California: Perceptions, Challenges and Needs of District Leadership Teams* (2008), available at: <http://www.csba.org/NewsAndMedia/Publications/Other%20Newsletters/LinkToLearning/2008/Fall/InThisIssue/ResearchProvidingSchoolHealthServices.aspx>.

⁵ CAL. EDUC. CODE § 49413.

⁶ Asthma and obesity are the two most frequent medical conditions for American children, but obesity does not produce emergency situations at the same rate as asthma (*see* note 48 to main report, *supra*).

⁷ A.N. Dey and B. Bloom. *Summary of Health Statistics of U.S. Children: National Health Interview Survey, 2003* (2005) 10 VITAL HEALTH AND STATISTICS 1-78.

⁸ *See* CAL. EDUC. CODE § 49423.1.

⁹ *McCoy, supra*.

¹⁰ *K. C., et al., v. Jack O'Connell*, Case No. C-05-4077 MMC, U.S. District Court for the Northern District of California.

¹¹ CAL. EDUC. CODE § 49480.

¹² *See, e.g.*, Ken Dixon. *Nurse Shortage Affecting Elder Care*, THE CONNECTICUT POST (3/2/08) available at http://www.connpost.com/localnews/ci_8423459; Sreekanth Chaguturu, M.D., and Snigdha Vallabhaneni, B.A. *Aiding and Abetting — Nursing Crises at Home and Abroad*, 354 THE NEW ENGLAND JOURNAL OF MEDICINE, 1648-1649 (2005); Sreekanth Chaguturu, M.D., and Snigdha Vallabhaneni. *Curing the Nursing Shortage —The Role of Compensation*. 354 THE NEW ENGLAND JOURNAL OF MEDICINE, 1648-1649 (2006).

¹³ Elementary schools reported no negative outcomes in 26.8% of cases and junior high schools reported no negative outcomes in 26.1% of cases.

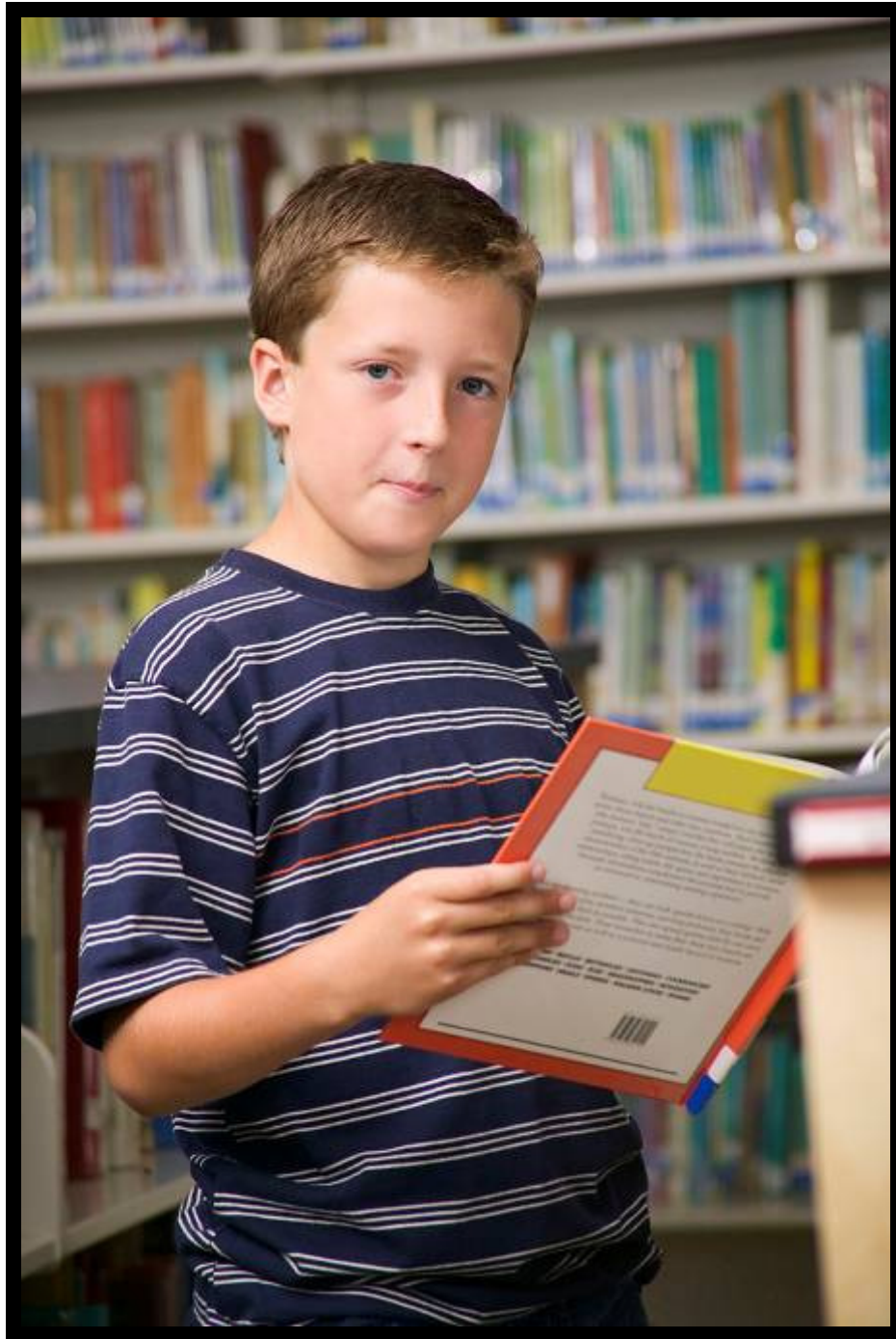
¹⁴ OTC is an acronym for “Over the Counter” medication.

