



PROMOTING HEALTH AND LEARNING

SCHOOL NURSING
PRACTICE IN
NEW JERSEY'S
PUBLIC SCHOOLS



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SCHOOL NURSING PRACTICE IN NEW JERSEY'S PUBLIC SCHOOLS

New Jersey State School Nurses Association
June 2018

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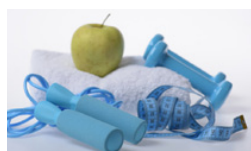
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INTRODUCTION



Unlike nurses working in healthcare institutions or public health agencies, school nurses often work independently. School nursing encompasses two distinctly different disciplines: health and education. Essentially, school nursing is rooted in public health and grounded in education.

This document attempts to bridge the gap between health and education. It

provides local boards of education and school administrators with current information and resources on mandated school health programs and services and the role of the school nurse in New Jersey's public schools. In essence, this document provides an overview of requirements and expectations for those aspiring to become school nurses or for novice school nurses. It is also an important resource for seasoned school nurses to support their practice. This document provides information and resources to guide school health policy development.

This document was written **by school nurses, for school nurses**. As a living document, it reflects current practice yet acknowledges that both public health and education are constantly changing. The **New Jersey State School Nurses Association (NJSSNA)** intends to update this document on a regular basis as new laws and regulations take effect or as new standards of practice are adopted by the **National Association of School Nurses (NASN)**.

History and the Revision Process

Over the years, the New Jersey Department of Education (NJDOE) published several editions of the School Health Services Guidelines. The document was used by colleges and universities to prepare certified school nurses. For many working school nurses, the document was the “go-to” resource for information on school health requirements.

The most recent edition was published by the NJDOE in 2001. Since that time, the NJDOE encouraged school nurses to use the **Keeping Our Kids Safe, Healthy & In School** website for updated information and guidance. However, school nurses continued to ask for an update to the Guidelines. Efforts to update the resource began in 2014 but were discontinued after the retirement of the state school nurse consultant/school health specialist. Knowing that this position had not yet been filled, the NJSSNA explored the pos-



sibility of producing and publishing a new document that reflects current school nursing practice with a focus on school health mandates.

In March 2017, NJSSNA convened the first meeting of the project's steering committee. The committee reviewed the 2001 document and discussed how the resource might be used differently by today's school nurses. The group determined those areas needing revision due to changes in law and code and identified new issues not addressed in the 2001 document. The committee agreed that the document must be electronic, searchable, and highlight school health mandates. Focused on what school nurses are expected and required to do, it would be written "by school nurses, for school nurses." The committee envisioned a document that might also be used by local boards of education and school administrators to develop policies and practices supporting high-quality school nursing services.

NJSSNA received funding from the **New Jersey Department of Health** (NJDOH) to develop an electronic document and conduct focus groups, followed by training on the use of the document. After developing a draft outline and format, authors were solicited for the various chapters and submissions were sent to a project editor who continuously updated the outline and coordinated the work. The NJSSNA worked with a vendor to design and format the electronic document for easy access and utility.

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About NJSSNA

President John F. Kennedy once said that “leadership and learning are indispensable to each other.” This project has been a learning process for all school nurses and a leadership opportunity for NJSSNA. As chair of the steering committee, Anna Tupe served as the driving force behind the publication of this document. Each member of the steering committee authored sections of the document. Additional authors were solicited to address specific areas of expertise or need. Some members of the steering committee also served as reviewers, providing important feedback during the process. In total, more than 30 New Jersey certified school nurses contributed to the completion of this document.

The NJSSNA values the thoughtful contributions of the writers and the wisdom and clarity provided by the reviewers. It also appreciates NJSSNA members who attended focus groups and provided timely feedback and suggestions. A project of this magnitude cannot be completed without the valuable assistance and support of New Jersey’s school nurses. Listed below are members of the project steering committee. In addition, a list of contributing authors and reviewers follows.

The **New Jersey State School Nurses Association (NJSSNA)** is a professional organization dedicated to advancing the practice of school nursing. Organized in 1937 and incorporated in 1938, the NJSSNA serves as the voice for New Jersey’s school nurses. In 2010, the NJSSNA proudly affiliated with the **National Association of School Nurses (NASN)** enabling New Jersey’s school nurses a new level of professional support and advocacy. The mission of the NJSSNA is to improve health and educational outcomes for children and youth by building the capacity of school nurses to promote school and community wellness and deliver high-quality healthcare in the school setting. The Association envisions a school nurse in every school, leading the way to wellness for the entire school community.

Members of the NJSSNA include certified school nurses working in the state’s public school districts and charter schools, nursing faculty charged with preparing school nurses, and registered nurses working in early childhood programs or in New Jersey’s private and parochial schools. Others interested in the delivery of school health services may also join the association. The NJSSNA is governed by a **volunteer executive board** with officers elected by the membership and operates under by-laws also approved by the membership. The NJSSNA also has **county associations** that facilitate local networking and targeted professional development.

How to Use This Document

This document has been developed to assist school nurses, district boards of education and other school health stakeholders to understand school health mandates and requirements. **It serves as a reference but does not replace the actual text of laws and regulations or specific guidance from regulatory bodies such as the NJDOE or NJDOH.** The electronic format enables school nurses to easily access many of the resources in the document.

Each chapter is “color-coded” and corresponds to the colored tabs on the right side of the document. Within each chapter, corresponding hyperlinks to laws, regulations, organizations, and other resources appear in the chapter’s “color,” enabling readers to access additional information about the topic. Most chapters begin with an Introduction of the issue followed by **Background and Rationale**. These two sections provide the reader with context, data, and other important information about the topic or issue. Summaries or full text of **Applicable Laws and Regulations** impacting school health and school nursing practice are included in each chapter. **Additional Points for School Nursing Practice** provide practical ideas to help school nurses implement the school health mandates. **Key Points** may be found throughout the chapter. These serve to emphasize critical points and bold text within a **Key Point** serve as links to important information and resources. The document also includes links to federal and state health and education agencies and organizations, a list of commonly used school health websites and materials, and a key to acronyms and abbreviations used throughout the document.

The NJSSNA acknowledges that this document does not answer every question about school nursing practice. When questions or issues arise, it is tempting to simply “call the state” for a response. However, in practice, always start local. Go through channels and keep a record of your contacts and communications. That means, first ask an appropriate administrator in your school district for assistance. You may also confer with the board-appointed school physician. If the question cannot be addressed, contact your **county office of education** or **your county and local health department**. These agencies are the official liaisons between the state and local school districts and communities and need to know if significant and similar issues are surfacing in a number of schools and communities. If your question cannot be answered at that level, you will usually be referred to someone at “the state” who may be able to assist you. Be advised that questions about school nursing practice should also be sent to the NJSSNA Executive Director.

This document focuses on school nursing services in New Jersey’s K-12 public schools. Nurses working in other settings such as early childhood programs, nonpublic schools, school-based clinics, or community healthcare settings may find this resource helpful; however, it was specifically developed for school nurses working in K-12 public school settings. The NJDOE’s Office of Nonpublic Schools maintains a separate website for school nursing services in nonpublic schools. It developed a guidance document specifically for school health services delivered in nonpublic schools. The NJDOE’s Division of Early Childhood Education and Family Engagement provides preschool guidance and materials which may be helpful to school nurses delivering services in an early childhood setting.

School nursing is always changing. This document was written by members of the NJSSNA and is published and maintained by the organization. It does not necessarily reflect the views of any state or federal agency, district board of education, or individual contributor. Please be advised that:

- This document provides guidance to school nurses and others responsible for school health programs. It is not intended to replace or supplant any official



communication from a responsible federal or state agency nor is it intended to be the sole source of laws, regulations, or policies that address school health requirements.

- This document includes references to laws and regulations that are subject to change and were current at the time of publication of this document. To the best of its ability, the NJSSNA intends to conduct periodic reviews of the document to ensure it is current and accurate.
- The NJSSNA acknowledges that this document may not include every federal or state law or regulation that impacts school health, school health services, school nursing, or other related topics. Similarly, it does not attempt to address every health issue impacting children and adolescents. NJSSNA requests that any omissions be brought to the attention of the NJSSNA Executive Director or President.
- Many laws and regulations address multiple issues and audiences. Whenever appropriate, this document summarizes laws and regulations to focus on the elements central to school nursing practice. When the meaning or intent of the law requires it be written verbatim, the source is hyperlinked rather than printing the entire text.
- NJSSNA will periodically review all hyperlinks and electronic resources.
- This document provides school nurses with suggested print and electronic resources. The NJSSNA does not endorse any product or service associated with school nursing practice and the resources listed herein are for information only.

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NJSSNA reminds readers that district board of education policies must align with statutes and administrative code and must be updated accordingly. Use of the document does not replace any mandated licenses, certifications, or endorsements required to practice school nursing in New Jersey's public schools.

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CHAPTER ONE: Advancing School Nursing Practice

Introduction



The National Association of School Nurses (NASN) defines school nursing as a specialized practice of nursing that protects and promotes student health, facilitates optimal development, and advances academic success. School nurses, grounded in ethical and evidence-based practice, are leaders who bridge health care and education, provide care coordination, advocate for quality student-centered

care, and collaborate to design systems that allow individuals and communities to develop their full potential (NASN, 2017a).

Today's school nurse has moved beyond the walls of the health office and into the community. School nurses work to build a culture of health where students, families, and school community members live, work, learn, and play. New Jersey's school nurses aim to improve health and educational outcomes for children and youth by promoting school and community wellness and providing high-quality health care in the school setting.

School nurses are licensed registered professional nurses and must fulfill continuing education requirements as required by the New Jersey Board of Nursing (NJBON) in order to maintain that license. In addition, nurses working in a K-12 public school as a "school nurse" must complete NJDOE requirements to secure an educational endorsement as a certified school nurse. Certified school nurses must fulfill any continuing education requirements established by the NJDOE. Thus, the certified school nurse must adhere to both education and health laws and regulations.

School nurses benefit from participation in professional learning activities sponsored by their county, state, and national school nursing organizations. NASN is a non-profit specialty nursing organization, first organized in 1968 and incorporated in 1977, representing school nurses exclusively. NASN has more than 16,000 members and approximately 50 state and territorial affiliates. The mission of NASN is to optimize student health and learning by advancing the practice of school nursing. NASN offers professional resources such as webinars, journals, and position statements as well as an annual national conference. It coordinates with its affiliates to offer professional support and education (NASN, 2017b). NASN has adopted a Code of Ethics to guide school nursing practice.



What does a school nurse do? A school nurse:

Provides direct care to students, helping students manage chronic illness and attending to injuries and acute illnesses;

Collaborates with the student, the family, and the student's medical home to develop and implement a plan of care;

Provides care to students with special health care needs, working with the child study team and the medical home to ensure that appropriate health accommodations are implemented;

Provides leadership for all aspects of school health by working with administrators to ensure that health-promoting policies and practices are adopted, implemented, and evaluated;

Participates on school and district committees that address health and safety;

Implements screening and referral programs to address student health issues that may impact both health and learning;

Works closely with the school physician, community healthcare providers, the student and his/her family to ensure that identified health problems are addressed;

Supports public health initiatives that address infectious disease control, immunization requirements, and sanitation efforts;

Promotes a safe and healthy physical environment;

Collaborates with the school and community to promote a safe and positive climate and culture;

Educates students, staff, families, and the community about health issues; and,

Supports school and community-based programs and services focused on health and wellness.



Understanding the Legal Basis for School Nursing Practice

The nation's healthcare delivery systems strive to ensure quality, safety, access, and efficiency. Nurses, as members of the healthcare team, are the foundation of the health care delivery system. Because New Jersey school nurses hold both a nursing license and an educational certificate, they must comply with laws and regulations emanating from both public health and education. Making this a bit more complicated, registered nurses are licensed by the [New Jersey Board of Nursing](#) which is housed in the New Jersey Department of Law and Public Safety (NJLPS), Office of the Attorney General (OAG), Division of Consumer Affairs (DCA); however, certified school nurses receive their educational endorsement from the NJDOE. School nursing practice is also governed by a myriad of laws, statutes, rules, regulations, policies, guidelines, and advisories issued by numerous federal and state agencies.

At the federal level, school nurses are often considered part of the public health system. In many states, school nurses actually work for local or state health departments rather than individual schools or school districts. The federal Department of Health and Human Services (DHHS) includes eight agencies in the U.S. Public Health Service (USPHS) and three human services agencies. As part of DHHS, the [Centers for Disease Control and Prevention \(CDC\)](#) serves as an important resource for school health policy development and provides training and technical support for states and school districts in the full range of health issues. Despite not being employed in the public health sector, New Jersey's school nurses are considered a vital part of the state and local public health system, which is described in more detail later in this chapter and in Chapter Four. To help public health and education stakeholders better understand complex educational systems, the National Association of State Boards of Education (NASBE) developed [How Schools Work and How to Work with Schools](#).

Despite the existence of the United States Department of Education (ED or USED), education is primarily a state and local responsibility with approximately 92% of K-12 school funding coming from non-federal sources. The Every Student Succeeds Act (ESSA), signed by President Obama on December 10, 2015, reauthorizes the 50-year-old Elementary and Secondary Education Act (ESEA) which is the nation's national education law. It continues a longstanding commitment to equal opportunity for all students. A provision within ESSA highlights the work of school nurses in chronic disease management. The ED provides an [overview](#) of the federal role of education and [ESSA](#) which school nurses may find helpful.

The New Jersey Legislature consists of two Houses: a 40-member Senate and an 80-member General Assembly. The Legislature enacts laws and adopts resolutions which express the sentiments or opinions of the members. The legislature can also propose amendments to the New Jersey Constitution. A proposal to make a new law, or to change or repeal an existing law, is presented to the Legislature as a bill. To become law, a bill must pass both Houses by a majority vote and be approved by the Governor. [How a Bill Becomes Law](#) presents the steps in the process. Approved legislation becomes law or statute (commonly seen as New Jersey Statutes Annotated/N.J.S.A.) or Chapter



Laws (New Jersey Legislature, 2017). The NJDOE explains how to [locate statutes online](#).

Despite its geographic small size, New Jersey has 590 operating school districts, 2418 schools, and 88 charter schools that serve approximately 1.4 million students (NJDOE, 2017a). The Commissioner of Education is appointed by the Governor with the advice and consent of the Senate and serves as a member of the Governor's cabinet. As education leader of the state, the Commissioner recommends legislative initiatives and changes, suggests rules and regulations for state board consideration, produces educational research, conducts initiatives to meet the state's educational needs, and serves as liaison between local school districts and the federal government. The Commissioner is responsible for [NJDOE organization and staffing](#) (NJDOE, 2017b).

The Commissioner serves as secretary of the [State Board of Education](#). The State Board consists of 13 members appointed by the Governor with the advice and consent of the New Jersey State Senate and serves without compensation for six-year terms. The State Board adopts Administrative Code, which establishes the rules to implement state education law. In addition, the State Board advises on educational policies proposed by the Commissioner and confirms NJDOE staff appointments made by the Commissioner (NJDOE, 2017c). Proposed rules for education are published in the [New Jersey Register](#) with written comments on proposed rules accepted 30 to 60 days following publication. School nurses should understand the [code adoption process](#) as these regulations govern schools and school health programs and services (NJDOE, 2017d). School nurses may also find the [legislative glossary](#) helpful.

In summary, **laws or statutes** are adopted by the New Jersey Legislature. **Executive orders**, which have the force of law, are issued based on the general executive power of the Governor authorized by the Constitution or in accordance with laws which delegate specific powers to the Governor. Executive orders may be temporary or may remain in force indefinitely. The beginning of a new administration does not affect the status of the orders of prior administrations. A **Resolution** is an action of the Legislature that expresses the policies, sentiment, opinions, or direction of one or both Houses and includes joint, concurrent, ceremonial, and one House resolutions (New Jersey Legislature, 2017).

Administrative Code is promulgated by the State Board of Education or another state agency. Administrative Code (sometimes called **rules or regulations**) may be developed in response to a new law or may provide clarification or more detail than the law itself. The regulations have a five year expiration period and are assigned a "sunset date." However, the regulations can be amended at any time during that period based on changing needs or policies. This ensures that each chapter of code is reviewed at least every five years. School nurses may find the NJDOE's overview of [education law and policy](#) helpful (NJDOE, 2017e). Other state agencies have similar processes for the review and adoption of regulations such as the NJDOH's **State Sanitary Code**. A code "citation" (the reference numbers and letters) is subject to change during the sunset and review process or during the addition of new regulations. For example, N.J.A.C. 6A:16 (commonly called Chapter 16) currently addresses many school health issues. Should the Legislature pass a new law addressing a topic that must be included in Chapter 16, the NJDOE develops

new regulations and determines where they best fit. This may require new citations for existing regulations. Thus, when developing local policies, it is important to check the most current version of Administrative Code for any recent or proposed changes. The New Jersey State Library offers [Library Laws of New Jersey](#) which explains how to locate citations.

The state establishes the broader framework for school district operations; however, local boards of education establish the **policies and procedures** that most directly affect students and staff. Local policies generally are considered valid as long as they do not conflict with provisions of federal or state statutes and regulations. Local boards of education represent the concerns of citizens, taxpayers, and parents to the school administrators and conversely, represent the needs of the students and school district to the citizens, taxpayers and parents of the community. The board of education sets the policies, goals, and objectives for the district and holds the superintendent/chief school administrator responsible for implementing the policies and achieving the goals (NJSBA, 2017). Members must adhere to the [Code of Ethics for School Board Members](#). The [New Jersey School Boards Association](#) (NJSBA) provides information to help school nurses better understand the responsibilities of local boards of education.

From time to time, state agencies may develop an **advisory** to assist local school boards to develop policy in response to a new law that takes effect immediately and has yet to be codified. State agencies also develop **guidelines** which may address law and code, offer suggested policy language, and include resources or programmatic guidance.



Key Point

*When told that a law or rule has “changed,” ask to see evidence of the change. School administrators often receive notices from the NJDOE or other agencies advising them of pending changes, waivers, or other information that may be important to the delivery of school health services. Most rule changes, advisories, and NJDOE memos are available at **NJDOE News**. Always verify the change before changing your practice.*

School Nursing: Public Health and Population Health

In [Why School Nurses are the Ticket to Healthier Communities](#), Susan B. Hassmiller, PhD, RN, FAAN, senior adviser for nursing for the Robert Wood Johnson Foundation, and the director of the Future of Nursing: Campaign for Action makes the point that:

School nurses need to be ready at a moment’s notice for whatever may walk through the door and make accurate assessments for conditions that may not be readily apparent. School nurses are also the frontline of disease surveillance. School nurses have always been and will continue to be, an important part of the public health system (Hassmiller, 2016).

The CDC defines public health systems as public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction. This



concept ensures that all contributions to the health and well-being of the community or state are recognized. Schools are considered part of the public health system. The **10 Essential Public Health Services** describe those public health activities all communities should undertake (CDC, 2017a). School nurses have a critical role in implementing those activities and achieving public health goals.

In 2003, the American Public Health Association (APHA) published **What is Population Health?**. The authors provide a working definition of population health:

The health outcomes of a group of individuals, including the distribution of such outcomes within the group, including geographic regions and groups such as employees, ethnic groups, disabled persons, or prisoners. Population health considers many determinants of health, such as medical care systems, the social environment, and the physical environment because they may have a biological impact on individuals in part at a population level (Kindig & Stoddart, 2003).

Using a population health framework, students and school communities are viewed through both a magnifying glass and a wide-angle lens. Health trends are often first identified through the adept assessment skills of the school nurse. Health, as it has now understood, is a confluence of factors that include access to care as well as social determinants that may become barriers to healthy outcomes. The World Health Organization (WHO) defines the **social determinants of health** (SDH) as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems (WHO, 2017). **Healthy People 2020** and the CDC define **social determinants** and provide data resources to better understand this approach to health (CDC, 2017b).

Clearly, school nurses must understand the complex health and social issues that impede a student's ability to learn. Despite being educational professionals, school nurses must know how to work with and within the public health system. The challenging goal is to address both the health and educational needs of students using multiple means and perspectives.

NASN Framework for 21st Century School Nursing Practice

NASN's Framework for 21st Century School Nursing Practice provides structure and focus for the key principles and components of current day, evidence-based school nursing practice. Aligned with the **Whole School, Whole Community, Whole Child Model** (WSCC), the Framework focuses on student-centered nursing care that occurs within the context of the student's family and school community. The Framework consists of four key principles (Care Coordination, Leadership, Quality Improvement, and Community and Public Health) surrounded by the Standards of Practice. Every school nurse should be familiar with the new Framework. In addition, NASN and the American Nurses Association (ANA) updated the Scope and Standards of Practice, 3rd Edition (2017). This comprehensive document includes the Framework, standards and competencies, and the Code of Ethics as well as information on the WSCC model. It is available from NASN.

Health and Learning



Healthier students are better learners. While this statement may seem obvious to most school nurses, it has been difficult to prove. Schools conduct formative and summative assessments of student learning but rarely do they connect the results to factors outside of teacher behavior or instructional strategies. Studies may look at student attendance and learning but most school improvement

plans do not consider health interventions as a means to improve student absenteeism unless the school nurse influences the development of the plans. The conversation about health and learning was jumpstarted in 2010 by [Healthier Students Are Better Learners: A Missing Link in School Reforms to Close the Achievement Gap](#). Written by Dr. Charles E. Basch of Teachers College, Columbia University, this document made the case that educationally relevant health disparities contribute to the achievement gap affecting urban minority youth.

If children can't see well, if their eyes do not integrate properly with their brain and motor systems, they will have difficulty acquiring the basic and essential academic skills associated with reading, writing, spelling and mathematics. If their ability to concentrate, use memory, and make decisions is impeded by ill-nourishment or sedentary lifestyle, if they are distracted by negative feelings, it will be more difficult for them to learn and succeed in school. If their relationships at school with peers and teachers are negative, they will be less likely to be connected with and engaged in school, and therefore less motivated and able to learn. If they are not in school, because of uncontrolled asthma or because they are afraid to travel to or from school, they will miss teaching and learning opportunities. If they drop out, perhaps because they are failing or faltering; or because they are socialized to believe that, even if they complete school, there will be no better opportunities; or because they associate with peers who do not value school; or because they become pregnant and there are no resources in place that enable them to complete school while pregnant and after they have a newborn, it is not likely that they can succeed. If they cannot focus attention and succeed socially, it is unlikely that they will succeed academically (Basch, 2010, p.76).

Dr. Basch called for health efforts to become part of school reform efforts and for an end to fragmented and categorical efforts. Instead, he recommended a coordinated system of policies and programs that work synergistically to address both health and educational disparities.

In the [September 8, 2017 Morbidity and Mortality Weekly Report](#) (MMWR), the CDC presented the results of the 2015 Youth Risk Behavior Survey (YRBS), a national school-



based survey measuring health-related behaviors among U.S. students in grades 9–12. The CDC analyzed self-reported letter grades in school and 30 health-related behaviors that contribute to the leading causes of morbidity and mortality among adolescents. The article poses a link between health-related behaviors and education outcomes and provides support for education and public health professionals to develop mutually beneficial education and health improvement goals. Both health and education professionals will benefit from reviewing the entire article.

The School-Based Health Alliance (SBHA), a national organization dedicated to bringing health care to students in schools, believes that health problems and risk-taking behaviors contribute to poor student achievement. The SBHA believes that **health and learning** are intertwined and cite issues such as chronic absenteeism, adolescent pregnancy, asthma, and substance abuse as factors that can be addressed through school-based health care.