¹⁵ UAP is an acronym for “unlicensed assistive personnel”.

¹⁶ No other option received a significant response rate.

¹⁷ 26.9% of respondents felt that lack of funds was an obstacle to providing adequate immunization services.

¹⁸ 30.1% of respondents felt that lack of funds was an obstacle to reporting and review of reports.



Appendix C: Medical Analysis of Report

By Liana Gefter, MD

December 16, 2008

Introduction: Why School Nurses Are Medically Necessary

Children and adolescents constitute a medically vulnerable group because they lack control over their health care and maintenance.

School nurses serve several important roles to ensure the health of school-age children and adolescents. In the case of uninsured children and/or children without access to healthcare, school nurses fill a gap to ensure basic health needs are met. For all children, school nurses play an important role in many areas including: management of chronic illnesses, management of acute exacerbations of chronic illnesses, managing acute illnesses, dispensing medication, providing first aid, addressing school absences due to illness, improving health education, precluding unnecessary emergency 911 calls, helping enroll students in state health insurance programs, and serving as a point person to manage reporting about student safety and individual student well being.¹

School nurses are necessary and cannot be replaced by substitutes such as teachers, administrative staff, or other school personnel because training and an ability to provide focused attention affect health outcomes². Adequate training is essential to provide competent and safe medical care. The importance of training is often subtle but vital. For example, although tasks like administering over the counter medications may seem routine or simple, medical training is necessary to assess a student's health status, understand an individual student's medical history, properly dose the medication, consider drug interactions, and understand contraindications to use.

Additionally, when addressing the health care needs of a child or adolescent, it is essential that the health care provider's attention is completely focused on that child or adolescent. Distraction by other duties or other students is unacceptable and can lead to medical errors. For that reason, asking school staff including teachers, secretaries, or in some instances, even security guards to care for the health needs of children and adolescents is irresponsible and unsafe³.

Management of Acute Illness, Acute Exacerbations of Chronic Illness, and Chronic Illness

In the management of acute illness or acute exacerbation of a chronic illness, assessment of a student's health status (how sick is this child?) is necessary for appropriate management and to ensure the well being of the student. Expertise is needed to properly assess a student's health status, and the only way to ensure proper assessment is to have credentialed, trained professionals making the assessments. For the purpose of this analysis, management of chronic illness, management of acute injury, and student health status assessment will be emphasized.