There is a growing body of evidence that health and academic achievement are connected. The relationship between physical activity and test scores or nutrition and academic success are most often studied. The CDC supports the connection between **Health and Academics** and **Health and Academic Achievement** and provides resources to help school nurses make the case for health-promoting programs in schools. Action for Healthy Kids (AFHK) publishes **The Learning Connection** which provides an overview of the connection between healthy eating, physical activity, and academic achievement.

In 2015, the New Jersey School Boards Association (NJSBA) published a **Health and Wellness Report** summarizing the work of a multi-disciplinary task force charged with examining student health and academic achievement. While much of the report focuses on the impact of school climate, nutrition, and physical activity, the task force recommended that New Jersey school districts implement a coordinated school health model. The task force also concluded that improving school health and wellness is a valuable, child-centered means of improving student achievement; however, it expressed concerns that local school districts focus more on compliance with federal and state requirements, rather than adopting proactive strategies to drive change (NJSBA, 2015).

School nurses must understand how children learn and connect health-related factors that enhance or impede the learning process. As health professionals and educators, school nurses are uniquely positioned to help teachers better understand how student health issues impact learning. Working with students, families, healthcare providers, and education professionals, school nurses play an important role to ensure that all students are healthy and ready to learn.

The Whole School, Whole Community, Whole Child Model

In 1987, noted school health experts Diane Allensworth and Lloyd Kolbe introduced the Coordinated School Health (CSH) model. The model consisted of eight elements that promoted health and supported learning. School health was viewed as the “missing piece” and foundation for healthy students, but also a means to support the development of healthy and effective schools. The CSH model was embraced by public health

professionals and organizations and supported by the CDC; however, the model never resonated with the education community and was not widely implemented in schools.

Enter ASCD (formerly known as the Association for Supervision and Curriculum Development), a global membership organization dedicated to developing and delivering innovative programs, products, and services that empower educators to support the success of each learner. In 2007, ASCD launched its **Whole Child Initiative**, changing the conversation from an assessment-driven academic achievement approach to one that focused on the long-term needs of children. This approach opened the door to new conversations about the eight-component CSH model and led to discussions about how to get the education community to recognize the value of health as a component of school improvement and success (ASCD, 2017).

ASCD's Whole Child Initiative is based on **five tenets**:

- Each student enters school healthy and learns about and practices a **healthy** lifestyle.
- Each student learns in an environment that is physically and emotionally **safe** for students and adults.
- Each student is actively **engaged** in learning and is connected to the school and broader community.
- Each student has access to personalized learning and is **supported** by qualified, caring adults.
- Each student is **challenged** academically and prepared for success in college or further study and for employment and participation in a global environment.

In 2013, ASCD and CDC jointly convened leaders from education and health to create a new paradigm embracing the original CSH model and redefining it to resonate with educators. The result is the **Whole School, Whole Community, Whole Child Model (WSCC)** which aims to demonstrate the symbiotic relationship between education and health. The model merges the five Whole Child Tenets with a revised CSH model. The November 2015 special issue of the **Journal of School Health (JOSH)**, published by the **American School Health Association (ASHA)**, focused on the evolution of the WSCC model and its implications for health and education. The WSCC model focuses on the development and implementation of policies, programs, and practices in both the school and the community that positively impact the health and wellness of students and their families. Ultimately, the goal is healthy students who are ready to learn and who are prepared to become educated, caring, productive adults.

To inform this ongoing process, the CDC conducts the **School Health Profiles (Profiles)**, a system of surveys assessing school health policies and practices in states, large urban school districts, and territories. Profiles helps us better understand the state of school health, especially in light of the WSCC model and requirements set forth in mandated school improvement plans. Profiles surveys are conducted biennially by education and



health agencies among middle and high school principals and lead health education teachers. Profiles monitors the current status of:

- School health education requirements and content;
- Physical education and physical activity;
- Practices related to bullying and sexual harassment;
- School health policies related to tobacco-use prevention and nutrition;
- School-based health services;
- Family engagement and community involvement; and,
- School health coordination.

Making the Connection: Other Health Behaviors and Conditions and Academic Grades provides schools nurses with information on how certain health factors may impact academic achievement. While much of the research has focused on the relationship between healthy eating, physical activity and achievement, school nurses should play a role at the local level collecting and analyzing data about student health in general and how it correlates to attendance and achievement.

School nurses should become familiar with all **ten components** of the WSCC model but especially the school health services component. The WSCC model describes a broad school health services approach that involves members of the school health team, including school nurses. School nurses provide screenings and assessments, plan, coordinate and manage care, and promote wellness. School nurses work with school and community services to assist students and their families to adapt to health and social stressors. In addition, school nurses should be involved with all aspects of the school health program and should be knowledgeable of what occurs locally and across the country. School nurses may want to visit CDC's **Virtual Healthy School** to see the WSCC model "in action."

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CHAPTER TWO: Working with the School Health Team

Introduction



Implementing a coordinated approach to school health as envisioned in the WSCC model requires the collective expertise of a school health team. Meeting the health needs of students and staff requires a collaborative team-based approach that utilizes the knowledge and skills of an array of school health professionals. While each health professional has a distinct role on the school health team, school

nurses play an integral role in coordinating care; communicating with school personnel, students, and their families; and, working with community-based providers to establish effective care and support. New Jersey has a long-standing commitment to ensuring that school health personnel are appropriately educated and certificated to provide services to K-12 students.

This chapter focuses on four school health professionals who serve at the core of the school health team: school nurses, school physicians, athletic trainers, and student assistance professionals. Other members of the school health team might include health educators, physical educators, school counselors, school psychologists, dietitians or food service directors, and school social workers. It is beyond the scope of this document to address the roles and requirements of all members of the school health team; however, this does not diminish their important contributions to student health and wellness. The CDC provides school districts with recommendations on the composition and role of the [school health team](#).

Certified School Nurses

Nursing practice is governed by the [New Jersey Board of Nursing \(NJBN\)](#). The NJBN licenses registered nurses and practical nurses and regulates the nursing profession in New Jersey. Individuals who are interested in becoming certified school nurses in New Jersey must hold a current and valid license as a registered nurse issued by the NJBN and complete specific educational requirements leading to an educational endorsement issued by the NJDOE.

School nursing practice combines two statutory and regulatory models, health and education. As a result, school nurses face unique legal, policy, practice, supervisory, and



ethical issues. As members of the larger nursing profession, school nurses are also governed by the American Nurses Association's (ANA) **Code of Ethics for Nurses** which provides a guide for carrying out nursing responsibilities in a manner consistent with quality in nursing care and the ethical obligations of the profession. The American Academy of Pediatrics (AAP) recommends that all schools have a registered professional school nurse to provide health services in schools (AAP, 2016).

The **NASN Position Paper: Education, Licensure and Certification** describes school nursing as a specialized practice of nursing focused on protecting and promoting student health, facilitating optimal development, and advancing academic success. The paper states that school nurses, grounded in ethical and evidence-based practice, are the leaders who bridge health care and education, provide care coordination, advocate for quality student-centered care, and collaborate to design systems that allow individuals and communities to develop their full potential (NASN, 2016).

Certification issued by the NJDOE is required for employment as a school nurse in a New Jersey public school. **The National Board for Certification of School Nurses, Inc.** (NBCSN) is an independently incorporated organization established for the purpose of developing and implementing the voluntary certification process of school nurses. However, the two certification programs are not interchangeable or reciprocal. Some school nurses choose to complete the national program in addition to New Jersey's state requirements. Those that do may use the NCSN designation after their name. School nurses who have completed the NJDOE's certification process may use CSN-NJ after their name.



Key Point

Some larger school districts may designate a "head nurse" or "lead nurse" to coordinate the work of the district's school nurses. While a certified school nurse may be appointed by the Board of Education to serve as the "lead" nurse for the district, if the job responsibilities include the supervision and evaluation of certificated/instructional school personnel, including certified school nurses, the individual must complete advanced education and hold the appropriate supervisory or administrative credential issued by the NJDOE. The NJDOE issues a Supervisor title which is required for both supervisors of instruction and athletic directors who do not hold a standard principal's title. A supervisor is defined as any school officer who is charged with authority and responsibility for the continuing direction and guidance of the work of instructional personnel.

*The NJDOE establishes the requirements for **school leaders** including supervisors, principals, school administrators, and school business administrators.*

Key Point

*Key Point: Individuals holding an educational services endorsement are not required to complete the same Student Growth Objectives as those who hold an instructional certificate. A sample **School Nurse Vision Screening Referrals SGO** is available as an example of how to modify the instructional model.*

Applicable Laws and Regulations

N.J.A.C. 6A:16-1.3 – Definitions

A certified school nurse is a person who holds a current license as a registered professional nurse from the State Board of Nursing and an educational services certificate, school nurse or school nurse/non-instructional endorsement from the Department of Education pursuant to N.J.A.C. 6A: 9B-12.3 and 12.4.

Medical staff means employees of the district board of education serving as school physician, certified school nurse, noncertified nurse, advanced practice nurse, registered nurse, or licensed practical nurse.

A noncertified nurse is a person who holds a current license as a registered professional nurse from the State Board of Nursing and is employed by a district board of education or nonpublic school, and who is not certified as a school nurse by the Department of Education.

A substitute school nurse is a person who holds a current license from the State Board of Nursing as a registered professional nurse and who has been issued a certificate to serve as a substitute for a certified school nurse in accordance with N.J.A.C. 6A:9B-6.5(i).

N.J.A.C. 6A:9B-14.3&14.4 – School Nurse Certification

New Jersey offers two educational certificates with an endorsement as a certified school nurse available to registered professional nurses who hold, at minimum, a bachelor's degree.

1. Instructional

- Requires at least 21 semester hours including methods of teaching health and curriculum development in preschool through grade 12; and,
- Authorizes the holder to perform nursing services and to teach in areas related to health in all public schools.

An emergency certificate is NOT available for this endorsement.

2. Non-Instructional:

- Requires at least 15 semester hours and does not require methods of teaching and curriculum development; and,
- Authorizes the holder to perform nursing services in all public schools but the holder is NOT authorized to teach in areas related to health.

An emergency certificate is available for this endorsement.



School Nurse Standard Certificate (Educational Endorsement Code 3000)

School Nurse/Non-Instructional Standard Certificate (Educational Endorsement Code 3010)

School Nurse Certification Regulations

N.J.S.A. 18A:40-1 – Employment of Medical Inspectors, Optometrists, and Nurses

This law requires every board of education to employ one or more physicians, licensed to practice medicine and surgery within the state, to be known as the medical inspector or medical inspectors. The law also requires every board of education to employ one or more school nurses. The board of education may also employ one or more optometrists, licensed to practice optometry within the state, to be known as the school vision examiner or school vision examiners, and the board shall fix their salaries and terms of office. Every board of education shall adopt rules, subject to the approval of the state board, for the government of such employees.

N.J.S.A. 18A:40-3.1 – Appointment and Salary of School Nurses

This law states that every person employed as a school nurse, school nurse supervisor, head school nurse, chief school nurse or school nurse coordinator, or performing any school nursing service, in the public schools of this state must be appointed by the board of education having charge of the school or schools in which the services are to be rendered. It also states that the school nurse serves under the direction of said board or an officer or employee of the board designated by it and the salary of such person shall be fixed by, and paid from the funds of said board according to law.

N.J.S.A. 18A:1-1 – Definitions

“School nurse” means and includes any school nurse, school nurse supervisor, head school nurse, chief school nurse, school nurse coordinator or any other nurse performing school nursing services in the public schools.

“Teaching staff member” means a member of the professional staff of any district or regional board of education, or any board of education of a county vocational school, holding office, position, or employment of such character that the qualifications, for such office, position, or employment, require him to hold a valid and effective standard, provisional, or emergency certificate appropriate to his office, position, or employment, issued by the State Board of Examiners and includes a school nurse and a school athletic trainer.



Key Point

Teaching staff members are eligible for tenure. This means that a public school employer may not dismiss an employee during good behavior or reduce his/her compensation for any reason other than incapacity, inefficiency, conduct unbecoming, or “other just cause.” A tenured teaching staff member can be laid off because of reduced enrollment or economic reasons, so long as the employer follows seniority rules. Certified school nurses are considered teaching staff members and are protected by tenure rules.

Information on Teacher Evaluation and Tenure Cases

TEACHNJ Act

Achieve NJ

N.J.A.C. 6A:16-2.3 – Health Services Personnel

These regulations require the district board of education to employ a certified school nurse to provide nursing services while school is in session. The certified school nurse works under the direction of the school physician and chief school administrator. It requires the certified school nurse to receive training in airway management and in the use of nebulizers and inhalers consistent with nationally recognized standards including, but not limited to, those of the National Institutes of Health and the American Academy of Allergy, Asthma, and Immunology.





The role of the certified school nurse shall include, but not be limited to:

Carrying out written orders of the medical home and standing orders of the school physician;
Conducting health screenings, which include height, weight, blood pressure, hearing, vision, and scoliosis;
Monitoring vital signs and general health status for emergent issues for students suspected of being under the influence of alcohol and controlled dangerous substances;
Maintaining student health records;
Recommending to the school principal students who shall not be admitted to or retained in the school building based on a parent's failure to provide evidence of the child's immunization according to the schedules specified in N.J.A.C. 8:57-4;
Annually reviewing student immunization records to confirm with the medical home that the medical condition for the exemption from immunization continues to be applicable, pursuant to N.J.A.C. 8:57-4.3;
Recommending to the school principal exclusion of students who show evidence of communicable disease;
Directing and supervising the emergency administration of epinephrine and glucagon, and training school staff designated to serve as delegates;
Administering asthma medication through the use of a nebulizer;
Directing and supervising the health services activities of any school staff to whom the certified school nurse has delegated a nursing task;
Providing classroom instruction in areas related to health education if certified to do so;
Reviewing and summarizing available health and medical information regarding the student and transmitting a summary of relevant health and medical information to the child study team for the meeting;
Writing and updating, at least annually, the individualized health care plans and the individualized emergency healthcare plans for students' medical needs, and instructing staff as appropriate;
Writing and updating, at least annually, any written healthcare provisions required under Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a), for any student who requires them;
Assisting in the development of and implementing healthcare procedures for students in the event of an emergency;
Instructing teachers on communicable diseases and other health concerns;
Reviewing completed health history update questionnaires and sharing with the school athletic trainer for review, if applicable; and,
Providing other nursing services consistent with the nurse's educational services certification endorsement as a school nurse issued by the State Board of Examiners and current license approved by the State Board of Nursing.

N.J.S.A. 18A:40-3.2 – School Nursing and Clinical Nursing 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. Special education students and those with medical needs requiring specialized care shall have that care rendered by an appropriate provider as appointed by the State Board of Education. No person shall be issued such certificate unless the person is licensed as a registered nurse pursuant to the provisions of P.L.1947, c.262 (C.45:11-23 et seq.) and meets all of the requirements prescribed by the board for a nursing endorsement. A school district may supplement the services provided by the certified school nurse with non-certified nurses, provided that the non-certified nurse is assigned to the same school building or school complex as the certified school nurse.

N.J.S.A. 18A:40-3.2 – School Nursing and Clinical Nursing Services for Medically Fragile Students

This law states that school nursing is a separate and distinct specialty within the nursing and educational professions and competence in specified areas of health and education is needed in order for school nurses to act as health advocates for school-age children. It goes on to specifically address the needs of “medically fragile students” who require clinical nursing services.

The law states that medically fragile students are often diagnosed with medical conditions and life-threatening diseases, including cerebral palsy, seizure disorder, and other neurological diseases, that require mechanical ventilation and emergent intervention by providers of clinical nursing services while attending school. Medically fragile students who require clinical nursing services while attending school should expect and receive the same level of care they receive at home. Maintaining a continuity of care for medically fragile students creates a safer environment at school, fosters learning, and gives parents confidence that their children’s medical needs are being met by qualified health care providers. Currently, there are no standards of practice in place for providers of clinical nursing services. As a result, the quality of care medically fragile students receive in school is often inadequate to meet their health care needs. Therefore, it is in the public interest that, in order to guarantee the health and safety of medically fragile students while attending school, providers of clinical nursing services for such students meet the same qualifications as providers of clinical nursing services certified to participate in the State’s Medicaid and NJ FamilyCare programs, and that parents should be given the option to choose the provider who will render clinical nursing services to their children while attending school, if the cost remains neutral to the school district.

The law reiterates that nursing services provided in the public schools must be delivered by an individual 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. Special education students and those with medical needs requiring



specialized care shall have that care rendered by an appropriate provider as appointed by the State Board of Education. No person shall be issued such certificate unless the person is licensed as a registered nurse pursuant to the provisions of P.L.1947, c.262 (C.45:11-23 et seq.) and meets all of the requirements prescribed by the board for a nursing endorsement. A school district may supplement the services provided by the certified school nurse with non-certified nurses, provided that the non-certified nurse is assigned to the same school building or school complex as the certified school nurse.

A medically fragile student requiring clinical nursing services shall have those services rendered by a provider of clinical nursing services as defined in this subsection. Nothing in this section shall be construed to exclude a licensed health care service firm that is approved to provide private duty nursing under the Medicaid Program and is in compliance with State Board of Education regulations. The parent or legal guardian of a medically fragile student shall have the option to choose a provider to render clinical nursing services to the student and the State Board of Education shall allow the provider chosen by the parent or legal guardian to render such services to the student only if the cost to the school district remains neutral.

The law defines the following:

“Medically fragile student” means a school-aged child who suffers from a life-threatening medical condition, and as a result of such condition, requires more individualized and continuous care than is available from a school nurse.

“Clinical nursing services” means specific health care services, based on a medically fragile student’s individualized education plan and a physician’s or advanced practice nurse’s orders, as provided by a registered nurse or licensed practical nurse with specialized pediatric training who attends to the student.

“Provider of clinical nursing services” means an agency that renders clinical nursing services and is approved to provide private duty nursing under the Medicaid program pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.) or the NJ FamilyCare Program pursuant to P.L.2005, c.156 (C.30:4J-8 et al).



Key Point

The certified school nurse provides care for all students enrolled in the school; therefore, the school nurse cannot provide 1:1 care for medically fragile students. Nurses that provide care for medically fragile students may work for a clinical nursing provider (agency) under a contract between that agency and the district board of education. As such, the agency must ensure that the healthcare professional has the appropriate credentials and training for the type and level of health care required under the contract. The school nurse does not supervise the healthcare provider as that is the responsibility of the agency. The school nurse maintains the child’s health records and ensures compliance with other health requirements such as immunizations or screenings.

N.J.S.A. 18A:40-3.5 – School Nurse Substitutes

This law states that the holder of a valid New Jersey registered nurse license may be issued a county substitute certificate to serve as a substitute for a certified school nurse. Emergency certificates may be issued.

N.J.A.C. 6A:16-2.3 – Noncertified Nurse

The regulation states that school districts may appoint a noncertified nurse under the supervision of a certified school nurse to supplement the services of a certified school nurse provided that the noncertified nurse is assigned to the same school building or complex as the certified school nurse. A noncertified nurse is limited to providing services only as permitted under the noncertified nurse's license issued by the State Board of Nursing.

N.J.S.A. 18A:40-3.4 – Health Services Secretarial or Clerical Support Staff

A school district may utilize or employ a person to perform secretarial or clerical duties that assist in providing nursing services only under the supervision of a certified school nurse. Secretarial or clerical duties may include, but not be limited to, recording information on a pupil or school record, making telephone calls, and preparing correspondence.

**Key Point**

School employees providing clerical support in the school health office must be educated about privacy and confidentiality.

Key Point

N.J.A.C. 6A:16 no longer defines “school complex.”

Key Point

Candidates for the school nurse certificate must hold a valid and current New Jersey license as a professional registered nurse (RN). Licensed practical nurses (LPNs) are not eligible to apply for school nurse certification and may not serve as school nurse substitutes.

N.J.A.C. 6A:26-12.3 – Health Facilities, Equipment and Supplies

These rules require district boards of education to provide the necessary facilities, equipment, and supplies for the performance of the duties required under State law and rules by health services personnel.

Other Members of the School Health Team**School Physician/Medical Inspector**

The AAP Council on School Health (AAP-COSH) policy paper, [Role of the School Physician](#), states that modern school physicians focus on the needs of individual children as well as the public health of the school community. They work with schools to address special healthcare needs, manage acute and chronic illness, and oversee emergency



response, environmental health and safety, health promotion, and education. Physicians are important members of the school health team (AAP, 2013). Additionally, the American Medical Association (AMA) concurred with the AAP, recommending that school health services be provided by a professionally prepared school nurse, working under the direction of a physician, preferably one who is experienced in the care of children and adolescents. The physician should be accessible to administer care on a regular basis.

School physicians should be board-certified pediatricians or physicians with expertise and experience in pediatrics. School physicians need an understanding of child growth and development, disease processes, and well-child maintenance including adolescent and reproductive health and sports medicine. School physicians should be experts in key school health topics and be educated about the medical-legal environment in which they practice (AAP, 2013).

The role of the school physician has evolved from the “medical inspector” model that primarily focused on infectious disease control. Today’s school physician works with the local board of education, district administration, and staff to develop and implement policies, procedures, and mechanisms to support health and safety and prepare for and address medical emergencies. Most school physicians are not housed in school facilities; rather, they maintain private practice and work for the school district under contract. In larger school districts, several school physicians may be employed with one serving as the lead.

In New Jersey, the school physician annually provides written standing orders for the provision of care in district schools, establishes standards of care for emergency situations and medically-related care for students and staff, and directs the professional duties of other school health services staff. The school physician works with other school health personnel to meet the special healthcare needs of technology supported and medically fragile children and those identified under the Individuals with Disabilities Education Improvement Act (IDEA). The school physician also authorizes the tuberculin testing program as required by the NJDOH.

Physical examinations may be conducted in the school physician’s office or other comparably equipped facility for students who do not have a medical home or whose parent has identified the school as the medical home for the purpose of the sports physical examination. The school physician must provide written notification to the parent/guardian stating approval or disapproval of the student’s participation in athletics based upon the medical report. In addition, the school physician reviews, as needed, reports and orders from a student’s medical home addressing student health conditions and interventions.

The school physician also reviews requests for home instruction. As a member of the school health team, the school physician assists the school nurse to conduct health screenings of students and staff and assists with the delivery of school health services, as appropriate. For example, the school physician may establish parameters for referrals for health screenings such as vision or hearing.

Some school districts may contract with physicians specifically to service student athletes or to attend to student athletes at sporting events such as football games. Law and code does not specifically address the qualifications, roles, and responsibilities of “team physicians.” The New Jersey Interscholastic Athletic Association (NJSIAA) convenes a Medical Advisory Committee where team physicians, athletic trainers, and other health-care personnel discuss health issues related to student athletes. However, as defined in law and code, the school physician serves all students not just student athletes. As such, the school physician serves as the chief medical advisor for all school policies and procedures, including those addressing the needs of student athletes.



Key Point

*Statute and regulations do not specifically address the qualifications and responsibilities of a “team physician.” However, the NJDOE’s **Model Policy and Guidance for the Prevention and Treatment of Sports-Related Concussions and Head Injuries** uses the term “school/team physician” indicating that all physicians serving under contract must complete the head injury training program required by N.J.S.A. 18A:40-41.2.*

Key Point

The Academy of Pediatrics, New Jersey Chapter, recommends that physicians have at least one year of pediatric practice (preferably two years) before becoming a school physician (Agathis, December 21, 2017).