Children and adolescents suffer from a variety of serious chronic illnesses. Among the most common are asthma and diabetes. Serious allergic reaction is not as common, but preparation for serious allergic reaction is essential due to the life-threatening nature of the event. Injury is the most common cause of child and

¹ Role of the School Nurse in Providing School Health Services. Council on School Health. *Pediatrics* 2008;121;1052-1056.

² National Association of School Nurses. *Position Statement: Education, Licensure, and Certification of School Nurses*. Silver Spring, MD: National Association of School Nurses; 2002.

³ Kamei, Shelly Ann. 'The Health of California's School Children: A Case of State Malpractice, Children's Advocacy Institute at the University of San Diego School of Law, 2008.

adolescent morbidity and will be discussed here for that reason. For the purposes of this analysis, asthma, diabetes, allergy, and injury will be discussed. The purpose of this discussion is to underscore the idea that although these illnesses may be commonplace occurrences among school-age children and adolescents, improper assessment of a student's health status in these conditions can lead to harmful mismanagement and poor health outcomes. These illnesses will be used as examples of the need for trained nurses in schools with the understanding that many other conditions exist for which the expertise of a school nurse would be necessary.

Asthma

Asthma is the most common chronic disease of children in the United States. Routine management of asthma in school-age children often requires the administration of inhaled medications. Delivery of asthma medication is challenging even for medical professionals; in fact, up to two-thirds of patients and healthcare professionals do not use proper technique when delivering inhaled asthma medications⁴. Improper technique in the administration of inhaled steroids (common asthma treatment) can lead to decreased effectiveness of the medication and more side effects like fungal infections⁵. Inhaled beta-2 agonists (another common asthma treatment) come with a black box warning that medication administration may lead to a worsening of asthma symptoms due to increased spasm of the smooth muscles of the airway and could result in death if the patient is not properly monitored and assessed in that situation.⁶ For this reason alone, it is also important that the person administering medication have time and ability to monitor the child or adolescent after administration of medication⁷.

Additionally, for many meter-dosed inhalers, the person administering the medication must keep track of the number of doses administered in order to determine when the inhaler is empty and needs to be replaced. Improper monitoring of quantity of medication can lead to a situation where medication is required but not available.

In the management of respiratory distress seen in asthma, a trained professional is necessary to make a proper assessment of a child's respiratory status (often to determine whether the child needs a more advanced level of care). The person assessing a child's respiratory status should be trained to take a history of medication use; listen for wheezing or other respiratory sounds with a stethoscope; look for air entry, skin retractions, nasal flaring, and skin discoloration; and observe the respiratory rate and general appearance⁸. Children and adolescents can die from poorly managed asthma exacerbations. Therefore, it is essential that a trained professional be available to assess them.

Diabetes

Type I diabetes is one of the most common chronic diseases of childhood, and the incidence of type II diabetes is on the rise. Etiology and management of type I and type II diabetes varies greatly, but for the purposes of this analysis, they will be discussed jointly. It is well documented that children and adolescents with diabetes have better control of blood sugar with direct supervision and support in their diabetes management. Children and adolescents who assume too much responsibility for their care have significantly

⁴ Inhalation treatment: errors in application and difficulties in acceptance of the devices are frequent in wheezy infants and young children. Marguet C; Couderc L; Le Roux P; Jeannot E; Lefay V; Mallet E. *Pediatr Allergy Immunol* 2001 Aug;12(4):224-30.

⁵ Toogood, JH, Jennings, B, Greenway, RW, Chuang, L. Candidiasis and dysphonia complicating beclomethasone treatment of asthma. *J Allergy Clin Immunol* 1980; 65:145.

⁶ www.fda.gov/cder/drug/advisory/LABA.htm.

⁷ National Asthma Education and Prevention Program: Expert panel report III: Guidelines for the diagnosis and management of asthma. Bethesda, MD: National Heart, Lung, and Blood Institute, 2007. (NIH publication no. 08-4051).