Applicable Laws and Regulations

N.J.S.A. 18A:40-1 – Employment of Medical Inspectors, Optometrists, and Nurses

Every board of education shall employ one or more physicians, licensed to practice medicine and surgery within the state, to be known as the medical inspector or medical inspectors, and any board, not furnishing nursing services under a contract pursuant to section N.J.S.A.18A:40-3.1 shall employ one or more school nurses, and it may also employ one or more optometrists, licensed to practice optometry within the state, to be known as the school vision examiner or school vision examiners, and the board shall fix their salaries and terms of office.

Every board of education shall adopt rules, subject to the approval of the state board, for the government of such employees.

N.J.S.A. 18A:40-1.1 – Student-Athlete Cardiac Screening Professional Development Module

A contract between a school district and a school physician appointed pursuant to N.J.S.A.18A:40-1 shall include a statement of assurance that the school physician has completed the Student-Athlete Cardiac Screening Professional Development Module



developed pursuant to section 3 of P.L. 2013, c.71 P.L. 2013, c.71 (C.18A:40-41d) and has read the pamphlet developed pursuant to section 1 of P.L. 2007, c.125 (C.18A:40-41).

N.J.A.C. 6A:16-2.3 – Health Services Personnel

These regulations require each district board of education to appoint at least one school physician and in school districts where there is more than one school physician, a lead physician must be appointed to serve as health services director. The school physician must be currently licensed by the New Jersey Board of Medical Examiners in medicine or osteopathy with training and practice in child and adolescent health and development. Candidates for the position must undergo a criminal history background check. A contract between a school district and a school physician appointed pursuant to N.J.S.A. 18A:40-1 shall include a statement of assurance that the school physician has completed the Student-Athlete Cardiac Screening Professional Development Module developed pursuant to N.J.S.A. 18A:40-41d and has read the sudden cardiac arrest pamphlet developed pursuant to N.J.S.A. 18A:40-41.



While the role of the school physician is defined in regulations, he/she is critical to the success of all school health programs.

The school physician must provide the following services, at minimum:

- Consultation in the development and implementation of school district policies, procedures, and mechanisms related to health, safety, and medical emergencies pursuant to N.J.A.C. 6A:16-2.1(a);
- Consultation to school district medical staff regarding the delivery of school health services, which includes special health care needs of technology-supported and medically fragile children, including students covered by 20 U.S.C. §§ 1400 et seq., Individuals with Disabilities Education Act;
- Physical examinations conducted in the school physician's office or other comparably equipped facility for students who do not have a medical home;
- Provision of written notification to the parent stating approval or disapproval of the student's participation in athletics based upon the medical report;
- Direction for professional duties of other medical staff;
- Written standing orders that shall be reviewed and reissued before the beginning of each school year;
- Establishment of standards of care for emergency situations and medically related care involving students and school staff;
- Assistance to the certified school nurse or noncertified nurse in conducting health screenings of students and staff and assistance with the delivery of school health services;
- Review, as needed, reports and orders from a student's medical home regarding student health concerns;
- Authorization of tuberculin testing for conditions outlined in N.J.A.C. 6A:16-2.2(c);
- Review, approval, or denial with reasons of a medical home determination of a student's anticipated confinement and resulting need for home instruction; and,
- Consultation with the school district certified school nurse(s) to obtain input for the development of the school nursing services plan, pursuant to N.J.A.C. 6A:16-2.1(b).



Key Point

Written standing orders are to be reviewed and reissued by the school physician before the beginning of each school year.

Key Point

The school physician consults with the school district's certified school nurse(s) to develop the School Nursing Services Plan.

Key Point

The school physician may also be involved in the examination of students suspected of being under the influence as outlined in N.J.A.C. 6A:16-4.3.

Certified Athletic Trainer

Athletic trainers providing care to student athletes in K-12 public schools must be licensed by the [New Jersey Board of Medical Examiners](#) and hold an educational certificate issued by the NJDOE. The athletic trainer's practice consists of the physical conditioning and reconditioning of athletes, the prevention of injuries, and the application of physical treatment modalities to athletes under a plan of care designed and overseen by a supervising physician licensed in New Jersey. A plan of care means a documented arrangement between a licensed athletic trainer and a physician which establishes the physical treatment modalities a licensed athletic trainer will utilize while providing services to athletes in an interscholastic, intercollegiate, intramural, or professional athletic setting. It also includes any athletic training services, including physical treatment modalities, the athletic trainer will provide when he or she is working with an athlete outside of an interscholastic, intercollegiate, intramural, or professional athletic setting. A supervising physician means a physician with whom an athletic trainer has a plan of care. Supervision means that a physician licensed in New Jersey is accessible to a licensed athletic trainer, either on-site or through voice communication, during athletic training (NJDLPs, 2017). The [Athletic Trainers' Society of New Jersey](#) provides additional information, resources and training.

School nurses, physicians, and athletic trainers work together as part of the school health team providing prevention, care, and appropriate management of athletic-related injury and illnesses. Frequent communication among the members of the team allows for the implementation of effective policies and practices that support student athletes and promote school wellness.

Applicable Laws and Regulations

School Athletic Trainers Law

N.J.A.C. 13:35-10 – Athletic Trainers

The New Jersey Board of Medical Examiners establishes licensing requirements and defines the scope of practice for all athletic trainers. Individuals who wish to work in a K-12 setting must first complete these requirements before applying for an educational certificate.

Educational Endorsement Code 2930

N.J.S.A. 18A:40-41.7 – Pre-Participation Physical Evaluation Form Required for Student-Athletes; Certification Statement

The law requires each student whose physical examination was completed more than 90 days prior to the first day of official practice in an athletic season to provide a health history update questionnaire, completed and signed by the student's parent or guardian. The completed health history update questionnaire must be reviewed by the school nurse and, if applicable, the school's athletic trainer.



Key Point

*In order to ensure safe participation in school-sponsored athletic programs, the school nurse reviews and shares the completed **Preparticipation Physical Evaluation History Form Health and History Update Questionnaire** with the school's athletic trainer. It then becomes part of the student's school health record.*

Student Assistance Professionals/Substance Awareness Coordinators

Student assistance programs are a comprehensive framework for the delivery of K-12 universal, targeted, and selected prevention/intervention strategies and programs. Student assistance services are designed to reduce risk factors, promote protective factors, and increase asset development. Student assistance professionals may be called student assistance coordinators or SACs (previously known as substance awareness coordinators). These professionals identify, address, and monitor individual students; coordinate and oversee district prevention/intervention efforts; and, address student substance abuse and mental health and behavioral problems (ASAPNJ, 2017). Recognizing the challenges of this role, the NJDOE established specific criteria required for individuals to become certified student assistance coordinators. In addition, New Jersey requires schools to provide both education and intervention for students experiencing substance abuse and other social/emotional issues. Student assistance professionals work with the school health team to link students and their families with the resources and specialized services.

Applicable Laws and Regulations

In 1987, the New Jersey Legislature approved N.J.S.A. 18A:40A-18 which required the Commissioner of Education, in consultation with the Commissioner of Health, to develop and administer a program that provided for the employment of student assistance coordinators in certain school districts. To date, many school districts continue to employ part-time and full-time student assistance coordinators; however, the Legislature has yet to require school districts to employ them despite the clear need for their services in today's schools and dedicated funding has not been appropriated. Current legislative efforts focus on establishing a requirement based on district enrollment.

N.J.A.C. 6A:16-3.1 – Establishment of Comprehensive Alcohol, Tobacco, and Other Drug Abuse Programs

These regulations describe district substance abuse prevention requirements. When student assistance coordinators are employed by the district, they assist the school district in the effective implementation of the requirements set forth in N.J.S.A.18A:40A-1 through 18 and N.J.A.C. 6A:9B-12.2.

The **Association of Student Assistance Professionals of New Jersey (ASAPNJ)** keeps its members apprised of current **statutes** and **regulations** and the status of legislative initiatives to strengthen the role of its members. It also provides an overview of licensing requirements for **student assistance coordinators**.

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CHAPTER THREE: Conducting Health Assessments and Screenings

Topic: Medical Examinations and Evaluations

Background and Rationale



A child's health status significantly impacts his ability to learn and to fully participate in school sponsored programs. Some health conditions can be addressed to minimize their impact on the child's capacity to learn and adaptations can be made to accommodate a child's needs. The goals of school-based health assessment and screenings are the early identification of potential health issues that may im-

impact a child's educational program; referral to appropriate healthcare providers to address the health concern; the identification of students with special healthcare needs that require services during the school day; and, the reduction of absenteeism due to health issues.

The AAP endorses the importance of comprehensive periodic health assessments including attention to school health issues beginning at the age of three years. The AAP recommends and supports the continued strong partnership among school nurses, other school health personnel, and pediatricians and supports the goal of professional preparation for all school nurses (AAP, 2016). It is within the certified school nurse's scope of practice to routinely conduct various health screenings.

Bright Futures was developed by the AAP to support primary care practices (medical homes) to provide well-child and adolescent care. A complementary goal was to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that health promotion efforts can be aligned with the recommendations in the Bright Futures Guidelines. School nurses may find these materials helpful when communicating with parents about physical examinations and screenings.

While New Jersey no longer requires schools to provide routine physical examinations, it does require that evidence of an examination be submitted upon entrance to school. This examination establishes a baseline that is incorporated into the student's health record and monitored by the school nurse, working with the child's parents or guardians



and medical home, to ensure that current or potential health issues are identified and addressed. The **American Academy of Pediatrics-Committee on School Health (AAP-COSH)** states that an assessment on entry into school should include a review of the medical history with attention to physical, emotional, or family problems that might influence school achievement. Ideally, this assessment should be conducted at the child's medical home and should include a careful evaluation of the child's language, motor, social, and adaptive development. Students identified with potential behavioral, health, and learning issues may require evaluation by the school district's child study team (AAP, 2000).

New Jersey requires a number of different health evaluations, exams, and assessments.

- A pre-participation history and physical is required in order to participate in interscholastic sports. This serves to ensure the health and safety of the athlete in training and competition.
- An examination and evaluation must also be conducted after an athlete experiences a concussion, a type of traumatic brain injury caused by a bump, blow, or jolt to the head or by a hit to the body.
- A physical examination is required before minors under the age of 18 can obtain an employment certificate, also called "working papers," or a special permit for agricultural or theatrical employment or employment as a newspaper carrier.
- An evaluation and medical examination must be conducted on any student suspected of being under the influence of alcohol or a controlled dangerous substance.
- A comprehensive child study evaluation which includes cognitive, behavioral, physical, and developmental data is conducted for those students experiencing learning or behavioral difficulties.

The school nurse maintains the student's health record which includes the results of physical examinations, screenings, and evaluations. Further, the school nurse must work closely with the school physician and other members of the school health team, as appropriate and permitted by law, to review and analyze the results of the exams, make appropriate referrals, and follow-up. The school nurse is the critical link between the school, student, family, and medical home.

Referrals

School nurses often ask: When should I refer a child for additional evaluation or care? There is no easy answer to this difficult question. In some cases, New Jersey law or rule stipulates when a parent/guardian should be notified of a possible health concern that requires follow-up with a medical professional. For example, laws regarding the evaluation of a student suspected of being under the influence are very clear about the role of the school, parents, and medical care providers. However, other screening mandates may

have required the Commissioner of Education and the Commissioner of Health (NJDOE and NJDOH) to establish standards and procedures for the screening process at the time the law went into effect. The original requirements may have occurred many years ago and may not have been updated to reflect new equipment or standards of care.

In general, the screening and referral standards found in this document reflect current practice. Keep in mind that school nurses work under the direction of the school physician who establishes standing orders and protocols for the delivery of school health services in the school district which includes protocols for screening programs and follow-up care. A school physician with experience in child and adolescent health is critical to the process. The school physician and the school nurse should work collaboratively to establish a screening and referral process that ensures that parents/guardians are promptly notified when their child has a suspected deviation from the norm. The parents/guardians are encouraged to have the child evaluated by a qualified medical practitioner and then report the outcome of the examination to the school nurse. In some situations, the school nurse and the social worker may need to work together to assist the family to access appropriate medical care. This creates a “system of care” both within and outside the school.

Whenever appropriate, this document explains when a student should be referred based on the outcome of a thorough, properly conducted screening or examination. In some cases, a child may need to be rescreened to confirm the original outcome. Once the referral to the parent/guardian is made, the school nurse should communicate with the family to see if care has been received and if not, determine how the school health team may assist. Lack of follow-up care by the parent/guardian can result in an allegation of child neglect. Documentation of the initial referral and all follow-up communications is extremely important. The [Delaware School Nurse Manual](#) provides sample referral forms that could be easily modified for use in any school.

School-based screening and examination programs are medically and educational significant. Local boards of education must comply with all requirements, and if not delineated in law or code, then the appropriate personnel (the school physician and nurse) must establish the procedures and protocols which are approved by the board of education. An effective referral process is a key complement to ensure that all students are healthy and ready to learn

Applicable Laws and Regulations

N.J.S.A. 18A:40-4 – Examinations for Physical Defects

N.J.A.C. 6A:16-2

The medical inspector, or the nurse or licensed medical and health care personnel under the immediate direction of the medical inspector, shall examine every pupil to learn whether any physical defect exists, or in lieu thereof the medical inspector may accept the report of such an examination by a physician licensed to practice medicine and surgery within the State or by a nurse practitioner/clinical nurse specialist certified by the New Jersey Board of Nursing working in collaboration with a physician licensed to prac-



tice medicine and surgery within the State. If any deviations in health status are detected, the nurse practitioner/clinical nurse specialist shall refer the pupil to the collaborating physician. The frequency and procedure of and selection of pupils for examinations shall comply with the rules of the State Board of Education. Additionally a screening of hearing examination shall be conducted on each pupil during the school year pursuant to rules, regulations and standards established by the State Department of Education in consultation with the State Department of Health.

A pupil who presents a statement signed by his parents or guardian that such required examinations interfere with the free exercise of his religious beliefs shall be examined only to the extent necessary to determine whether he is ill or infected with a communicable disease or to determine his fitness to participate in any health, safety, and physical education course required by law.

A health record of each pupil shall be kept, in which shall be entered the findings of each examination, and such record shall be the property of the board of education and shall be forwarded to any public school to which the pupil is transferred, if such school is known.



Key Point

Parents may ask that their child be exempted from physical examinations; however, a child may be examined to determine if he/she is infected or ill with a communicable disease and if he/she is "fit" to participate in health, safety, and physical education courses required by law.

N.J.S.A. 18A:40-4 – Required Physical Examination Upon Enrollment

N.J.A.C. 6A:16-2.2

This section specifically addresses the physical examination required for enrollment in a New Jersey public school. For all new enrollees, including those enrolling from out of state or out of the country, the pupil's parents/guardians have 30 days to provide evidence of a medical examination that includes the following:

1. Evidence of immunizations pursuant to N.J.A.C. 8:57-4.1 through 4.24;
2. A medical history, including allergies, past serious illnesses, injuries, operations, medications, and current health problems;
3. Health screenings including height, weight, hearing, blood pressure, and vision; and,
4. A physical examination.

New Jersey recognizes the importance of a medical home for every child. The enrollment medical examination provides a baseline for future health and educational evaluations. However, if a student does not have a medical home, the school district shall provide the examination at the school physician's office or other comparably equipped facility.



Key Point

When a student transfers to another school, the sending school district must forward the entry examination documentation along with the official health records.

Key Point

The school district must notify parents through its website or other means about the importance of obtaining subsequent medical examinations of the student at least once during each developmental stage: at early childhood (preschool through grade three), pre-adolescence (grade four through six), and adolescence (grade seven through 12). These examinations should be conducted at the child's medical home in order to ensure continuity of care.

N.J.A.C. 6A:14-3.4(a)1 – Comprehensive Child Study Examination

N.J.A.C. 6A:14-3.4(j)

This section describes the school nurse's role in the identification of students with disabilities. The comprehensive child study evaluation uses cognitive, behavioral, physical and developmental data to determine how best to provide a student with educational programs and services in the least restrictive environment. School nurses deliver "related services" as defined by IDEA. Upon receipt of a written referral to the child study team, the school nurse reviews and summarizes available health and medical information regarding the student and transmits the summary to the child study team. Additional health appraisals or specialized medical evaluations may result from the CST's review.

N.J.A.C. 6A:16-4.3 – Evaluation of Students Suspected of Being Under the Influence

N.J.A.C. 6A:16-2.2-(h)5i

When a student is suspected of being under the influence of alcohol or controlled dangerous substances, the certified school nurse assesses the student's vital signs and general health status for emergent issues and takes appropriate emergency actions pending the required medical examination by a licensed physician. The principal (or his designee which may be the school nurse), arranges for an immediate medical examination of the student for the purposes of providing appropriate health care and for determining whether the student is under the influence of alcohol or other drugs, other than anabolic steroids.



Key Point

The medical examination must be performed by a physician licensed to practice medicine or osteopathy who is selected by the parent. The examination is at the expense of the parent and not the district board of education.



Key Point

If the physician chosen by the parent is not immediately available, the medical examination must be conducted by the school physician. If the school physician is not available, the student shall be accompanied by a member of the school staff designated by the principal to the emergency room of the nearest hospital for examination. When the medical examination is conducted by the school physician or a physician at the emergency room of the nearest hospital, the examination shall be at the expense of the district board of education.

N.J.S.A. 34:2-21.8(3) – Physical Examination for Working Papers

N.J.A.C. 6A:16-2.2h

All minors under the age of 18 who work in New Jersey must have an employment certificate, also called “working papers,” or a special permit (agriculture, newspaper carrier, or theatrical employment). The **A300 form** requires a physical examination with certification by a licensed physician attesting to the minor’s physical ability to perform. The school district is responsible for performing the physical examination at no cost to the minor. A school physical (including a sports physical) performed during freshman year (grade 9 or equivalent) is applicable for working papers for all four years of high school (unless the school district policy specifies more frequent physicals).



Key Point

If the minor’s parent/guardian prefers that the child be examined by a doctor other than the one employed by the school district, it is done at their own expense. A minor is not required to obtain a physical if the parent/guardian objects (in writing) based on their religious beliefs and practices.

N.J.S.A. 18A: 40-41.7 – Pre-Participation Physical Evaluation for Student Athletes

N.J.A.C. 6A:16-2.2h

Prior to participation on a school-sponsored interscholastic or intramural athletic team or squad, students enrolled in grades six to 12 must have a physical examination. The annual physical examination must be documented using the Pre-Participation Physical Evaluation (PPE) form developed by the Commissioner of Education. It is available in both **English** and **Spanish**.

The PPE form includes the history and physical examination components. The physical examination must be conducted within 365 days prior to the first day of official practice in an athletic season and be conducted by a licensed physician, advanced practice nurse (APN), or physician assistant (PA).

The medical report must be completed and signed by the original examining physician, APN, or PA explaining if the athlete has been approved or disapproved for participation. The PPE uses the following designations to fulfill the statutory requirement:

- Cleared for all sports without restriction;
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____;
- Not cleared pending further evaluation;
- Not cleared for any sports; or,
- Not cleared for certain sports (explanation required)



Key Point

An incomplete form must be returned to the student's medical home for completion unless the school nurse can provide documentation to the school physician that the missing information is available from screenings conducted by the school nurse or physician within the prior 365 days.

Key Point

*Any licensed physician, APN, or PA who performs student athlete physical exams must complete the **Student-Athlete Cardiac Screening Professional Development Module**. The PPE includes a certification statement that must be signed by the licensed physician, APN or PA who performed the student's physical examination, attesting to the completion of the current professional development module. If the licensed physician, APN, or PA from the student's medical home did not complete this requirement, the student's parent/guardian may obtain a physical examination from a physician who can certify completion. The school physician may also provide the examination.*

Each student whose medical examination was completed more than 90 days prior to the first day of official practice in an athletic season must provide a health history update of medical problems experienced since the last medical examination. This form must be completed and signed by the student's parent/guardian. The completed **Health History Update** is reviewed by the school nurse and, if applicable, the school athletic trainer.

The update asks the following questions:

- Has the student been advised by a licensed physician, APN, or PA not to participate in a sport?
- Has the student sustained a concussion, been unconscious, or lost memory from a blow to the head?
- Has the student broken a bone or sprained, strained, or dislocated any muscles or joints?



- Has the student fainted or blacked out?
- Has the student experienced chest pains, shortness of breath, or heart racing?
- Has the student had a recent history of fatigue and unusual tiredness?
- Has the student been hospitalized, visited an emergency room, or had a significant medical illness?
- Has the student started or stopped taking any over the counter or prescribed medications?
- Has the student had a sudden death in the family, or has any member of the student's family under the age of 50 had a heart attack or heart trouble?

After completion of the process, the school district must provide **written notification signed by the school physician** to the student's parent or guardian indicating either approval for participation in athletics based on the medical report or the reasons for the school physician's disapproval of the student's participation.



Key Point

A board of education of a public school district and the governing board or chief school administrator of a nonpublic school shall not permit a student enrolled in grades six to 12 to participate on a school-sponsored interscholastic or intramural athletic team or squad unless these requirements have been completed.

N.J.S.A. 18A:40-41h – Sudden Cardiac Arrest Prevention Act (P.L. 2013, C 209)

A student who exhibits symptoms or early warning signs of sudden cardiac arrest, as determined by an athletic trainer if one is on site, or if an athletic trainer is not on site, then a game official, team coach, licensed physician, or other official designated by the student's school, while participating in an athletic activity, must be immediately removed from the athletic activity by the coach.

The student is not eligible to return to athletic activity until he is evaluated and receives written clearance from a licensed physician. A student who exhibits symptoms or early warning signs of sudden cardiac arrest at any time prior to or following an athletic activity is prohibited from participating in an athletic activity. The student is not eligible to return to athletic activity until he is evaluated and receives written clearance from a licensed physician.

The board of education of a school district or the governing body or chief school administrator of a nonpublic school, as appropriate, must ensure that a person who coaches a school district or nonpublic school athletic activity who knowingly violates the provisions of subsection shall be suspended from coaching activities.

N.J.S.A. 18A:40-41.1-41.5 – Head Injuries and Student Athletes

Each school district is required to develop a written policy concerning the prevention

and treatment of sports-related concussions and other head injuries among student-athletes. The policy shall be reviewed annually, and updated as necessary, by the district to ensure that it reflects the most current information available on the prevention, risk, and treatment of sports-related concussions and other head injuries.

A student who participates in an interscholastic sports program and who sustains or is suspected of having sustained a concussion or other head injury while engaged in a sports competition or practice shall be immediately removed from the sports competition or practice. A student-athlete who is removed from competition or practice shall not participate in further sports activity until he is evaluated by a physician or other licensed healthcare provider trained in the evaluation and management of concussions, and receives written clearance from a physician trained in the evaluation and management of concussions to return to competition or practice.

Model Policy and Guidance for Prevention and Treatment of Sports-Related Concussions and Head Injuries

Additional Points for School Nursing Practice

The **A-45 Health History and Appraisal Form** is the official student health record for all screening data and the results of physical exams. The A-45 was revised in June 2014 to include a space in the history section to document a concussion and brain injury.

School nurses provide critical guidance to parents and guardians about the risk versus benefits of participation in athletics, particularly for a student athlete that is returning to sports after an illness or injury.