⁸ National Asthma Education and Prevention Program: Expert panel report III: Guidelines for the diagnosis and management of asthma. Bethesda, MD: National Heart, Lung, and Blood Institute, 2007. (NIH publication no. 08-4051).

poorer control over their health.⁹ The presence of a trained school nurse is important in the management of children and adolescents with diabetes because administration of medication alone is not adequate to care for diabetic students. A trained professional understands the severity of long term complications that occur if tight blood sugar control is not maintained and the life-threatening nature of dangerously low blood sugar. A professionally trained nurse recognizes the nuances of management. For example, a trained nurse knows that for a diabetic student, common illnesses like a stomach bug can lead to a dangerous drop in blood sugar requiring adjustment of medication dosage and nutritional plan¹⁰. Additionally, a school nurse can serve as an advocate for students who may have learning or other cognitive problems as a result of challenges with low blood sugar¹¹.

Allergy

Allergy is common in childhood, and although many forms of allergy exist, for the purposes of this analysis, serious allergic reaction that can be fatal (known as anaphylaxis) will be discussed. Serious allergic reactions are becoming more frequent in the United States¹², but the diagnosis of a serious allergic reaction can be challenging because it mimics other common allergic reactions¹³. Although administration of epinephrine for initial management of serious allergic reactions is possible by an untrained person, a trained professional is needed to rapidly diagnose, recognize the urgency, and begin initial management of serious allergic reactions in order to prevent negative outcomes.

Injury

Injuries are one of the most common causes of child and adolescent morbidity, and are the leading cause of death and disability¹⁴. The role of the school nurse is essential for both prevention and treatment of injury. The most effective means of managing childhood injury is prevention¹⁵. The school nurse plays an important role in injury prevention through both education and assessment of safety in the school and surrounding area. Although the American Academy of Pediatrics and American Academy of Family Physicians agree that counseling regarding injury prevention is critical for child and adolescent health, time constraints in physicians' offices prevents adequate prevention counseling¹⁶. The school nurse plays a vital role in closing the gap of injury prevention education. Additionally, the school nurse plays an important role in environmental safety monitoring for hazards on school property. Unintentional falls and being unintentionally struck are the leading causes of non-fatal childhood and adolescent injury¹⁷. These injuries are often preventable with adequate safety monitoring of environmental hazards. Lastly, the school nurse is an important first responder in the case of child injury during the school day. The school nurse has the training to perform an initial evaluation of a child's injury using the principle of primary and secondary survey that is

⁹ Fonagy, P, Moran, GS, Lindsay, MK, et al. Psychological adjustment and diabetic control. *Arch Dis Child* 1987; 62:1009.

¹⁰ Clarke, W, Jones, T, Rewers, A, et al. Assessment and management of hypoglycemia in children and adolescents with diabetes. *Pediatr Diabetes* 2008; 9:165.

¹¹ McAulay, V, Deary, IJ, Ferguson, SC, Frier, BM. Acute hypoglycemia in humans causes attentional dysfunction while nonverbal intelligence is preserved. *Diabetes Care* 2001; 24:1745.

¹² Neugut, AI, Ghatak, AT, Miller, RL. Anaphylaxis in the United States. An investigation into its epidemiology. *Arch Intern Med* 2001; 161:15.

¹³ Moneret-Vautrin DA, Morisset M, Flabbee J, Beaudouin E, Kanny G. Epidemiology of life-threatening and lethal anaphylaxis: a review. *Allergy* 2005; 60:443.

¹⁴ Murphy SL. Deaths: final data for 1998. *Natl Vital Stat Rep* 2000;48:1--106.

¹⁵ Gardner, HG. Office-based counseling for unintentional injury prevention. *Pediatrics* 2007; 119:202.

¹⁶ Quinlan, KP, Sacks, JJ, Kresnow, M. Exposure to and compliance with pediatric injury prevention counseling--United States, 1994. *Pediatrics* 1998; 102:E55.