The school nurse has access to student health information and therefore, plays a critical role to ensure that the PPE form and Health History Update, as submitted, accurately reflect the past and current health status of the student.

The school nurse and the athletic trainer should work closely to ensure the health and safety of every student athlete

At Your Own Risk was developed by the National Athletic Trainers Association to help student athletes better understand injury prevention in sports.

Conducting Health Assessments and Screenings

Topic: Auditory Screenings

Background and Rationale

According to the **American Academy of Audiology**, hearing loss is the most common developmental disorder identifiable at birth (ranging from 1 to 3/1000) and its prevalence increases throughout school-age due to the additions of late-onset, late identified, and acquired hearing loss. It has been estimated that the prevalence of permanent hearing loss in infants can be expected to increase to 9-10/1000 in the school age population (White, 2010). Early identification and intervention is critical to maximize the optimum



window that continues until approximately age five. Children must develop language to think and to attain cognitive, abstract thinking skills.

The purpose of a school-based auditory screening program is to identify students with hearing loss that may impact their intellectual, emotional, social, speech, or language development. Even minimal or unilateral hearing losses may be educationally and medically significant. Children may have difficulty listening due to auditory processing problems. The earlier a child develops hearing loss, the more likely it will impact the child's development. Similarly, the earlier the problem is identified and intervention begun, the less serious the ultimate impact. Delays in expressive and receptive communication skills and a related speech-language deficit may lead to learning difficulties impacting academic achievement. As a result, students may have limited educational or vocational choices. Children with communication disorders may also develop a poor self-concept leading to social isolation (ASHA, 2017).

The school-based hearing screening program aims to identify children who present with hearing loss. While the school nurse is responsible for the auditory screening program, larger school districts may also employ an audiologist or speech-language pathologist who are specially trained to detect hearing loss and who may serve as valuable assets in the screening process. Once a student is identified with a possible hearing loss, the school nurse must work closely with the student's parents and medical home to ensure that an appropriate evaluation is completed and the results must be recorded on the student's health record. Students may also be referred to a specialist for a more complete audiological examination and the results should also be included in the student's health record. The American Speech-Language-Hearing Association (ASHA) identifies **key issues** when conducting hearing screening programs.

Hearing loss can be categorized by which part of the auditory system is damaged. There are three basic types of hearing loss: conductive hearing loss, sensorineural hearing loss, and mixed hearing loss.

- Conductive hearing loss occurs when sound is not conducted efficiently through the outer ear canal to the eardrum and the tiny bones (ossicles) of the middle ear. Some possible causes include fluid in the ear, an ear infection, allergies, a perforated eardrum, impacted earwax, or the presence of a foreign body.
- Sensorineural hearing loss (SNHL) occurs when there is damage to the inner ear (cochlea), or to the nerve pathways from the inner ear to the brain. This is the most common type of permanent hearing loss. It may be caused by ototoxic drugs, illnesses, head trauma, malformation of the inner ear, noise exposure, or heredity.
- Mixed hearing loss involves both a conductive hearing loss and a sensorineural hearing loss (SNHL). There may be damage in the outer or middle ear and in the inner ear (cochlea) or auditory nerve (ASHA, 2017b).

Applicable Laws and Regulations

N.J.S.A. 18A:40-4 – Auditory Screening

This law requires that an auditory screening be conducted on each pupil during the school year pursuant to rules, regulations, and standards established by the State Department of Education in consultation with the State Department of Health.

N.J.A.C. 6A:16-2.2(l)3 – Frequency of Screening

This requires that screening for auditory acuity be conducted annually for students in Kindergarten through grade three and in grades seven and 11.

N.J.A.C. 6A:16-2.2(l)5&6 – Screenings

These rules require that screenings be conducted by a school physician, school nurse, or other school personnel properly trained and that the school district notify the parent of any student suspected of deviation from the recommended standard.

N.J.A.C. 6A:16-2.2(g)3 – Mandated Health Screenings

This rule establishes that health screenings including height, weight, hearing, blood pressure, and vision are part of any required medical examination.

N.J.A.C. 6A:16-2.3(b)3ii – School Nurse and Screenings

This rule establishes that the school nurse is responsible for conducting health screenings which include height, weight, blood pressure, hearing, vision, and scoliosis.

N.J.A.C. 6A:16-2.4(a)1 – Health Records

School districts must maintain for each student a student health record that includes the findings of health histories, medical examinations, and health screenings.

N.J.A.C. 6A:14-3.3(g) – Hearing Screening and Special Education Evaluation

Audiometric screening shall be conducted for every student referred to the child study team for a special education evaluation.

Additional Points for School Nursing Practice

In addition to those grade levels specified in regulations, hearing screenings should be conducted for students entering the district with no recent record of audiometric screening or those considered at risk for hearing impairments. The school nurse should also screen students referred by a teacher, parent or guardian, or at the student's own request.

The school nurse should establish screening procedures based on the age and developmental level of the students being screened.



Key Point

Explain to very young children that the procedure will not hurt. The school nurse may demonstrate the procedure on a doll or stuffed animal.



The school nurse should examine the outer ear and make note of any abnormalities (e.g. shape, size, symmetry, variations from normal). If appropriately trained, the school nurse should use an otoscope to visualize the tympanic membrane and external ear canal for signs of drainage, foreign bodies, impacted cerumen, infection, or other abnormalities. The school nurse should consider if any detected abnormalities might impact the outcome of additional screening, and if appropriate, immediately refer the child to the medical home for care. The results of this examination and follow-up must be documented on the child's school health record.



Key Point

The school health office may not be the best place to conduct hearing screenings. The screenings should take place in a quiet room without distractions and ambient noise. A soundproof room is preferred but if not available, a room without windows may help reduce competitive noise.

Sound is measured in decibels (loudness). In addition to loudness, sound has pitch, or high and low sounds, measured in Hertz (Hz). School hearing screening programs generally focus on pure tone recognition for populations aged three and older.

Audiometers are used to test hearing. For small children, the picture audiometer may be used. The audiometer can test both decibels (dB) and Hertz (Hz). According to the Occupational Health and Safety Administration (OSHA) Audiometric Test Requirements, the audiometer should be calibrated annually in accordance with the American National Standards Institute (ANSI) Specifications for Audiometers. Make sure to check the equipment prior to beginning the screening program.



Key Point

If the student is experiencing allergy symptoms, a respiratory illness, or ear, nose, or throat problems, reschedule the screening and notify the child's parent guardian.

Screening Process

Conduct a brief practice test at 20dB and 4000Hz. Then screen each ear individually at 20dB at 1000Hz, 2000Hz, and 4000Hz. Present each tone for 1-2 seconds. Present a tone at least twice but no more than four times if a child fails to respond.



Key Point

Older children can indicate hearing the tone with a raised hand signal. Because younger children may not fully understand directionality (e.g. left and right, up and down), the test can be made into a game. For example, the child can be asked to touch a toy every time a sound is heard or place a block in a bucket.

If the student does not respond at criterion dB level at any frequency in either ear, explain the process again, check placement of the earphones, and then re-screen. Lack of response at any frequency in either ear constitutes a failed screening.

If a student fails the first screening, notify the child's teacher that the student will need a follow-up screening and schedule a date and time in two to four weeks. A student who fails the second (follow-up) screening requires a referral for further evaluation by the medical home.

The [Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies](#) in the *Journal of Adolescent Health* raises issues about the current AAP standards for audiometric testing in adolescents.



Key Point

Be sure to document each screening on the student's health record in the designated area.



Key Point

Inform the parent/guardian that a referral for medical attention is indicated and answer their questions regarding audiometric screening. Complete a referral form and send it to the child's parent/guardian.



Key Point

Notify the student's teacher(s) that a referral has been made and communicate appropriate follow-up information with the teacher(s) once a report from the medical home and/or audiologist has been received.

Key Point

Use a disinfectant wipe to clean earpieces after each student's use.

Key Point

Some districts employ an audiologist or speech-language professional who can work with the school nurse to conduct screenings on students with significant disabilities or confirmed speech-language disorders.

The [American Speech-Language-Hearing Association](#) established guidelines for hearing screening protocols with respect to age, developmental status and grade levels of children to be screened; types of screening procedures to be utilized; follow-up procedures for children who do not pass a screening; and, qualifications of screening personnel. The [CDC Childhood Hearing Guidelines](#) reflect the American Academy of Audiology's recommendations. The [American Academy of Otolaryngology-Head and Neck Surgery](#) provides information for nurses and parents on child hearing screening.

[NJDOE Resources for Hearing Loss or Deaf-Blindness](#)



Conducting Health Assessments and Screenings

Topic: Blood Pressure Screenings

Background and Rationale

High blood pressure, also called hypertension, happens when the force of blood flowing through the arteries is too strong. An individual's blood pressure may be temporarily higher after exercise or during stress. When the individual's blood pressure is elevated for longer periods of time, serious health problems such as stroke, kidney failure or heart attack can occur. The long term health risks can be significant, since elevated blood pressure in children correlates with hypertension in adulthood.

Pediatric hypertension and prehypertension are largely undiagnosed, partially because identifying hypertension in children is complicated. Variation in normal BP ranges across sex, height percentile, and age; therefore, percentiles of height, the child's age, and sex must be used in determining a referral for hypertension. The National Heart, Lung and Blood Institute developed *A Pocket Guide to Blood Pressure Management in Children* and *Blood Pressure Guidelines for Children and Youth* to assist health professionals conducting screening programs.

The Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents defined hypertension as the average systolic BP (SBP) and/or diastolic BP (DBP) greater than or equal to the 95th percentile for sex, age, and height on three or more occasions. Prehypertension in children was defined as average SBP or DBP levels greater than or equal to the 90th percentile, but less than the 95th percentile (NHLBI, 2005, p.4). However, the Report was updated in 2017 with the release of the *Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents*. The 2017 document replaces the term "prehypertension" with the term "elevated blood pressure." It provides new normative pediatric BP tables based on normal-weight children and a simplified screening table for identifying BPs needing further evaluation. It also outlines a simplified BP classification in adolescents ≥ 13 years of age that aligns with the new American Heart Association (AHA) and American College of Cardiology (ACC) *2017 Guideline for High Blood Pressure in Adults* (AAP, 2017). The AAP Guideline provides numerous tables, directions for accurately measuring cuff size, and step-by-step directions to take an accurate BP reading.

Elevated blood pressure in children and adolescents has a strong association with the marked increase in the prevalence of overweight children. Other factors impacting blood pressure include sleep disorders and undiagnosed metabolic syndrome. In addition, some nutritional supplements and over-the-counter, prescription, and illicit drugs may increase blood pressure. While a school-based annual blood pressure screening may be insufficient to detect hypertension, the school nurse should carefully review medical histories submitted for mandated medical exams such as sports physicals. (NHLBI, 2005, p.16).

Applicable Laws and Regulations

N.J.A.C. 6A:16-2.2(g)3 – Required Health Screenings as Part of Medical Examinations

Blood pressure screening is required as part of mandated medical examinations for sports participation, upon enrollment in school, when applying for working papers, as part of a comprehensive child study team evaluation, and when a student is suspected of being under the influence.

N.J.A.C. 6A:16-2.2(l)1 – Mandated Health Screenings

N.J.A.C. 6A:16-2.2(l)5-6

Screening for height, weight, and blood pressure shall be conducted annually for each student in Kindergarten through grade 12. Screenings shall be conducted by a school physician, school nurse, or other school personnel properly trained. Parents/guardians of any student suspected of deviation from the recommended standard shall be notified.

N.J.A.C. 6A:16-2.3(b)3ii – Role of School Health Personnel

The certified school nurse conducts health screenings, including height, weight, blood pressure, hearing, vision, and scoliosis and monitors vital signs and general health status for emergent issues for students suspected of being under the influence of alcohol and controlled dangerous substances.

Additional Points for School Nursing Practice

The aneroid sphygmomanometer is considered the gold standard for measuring blood pressure; however its use of mercury, a hazardous material, makes it less likely to be used in healthcare today. The use of a high-quality automatic machine is acceptable if calibrated according to manufacturers' directions.



Key Point

The 2017 AAP Blood Pressure Guideline Tables and related information should replace older information and tables on BP readings and interventions for children and adolescents.

Blood pressure tables for children and adolescents help determine the normal range based on body size and age. Those adding sex and height provide a more precise classification of BP according to body size. This approach avoids misclassifying children who are very tall or very short (NLHBI,2005,p.8).

Screening Process

To measure BP:

- The student should sit with feet on the floor and the right arm supported at heart level.
- The cuff width should be 40% of the student's upper arm. The cuff length should be adjusted for diameter of the arm. The use of the proper size cuff is essential. A variety of cuffs should be available in the school health office including pediatric, regular adult, large adult, and thigh cuff.
- If the Korokoff sounds go all the way to "0," try again with less pressure on the stethoscope head. If they still go to "0," record muffling as the diastolic number.
- Calculate the BP percentile using the child's age, sex, and percentile of height as per current tables.
- Refer all BP above or equal to the 95th percentile. BMI may be included at your discretion.
- Document the findings and referral on the Health History and Appraisal Form A-45.



Conducting Health Assessments and Screenings

Topic: Dental and Oral Screenings

Background and Rationale

Tooth decay (cavities) is one of the most common chronic conditions of childhood in the United States. Untreated tooth decay can cause pain and infections that may lead to problems with eating, speaking, playing, and learning. Both the AAP and the American Academy of Dentistry (AAD) recommend that all children see a pediatric dentist and establish a "dental home" by age one. Visiting the dentist regularly for professional cleanings and oral examination allows for the identification and treatment of dental problems at an early stage before negative repercussions on overall health occur.

- About 1 of 5 (20%) children aged 5 to 11 years have at least one untreated decayed tooth.
- 1 of 7 (13%) adolescents aged 12 to 19 years have at least one untreated decayed tooth

- The percentage of children and adolescents aged 5 to 19 years with untreated tooth decay is twice as high for those from low-income families (25%) compared with children from higher-income households (11%) (CDC, 2014).

Oral health impacts general health and quality of life. Oral health involves being free of mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual's capacity to bite, chew, smile, and speak. Poor oral health can also impact an individual's psychosocial wellbeing (WHO, 2012). School nurses who perform a dental and oral health screening may find the [Bright Futures Oral Risk Assessment Tool](#) helpful.

Some schools participate in a fluoride rinse program. Fluoride acts to impede demineralization and to enhance the remineralization of dental enamel, both of which prevent dental caries. While fluoride occurs naturally in water across the country, it is usually lower than the optimal concentration needed to prevent caries (Community, 2017). The New Jersey Dental Association (NJDA) believes that [public fluoridation](#) is an important part of preventing tooth decay.

While school nurses may focus on dental care and hygiene, they are often called upon to deal with dental trauma due to playground injuries, sports, or falls. The [American Academy of Pediatric Dentistry \(AAPD\)](#) established guidelines for the general management of acute traumatic dental injuries. According to the AAPD, trauma to the primary teeth most often occurs at 2 to 3 years of age with injuries to permanent teeth occurring due to falls, accidents, violence, and sports. The [American Association of Endodontists](#) also provides information on dental trauma and care. RDH, The National Magazine for Dental Hygiene Professionals published [Dental Emergencies at School](#) which provides helpful tips for school nurses dealing with dental triage and emergencies.

Applicable Laws and Regulations

New Jersey statutes do not require local boards of education to employ a dentist and schools are not required to implement a school-based dental screening or examination program for students in grades K-12. The extent of dental services provided by school districts should be determined by the needs of the students and the availability of services. However, N.J.A.C. 13A-4.5(b) includes dental screenings as part of basic child health services for children enrolled in a state-funded pre-school programs for three and four-year olds.



Key Point

School nurses play an integral part in educating students and families of the importance of dental and oral health.

Key Point

School nurses assist students and families with obtaining dental care and help them understand dental health resources that are available in the community.



Additional Points for Nursing Practice

Healthy Teeth NJ is a new website designed to support the Oral Health Wellness Campaign, supported by the NJAAP and the New Jersey Oral Health Coalition's Pediatric Health Home Subcommittee. The Subcommittee defines inspection of the oral cavity as the assessment of the teeth, gums, tongue, sublingual veins, frenulum, buccal mucosa, palate, and uvula and should include an assessment of the teeth, gingiva, tongue, oral mucosa, and associated structures. Dental screenings encourage student awareness of the value of maintaining oral/dental health and can be performed by the school nurse and/or registered dental hygienist. To receive external resources to conduct dental screenings in your school, contact the **NJ Dental Hygienist Association**.

The **New Jersey Children's Oral Health Program** provides a variety of age-appropriate educational activities for children. Registered dental hygienists are available to conduct educational oral health presentations in schools. The program also distributes newsletters and offers loaner teaching kits for use by teachers and school nurses. Additionally, the program funds the **Save Our Smiles** voluntary fluoride mouth rinse program (FMR) for eligible schools.

Through the ADA Foundation's **Give Kids A Smile** program more than 5.5 million underserved children have received free oral health services. These free services are provided by volunteer dentists and dental team members the first Friday of February each year.

Some schools may participate in **school-based sealant programs**.

Conducting Health Assessments and Screenings

Topic: Height and Weight

Background and Rationale

Obesity in the United States is a serious health issue, contributing to an increase in diabetes and heart disease. There are many **risk factors for overweight and obesity**. Some risk factors can be changed such as unhealthy lifestyle habits and environments. However, other risk factors such as age, family history and genetics, race and ethnicity, and sex cannot be changed. Many unhealthy habits and choices originate in childhood (NHLBI, 2017). In fact, the **CDC's Healthy Schools** website outlines a number of **obesity facts** about children. The percentage of children with obesity in the United States has more than tripled since the 1970s. Today, about one in five school-aged children (ages 6–19) has obesity (CDC, 2017).

Obesity is defined as having excess body fat while overweight is defined as having excess body weight for a particular height from fat, muscle, bone, water, or a combination of these factors. Body mass index (BMI) is a widely used screening tool for measuring both overweight and obesity. BMI percentile is preferred for measuring children and young adults (ages 2–20) because it takes into account that they are still growing, and growing at different rates depending on their age and sex. Health professionals use growth charts to see whether a child's weight falls into a healthy range for the child's height, age, and sex (CDC, 2017).

NHLBI defines **healthy weight** for children as a BMI at the 5th percentile up to the 85th percentile, based on growth charts for children who are the same age and sex.

Weight Category	Body Mass Index	
	Children	Adults
Underweight	Below 5th percentile*	Below 18.5
Healthy weight	5th percentile to less than 85th percentile	18.5 to 24.9
Overweight	85th percentile to less than 95th percentile	25 to 29.9
Obese	95th percentile or above	30 or above

Source: NHLBI Screening and Prevention

Childhood obesity has immediate and long-term impacts on physical, social, and emotional health. Children with obesity are:

- At higher risk for other chronic health conditions and diseases that impact physical health such as asthma, sleep apnea, bone and joint problems, type 2 diabetes, and risk factors for heart disease;
- Bullied and teased more than their normal weight peers, and are more likely to suffer from social isolation, depression, and lower self-esteem; and,
- More likely to become obese adults which is linked to serious conditions and diseases such as heart disease, type 2 diabetes, metabolic syndrome, and several types of cancer (CDC, 2017).

Because health issues related to obesity often begin in childhood, the American Academy of Family Physicians (AAFP) provides an overview of obesity throughout the lifespan in its 2013 monograph **Diagnosis and Management of Obesity**. The US Preventive Services Taskforce published **Screening for Obesity in Children and Adolescents: Recommendation Statement** which outlines screening recommendations for children above age six and related interventions (USPST, 2017). In response to the obesity epidemic the AAP created the **Institute for Healthy Childhood Weight**, which provides case studies, role play simulations for healthcare practitioners, and a Healthy Growth App.

The Institute of Medicine (IOM) developed a comprehensive review of obesity prevention strategies, including a special report, **Accelerating Progress in Obesity Prevention**. The school nurse, as a member of the school health team, can implement many of these strategies through school-based programs, screenings, and education of students and their families. These include:



- Integrating physical activity every day in every way;
- Marketing a healthy life;
- Making healthy foods and beverages available everywhere;
- Activating employers and health care professionals; and,
- Strengthening schools as the heart of health.

These strategies "...on their own, accomplishing any one of these might help speed up progress in preventing obesity, but together, their effects will be reinforced, amplified, and maximized" (IOM, 2012).

Some schools have opted to report BMI measurements to parents. Those that chose to do so must educate parents about "obesity" and "overweight" before embarking on parental notification. Communication and confidentiality is critical. The CDC does not make a recommendation for or against the measurement of BMI. However, it outlines safeguards that should be in place to ensure the effectiveness of such programs. The CDC developed several tools to assist schools that chose to use BMI measurements. [About Child and Teen BMI](#) explains what BMI is and how it is calculated. [BMI Tools for Schools](#) provides information on how to conduct a mass screening program. CDC also provides a [BMI Calculator](#).

The school nurse monitors each child's growth, development, and nutritional status. Annual measures of height and weight are critical as deviations from normal can be noted and referred for further investigation. Both poor weight gain and overweight can indicate medical problems with adverse outcomes. While New Jersey does not require that the school nurse calculate or record BMI, some school districts have chosen to report the BMI to parents/guardians as part of the school's screening program.



Key Point

In general, children with a BMI at or above the 85th percentile and less than the 95th percentile are considered overweight and children at or above the 95th percentile have obesity.

Applicable Laws and Regulations

N.J.A.C. 6A:16-2.2(l)1 – Mandated Health Screenings

N.J.A.C. 6A:16-2.2(l)5-6

Screening for height, weight, and blood pressure shall be conducted annually for each student in kindergarten through grade 12. Screenings shall be conducted by a school physician, school nurse, or other school personnel properly trained. Parents/guardians of any student suspected of deviation from the recommended standard shall be notified.

SCREENING PROCESS

When conducting height screening:

- The student should remove his/her shoes.
- The student should stand with the bottom of his/her heels on the floor and the back of his/her feet touching the wall. The knees should be straight, with the scapula and occiput on the wall.
- The student should look straight ahead with the head held level.
- The measuring bar must be perpendicular to the wall and parallel with the floor on the top of the head.
- The school nurse should plot the measurement on a standardized growth chart for the child's age and gender and record the data on the student health record Form A-45.

When conducting weight screening:

- Use only a high-quality, medical-grade, beam balance or electronic scale. The scale should be calibrated ("zeroed") often and periodically serviced. Electronic scales are generally more costly, but allow for faster weighing. Do not use home bathroom scales as these are unreliable.
- The student should remove shoes and any heavy coat or sweater.
- The school nurse should record the weight to the nearest half-pound, if using a balance scale. Plot on a standardized growth chart and record the results on the student health record Form A-45.
- Note that all weights between the 5th and the 85th percentiles are considered normal.

When screening results deviate from the norm, notify the parent/guardian in writing with a recommendation of follow-up with the child's medical home. Document contacts with the parents/guardians and any follow-up by the medical home. Should a family need assistance securing medical care, the school nurse can work with the school social worker and community healthcare providers to help the family access care.

For students with certain disabilities, the school nurse should discuss with the school physician how best to measure height and weight.





N.J.A.C. 6A:16-2.3(b)3ii – Role of School Health Personnel

The certified school nurse conducts health screenings which include height, weight, blood pressure, hearing, vision, and scoliosis.



Key Point

New Jersey does not require the calculation of or the reporting of BMI.

Additional Points for School Nursing Practice

Conduct height and weight measurements in a location that ensures student privacy.