¹⁷ Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2004). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer).

recognized as being the most effective method for evaluating trauma and is standard practice in the medical field¹⁸. Using the primary and secondary survey, the school nurse can determine the injury extent, type, and severity and recommend the most appropriate next steps in providing care.

General Health Screening

General health screenings are critical for all children, especially those without access to routine medical care. Simple screening for vision, hearing, and BMI, along with other various screening exams (i.e. tuberculosis, sexually transmitted infections, lead toxicity, iron deficiency, oral health) can prevent serious long term health consequences and improve a child's ability to partake successfully in the education system¹⁹. Prevention of complications is more effective and efficient than acute management. Trained professionals are necessary to adequately screen for preventable illnesses. Especially because students from poor families lack access to healthcare at much higher proportions than those of affluent families, providing adequate health screenings in public schools can begin to address the marked disparities in the health of poor versus affluent children in the United States²⁰.

Regulation of Health Records

Regulating the health records of students is another important role for school nurses because school nurses act as liaisons between students, parents, health care providers, and the community. For many students who do not have regular access to healthcare, the school nurse can be the bridge to receiving necessary health services, whether they are screening exams, physical exams, or immunizations. Even for students who do have access to health care, the school nurse plays an important role as an advocate for each student's health. For any students with medical illnesses or disabilities, the school nurse understands the health history of a student and unique needs of the student within the school environment. This knowledge makes the school nurse a critical contributor to a student's IEP (individualized education plan)²¹.

Immunization Verification

In the US, it is estimated by the American Academy of Pediatrics that 35 million teenagers are missing one or more doses of vaccines that they should have received in childhood. In addition to being susceptible to dangerous illnesses themselves, unvaccinated children pose a health risk to other students in the school. Recent studies show even for children who have access to healthcare, parents are often unclear about the immunization history of their children²². For these reasons, maintaining and verifying immunization records of students is critical.

Medical Importance of Reporting Procedures

In order to ensure the health and well being of students, there must be a system in place for teachers and other staff to report observations of student well being. Whether the observations are about behavioral,

¹⁸ Lee, L, Fleisher, G. Approach to the initially stable child with blunt or penetrating injury. In: UpToDate, Basow, DS (Ed), UpToDate, Waltham, MA, 2008.

¹⁹ Rationale and Evidence. In: Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd ed. Hagan, JF, Shaw, JS, Duncan, PM (Eds). American Academy of Pediatrics, Elk Grove Village, IL 2008. p. 221.

²⁰ Transdisciplinary Teams in Primary Care for the Underserved: A Literature Review. Journal of Health Care for the Poor and Underserved - Volume 16, Number 2, May 2005, pp. 248–256.

²¹ Role of the School Nurse in Providing School Health Services. Council on School Health. *Pediatrics* 2008;121;1052-1056

²² Luman ET, Ryman T, Sablan M. Estimating vaccination coverage: Validity of household-retained vaccination cards and parental recall. Vaccine. Oct. 2008 [Epub ahead of print.] Global Immunization Division, National Center for Immunization and Respiratory Diseases, US Centers for Disease Control and Prevention, United States.

physical, or other changes in a student's well being, addressing these changes early can significantly improve a student's chances of getting help and avoiding poor outcomes. In schools without school nurses, there may be no person designated to receive and manage reports, and for that reason, students with health challenges may not get the attention they need. Additionally, the school nurse can serve as a contact person for reporting student injury at school. Injury reporting is necessary for safety assessment and prevention of future injury²³.

Education

Health education in schools is critical to help fight the growing trends of childhood illness related to obesity, lack of physical activity, poor nutrition, poor sleep, substance abuse, and other pressing issues. According to the New England Journal of Medicine's reporting in 2005 and other similar reports since, the current generation of students is the first in recent history with a lower life expectancy than their parents. The need for prevention through health education cannot be overstated, and the school nurse serves an important role in educating students, parents, and community members about health issues that significantly impact the lives of students²⁴.