Document results and referrals on the Health History and Appraisal Form A-45.

The school nurse must use consistent measures for height and weight. Variations in equipment may result in discrepancies from year to year that make analysis of height and weight data difficult and inaccurate. Stadiometers can be either portable or wall mounted. The stadiometer should be stable and checked for accuracy after mounting. If heights are to be measured annually, permanent wall-mounted stadiometers are recommended. Height rods attached to scales do not provide reliable measurements.

The CDC provides guidance for parents on [measuring height and weight](#) at home. The recommendations are applicable to school-based screenings as well.

CHOP Resources for Growth and Height Issues

CHOP Growth Problems Information

Conducting Health Assessments and Screenings

Topic: Scoliosis Screening

Background and Rationale

Scoliosis is a condition of side to side spinal curves that measure greater than 10 degrees. On an x-ray, the spine looks more like an “S” or a “C” than a straight line, making the shoulders, hips, or waist appear uneven. The spine’s vertebrae may also be rotated, causing one shoulder blade or trunk muscles to be more prominent than the other. Carrying heavy items, sports, poor posture, or minor leg length abnormalities do not cause scoliosis. In more than 80 percent of scoliosis cases, a specific cause is not known (SRS, 2017). Adolescent [idiopathic scoliosis](#) is the most common spinal deformity in the world. Idiopathic scoliosis usually occurs in adolescents 10 to 18 years of age, but can occur in younger children, and is more likely to progress in girls (CHOP, 2017).

Scoliosis can also be associated with neuromuscular diseases such as cerebral palsy (CP), spinal muscle atrophy (SMA), Angelman syndrome, Arnold-Chiari malformation/syrinx, or trauma to the spinal cord. Connective tissue diseases such as Marfan syndrome

and Ehlers-Danlos syndrome, genetic conditions such as dwarfism, and muscular systems related diseases such as muscular dystrophy or spina bifida, can also lead to the development of scoliosis (SRS, 2017).

Scoliosis is most common in those over 10 years of age and two times more common in girls than boys. The most common symptoms of idiopathic scoliosis are:

- A difference in shoulder height;
- The head not centered with the rest of the body;
- A difference in hip height or position;
- A tilted pelvis;
- Arms that hang differently when standing; and/or,
- The sides of the back differ in height when bending forward.

A scoliosis curve will not get better on its own. Certain types of scoliosis have a greater chance of getting worse, so the type of scoliosis also helps to determine the proper treatment. There are three main categories of treatment: observation, bracing, and surgery (Davis, 2017). The presence of scoliosis may be detected during a routine physical examination by a child's healthcare provider. The school nurse may detect abnormalities during the school-based screening process, especially in students who do not have a medical home or a recent physical examination. The school nurse should refer students with suspected deviation and follow-up. Based on the results of the medical screening, the student may no longer need to be included in the required screening process, especially if the student is receiving appropriate care for the condition. Students with scoliosis should have an IHP, particularly when the student's condition involves bracing or surgery. The IHP should address physical mobility limitations and pain management. Attention should be paid to the student's mental health and body image.

The [National Institute of Arthritis and Musculoskeletal and Skin Diseases \(NIAMS\)](#) provides extensive information on scoliosis.

Applicable Laws and Regulations

N.J.S.A. 18A:40-4.3 – Biennial Examination for Scoliosis

District boards of education must provide for biennial (occurring every two years) scoliosis screening programs. Every pupil between the ages of 10 and 18 must be examined for scoliosis in accordance with standards jointly established and promulgated by the NJDOH and NJDOE. The examination must be carried out by a school physician, school nurse, physical education instructor, or other school personnel properly trained in the screening process. District boards of education must provide for the notification of the parents or guardian of any pupil suspected of having scoliosis. The notification must include an explanation of scoliosis, the significance of treating it at an early stage, and the public services available, after diagnosis, for such treatment.



N.J.S.A. 18A:40-4.4 – Exemption

Pupils shall be exempt from the examination upon written request of their parent or guardian.

N.J.A.C. 6A:16-2.2(l)4-64 – Required Health Services

Screening for scoliosis must be conducted biennially (occurring every two years) for students between the ages of 10 and 18. Screenings must be conducted by a school physician, school nurse, or other school personnel properly trained and the school district must notify the parent of any student suspected of deviation from the recommended standard.

Additional Points for School Nursing Practice

While the requirements may be different, the [Texas Spinal Guidelines](#) provide diagrams of scoliosis and information on screening procedures, including the use of an inclinometer/scoliometer.

The screening program is not a diagnosis. Students with suspected deviations should be referred to their medical home or an appropriate community healthcare provider for further testing.

The results of the biennial screening should be recorded on the Health History and Appraisal Form A-45.

The law allows others, appropriately trained, to conduct the screenings. Since there is no longer a mandated state training program, the school nurse should ensure that school personnel assigned to screen students for scoliosis are appropriately trained and understand privacy and confidentiality issues. The results of these screenings should be submitted to the school nurse for possible rescreen, referral, and follow-up. The results must be recorded on the student's health record.

The student's parent or guardian should be notified, in writing, when a deviation is detected. The notification and referral should include an explanation of scoliosis, the importance of early treatment, and community-based services available after diagnosis.



Key Point

A pupil can be exempted from screening with a written request from the parent/guardian. The local board of education must inform all parents/guardians, in advance of the screening program, of their right to exempt their child from the screening program. Notification of the screening program should appear on the district's website and sent to parents via usual district communication systems.

Screening Process

It is important to ensure a student's privacy during the screening process. Students should be screened individually in a well-lit private area. The school nurse or other screener should explain the procedure to the student to reduce anxiety. The screening process is easier if students wear close fitting clothing such as a T-shirt, tank top, or bathing suit rather than bulky sweatshirts or sweaters. The student should stand with his/her back exposed to the screener, who checks for the following:

- Unequal shoulder levels;
- Symmetry of the scapula;
- Uneven or a greater crease at one side of waist; and,
- Unequal distance between the body and the elbow when both arms are hanging straight down from the shoulder.

The student then faces the screener and bends 90 degrees at the waist with feet together, knees straight, and arms hanging in front, palms together.

The screener sits and faces the student looking for a rib hump and/or a hump in both upper and lower back. The screener notes the levels of the back on both sides of the spine.

Next, the student turns to the side and bends. The screener checks for symmetry of both sides of the spine and looks for a smooth continuous curve of the spine.

Conducting Health Assessments and Screenings

Topic: Vision Screening and Eye Health

Background and Rationale

Impaired vision may significantly impact a child's ability to learn. Learning to read and write at grade level is critical to future academic success. Undetected or uncorrected visual impairments may impact a child's ability to learn and hinder his/her social development as well. In *Healthier Students are Better Learners: A Missing Link in School Reform to Close the Achievement Gap*, Dr. Charles Basch found that low-income minority youth may experience a disproportionately high prevalence of vision problems that may impact their ability to learn and are at high risk for inadequate treatment of those problems. While the report focuses on educationally relevant health disparities of which impaired vision is but one, it makes the case for a stronger system of screening, referral, and follow-up, particularly in low income communities where under-diagnosis and under-treatment are the norm (Basch, 2010).

Basch's report drew attention to what schools can do to reduce health disparities that may significantly impact learning. Students with visual impairments are found in every school building. School-based vision screening programs are designed to identify children that require further evaluation by an eye specialist. A child with possible visual dis-



turbances may avoid reading or math and other near visual work as much as possible. The student may try to do the work, yet struggle with comprehension or efficiency. The child may develop a short attention span, grow fatigued, or even exhibit signs of discomfort. Teachers may report that the child rubs his/her eyes, squints or blinks incessantly, or just lays his/her head down on the desk. The school nurse may see this child in the health office, complaining of frequent headaches. While implementing mandated vision screening programs is important, the school nurse must work closely with all school staff to identify those children most in need of vision screening based on changes in school performance, physical symptoms, or student complaints (AOA, 2017).

The school-based vision screening program as conducted by the school nurse serves to identify those students with possible visual impairments that may have already impacted their ability to learn. NASN outlines the role of the school nurse and provides related resources in [Vision and Eye Health](#). NASN also worked with the American Association for Pediatric Ophthalmology and Strabismus to develop a [Vision Screening Tutorial](#).

In addition, the [National Center for Children's Vision and Eye Health](#) at Prevent Blindness works towards a coordinated public health infrastructure to promote and ensure a comprehensive, multi-tiered continuum of vision care for young children. To educate the public about vision issues impacting children and youth, it published a [Children's Vision and Eye Health: A Snapshot of Current National Issues](#). This report provides information about vision problems, national and state-level policies, and efforts to build comprehensive systems to promote vision and eye health (Ruderman, 2016).

The AAP's Committee on Practice and Ambulatory Medicine and Section on Ophthalmology; the American Association of Certified Orthoptists; the American Association for Pediatric Ophthalmology and Strabismus; and the American Academy of Ophthalmology developed a joint policy statement, [Eye Examination in Infants, Children, and Young Adults by Pediatricians](#). The statement makes clear that vision plays an important role in children's physical, cognitive, and social development. While directed at pediatricians, it is relevant for school nurses as well.

The American Association for Pediatric Ophthalmology and Strabismus (AAPOS) defines [vision screening](#) and provides information on the various screening methods. Visual acuity testing is considered subjective testing. For example, the use of an eye chart requires a cooperative child, so testing is most successful with a child older than 3 years. The eye chart is the only screening method that directly measures visual acuity and is the preferred exam for older children. Modifications of the adult eye chart make it easier to test children. For example, the school nurse can shorten the 20-foot testing distance to 10 feet. Symbols or shapes can be used in place of letters. Testing with both eyes open initially is performed before carefully covering one eye at a time with a patch occlusion to test each eye separately. The school nurse is advised to use a secure eye patch as young children may peek, especially if there is a difference in vision between the two eyes (AAPOS, 2016).

The National Eye Institute (NEI) provides an excellent overview of **color blindness**. Color blindness can have a significant impact on a student's ability to learn, especially in areas such as mathematics which often includes color-coded information such as bar graphs and pie charts. It may also impact a child's participation in art classes and STEAM (Science, Technology, Engineering, Arts and Math) projects which require selecting appropriate colors. While there is no cure for color blindness, people may be able to use a special set of lenses to help them perceive colors more accurately. There are iPhone and iPad apps, for example, that help people with color blindness discriminate among colors and more sophisticated apps allow users to find out both color and shades of color (NEI, 2015).

In addition to vision screening, the school nurse plays an important role in treating and preventing eye injuries. As a member of the school health team, the school nurse educates students, staff, and families about eye protection during sports activities. Protective eyewear is also important for students and staff when instructional programs involve the use of chemicals, hot liquids or solids, or explosives or that involve welding, sawing, or related activities. The American Academy of Ophthalmology provides information on the **prevention and care of eye injuries**. The school physician should address eye injuries as part of the district's standing orders for emergency care.

School nurses also need to understand issues that may arise when students wear **contact lenses**. The Food and Drug Administration (FDA) provides information on **contact lenses** while the American Optometric Association (AOA) conducted a **sponsored study** about contact lenses and children that school nurses may find helpful.

Applicable Laws and Regulations

N.J.A.C. 6A:16-2.2(l)2 – Health Services Policy and Procedural Requirements

Each district board of education shall ensure that students receive health screenings. Screening for visual acuity shall be conducted biennially (every two years) for students in kindergarten through grade 10.

N.J.A.C. 6A:16(b)3ii – Health Services Personnel

The district board of education shall employ a certified school nurse to provide nursing services while school is in session. The certified school nurse is responsible for conducting health screenings which include height, weight, blood pressure, hearing, vision, and scoliosis.

N.J.A.C. 6A:14-3.3(h) – Special Education Evaluation

Vision screening shall be conducted by the school nurse for every student referred to the child study team for a special education evaluation.

N.J.S.A. 18A:40-12.1-2 – Protective Eye Devices Required for Teachers, Pupils, and Visitors in Certain Cases

This law addresses the need to wear industrial quality eye protective devices while attending classes in vocational or industrial art shops or laboratories in which caustic or



explosive chemicals, hot liquids or solids, hot molten metals, or explosives are used or in which welding of any type, repair or servicing of vehicles, heat treatment or tempering of metals, or the milling, sawing, stamping or cutting of solid materials, or any similar dangerous process is taught, exposure to which might have a tendency to cause damage to the eyes. Visitors to such classrooms or laboratories must be required to wear such protective devices.

N.J.A.C. 6A:26-12.5(b) – Eye Protection in Schools

The term “appropriate eye protective device” shall include plain or prescription lenses provided the lenses and other portions of the device meet or exceed the prescribed specifications for the device. Specifications for appropriate eye protection for various activities shall meet or exceed one of the following standards:

- American National Standard Practice for Occupational and Educational Eye and Face Protection, ANSI Z87.1-1989.
- American National Standard Practice for the Safe Use of Lasers, ANSI Z136.1-1986 and eye protective procedures recommended by the manufacturer of the laser device.

N.J.A.C. 6A:26-12.5(d) – Emergency Eye Wash Fountains

Emergency eye wash fountains or similar devices capable of a minimum 15 minutes continuous flow of eye-wash solution shall be provided in classrooms, shops, laboratories, or other areas where pupils or instructors are exposed to caustic materials that can cause damage to the eyes.

N.J.A.C. 6A:26-12.5 (g) – Policy Required

Each district board of education shall establish and implement a specific eye protective policy and program.

N.J.A.C. 6A:26-12.5(h) – Training Required

Each school district shall provide annual training and appropriate supplies and equipment to all school personnel responsible for implementing the eye-safety policies and program.

N.J.S.A. 18A:41-8-9 – Eye Wear Sports/Educational Fact Sheet

Acknowledging that eye injuries are the leading cause of preventable blindness and visual impairment, this law required the NJDOE to develop a **Sports Related Eye Injury Fact Sheet** that provides information on sports-related eye injuries including symptoms of injuries and recommendations regarding the use of protective eyewear during school or recreational sports.



Key Point

*The U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) develops eye protection standards and resources available at **OSHA Eye and Face Protection**.*

Additional Points for School Nursing Practice



Key Point

New Jersey statutes and regulations require biennial screening for visual acuity; however, the law does not stipulate the kind of equipment or procedures to accomplish this requirement. The school physician should address screening protocols and standards for referrals.

School nurses who want to update their knowledge and skills about vision problems may find the [Prevent Blindness Vision Screening Certification](#) program helpful.

Document the results of vision screenings and referrals on the Health History and Appraisal Form A-45.

In August 2015, Prevent Blindness published a [Position Statement on School-Aged Vision Screening](#). It is designed as a guide to policy development and as such, provides recommendations to assist the development of quality vision screening programs and states:

While vision screenings and eye examinations are complementary approaches to assessing the eye problems of a child, a screening is used to identify a child at risk for vision problems and does not replace a comprehensive examination performed by an eye doctor. Additionally, vision screenings provide a critical bridge from detection to eye care for families that may not regularly access health or eye care services, may need financial assistance to afford care, or those that may not fully understand the impact an undiagnosed and untreated vision problem might have on the rest of their child's life. Prevent Blindness advocates for good vision for all throughout the life spectrum, and that all children are visually ready as they begin school and beyond (Prevent Blindness, 2015).

The [NASN Vision and Eye Health](#) page features numerous resources, sample letters, educational materials, and a [Vision Screening Flowchart](#). NASN members can also participate in the Vision Service Plan program that assists families to access vision care.

The [Lions Clubs Eye Health Program](#) offers a range of information and supports.

Make sure that the screening process and the equipment are designed for the child's developmental level, age, and size. Screening young children and children with special needs requires the school nurse to work with the parents/guardians, teachers, and other school personnel. These children may be fearful of health professionals and afraid of being "tested." Whenever possible, conduct the test in surroundings where the child feels comfortable. It may be helpful to present the screening as a game. Keep in mind that some children may not be able to differentiate between "left" and "right" or may have difficulty with colors, sizes, and shapes.



Some students may have difficulty reading left to right or top to bottom. If the student makes numerous mistakes while reading a letter chart, have the student read aloud from a grade-appropriate book and observe how the student tracks the letters and paragraphs. Some cultures read right-to-left and may not use upper and lower case letters. If the student has difficulty reading a letter chart, the issue might be a language issue not a visual one.

Allocate sufficient time to conduct screenings. Inform teachers in advance of screening days and schedule rescreen days, as necessary.

Educate teachers and other school staff about possible symptoms of eye disturbances they may observe. These may include a short attention span, frequent eye rubbing or blinking, or frequent headaches. The American Optometric Association's [School-aged Vision 6 to 18 Years of Age](#) provides basic information that can be shared with school personnel.

The [NJ Safe Schools Program](#) at the Rutgers University School of Public Health provides guidance on eye safety programs.

The American Academy of Ophthalmology says that a serious eye injury is not always obvious. [Recognizing and Treating Eye Injuries](#) addresses numerous topics related to eye injury prevention and emergency care.

Mandated Screenings						
Required Grade Level	Height	Weight	Blood Pressure	Vision	Hearing	Scoliosis
K – 12	X	X	X			
K – 2, 4, 6, 8, 10				X		
K – 3, 7, 11					X	
Biannually for students between 10 – 18 years old						X

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CHAPTER FOUR: Addressing Communicable Diseases in the School Setting

Topic: The Prevention, Control, and Management of Communicable Diseases

Introduction



School nursing began as part of the public health system to identify and prevent communicable diseases in school-aged children. While the role of the school nurse has changed and expanded significantly since then, exposure to a variety of infectious diseases in a school population is still the norm. Today's school nurse deals with a variety of vaccine-preventable diseases, common childhood illnesses,

and food-borne illnesses in addition to an array of emerging infectious diseases that impact a mobile society. The local board of education and the school nurse must work closely with public health agencies responsible for the health and well-being of New Jersey's citizens. The Association of State and Territorial Health Officials (ASTHO) describes school nurses as public health partners in [Public Health and School Nursing: Collaborating to Promote Health](#).

This chapter summarizes the responsibilities of the local board of education, school administration, and the school nurse in the prevention, control, and management of communicable diseases in the school setting. The focus is on district policies and procedures that must be in place to ensure compliance with public health laws, regulations, and protocols. This chapter does not focus on specific infectious diseases. For information on specific infectious diseases, see the AAP's [Overview of Infectious Diseases](#) or the [infectious diseases](#) website from the National Library of Medicine. The CDC also provides an extensive list of [diseases and conditions](#) with a section dedicated to [children's diseases](#). The NJDOH also provides information on a variety of [communicable diseases](#).

Dedicated sections on immunization requirements and tuberculosis testing follow this overview. Laws and regulations specific to those two areas are enumerated in those sections. Blood-borne pathogens and school-based sanitation issues are addressed in Chapter Thirteen: Promoting a Healthy School Environment. Health education for students, families, and school personnel is addressed in Chapter Twelve.



The NJDOH aims to improve health through leadership and innovation by strengthening New Jersey's health system which includes four branches: Public Health Services; Health Systems; the Office of Population Health; and, the Office of Policy and Strategic Planning. Population health promotes prevention, wellness, and equity in all environments, resulting in a healthy New Jersey. The NJDOH is composed of numerous divisions and offices that work together to promote health and wellness (NJDOH, 2017a).

In New Jersey, every municipality must be served by a **local health department** that meets the requirements of state public health laws and regulations. Local health departments are community-based public health service providers responsible for essential public health services that protect the health of New Jersey's citizens. Many of these laws and regulations apply to schools and childcare settings, and while codified by the NJDOE, the NJDOH retains the authority to enforce those laws and rules that impact the public's health and well-being (NJDOH, 2017b).

The NJDOH's Communicable Disease Service (CDS) is responsible for communicable disease surveillance, research, education, treatment, prevention and control. The mission of the CDS is to prevent communicable disease among all citizens of New Jersey and to promote the knowledge and use of healthy lifestyles to maximize health and well-being. Within the CDS, the Vaccine Preventable Disease Program (VPDP) is responsible for the New Jersey Immunization Information System (NJIIS), the Vaccines for Children Program and other initiatives related to infectious diseases that can be prevented with immunizations (NJDOH, 2017c).

The Infectious and Zoonotic Disease Program (IZDP) is responsible for food-borne, vector-borne, and zoonotic illnesses, as well as healthcare-associated infections. It works closely with the VPDP on diseases that have a vaccine available. The IZDP works with local public health officials to investigate reportable infectious diseases, monitor and track reportable diseases and conditions, and notify the public of its risk for infectious diseases (NJDOH, 2017d).

The agency investigates outbreaks and enacts control measures to prevent further disease spread, providing technical information about infectious diseases for physicians, health officers, and other public health officials. It also provides consultation and educational materials on infectious diseases, including fact sheets, disease investigation guides, and case definitions for reportable diseases. These services are available to the school nurse and are a critical part of the nurse's ongoing professional development (NJDOH, 2017c).

The NJDOH also includes the Division of HIV, STD, and TB Services which aims to prevent and reduce the spread of HIV, STDs and Tuberculosis by delivering comprehensive services through community-based networks. The division provides education and training as well as screening, surveillance, and treatment (NJDOH, 2017e).

The Consumer, Environmental, and Occupational Health Service (CEOHS) focuses on activities aimed at improving the health and well-being of New Jersey citizens, such as preventive initiatives to decrease disease and injury by reducing exposure to chemical,

physical and biological hazards. CEOHS services include child care center health assessments, hazardous site health evaluation, food and drug safety, asbestos and lead training and certification, and environmental and occupational disease tracking. CEOHS also oversees the regulation of pools, tanning facilities, body art studios, and youth camps (NJDOH, 2017f).

As the school's onsite health "expert," the school nurse must take appropriate actions to identify infectious diseases and ensure that appropriate health care for students and staff is available. The school nurse's actions are critical to control the spread of disease. In addition, certain individuals are potentially at higher risk of complications if exposed to specific diseases including, but not limited to, students and staff with anemia, immunodeficiencies, or nutritional deficiencies; those who are pregnant; and individuals with a chronic disease or debilitating illness. The school nurse does not determine the extent of that risk, but informs the individuals whenever there is increased risk of exposure to an infectious disease. The school nurse works with students, their families, healthcare providers, and public health officials to minimize the impact and prevent additional infections.

The school nurse is also the first line of defense against an outbreak of infectious disease in the school setting. A classroom teacher sends a child who is feeling ill to the nurse for an assessment, which may include vital signs, temperature, and a skin assessment for color (e.g. pale vs. flushed), and evidence of a rash. The nurse may also ask the child about changes in diet and bowel habits, sleep patterns, aches and pains (e.g. stomach, joints, head), sore throat, cough, or nasal congestion. The school nurse does not diagnose the illness; rather, the nurse collects important data that is shared with the child's parent/guardian and medical home. Information may also be shared with public health officials, as appropriate and required by law and regulation.

When more than one individual exhibits similar symptoms, the school nurse must be concerned about a possible outbreak. The NJDOH defines an outbreak as an occurrence of disease greater than would otherwise be expected at a particular time and place. Often in the school setting it is difficult to determine whether or not an outbreak exists.

An outbreak may be occurring if:

- Several children who exhibit similar symptoms are in the same classroom, the same wing of a facility, or attended a common event;
- There is an increase in school absences with many parents reporting similar symptoms as the reason why their child is not attending school;
- Two or more students are diagnosed with the same reportable disease (e.g. salmonellosis); and,
- A single case of a highly infectious disease (e.g. measles or pertussis) exists or is suspected to exist. The school nurse should not wait for confirmation in these instances as the potential for an outbreak exists (NJDOH, May 2016).