Specific Procedures – Potential for Harm When Treatment Administered Without Adequate Training

As confirmed by the study conducted by Shelly Ann Kamei through the Children's Advocacy Institute at the University of San Diego School of Law, many schools in the state of California have inadequate or no school nursing staff. As a result, numerous health care related tasks are relegated to individuals with little or no medical training. Allowing untrained staff to assess student health status, dispense medication, and in some cases, perform medical procedures is irresponsible and unsafe. Without professional training, individuals do not have the expertise needed to responsibly care for the health of children.

In the case of administering medication, a moderate level of training is necessary to understand dosing and dispensing regimens. More importantly, the individual dispensing medications to children should have no distractions or other duties that could easily lead to medication errors. Although a teacher, school secretary, or other non-medically trained staff member may be able to dispense medication, there is no assurance that they will have the time and focus necessary to prevent making serious errors. Additionally, they may not have the time and focus necessary to adequately observe and monitor a student after dispensing medication.

In the case of assessing a student's health status to determine whether medication or other medical interventions are necessary, a high level of training is necessary. Making a decision about a student's health status without professional training is negligent and unacceptable.

Lastly, it is essential that a trained, credentialed professional perform any medical procedure on a student at school. This professional must have knowledge of anatomy, warning signs and symptoms of infection, and the ability to assess distress. Anything less constitutes negligence.

Conclusion

In summary, the school nurse plays a critical role in providing for the health and well being of students. Untrained substitutes for school nurses pose a threat to the health of children, and action must be taken to correct this unacceptable reality in many of California's public schools.

²³ American Academy of Pediatrics, Committee on School Health. *School Health: Policy and Practice*. Elk Grove Village, IL: American Academy of Pediatrics; 1993:9-16

²⁴ Rationale and Evidence. In: Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd ed. Hagan, JF, Shaw, JS, Duncan, PM (Eds). American Academy of Pediatrics, Elk Grove Village, IL 2008. p. 221.



Appendix D: Proposed School Nursing Law

(a) Required School Nurse Ratio

- (1) **School Nurse Ratio:** By the commencement of the 2013–14 school year, each school board of a district shall employ fulltime at least one school nurse for every seven-hundred fifty kindergarten through twelfth grade mainstreamed pupils in net enrollment or major fraction thereof: at least one school nurse for every four hundred students with disabling conditions, as determined by the State Board of Education; and at least one school nurse for every one hundred twenty-five profoundly disabled students. Provided, that each district shall employ full time at least one school nurse per school facility or school complex.

(2) Compliance with School Nurse Ratio

- (i) **Federally-funded nurses excluded:** Nurses employed exclusively from federal funds or for care of students who require individual care under federal statutes shall not be considered in the ratios as required by this section. Nurses employed with local funds are to be included in the ratios as required by this section.
- (ii) **School Nurse Consultant:** The State Board of Education shall employ a School Nurse Consultant, who shall be a registered nurse, to provide supervision of programs statewide and implement school nursing programs as established by the State Board of Education.
- (iii) **Salary schedule:** There shall be a minimum statewide salary schedule for school nurses, which shall be included in the annual budget act for the public schools.
- (iv) **Budget requirement:** The amounts necessary to meet the requirements of this act shall be appropriated in the annual budget act for the public schools.

(b) School Nursing Services

- (1) **Provision of Services:** A school district shall only utilize or employ for the provision of nursing services in the public schools of the district persons holding an educational services certificate with an endorsement as a school nurse issued by the State Board of Examiners, except for those non-nursing personnel who are otherwise authorized by statute or regulation to perform specific health related services.
- (2) **Employment of Other Certified Nurses:** A school district may supplement the services provided by the certified school nurse by employing licensed nurses not possessing the school nurse certification, provided that the non-certified nurse is assigned to the same school building or school complex as the supervising certified school nurse.
- (3) **Contract with External Health Organizations:** A school district may supplement the services provided by the certified school nurse by contracting with a public or private health organization or another public agency for licensed nurses not possessing school nurse certification, provided that the non-certified nurse is assigned to the same school building or school complex as the supervising certified school nurse.