Reporting communicable disease outbreaks in schools serves many purposes. The immediate goal is to control further spread of the disease. Information gained from outbreak investigations can help schools and public health agencies identify and eliminate sources of infection such as contaminated products, help identify carriers to mitigate their role in disease transmission, and implement new strategies for prevention within schools.

To assist personnel in schools and child care facilities, the NJDOH published [Guidelines for Outbreaks in School and Child Care Settings](#). This document provides detailed information on reporting, surveillance, control measures, exclusions, and school closings. It includes a chart that outlines possible control measures schools can put into place such as disinfection, improved hand washing, respiratory etiquette, and food service improvements. The NJDOH provides additional information on outbreaks in school and daycare settings on its website. The school nurse, in collaboration with school administrators, should confer with local public health officials to determine which measures must be implemented based on the nature of the outbreak. The NJDOH document includes a [School Exclusion List](#), a chart that provides information about some communicable diseases that may occur in schools, day care centers, summer camps and other group settings for children. While not an all-inclusive list of significant diseases or a comprehensive guide to all information about each disease or condition, it is a helpful guide for school personnel.

The CDC published [Guidance for School Administrators to Help Reduce the Spread of Seasonal Influenza in K-12](#). While it specifically addresses seasonal influenza, many of the recommendations are applicable to outbreaks of other illnesses as well. The CDC's [flu information](#) section provides resources for health professionals and information for parents. The AAP's Committee on Infectious Diseases (CID) monitors current developments in the prevention, diagnosis, and treatment of infectious diseases and prepares updated editions of the [Red Book](#) which is now available as an electronic resource. In addition, the AAP publishes [Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide \(Fourth Edition\)](#), an invaluable book that provides information on specific diseases as well as sample letters and forms.

The school nurse is required to provide general information about communicable disease prevention to all school personnel. **However, the school nurse, school physician, and school administrators must work together to ensure that district policies reflect current practice and that state laws and rules are followed.** While many of New Jersey's infectious disease laws were written prior to current immunization requirements and treatments, the key to prevention remains the same: education. In addition, the school nurse serves as the school's liaison to the local health department.

Applicable Laws and Regulations

N.J.A.C. 8:57 Communicable Diseases addresses the identification and reporting of specified communicable diseases. It includes regulations on immunizations and tuberculosis testing.

N.J.S.A. 18A:40-7 – Exclusion of Pupils

When there is evidence of departure from normal health of any pupil, the principal of the school shall upon the recommendation of the school physician or school nurse exclude such pupil from the school building. In the absence from the building of the school physician or school nurse, the classroom teacher may exclude the pupil from the classroom and the principal may exclude the pupil from the school building.

N.J.S.A. 18A:40-8 – Exclusion of Pupils

The principal may, upon the recommendation of the school physician or the school nurse if either of them are present in the building, exclude from school any pupil who has been exposed to a communicable disease or whose presence in the school may be detrimental to the health or cleanliness of the pupils in the school. In the absence from the building of the school physician or school nurse, the classroom teacher may exclude the pupil from the classroom and the principal may exclude the pupil from the school building and the principal or the classroom teacher, as the case may be, must notify the parent, guardian, or other person having control of the pupil of the reason for the exclusion.

N.J.S.A. 18A:40-9 – Failure of Parent to Remove Cause for Exclusion

If the cause for exclusion can be remedied and the parent, guardian, or other person having control of the pupil excluded fails within a reasonable time to have the cause for the exclusion removed, the parent, guardian, or other person shall be proceeded against, and upon conviction, be punishable as a disorderly person.

N.J.S.A. 18A:40-10 – Exclusion of Teachers and Pupils Exposed to Disease

No teacher or pupil who is a member of a household in which a person is ill with smallpox, diphtheria, scarlet fever, whooping cough, yellow fever, typhus fever, cholera, measles, or such other contagious or infectious disease as may be designated by the board of education, or of a household exposed to contagion as aforesaid, shall attend any public school during such illness, nor until the board of education has been furnished with a certificate from the board of health, or from the physician attending such person, or from a medical inspector, certifying that all danger of communicating the disease by the teacher or pupil has passed.

N.J.S.A. 18A:40-12 – Closing Schools During Epidemic

Whenever the board of health of any municipality declares any epidemic or cause of ill health to be so injurious or hazardous as to make it necessary to close any or all of the public schools in the municipality, the board of health shall immediately serve notice on the board of education that it is desirable to close the school or schools. Upon receipt of the notice the board of education may close the schools under its control, or such of them as may be designated by the board of health. The schools so closed shall not be



reopened until the board of education is satisfied that all danger from the epidemic or cause of ill health has been removed.

N.J.A.C. 6A:16-2.1(a)4iii-v – Health Services Policy and Procedures

District boards of education must develop and adopt written policies, procedures, and mechanisms to address the care of any student who becomes injured or ill while at school or participating in school-sponsored functions. The policy must address transportation and the supervision of any student needing immediate care as well as the notification to parents of any student determined to be in need of immediate medical care.

N.J.A.C. 6A:16-2.2(d) – Required Health Services

School districts must immediately report any communicable diseases identified to the health officer at the local or county health department of the jurisdiction in which the school is located. The report must be made by telephone.

N.J.A.C. 6A:16-2.3(b)3iv – Health Services Personnel

The school nurse recommends to the school principal exclusion of students who show evidence of communicable disease.

N.J.S.A. 18A:40-3 – Lectures to Teachers

N.J.A.C. 6A:16-2.3(b)3xv

A medical inspector or nurse lectures to the teachers at such times as may be designated by the board of education instructing the teachers concerning the methods employed to detect the first signs of communicable disease and the recognized measures for the promotion of health and the prevention of disease. The school nurse instructs teachers on communicable disease and other health concerns.



Key Point

While the law and regulations specify “teachers” as the recipients of this training, all school personnel and volunteers need to be educated about infectious disease prevention strategies.

N.J.S.A. 18A:40-4 – Examinations for Physical Defects

A pupil who presents a statement signed by his parents or guardian that required examinations interfere with the free exercise of his religious beliefs shall be examined only to the extent necessary to determine whether he is ill or infected with a communicable disease or to determine his fitness to participate in any health, safety, and physical education course required by law.

Additional Points for School Nursing Practice

New infections are emerging, and old ones are changing. The school nurse, as the liaison between the education and public health communities, must stay informed about new developments and requirements. The school nurse must establish a collegial relationship with local public health officials before an outbreak occurs. School nurses should

frequently update their knowledge of communicable diseases and know when a disease is reportable.

The law establishes that the school nurse recommends exclusion to the building principal. The recommendation must be based on data—a history and physical assessment of the pupil. Document the findings and recommendations on the student’s health record.

The school nurse plays a pivotal role in the prevention of infectious diseases in the school setting. Remind students and staff frequently about proper hand washing and respiratory protections.

All immunizations must be current. Encourage all school personnel and volunteers to become immunized against common illnesses such as influenza.

District policies and procedures must be followed regarding safe cleaning, disinfecting, and sanitizing, not just during times of illness, but as part of routine environmental services in the school. In addition, the school health office may need an extra level of cleaning and sanitation during outbreaks.

School personnel who deal with special needs students requiring toileting or diaper care must be instructed on proper hand washing, sanitation, and disposal.

The CDC created [Animals in School Settings](#), a resource for policy development and prevention for schools and classrooms that choose to include animals as part of the instructional program.

The school nurse should closely monitor absences and work with the district’s attendance officer to analyze trends such as common symptoms or illnesses.

Infectious disease outbreaks amongst athletes have become more common and due to the extent and type of exposure, difficult to track. Athletic trainers and coaches must work with the school nurse to implement board policies and procedures that support hygienic practices to reduce the likelihood of infections. For example, coaches, trainers, and physical education instructors should be educated about the need to prevent sharing of water bottles and pails by athletes during sports-related activities. The AAP recently released [New Guidance on Preventing the Spread of Infectious Diseases Associated with Organized Sports](#).

The NJDOH provides information on [MRSA](#).

The CDC provides information for [athletic directors, coaches, and team healthcare providers](#) on disease prevention as well as guidance on cleaning and disinfecting athletic facilities and equipment.

Because of the nature and scope of many school-sponsored athletic events, it is crucial that the local health department be notified immediately of a case or suspected case of a reportable disease in an athlete. Timely reporting of even a suspected case of an infectious disease may help to prevent further spread among athletes, spectators, and the community.



Addressing Communicable Diseases in the School Setting

Topic: Immunizations

Background and Rationale

Infectious diseases impact all persons regardless of age, sex, lifestyle, ethnic background, and socioeconomic status. These diseases can lead to suffering and death, imposing a financial burden on families and society. School-aged children are especially vulnerable to infectious diseases, resulting in increased absenteeism and the potential for complications that may impact health and learning.

To keep children in schools healthy, the NJDOH establishes specific immunization requirements based on the recommendations of the [Advisory Committee on Immunization Practices \(ACIP\)](#), a group of national medical and public health experts convened by the CDC and AAP.

The NJDOH [Communicable Disease Service](#) provides information for healthcare providers, families, and school nurses on [preschool](#) and [K-12 immunization requirements](#). It includes immunization tables, sample letters, and information on religious and medical exemptions as well as updates. The website also includes the [annual immunization status report \(IMM-7\)](#) and information on school audits. The NJDOH and local health departments have the authority to establish and enforce immunization laws, regulations, and requirements. A comprehensive [immunization FAQ](#), last updated in September 2017, provides current information on all requirements.



Key Point

School nurses are advised to visit the NJDOH-CDS website often to ensure that district policies and practices reflect requirements for the current school year.

The school nurse monitors compliance with immunization requirements in order to ensure that students are protected from common vaccine preventable diseases. Working with public health officials, the school nurse maintains accurate immunization records, including exemptions, and ensures compliance with mandated reporting to public health officials. An important part of this process is the annual school immunization audit conducted by the local health department. The annual audit aims to capture accurate, current and relevant data for assessing immunization status of a community and vulnerability during a potential outbreak. During an outbreak, the school nurse works with the local health department and the school administration to ensure that all students and staff are protected from exposure. Additionally, the school nurse assists families to access health-care providers that provide immunizations. The nurse educates students and their families and staff about important immunizations and collaborates with community health providers and public health officials to organize and implement immunization outreach and services to students, families, school personnel, and the community.

Applicable Laws and Regulations

N.J.A.C. 8:57-4 – Immunization of Pupils in School

These regulations apply to all children attending any public or private school, child care center, nursery school, preschool or kindergarten in New Jersey.

N.J.A.C. 8:57-4.23 – Optimal Immunization Recommendations

The specific vaccines and the number of doses required under this subchapter are intended to establish the minimum vaccine requirements for child-care centers, pre-schools, or school entry and attendance. Additional vaccines, vaccine doses, and proper spacing between vaccine doses are recommended by the NJDOH in accordance with the guidelines of the AAP and ACIP, as periodically revised, for optimal protection and additional vaccines or vaccine doses may be administered, although they are not required for school attendance unless otherwise specified in this subchapter.

This section also states that all vaccine doses included within and mandated by this subchapter that are administered less than or equal to four days before either the specified minimum age or dose spacing interval shall be counted as valid and shall not require revaccination in order to enter or remain in a school, preschool, or child-care facility.

N.J.A.C. 8:57-4/10-4.20 & 2.1 – Specific Immunization Requirements

These regulations address the requirements for each mandated vaccine.

N.J.A.C. 8:57-4.3 – Medical Exemptions

This section states that a child shall not be required to have any specific immunizations which are medically contraindicated. A written statement to the school from a physician or advanced practice nurse (APN) indicating the time period and reason for the medical contraindication based on valid reasons as enumerated by the ACIP or the AAP is required. The statement shall be retained as part of the student's health record and reviewed annually. When the student's health condition permits immunization, the exemption is terminated and the student is required to obtain the exempted immunizations.

N.J.A.C. 8:57-4.4 – Religious Exemptions

This section states that schools shall exempt a student from mandatory immunization if the child's parent/guardian submits to the school a written, signed statement requesting an exemption based on the requirements set forth in N.J.S.A.26:1A-9.1, and on the grounds that the immunization interferes with the free exercise of the pupil's religious rights. The school is prohibited from exempting a child from mandatory immunization on the sole basis of a moral or philosophical objection to immunization. The written statement requesting the exemption shall be kept with the child's immunization and health records.

N.J.A.C. 8:57-4.5 – Provisional Admission

This section permits a school to admit a child on a provisional basis if a physician, APN, or health department can document that at least one dose of each required age-appro-



priate vaccine has been administered and that the pupil is in the process of receiving the remaining immunizations. This section details specific requirements for children under age five and for children aged five or older. Provisional status shall only be granted one time for students entering or transferring into New Jersey schools. Evidence of this status shall be retained with other student health records and sent by the original school to the new school. Children transferring into a New Jersey school from out-of-state or out-of-the-country shall be allowed 30 days to obtain past immunization documentation before provisional status begins.

It may be difficult to obtain immunization and health records for some students. Eligibility to attend school is contingent on a number of factors that are addressed in multiple rules and laws. [N.J.A.C. 6A:22](#) specifically addresses issues of student residency and enrollment. The rules in this chapter have been adopted to implement N.J.S.A. 18A:38-1.a through e. However, the chapter does not address attendance at school by nonresidents (N.J.S.A. 18A:38-3.a); children of certain military parents (N.J.S.A. 18A:38-3.b and 18A:38-3.1); children residing on Federal property (N.J.S.A. 18A:38-7.7 et seq.); or persons qualifying under N.J.S.A. 18A:38-1.f, which provides for attendance by homeless students and is implemented through [N.J.A.C. 6A:17-2](#): Education of Homeless Children. This chapter is important because it states that enrollment in the school district shall not be denied based upon the absence of student medical information. Actual attendance at school may be deferred until the student complies with student immunization rules at N.J.A.C. 8:57-4.

N.J.A.C. 6A:17-2.5 – School District Enrollment/Homeless Students

This section states that school districts shall immediately enroll a homeless child or youth even if academic and medical records are unavailable.



Key Point

Students with medical or religious exemptions or on provisional status may be temporarily excluded from school during a vaccine-preventable disease outbreak or threatened outbreak. NJDOH provides guidance on the appropriateness of such exclusions.

Key Point

When a student is granted provisional admittance, the school must monitor that the needed vaccines are being received on schedule. If at the end of the provisional period, the required immunizations have not been completed, the child must be excluded from school until appropriate documentation has been presented.

N.J.A.C. 8:57-4.6 – Documents Accepted as Evidence of Immunization

The following documents shall be accepted as evidence of a child's immunization history, provided that the type of immunization and date of administration indicates compliance with immunization requirements:

- An official school record;
- A record from any public health department;
- A certificate signed by a physician licensed to practice medicine or osteopathy or an APN; or,
- The official NJIIS record.

**Key Point**

Immunization records submitted by a parent or guardian in a language other than English shall be accompanied by a translation sufficient to determine compliance.

Key Point

Laboratory evidence of protective immunity, as enumerated by the ACIP, shall be accepted as evidence if a parent or guardian cannot produce a documented history of immunization.

N.J.A.C. 8:57-4.7 – Records Required

This section requires schools to maintain an official State of New Jersey Immunization Record for every pupil that include the date of each immunization. The immunization record shall be separated from the child's educational record and other medical records for the purpose of the immunization record audit. Any computer-generated document or list shall be considered a supplement to, and not a replacement for, the official New Jersey Immunization Record.

If a child withdraws, is promoted, or transfers to another school, the immunization record or certified copy along with any statements pertaining to exemptions shall be sent to the new school or shall be given to the parent or guardian upon request, within 24 hours of such a request (emphasis added). When a child graduates from secondary school, the immunization record or certified copy shall be sent to an institution of higher education or given to the parent or guardian upon request.

N.J.A.C. 6A:32-7.8 – Retention and Disposal of Student Records

The New Jersey public school district of last enrollment (graduation or permanent departure) shall retain student records, including the student's health history and immunization records, for 100 years after that student leaves the district.



Key Point

The official New Jersey Immunization Record or a certified copy shall be retained by the secondary school for a minimum of four years after the pupil has left the school and shall be retained by the pupil's elementary school for a minimum of one year after the child has left the school.

N.J.A.C. 8:57-4.8 & 4.9 – Reports and Records

The principal, director, or other person in charge of the school must submit no later than January 1 of each academic year the Annual Immunization Status Report (IMM-7) to the NJDOH either via postal or electronic mail. A copy of the report is also sent to the local board of health. Schools not submitting the required report are considered delinquent and may be reported to the NJDOE or the New Jersey Department of Children and Families (NJDCF). Upon 24 hours notice, student immunization records shall be made available for inspection by authorized representatives of the NJDOH or the local board of health.



Key Point

The original law required the form to be submitted by January 1; however, the NJDOH now accepts the IMM-7 report by February 1.

N.J.A.C. 8:57-4.21 – Providing Immunizations

N.J.S.A. 18A:40-20

Local boards of education or health are permitted to provide, at public expense, the necessary equipment, materials and services for immunizing pupils from the diseases as required by the NJDOH in the State Sanitary Code.

N.J.A.C. 8:57-4.22 – Emergency Powers

The Commissioner of the NJDOH may modify immunization requirements or issue additional immunization requirements to control an outbreak or threat of an outbreak of vaccine-preventable disease. All children failing to meet these additional immunization requirements shall be excluded from school until the outbreak or threatened outbreak is over. Should a national or state vaccine supply shortage as determined by the CDC and the Commissioner of NJDOH occur, the Commissioner may temporarily suspend the immunization requirement for that particular vaccine with due notice to the public via electronic posting on the NJDOH website, print and electronic news media, [NJLINGS](#), the NJDOH's Vaccine Preventable Disease Program, or any other method reasonably calculated to inform those most affected by the temporary immunization suspension.



Key Point

*The NJDOE sent all school districts a memo, **Enrollment Considerations for Homeless and Immigrant Students**, in August 2016.*

Additional Points for School Nursing Practice



Key Point

According to N.J.A.C. 8:57- 2, a principal, administrator or person in charge of a school shall not knowingly admit or retain any child whose parents have not submitted acceptable evidence of immunizations unless, however, they have a valid exemption. Failure to do so would be a violation of the state sanitary code N.J.S.A. 26:1A-10 and the school may be subject to a fine. The statute stipulates that each violation of any provision of the State Sanitary Code shall constitute a separate offense and shall be punishable by a penalty of not less than \$50 nor more than \$1000.

School nurses are responsible for maintaining official student health records including the [Health History and Appraisal Form \(A-45\)](#) and the IMM-8, the Standard School/Child Care Center Immunization Record, which can be obtained from the VPDP by calling 609-826-4861. The [IMM-7](#) is the immunization audit form due by February 1.

NJDOH provides a list of [communicable disease forms](#).

All documentation must include the date and type of immunization.

The school nurse works with the principal to prepare and submit the Annual Immunization Status Report (IMM-7) to the NJDOH and local board of health. This report is due no later than February 1 of the current academic year.

The school nurse must review each student's immunization records annually to ensure compliance with current requirements. When a student is not in compliance, the school nurse must notify the principal, who has the authority to exclude the student from school attendance until all requirements are met. The principal should confer with local public health officials.

Addressing Communicable Diseases in the Schools Setting

Topic: Tuberculosis Testing

Background and Rationale

Tuberculosis (TB) is caused by a bacterium called *Mycobacterium Tuberculosis*. It is a disease that is spread through the air from one person to another. When someone who is sick with TB coughs, speaks, laughs, sings, or sneezes, people nearby may breathe TB bacteria into their lungs. TB usually attacks the lungs, but can also attack other parts



of the body, such as the brain, spine, or kidneys (CDC, 2017a). TB bacteria can live in the body without making a person sick. This is called latent TB infection (LTBI). People with latent TB infection do not feel sick, do not have TB symptoms, and cannot spread TB bacteria to others. Some people with latent TB infection go on to develop TB disease. People with TB disease can spread the bacteria to others, feel sick, and have symptoms including fever, night sweats, cough, and weight loss. People with TB disease are most likely to spread it to people they spend time with every day such as family members, friends, and coworkers or schoolmates (CDC, 2017b). While the occurrence of TB in New Jersey's school-aged population is rare, the NJDOH works closely with national public health officials to monitor TB morbidity.

Two kinds of tests are used to determine if a person has been infected with TB bacteria: the tuberculin skin test (TST) and TB blood tests. The Mantoux tuberculin skin test is given to determine if a person has been infected with TB bacteria. The person given the TST must return within 2-3 days to have a trained health care worker look for a reaction on the arm. The health care worker will look for a raised, hard area or swelling, and if present, measure its size using a ruler. Redness by itself is not considered part of the reaction (CDC, 2017c). If the test is positive, the person's body has been infected with TB bacteria and additional tests are needed to determine if the person has latent TB infection or TB disease. If the test is negative, the person's body did not react to the test, and latent TB infection or TB disease is not likely (CDC, 2017c). For more information, refer to this [CDC podcast on skin testing for TB](#).

The NJDOH [TB Program](#) provides [guidance](#) and [mandates](#) for TB screening of students as a condition for admission to New Jersey schools and addresses the screening of employees and other adults having direct contact with the student population. The requirements are based on the incidence of tuberculosis or reactor rates in specific local and global communities or population groups. Enforcement of these requirements is the responsibility of the NJDOE. The purpose of these guidelines is to identify new students and employees who are at the highest risk of LTBI so they can receive treatment and prevent the development of TB disease at a later time. Schools are no longer required to submit the [Annual Report of TB testing in Schools: TB-57](#). School districts may continue to use the form for internal data collection and reporting pursuant to local district policy.

These recommendations restrict TB screening in New Jersey's schools to teachers/other employees and ONLY those students who are at the highest risk for latent TB infection. Knowledge of the result of a TB test does not provide any benefit to the district without treatment for LTBI for those persons most at risk for developing tuberculosis. The decision to test is a decision to treat.

An interferon gamma release assay (IGRA) is a blood test that can determine if a person has been infected with TB bacteria. It measures how strong a person's immune system reacts to TB bacteria by testing the person's blood in a laboratory (CDC, 2017c).

The NJDOH now permits the use of either an IGRA blood test or a TST in schools. A "positive" IGRA or "10mm" or greater induration on a TST is considered a "significant

reaction” and requires a subsequent medical evaluation to rule out active disease. Any person with symptoms of pulmonary TB should be evaluated regardless of the result of the IGRA or TST and excluded from school until disease is ruled out or they are no longer considered infectious, as indicated in writing by a licensed physician (Romano, 2017).

Applicable Laws and Regulations

N.J.A.C. 6A:16-2.2(c) – Performance of Tuberculosis Test on Students

N.J.S.A. 18A:40-16

The board of education of every school district shall periodically determine or cause to be determined the presence or absence of tuberculosis infection in any or all pupils in public schools, and, with respect to frequency, procedure, and selection of pupils, shall comply with the rules of the State Board.

N.J.S.A. 18A:40-17 – Equipment, Materials and Services for Tuberculosis Test

The board may provide at its expense the equipment, materials, and services necessary to make such determination, or it may contract to use for that purpose, with or without financial reimbursement, the equipment, materials, and services available through a hospital or public health agency approved by the State Department of Health.

N.J.S.A. 18A:40-18 – Exclusion of Pupils Failing to Comply with Rules and Orders

Any pupil failing to comply with the rules of the board of education relating to the determination of the presence of tuberculosis or any order issued by a school officer pursuant to such rules may be excluded from school.

N.J.S.A. 18A:40-19 – Records and Reports of Tuberculosis Testing

All records and reports of tuberculosis testing conducted by or under the auspices of a board of education shall be the property of the board, and shall be filed with the medical inspector as confidential information except that such records and reports shall be open for inspection by officers of the State Department of Health and of the local board of health, of the municipality in which the pupil resides and of the municipality in which the school is located.

N.J.A.C. 7:26-3A.1 – Medical Waste Rules

Additional Points for School Nursing Practice

The NJDOH provides a [Frequently Asked Questions \(FAQ\)](#) document that addresses special considerations such as religious exemptions, recent immunization concerns, actions for positive test results, and non-public school guidance. The FAQ also addresses mandatory testing populations, compulsory documentation and reports, use of the Symptom Assessment Form for Pulmonary TB, and BCG vaccination concerns. The FAQ also reviews actions to be taken for positive test values. These materials are frequently updated and should be reviewed each year for any changes.



In preparation for the annual testing program, the school nurse should order the supplies needed to perform tuberculin testing. It is important to review the manufacturer's instructions for the safe storage and use of the tuberculin solution.

School nurses and other school personnel dealing with medical waste review the New Jersey Department of Environmental Protection's [Guidance Document for Regulated Medical Waste](#).



Key Point

The school physician authorizes the tuberculin testing program as required by the NJDOH. This authorization must be included as part of the district's standing orders. In addition, individuals may have an allergic reaction to the Mantoux testing solution; therefore epinephrine should be readily available for use in case of an anaphylactic or acute hypersensitivity reaction. This should also be included in the standing orders.

Based on the current guidelines from the NJDOH's *Required Tuberculin Testing in NJ Schools*, the school nurse determines which students and staff/employees qualify for tuberculin screening.

Tips for TB Testing can be found at the end of this chapter.



Tips for TB Testing: Students

The school nurse:

- Informs the student's parent/guardian of the significance of tuberculin testing and explains the procedure to the parent/guardian and child (appropriate to development);
- Informs the parent/guardian that the TST may be performed by the school nurse, without a fee, or the test may be administered by their healthcare provider at their own expense;
- Offers to perform the test as directed by NJDOH and the district's standing orders and has the parent/guardian sign and date the board-approved consent form for the procedure;
- Invites the parent/guardian to be present during the test; and,
- Records the date of administration and results of the TST on the Student Health History and Appraisal Form (A-45). Records the results using "mm" of induration. If no induration is detected, records as "0" mm. Refers to Required Tuberculin Testing in NJ Schools for action to be taken for positive results.

Tips for TB Testing: School Employees

The school nurse:

- Explains the significance of the TST and explains the procedure;
- Informs the employee that the tuberculin screening test may be performed by the school nurse, without a fee, or he/she may choose to have the test administered by his/her healthcare provider at his/her expense;
- Obtains the employee's written consent using board-approved forms;
- Records the date of administration and the result of TST on the board-approved employee health form. Returns the completed form to the district personnel office; and,
- Records the results according to mm of induration. If no induration results, record as "0" mm. Refers to Required Tuberculin Testing in NJ Schools for action to be taken for positive results.



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CHAPTER FIVE: Meeting the Needs of Students with Chronic Health Conditions

Introduction



The [Maternal and Child Health Bureau](#) defines children and youth with special healthcare needs as those that are at increased risk for chronic physical, developmental, behavioral, or emotional conditions. These children require health and related services beyond that required by most children.

- Nearly 20% of U.S. children under age 18 years of age have a special healthcare need.
- One in five U.S. families have a child with a special healthcare need.
- Children and youth with special healthcare needs and their families often need services from multiple systems including health care, public health, education, mental health, and social services (HRSA, 2016).

The Association of Maternal and Child Health Programs (AMCHP) estimates there are 11.2 million children with special healthcare needs. Children and youth with special healthcare needs ([CYSHCN](#)) are a diverse group of children, ranging from children with chronic conditions to those with more medically complex health issues, to children with behavioral or emotional conditions (AMCHP, 2017). AMCHP, with support from the Lucille Packard Foundation for Children's Health, published [Standards for Systems of Care for Children and Youth with Special Healthcare Needs Version 2.0](#). These standards have been used by national, state, and local stakeholder groups including state Title V CYSHCN programs, health plans, state Medicaid and CHIP agencies, pediatric provider organizations, children's hospitals, insurers, health services researchers, families, consumers, and others to improve systems of care for CYSHCN.

School nurses provide services and support for students presenting a myriad of chronic health conditions. Chronic health conditions may impact attendance and interfere with a student's ability to participate in the full range of educational programs. Chronic health issues may even influence a student's ability to learn. Students with chronic health conditions may take medications that interfere with concentration, memory, or cognition.



They may miss school for healthcare appointments or simply because they are fatigued, feeling pain, or experiencing other symptoms of the disease itself or side effects related to treatment.

While the CDC addresses [chronic health conditions](#) in schools, the information is limited to asthma, diabetes, epilepsy, food allergies, and oral health. The [National Association of Chronic Disease Directors \(NACDD\)](#) supports chronic disease prevention and promotion through projects such as [Local Health Department and School Partnerships](#). There are limited resources addressing “chronic health conditions” since most available information focuses on specific health conditions and diseases.

This chapter addresses three specific areas: care coordination and the medical home; New Jersey mandates to address specific chronic health conditions; and generic information on common health conditions that may impact health and learning. This chapter does not provide lengthy background information on specific health problems nor does it provide a complete list of such conditions. The section focuses on the school nurse's role addressing the needs of children with chronic health conditions or special health-care needs. Chapter Eight: Supporting Students with Special Needs focuses on students eligible for services under Section 504 or IDEA.

Topic: Care Coordination and Medical Home

Background and Rationale

Evidence indicates that healthy students are better learners. For those students with a chronic health condition such as asthma or diabetes, juggling the demands of learning with the day-to-day management of their health condition can be overwhelming for students and their families. Educators are not prepared to deal with the myriad of new conditions and treatments presenting at school. School nurses, however, are members of two divergent communities: education and health. They are uniquely qualified to coordinate care for students with chronic medical conditions. The school nurse is able to communicate fluently and actively collaborate with practitioners from both health and education to ensure that every child succeeds.

Why should schools be concerned about care coordination? Studies show that chronic health conditions may be associated with lower academic achievement. This may vary by health condition, and other factors may also play a role. However, schools are responsible for helping students manage chronic health conditions because children and families may have difficulty accessing healthcare. They may rely on the school for clinical services, such as those provided by a school nurse or a school-based health center. Additionally, federal and state regulations require schools to provide services and accommodations for students with chronic health conditions (CDC, 2017a).

The CDC offers six strategies to address the needs of students with chronic health conditions. Schools should:

1. **Plan and develop a coordinated system to meet the needs of students with chronic health conditions.** Schools should create a school health team and implement a coordinated approach, such as the WSCC model (see Chapter One). District policies and procedures must be consistent with federal and state laws and regulations such as the Individuals with Disabilities Education Act (IDEA), Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA), the Health Insurance Portability and Accountability Act (HIPAA), and the Family Educational Rights and Privacy Act (FERPA).
2. **Provide school-based health services and care coordination for students with chronic health conditions.** Care coordination by school nurses helps create connections between students, families, and primary health care providers. School nurses keep track of health status updates and medications and support students to follow their health care plan. Some studies show that students in schools with case management have significantly fewer urgent care visits, emergency room visits, and hospitalizations.
3. **Provide specific and age-appropriate education to students and their families to improve self-management of chronic health conditions.** Schools can offer bilingual or culturally appropriate education and programs for children and their families. If in-person classes are not available or accessible, schools can use web-based education or partner with a community partner to deliver educational programs for students and families.
4. **Provide professional development opportunities for school staff on improving health and academic outcomes of students with chronic health conditions.** School nurses provide training for appropriate school staff on the connection between health and learning and the impact of health issues on academic achievement. School staff should participate in on-site learning opportunities, e-learning modules, or webinars on relevant student health issues.
5. **Provide appropriate counseling, psychological, and social services for students affected by chronic health conditions.** In addition to addressing physical health, students with chronic health conditions may need emotional support. These students may be at higher risk for bullying than other students. Students with chronic health conditions may need additional support during transitions such as moves and school transfers or changes in family structure or living arrangements. The goal is a positive school climate in which students can seek help from trusted adults.
6. **Provide a safe physical environment with appropriate nutrition, physical education, and physical activity opportunities for students with chronic health conditions.** Students with chronic health conditions may be sensitive to conditions inside and outside the building. Students need a safe and healthy environment in classrooms, the cafeteria, gymnasium, and on the playground. All students should participate in physical activity, regardless of ability, unless medical needs prevent it (CDC, 2017a).



The [National Center for Medical Home Implementation](#) defines care coordination as the deliberate organization of patient care activities between two or more participants (including the patient) to facilitate the appropriate delivery of healthcare services. To achieve optimal outcomes for children and youth, especially those with special healthcare needs, multiple care systems and individuals must work together across settings. This is best accomplished when a child or adolescent has a medical home (AAP, August 2016). New Jersey has a number of [medical home state initiatives](#).

A [medical home](#) is a nationally known healthcare standard based on a cultivated partnership between the patient, family, and primary healthcare provider in cooperation with specialists and support from the community. The medical home delivers primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective to every child and adolescent. The medical home addresses preventative, acute, and chronic care from birth through transition to adulthood (AAP, January 2017).

Registered nurses work to improve the quality of health care and healthcare outcomes across populations and healthcare settings. They support the efficient and effective use of healthcare resources. School nurses (who are also registered nurses) use student-centered care coordination to ensure that student and family needs are met and that care is delivered in a safe and effective manner. Care coordination requires school nurses to partner with other healthcare professionals and support personnel to design, deliver, and evaluate school health programs and services (ANA, June 2012).

As a case manager, the school nurse coordinates student health care between the medical home, family, and school. If a student does not have a medical home, the school nurse can help the family identify and access appropriate services. School nurses may also identify children having undiagnosed chronic medical conditions. The school nurse plays an important role in coordinating evaluation and intervention services. Effective care coordinators help students manage their illness, thus improving school attendance.

Care coordination involves planning care, identifying resources, connecting families to services, and ensuring the student's healthcare needs are met in the school setting.

The school nurse, as part of a school health team, works to bring together health services, health education, and a healthy school environment. Care coordination addresses the needs of all students with a focus on each student's unique needs. The school nurse helps make connections between student health and academic achievement (Wolfe & Hoffman, March 2017).

School nurses use a student-centered approach to educate and empower students to make healthy decisions. School nurses must become more student-centered, educating and empowering students to make healthy decisions. The school nurse plays a pivotal role in helping parents/guardians understand why students need to develop self-management skills particularly when dealing with a chronic health condition such as asthma or diabetes. This aspect of care coordination may be difficult, as the "adults" may not feel comfortable yielding control to the child or adolescent. At the very core, the role of

the school nurse is to build the capacity of children and youth to make healthy choices, manage their own care in appropriate and responsible ways, and help transition them to adulthood. The student plays a key role in this process and the impact of student voice and participation in the planning and implementation of health care is critical.

NASN believes that coordinated and deliberate transition planning to maximize lifelong functioning and well-being should be available for all children with chronic illnesses (NASN, 2014). Transition planning involves coordinated activities that assist students with chronic health conditions to begin school and move from one school to another; to move from hospitalization back to school; and from the secondary school system into their next stage of life (Selekman, Bochenek, & Lukens, 2013).

Care coordination involves school nurses sharing information and maintaining communication among those concerned with the needs and care of students with chronic health conditions. Care coordination can improve medical management, provide more detailed follow-up, and reveal the need for additional resources (CDC, 2017b).

Students with chronic health conditions require treatment specific to their health condition. A key element of care coordination includes creating the student's Individualized Healthcare Plan (IHP) and Individualized Emergency Healthcare Plan (IEHP). The school nurse retrieves orders from the medical home and coordinates their implementation with other healthcare and social service providers as well as with related services providers such as speech or physical therapists. As an essential member of the interdisciplinary team, the school nurse brings the health expertise necessary to develop a student's Individualized Education Plan (IEP) or Section 504 plan, which are designed to reduce health-related barriers to learning.

Creating, updating, and implementing IHPs for students with chronic medical conditions are fundamental to the school nurse role. School nurses provide for the direct care needs of the student, including medication administration and routine treatments and procedures. The [Every Student Succeeds Act \(ESSA 2015\)](#) recognized the important role of the school nurse to educate school staff to better understand the management of a child with a chronic condition or special healthcare need.

Applicable Laws and Regulations

N.J.A.C. 6A:16-1.3 – Definitions

Medical home is defined as a healthcare provider, including NJ FamilyCare providers as defined by N.J.S.A. 30:4J-12 and the provider's practice site chosen by the student's parent or guardian for the provision of health care.

N.J.A.C. 6A:16-2.2(j) – Required Health Services

The district board of education shall make accessible information regarding the NJ FamilyCare Program to students who are knowingly without medical coverage.



N.J.A.C. 6A:16-2.2(f) – Medical Examinations

Each student's medical examination must be conducted at the medical home of the student and if the student does not have a medical home, the school district must provide the examination at the school physician's office or other comparably equipped facility.

N.J.A.C. 6A:16-2.3(b)3i – Health Services Personnel

The certified school nurse carries out the written orders of the medical home; confers with the medical home to determine the validity of medical exemptions to immunizations; and, reviews DNR orders received from the student's parent/guardian or medical home and shares with the medical inspector for determination.



Key Point

Successful care coordination is the development, implementation, and evaluation of individualized plans of care for students with chronic health conditions. The regulations require school nurses to write and update the IHP and the IEHP for each student at least annually.

N.J.A.C. 6A:16-2.1(a)10 – Individualized Healthcare Plan and Individualized

N.J.S.A. 18A:40-12.11 – Emergency Healthcare Plan

These rules requires the development of an individualized healthcare plan and individualized emergency healthcare plan for students with chronic medical conditions, including diabetes, asthma, and life-threatening allergies, requiring special health services in accordance with N.J.S.A. 18A:40-12.11.c, 12.12, 12.13, and 12.15; and N.J.A.C. 6A:16-2.3(b)3xii.

N.J.A.C. 6A:16-2.1(a)5iii – Asthma Treatment Plan

Each student authorized to use asthma medication pursuant to N.J.S.A. 18A:40-12.3 or a nebulizer shall have an asthma treatment plan prepared by the student's medical home and submitted to the certified school nurse. The treatment plan shall identify, at a minimum, asthma triggers and shall be included in the individualized healthcare plan and individualized emergency healthcare plan, pursuant to N.J.A.C. 6A:16-2.3(b), for meeting the medical needs of the student while attending school or a school-sponsored function.



Key Point

As care coordinator, the school nurse educates school staff about the medical condition, makes them aware of appropriate responses to symptoms or concerns, and provides other critical information about the student's health issues as outlined in the IHP/IEHP.

Additional Points for School Nursing Practice

Students present with a myriad of health conditions, some that may be unfamiliar to the school nurse. The school nurse must learn about the health condition, any medications or treatments prescribed, and how the condition may impact the student's participation in school-based programs and activities. The school nurse must also maintain clinical competence through training and professional development.

While it is important to develop an IHP/IEHP for every student with a chronic health condition, the key word is "individualized." The IHP/IEHP should be specific to the child, rather than a boilerplate document.

Effective care coordination is about relationships—with the student, family, medical home, and other health services providers. Keep open lines of communication and develop trust.

School nurses should be aware of the [Catastrophic Illness in Children Relief Fund](#) which can provide families with assistance to meet expenses not covered by insurance.

The NJDOH provides information and services for [Children with Special Health Needs](#).

Meeting the Needs of Students with Chronic Health Conditions

Topic: General Principles of Medication Administration in School

Background and Rationale

Today's students present a myriad of health conditions that may require the administration of medications during the school day. Some of these medications are routine or daily prescribed medications to help the student control a diagnosed health condition. Other medications are administered in response to symptoms such as wheezing or shortness of breath. Still other medications are administered for life-threatening medical conditions such as anaphylaxis. New Jersey's school districts must continuously update their medication policies and practices to reflect new laws and regulations. However, unlike some other states, the NJDOE does not issue specific guidance or sample policies for the general administration of all medications. Only those medications specifically addressed in law have policy direction from the NJDOE.

The [AAP Guidelines for Administration of Medication in School](#) provides guidance for school districts and pediatricians and addresses over-the-counter products, herbal medications, experimental drugs that are administered as part of a clinical trial, and emergency medications and includes principles of student safety. However, be advised that because state laws vary, some of the guidance in the document may be in violation of New Jersey laws and regulations. Schools and school nurses must adhere to health and education laws and regulations as well as those adopted by the NJBON, particularly when it comes to the administration of medication and delegating that task to an unlicensed individual.



Similarly, NASN published a position paper, [Medication Administration in Schools](#). These national documents provide general guidance but are not New Jersey-specific. The NASN paper calls for policies and procedures that are consistent with federal and state laws including state nurse practice acts, rules, regulations, and any other laws that may apply. It also recommends that school policies be aligned with standards and safe, evidence-based information (NASN, 2017).

The NJDOE defines “medication” as a drug approved by the FDA for preventing, caring for, and assisting in the cure of disease and injury that has a written order from a physician licensed in medicine, dentistry, or osteopathy, or from an advanced practice nurse. Medication does not include herbal remedies (NJDOE, 2017).

Herbal remedies or botanicals are considered dietary supplements and are not subject to the same level of scientific scrutiny as FDA approved drugs or medications. Although most companies that market herbal supplements follow good manufacturing practices, they are not required to get approval from the FDA before putting the products on the market. Companies can claim that products address a nutrient deficiency, support health, or are linked to body functions based on their own research, but they must include a disclaimer that the FDA has not evaluated the claim. Once a dietary supplement is on the market, the FDA is responsible for monitoring its safety and can take action against a manufacturer if there are problems (Mayo Clinic, 2014).

The administration of medication and self-medication management is important because the health of the student may be jeopardized. Similarly, without certain medications, a student might not be able to attend school or a student's ability to learn might be compromised. In New Jersey's public schools, school nurses are responsible for administering medications during the school day. This process involves assessment, consultation with the student's family and medical home, and conferring with the school physician, as appropriate.

The school nurse is also responsible for training delegates under applicable laws. This has practice implications for the school nurse who must ensure that the delegate is adequately trained since administration by a delegate usually occurs when the school nurse is not physically present at the scene, such as an after school activity or when a nurse is assigned to more than one school building. The school nurse must adhere to any NJBON regulations regarding delegation and should be knowledgeable of the Board's [Decision-Making Model](#).

Pursuant to **NJBON Regulations** a registered professional nurse should not delegate if the nurse, in his or her professional judgment, determines that such delegation is not consistent with standards of practice. Should the nurse be in a situation where delegation is being considered, the registered professional nurse:

- Is responsible for the nature and quality of all nursing care including the assessment of the nursing needs, the plan of nursing care, the implementation, and the monitoring and evaluation of the plan;
- May delegate selected nursing tasks in the implementation of the nursing regimen to licensed practical nurses and ancillary nursing personnel (e.g. health aides);
- May not delegate the performance of a nursing task to persons who have not been adequately prepared by verifiable training and education; and,
- Is responsible for the proper supervision of personnel to whom such delegation is made (NJDCA:NJBON, 2017).

Supervision may require the direct continuing presence, or the intermittent observation, direction, and occasional physical presence, of a registered professional nurse. In all cases, the registered professional nurse shall be available for on-site supervision. In addition, the registered professional nurse is responsible for maintaining appropriate records in accordance with NJBON regulations (NJDCA:NJBON, 2017), NJDOE regulations, and school district policies.

New Jersey law permits the school nurse to delegate the administration of specific emergency medications to unlicensed individuals employed by the school district and who volunteer to be trained. The procedures for these specific medications and circumstances are outlined in law and regulations. These delegation rules are not transferrable; that is, the local school district does not have the discretion to require that the school nurse delegate any or all medication administration to any other school district employees outside of those specifically referenced in law and code. When in doubt, the school nurse should visit the NJDOE's [School Health Services](#) webpage or contact the [NJSSNA](#) for any changes or updates.

The school nurse should work with the local board of education, the school physician, and the district's administration to develop policies and procedures addressing all aspects of medication administration in the school setting. School district policies should state that medications administered to or taken by students must only be medications that must be administered or taken during school hours, inclusive of district transportation or at school-sponsored events. Medications that can be given at other times of the day should not be administered or taken at school. Students should be advised not to carry medications on their person during the school day unless the use of that medication has been ordered by the student's medical home and reviewed and approved by the school nurse.



N.J.A.C. 6A:16 defines medications and requires written authorization by a physician licensed in medicine, dentistry or osteopathy, or from an advanced practice nurse. At the present time, physician assistants (PAs) are not included in this definition. Certified school nurses are registered nurses (RNs) and must have a physician's order to administer any over-the counter medication or prescription medication. The school physician may also approve the administration of limited over-the-counter medications as part of the district's standing orders. Parental consent is also required before these medications can be administered to students.

Current New Jersey laws and regulations permit the school nurse to train school employees to administer epinephrine and glucagon. Students are permitted to carry and self-administer medications for asthma and other life-threatening illnesses. For example, students may carry an inhaler or epinephrine auto-injector for asthma or anaphylaxis. Students with diabetes may carry and administer insulin or glucagon.

This section of Chapter Five provides general information and guidance on required policies and procedures to support the safe administration of medication in the school setting. New Jersey laws and rules specifically addressing medications associated with asthma, anaphylaxis, and diabetes can be found later in this chapter.

Applicable Laws and Regulations

N.J.S.A. 18A:40-12.3-12.6

This law permits students to self-administer certain medications for asthma or other life-threatening illnesses.

N.J.A.C. 6A:16-2.1(a)2 – Medication Policies

These regulations require the local board of education to develop and implement policies and procedures to address the administration of medication to students in the school setting. The rules authorize the following to administer medications:

- The school physician;
- A certified school nurse or noncertified nurse;
- A substitute school nurse employed by the school district;
- The student's parent;
- A student approved to self-administer medication pursuant to N.J.A.C. 6A:16-2.1(a)5iii and 9 and N.J.S.A. 18A:40-12.3 and 12.4;
- Other school employees who volunteer to be trained and designated by the certified school nurse to administer epinephrine in an emergency pursuant to N.J.S.A. 18A:40-12.5 and 12.6; and,
- Other employees who volunteer to be designated as a delegate and trained to administer glucagon pursuant to N.J.S.A. 18A:40-12.14.

N.J.A.C. 6A:16-2.1(a)4 – Emergencies

These regulations require local boards of education to develop policies and procedures and for the provision of health services in emergency situations including the emergency administration of epinephrine via epinephrine auto-injector and the emergency administration of glucagon.

N.J.A.C. 6A:16-2.1(a)5 – Asthma Treatment

These regulations establish specific requirements for the treatment of asthma in the school setting. School nurses must be appropriately trained in airway management and the use of nebulizers and then are authorized to administer asthma medication through use of a nebulizer. Students who are authorized to use asthma medication or a nebulizer must have an asthma treatment plan prepared by the student's medical home and submitted to the certified school nurse.