(c) Delegation of Student Healthcare to School Personnel

- (1) **Allowed Delegation:** The school nurse is accountable and responsible for the nursing care delivered to students under the nurse's jurisdiction. The school nurse may delegate specific tasks to unlicensed assistive personnel, provided they meet statutory requirements. The school nurse is accountable for determining the tasks that may be safely performed by the unlicensed assistive personnel following appropriate training and demonstration of competency. The specific delegated tasks shall not require the exercise of independent nursing judgment or intervention. Healthcare that could not be provided by untrained personnel in a non-school setting shall not be provided in a school setting.
- (2) **Delegation of the Administration of Medication:** The task of providing prescribed oral, topical, ear, eye, nasal, and inhalation medications to a student through twelfth grade may be delegated to unlicensed assistive personnel by the school nurse only when the following conditions are met:
 - (A) The school nurse identifies the appropriate individual(s) to assist in providing prescribed medications.
 - (B) The unlicensed assistive personnel selected by the school nurse shall attend a minimum twelve hour course of instruction that includes a curriculum approved by the Board and demonstrated competency to perform the delegated task.
- (3) **Special Needs Students:** Special education students and those with medical needs requiring specialized care shall have that care rendered by an appropriate individual in compliance with federal and state law. After assessing the health status of the individual student, a school nurse, in collaboration with the student's physician, parents and, in some instances, an individualized education program team, may delegate certain health care procedures to a school employee who shall be trained pursuant to this section, considered competent, have consultation with, and be monitored or supervised by the school nurse.
- (4) **Non-Delegable Tasks:** The school nurse may not delegate any task where delegation would violate the Nursing Practice Act or any task that requires independent nursing judgment. Such tasks include, but are not limited to:
 - (A) Administration of injectable medications, other than **premeasured medication** for allergic reactions;
 - (B) Administration of rectal or vaginal medications;
 - (C) Calculation of medication dosages other than measuring a prescribed amount of liquid medication or breaking a scored tablet;
 - (D) Invasive procedures or techniques;
 - (E) Sterile procedures;
 - (F) Ventilator care; and
 - (G) Receipt of verbal or telephone orders from a licensed prescriber.
- (5) **Evaluation and Monitoring of Delegated Services:** The school nurse shall provide periodic and regular evaluation and monitoring of individuals

performing the delegated tasks. The school nurse shall routinely and periodically conduct quality monitoring of the tasks performed by the unlicensed assistive personnel, including, but not limited to:

- (A) Training;
- (B) Competency;
- (C) Documentation;
- (D) Error reporting; and
- (E) Methods of identification of the right student, the right task, the right method, and the right quantity at the right time.

(6) Suspension of Delegated Care: The school nurse delegating the task may, at any time, suspend or withdraw the delegation of specific tasks to unlicensed assistive personnel.

(d) Health Records

- (1)** For each child of school age, a comprehensive health record shall be maintained by the school district or joint school board, which shall include the results of the tests, measurements and regularly scheduled examinations and special examinations herein specified.
 - (2)** Medical questionnaires, suitable for diagnostic purposes, furnished by the Secretary of Health and completed by the child or by the child's parent or guardian, at such times as the Secretary of Health may direct, shall become a part of the child's health record.
- (e) Reporting:** All teachers shall report to the school nurse or school physician any unusual behavior, changes in physical appearance, changes in attendance habits and changes in scholastic achievement, which may indicate impairment of a child's health. The nurse or school physician or school dentist may, upon referral by the teacher or on his own initiative, advise a child's parent or guardian of the apparent need for a special medical or dental examination. If a parent or guardian fails to report the results to the nurse or school physician, the nurse or school physician shall arrange a special medical examination for the child.
- (f) Effect on Provision of Emergency Services:** Nothing in this section prohibits any school employee from providing specialized health procedures or any other prudent action to aid any person who is in acute physical distress or requires emergency assistance.
- (g) Effect on Other Law:** This section is cumulative and shall be construed in pari materia with other laws, but to the effect that this section specifically conflicts with other laws in direct conflict with this section, then those laws or parts of laws are hereby repealed.