N.J.A.C. 6A:16-2.3(b)3vii&viii – Epinephrine and Glucagon

The school nurse is responsible for directing and supervising the emergency administration of epinephrine and glucagon, and training school staff designated to serve as delegates. The school nurse is also responsible for administering asthma medication through a nebulizer.

N.J.A.C. 6A:32-7 – Records

These regulations require each district board of education to compile and maintain student records and regulate access, disclosure, or communication of information contained in educational records in a manner that assures the security of such records in accordance with this subchapter.

N.J.A.C. 6A:32-7.5(d) – Records

These regulations state that access to and disclosure of a student health record shall meet the requirements of the [Family Education Rights and Privacy Act, 34 C.F.R. Part 99 \(FERPA\)](#).

Federal laws addressing access to health services for students with disabilities include the Individuals with Disabilities Education Improvement Act of 2004 ([IDEA](#)) and [Section 504 of the Rehabilitation Act \(1973\)](#) as amended through the [Americans with Disabilities Amendment Act \[ADAA\] in 2008](#) . The USDE developed a [Section 504 FAQ](#) that provides useful information.

Access to student health records must meet the requirements of the Family Education Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g and 34 CFR Part 99, incorporated herein by reference, as amended and supplemented, and N.J.A.C. 6A:32-7.

The Office of Civil Rights (OCR) at the USDE provides Title 34 Education, [Part 104-Non-discrimination](#) that addresses the participation of handicapped individuals in programs or activities receiving federal financial assistance.

Congressional Findings on Controlled Substances



FDA Definitions

The **New Jersey Board of Nursing** regulates nursing practice by adopting rules, regulations, and policies governing the practice of nursing. The National Council of State Boards of Nursing created a **nurse practice act toolkit** to assist nurses to better understand the regulations and laws that address nursing practice in a particular state. This is particularly important if a New Jersey licensed school nurse is expected to provide nursing services to students on a field trip or activity outside New Jersey.

The State Board of Pharmacy oversees professional practice through **pharmacy regulations**. Specifically, N.J.A.C. 13-39-7 addresses drug dispensing and prescription records.

Additional Points for School Nursing Practice

School districts should develop standardized medication authorization forms used in all district schools. Authorized prescribers should be required to complete the form, print/stamp their name and credentials, and then sign their name. The form should include the name of the medication, the dosage, route of administration, time of administration, the duration of the order, any possible or anticipated side effects, and any special instructions (e.g. take with food, 30 minutes before eating). New Jersey does not require a specific form for medication permission and administration but many states and agencies have **sample forms** that can be adapted for use in New Jersey schools.



Key Point

The NJDOE defines medication as a drug approved by the FDA for preventing, caring for, and assisting in the cure of disease and injury that has a written order from a physician licensed in medicine, dentistry, or osteopathy, or from an advanced practice nurse. Medication does not include herbal remedies. Pursuant to these rules, school nurses should not take medication orders from chiropractic physicians or other holistic healthcare providers. When in doubt, discuss your concerns with your school physician.

With few exceptions, school nurses should avoid taking verbal orders from authorized providers. In those cases where a verbal order is a medical necessity, it should immediately be followed with a completed and signed medication authorization form.

School districts need to develop specific policies that address how medications are stored. All medications must be kept in a locked cabinet.

The NJ Drug Control Unit establishes regulations for **controlled substances security**. These rules should be incorporated into district policies. No more than a 30 day supply of controlled substances should be kept in the school health office. Documenting the number or amount of these medications should be conducted on a regular basis.



Key Point

When counting controlled substances, do so with a witness such as an administrator or designee.

School districts must ensure that all students and staff know where certain emergency medications are stored and how to respond in emergencies. Trained delegates must be able to access emergency medications quickly.

Schools need to develop specific policies to address the self-administration of medications. Students may not share medications with other students, and may be subject to disciplinary action if they do so.

The local board of education must develop policies that address the administration of medications on overnight field trips, out-of-state trips and activities, and other activities when a school nurse is normally not present. Policies must align with current NJ law; however, nursing and medication laws may differ in other states.



Key Point

The Nurse Licensure Compact (NLC), sponsored by the National Council of State Boards of Nursing (NCSBN), provides a multi-state nursing license. At this time, New Jersey is NOT a member of the Compact. Pending legislation would enter New Jersey in the NLC. This would create a mutual recognition system where a nurse only needs to obtain one license from the nurse's state of residence in order to be permitted to practice nursing in any other state that is a party to the compact, as long as the nurse complies with the state practice laws of the state in which the patient is located at the time that care is rendered. Currently, a nurse is required to be licensed in, and by, each state in which the nurse chooses to practice.



Key Point

When asked to accompany students on an out-of-state trip, the school nurse should advise his/her supervisor that nurses are only eligible to practice in states in which they hold an active nursing license. For more information on licensing and practice issues while on the trip, school nurses should contact the board of nursing in the state where the field trip occurs, and for out-of-country field trips contact the U.S. State Department. This information will be updated should New Jersey become a member of the NLC.

Delegation to other school personnel is limited by law to very specific situations. When students are unable or not permitted to self-administer medications while participating in these activities, the district must weigh the rights of the individual with the needs of all students and seek sensible solutions that do not compromise student health and safety. For example, it is ill-advised to send the district's only certified school nurse on a field



trip with 30 students, leaving the remaining students without a school nurse for the entire school day.

Other solutions might include the school nurse working with the student's parents and medical home to alter the time of administration of a medication on a given day (e.g., before or after a field trip). School districts may hire an approved substitute school nurse to administer medications on a school trip. The student's parent may accompany the child, but cannot be required to do so unless all parents are required to attend the activity. School districts must plan in advance for the possibility that one or more students will require medication during such activities.



Key Point

All medications should come to school in the original labelled container. School nurses should not accept medications in baggies, unmarked bottles, or unlabelled containers. In schools where a school nurse is not always present, school office personnel should never accept medication from parents or students without the appropriate authorizations and in the original containers.

All medications should be removed from the school at the end of the school year or when the medication or the order for it has expired. If a parent/guardian does not pick up the medication at the end of the school year, the school nurse should dispose of it following state and federal guidelines. Medications for students attending summer programs may remain locked in the health office; however, the school district must address who is appropriately credentialed to administer these medications to students if a school nurse is not present during extended year or summer programs.

The school district must adhere to laws and rules addressing the disposal of medical waste such as syringes and needles. Chapter Thirteen of this document addresses this issue.

School nurses need to document the administration of medication, noting who administered the medication and any side effects or issues. Each student's medication record should be separate rather than recording several students on one sheet or electronic log. Medication records are confidential and are part of the student's school health record.



Key Point

School nurses need to develop mechanisms to document and report medication errors. This may include giving the wrong medication or incorrect dose; giving the medication to the wrong student; or, giving the medication at the wrong time.

Key Point

School districts need to develop policies and procedures to address lost or stolen medications.

School nurses often serve more than one school. Parents and students must understand that medications will be administered within a reasonable time period as prescribed. School nurses must use nursing judgment to determine if this accommodation will impact the absorption and effectiveness of the medication.

Over-the counter medications cannot be administered in the school setting without an order from an authorized provider. Parental permission is also required.



Key Point

Some school physicians will write standing orders for common over-the counter medications. The standing order should specify the circumstances warranting administration, the dosage based on age and weight, and any contraindications. Parental permission is required to administer OTCs authorized by the school physician as part of approved standing orders.

School nurses must maintain confidentiality. A list of students receiving medications should not be publicly displayed or shared with school staff.

School nurses should educate all school personnel about the common side effects of medications. When students take medications during the school day, teachers may observe mood swings or behavior changes, drowsiness or hyperactivity, loss or change of focus, thirst or hunger, the need for frequent bathroom breaks, weight gain, and other side effects. The school nurse must regularly communicate with the student and his/her teachers about possible side effects to determine what, if anything, can be done to minimize them.

The National Association of Special Education Teachers provides information on [medications](#) taken for mental health and related disorders.

The American Association of Poison Control Centers and Scholastic, with support from McNeil Consumer Healthcare, developed [OTC Medicine Safety](#) to raise awareness about the safe use of over-the-counter medicine and provide resources to better equip educators, school nurses, and families with knowledge about OTC medicines and responsible usage. The program is designed for students in grades 5 and 6 and provides posters, newsletters, and information for students and families.

Meeting the Needs of Students with Chronic Health Conditions

Topic: Medical Marijuana

Background and Rationale

The term medical marijuana or cannabis refers to using the whole, unprocessed marijuana plant or its basic extracts to treat symptoms of illness and other conditions (NIDA, 2017). In its position paper, [Marijuana and Children](#), NASN concurs with the United States Drug Enforcement Agency (DEA) that the marijuana plant is a Schedule I controlled sub-



stance and that there is not sufficient scientific evidence for the FDA to approve the smoked marijuana plant for medical use (DEA, 2013).

Juxtaposed to these positions, New Jersey along with a growing number of states, territories, and the District of Columbia, have enacted laws to legalize its medical use when traditional therapies have been found to be ineffective. Medical marijuana or marijuana-derived products are approved in New Jersey for a number of medical conditions. The [Medicinal Marijuana Program](#), under the direction of the NJDOH, is responsible for the implementation of the [Compassionate Use Medical Marijuana Act](#).

To become a registered patient with the Medicinal Marijuana Program (MMP), an individual must maintain a bona fide relationship with a physician who is registered with the program. A bona fide relationship is defined as a relationship in which the physician has ongoing responsibility for the assessment, care, and treatment of a patient's debilitating medical condition. More details are provided on the program's website and in the actual law. The individual must also be a New Jersey resident (NJDOH, 2017).

The individual must be diagnosed with a debilitating medical condition by a New Jersey physician registered with the MMP. Approved debilitating medical conditions include:

- Amyotrophic lateral sclerosis;
- Multiple sclerosis;
- Terminal cancer;
- Muscular dystrophy;
- Inflammatory bowel disease, including Crohn's disease; and,
- Terminal illness, if the physician has determined a prognosis of less than 12 months of life (NJDOH, 2017).

The following medical conditions apply if the patient is resistant or intolerant to conventional therapy:

- Seizure disorders including epilepsy;
- Intractable skeletal muscular spasticity;
- Glaucoma; and,
- Post-Traumatic Stress Disorder (NJDOH, 2017).

The following medical conditions apply if severe or chronic pain, severe nausea or vomiting, cachexia, or wasting syndrome results from the condition or its treatment:

- Positive status for Human Immunodeficiency Virus (HIV);
- Acquired Immune Deficiency Syndrome (AIDS); and,
- Cancer (NJDOH, 2017).



Key Point

Governor Murphy issued Executive Order No. 6 (2018) (EO 6) directing the New Jersey Department of Health to undertake a review of all aspects of New Jersey's Medical Marijuana Program with a focus on ways to expand access to marijuana for medical purposes. Recommendations and changes can be found in the Medical Marijuana Report March 2018 issued by NJDOH. Information on the changes can be accessed [here](#).

Local boards of education must adopt and implement a comprehensive alcohol, tobacco, and other drug abuse program focused on prevention and intervention. However, the potential use of medical marijuana in schools creates possible conflicting policies and messages to students and their families. To assist in policy development, the NJDOE sent local school districts, charter schools, nonpublic schools, and private schools for the handicapped a [medical marijuana in schools memorandum](#) that outlines their responsibilities under the law.

As health leaders, New Jersey school nurses need to have an understanding of the implementation of the New Jersey Compassionate Use Medical Marijuana Act (CUMMA). Since school nurses are the link to the student's medical home, it is critical that school nurses work with the school health team and district administration to develop and implement medical marijuana policies and procedures that require a coordinated approach to care. The school nurse, as care coordinator, should work closely with the student and his/her family to ensure that district policies are followed. Crucial to this process is the development of an IHP.

Local school districts should also develop policy to address the use of medical marijuana by school staff.

Applicable Laws and Regulations

PL 2009 Chapter 307 – Compassionate Use Medical Marijuana Act

New Jersey, P.L.2015, c.158 – Amendments

N.J.S.A. 18A: 40-12.22 – Self Administration of Medication

The law requires all school districts to adopt policies permitting the administration of medical marijuana to qualifying students. Qualifying students are those processed through the New Jersey Medical Marijuana Registry (NJMMR) and who possess Medical Marijuana Program (MMP) identification cards for both parents and children enrolled in the NJDOH MMP.

There are several important points in the law that school nurses must understand. Only the parent, guardian, or registered caregiver is permitted to administer medical marijuana on school grounds, on a school bus, or at a school-sponsored activity. **The law does not permit the school nurse or any other school employee to administer medical**



marijuana in the school setting. The school district must identify locations on school grounds where medical marijuana may be administered. The administration of medical marijuana to a student by smoking or other form of inhalation while the student is on school grounds, aboard a school bus, or attending a school-sponsored event is prohibited.



Key Point

MMP alternative treatment centers dispense medical marijuana in the form of plant leaves or flowers which have no liveried dose due to the variations in dispensaries and preparation methods of the registered caregiver.

Additional Points for Nursing Practice

All New Jersey public and nonpublic schools must develop policies and procedures for the safe administration of medical marijuana.

The school nurse, along with other members of the school health team, may be involved in policy development.

Students and staff who participate in the MMP are entitled to confidentiality. The school nurse should develop an IHP that:

- Establishes protocols for verifying registration with MMP;
- Identifies the location(s) where medical marijuana will be administered;
- Documents the date, time, and location of medical marijuana administration;
- Assesses and monitors the student for trends and possible side effects;
- Determines the student's capacity to return to class and other activities;
- Creates an alternative plan for the student if he/she exhibits side effects that jeopardize a safe return to class or other activities; and,
- Maintains confidentiality.

Meeting the Needs of Students with Chronic Health Conditions

Topic: Asthma

Background and Rationale

Asthma is a serious chronic disease characterized by airway inflammation and bronchospasm. Asthma occurs when airways become temporarily blocked or narrowed due to exposure to allergens, irritants, strenuous exercise, anxiety, or other triggers. Most people with asthma experience shortness of breath, difficulty breathing, chest tightness, coughing and/or wheezing. Severe asthma attacks may require emergency treatment.

There is no cure for asthma, but asthma can be managed with proper prevention and treatment.

Data from the CDC indicates that 6.2 million children under the age of 18 have asthma or about 8.4% of that population. Approximately 2 million visits were made to the emergency room for asthma (CDC, 2017c). Asthma is the leading chronic disease in children and is the top reason for missed school days. It is more common in boys than girls. In the U.S., African-Americans die from asthma at a higher rate than people of other races or ethnicities (AAFA, 2017).

In New Jersey, over 600,000 adults (9.0%) and 167,000 children (8.7%) are estimated to have asthma. The number of women with asthma is almost double the number of men with asthma; however, asthma occurs more frequently in boys than girls. Children, Black, Hispanic, and urban residents are most likely to be affected. Individuals with allergies and people with a family history of asthma are also most likely to suffer from this disease. It is difficult to quantify asthma-related hospital visits for a number of reasons. However, rates for emergency visits are highest in Camden, Cumberland, and Essex counties, and lowest in Hunterdon, Morris, and Somerset counties. These disparities likely reflect differences in access to effective medical management, co-existing chronic diseases, and environmental or occupational asthma triggers (NJDOH, 2017).

According to [Healthy NJ 2020](#), strides have been made to reduce the incidence of asthma and improve access to care. The NJDOH monitors the percentage of residents with life-time asthma and current asthma using an ongoing, statewide telephone survey, the New Jersey Behavioral Risk Factor Survey ([NJBRFS](#)). The primary purpose of the NJBRFS is to monitor major behavioral risk factors and chronic conditions associated with disability and death among adults. Obtaining information about children with asthma is more difficult. However, the NJDOH provides [asthma data](#) by county and provides information on factors that impact asthma incidence such as air quality. The [State Health Assessment Data \(NJSHAD\)](#) system provides important data about asthma incidence, management, hospitalizations, and emergency room visits.

The [Pediatric/Adult Asthma Coalition of New Jersey \(PACNJ\)](#) provides resources for schools and school nurses and offers asthma information in multiple languages. On the national level, [CDC's National Asthma Control Program](#) funds states, school programs, and non-government organizations to improve surveillance of asthma, train health professionals, educate individuals with asthma and their families, and explain asthma to the public.



Key Point

When asthma is diagnosed early and properly managed, most severe flare-ups can be prevented. However, asthma is one of the leading causes of school absenteeism. According to the CDC, on average, in a classroom of 30 children, about 3 are likely to have asthma. Low-income populations, minorities, and children living in inner cities experience more emergency department visits, hospitalizations, and deaths due to asthma than the general population (CDC, 2017d).



The school nurse helps students understand and manage their asthma triggers. Asthma triggers may include pollen, dust mites, cockroaches, molds and animal danders; irritants in the air, such as smoke, air pollution, chemical fumes and strong odors; medications, such as aspirin and acetaminophen; extreme weather conditions; exercise; and stress. While some of these may be reduced or eliminated in schools, others may be more difficult to address (ACAAI, 2014).

The school nurse also needs to understand the most current treatments for asthma. Students may not want to take their medication and they may be concerned about social stigma. Their parents may be concerned about the cost of the medications. Generally, there are two main treatments for asthma: quick-relief medications and long-term control medications.

Quick-relief medicines are taken at the first sign of symptoms for immediate relief and include short-acting inhaled beta2-agonists and anticholinergics. Both types of drugs are bronchodilators and also help clear mucus from the lungs by allowing mucus to move more freely and get coughed out more easily. Students with exercise-induced bronchoconstriction (EIB), also known as exercise-induced asthma, may need these medications before exercise or other strenuous physical activity. Quick-relief medicines can stop asthma symptoms, but they do not control the airway inflammation that causes the symptoms. In general, if a student needs a quick-relief medicine to treat asthma symptoms more than twice a week, or two or more nights a month, then the asthma is not well controlled (ACAAI, 2014).

Long-term control medicines are taken every day to prevent symptoms and attacks and include antileukotrienes or leukotriene modifiers, cromolyn sodium, inhaled corticosteroids, long-acting inhaled beta2-agonists (always administered with another asthma-related drug), methylxanthines, oral corticosteroids and immunomodulators. These medicines must be taken every day (ACAAI, 2014).

Applicable Laws and Regulations

N.J.A.C. 6A:16-1.3 – Asthma Treatment Plan

This rule defines the asthma treatment plan as a form approved by the Commissioner and completed by the medical home that is specifically designed to indicate differentiated symptoms and appropriate action to be taken by school staff to manage the care of a student who suffers from asthma-related illnesses. The asthma treatment plan serves as an accompaniment to the student's Individualized Healthcare Plan (IHP).

N.J.S.A. 18A:40-12.3 – Self-Administration of Medication by Pupil

N.J.A.C. 6A:16-2.1(a)5 & 9

Pupils with asthma, life-threatening illnesses, or life-threatening allergic reactions are permitted to self-administer medication. In order to do so, the student's parent or guardian must provide the school with written authorization for the self-administration as well as a signed statement holding the school/district and its employees harmless against any claims arising out of the self-administration. Written verification from the student's

physician that the student has asthma, a life-threatening illness, or is subject to a life-threatening allergic reaction is also required. The physician must certify that the student is capable of and has been instructed in the proper administration of the medication. The pupil is permitted to carry an inhaler or prescribed medications for allergic reactions, including a pre-filled auto-injector, provided the pupil does not endanger himself or others by misuse.



Key Point

The board of education of a public school district, or the governing board or chief school administrator of a nonpublic school, must inform the student's parents or guardians in writing that the district, its employees, and agents shall be held harmless as a result of any injury arising from the self-administration of medication by the pupil.

Key Point

Permission to self-administer is effective for the school year in which it was granted and must be renewed annually.

N.J.S.A. 18A:40-12.7-12.9 – Nebulizer Required in Schools

N.J.A.C. 6A:16-2.3(b)2

Each public and nonpublic school must have and maintain at least one nebulizer for the use of pupils. Each school nurse or others authorized to administer asthma medication must receive training in airway management and the use of inhalers and nebulizers. Such training must be consistent with nationally recognized standards (e.g., NIH, AAAI).

An asthma treatment plan is required for each student authorized to self-medicate or use the nebulizer. The asthma treatment plan (asthma action plan) is prepared by the pupil's physician and identifies asthma triggers as well as the prescribed treatment plan. The certified school nurse is responsible for updating, at least annually, individualized health-care plans and individuated emergency healthcare plans to address students medical needs and instructing school staff, as appropriate.



Key Point

The student's parent/guardian must provide the medication, tubing, and mask or mouthpiece.

N.J.A.C. 6A:16-2.1(a)5 – Asthma Policies

These rules require school districts to adopt policies, procedures, and mechanisms to address the treatment of asthma in the school setting. Each school nurse shall be authorized to administer asthma medication through use of a nebulizer and must be trained in airway management and in the use of nebulizers and inhalers consistent with nationally



recognized standards, including, but not limited to, those of the National Institutes of Health and the American Academy of Allergy, Asthma, and Immunology.

The rules require that each student authorized to use asthma medication or a nebulizer have an asthma treatment plan prepared by the student's medical home and submitted to the certified school nurse. The treatment plan shall identify, at a minimum, asthma triggers and shall be included in the individualized healthcare plan and individualized emergency healthcare plan for meeting the medical needs of the student while attending school or a school-sponsored function.



Key Point

*The approved **Asthma Treatment Plan** (also called **Asthma Action Plan**) must be completed for students with asthma.*

Key Point

N.J.A.C. 6A:16-2.1(a) authorizes the school nurse to administer asthma medication through the use of a nebulizer. However, at this time, state funding is not provided for the purchase of or replacement of a nebulizer or related equipment.

Additional Points for School Nursing Practice

The school nurse plays a pivotal role in the management of asthma in the school setting by providing asthma education, obtaining and implementing the student's asthma treatment plan, and performing a comprehensive nursing assessment of each student with asthma.

The School-Based Asthma Management Program (**SAMPRO**) was created by the American Academy of Allergy, Asthma, and Immunology to assist schools to provide comprehensive care for students with asthma. It includes a toolkit, slides, sample forms, and materials to educate students and their families.

This [asthma medicine chart](#) from the American Lung Association was developed in 2009, but it is still a useful tool for school nurses.

NASN provides an [asthma resources](#) page which includes a [School Nurse Asthma Care Checklist](#).

New Jersey schools are also required to have a [nebulizer](#) available and the school nurse must be trained to use it. PACNJ provides a [nebulizer video](#) and a [nebulizer handout](#).

The American Lung Association provides a [model policy for stock bronchodilators](#).

The school nurse is an advocate for programs such as [Asthma Friendly Schools](#) from PACNJ and [IAQ Tools for Schools Program](#) from the Environmental Protection Agency (EPA). These programs support a healthy physical environment that minimizes or elimi-

nates known triggers and allergens. The American Lung Association provides an [Asthma Friendly Schools Toolkit](#).

The school nurse works with the student, family, and medical home/asthma specialist to ensure the safe and appropriate use of medications and treatments in the school setting. This may include checking the functionality of nebulizers and inhalers and ensuring that a back-up inhaler is kept in the school health office.

The school nurse, with parental permission, shares important IHP and IEHP information with school personnel such as physical education teachers, coaches, athletic trainers, bus drivers, and school nurse substitutes.

The National Asthma Education and Prevention Program (NAEPP), coordinated by the National Heart, Lung, and Blood Institute (NHLBI), developed [Managing Asthma Guide for Schools 2014](#) to help schools address the serious threat asthma poses to the health and education of children. It offers practical information and tools to help guide school staff to plan, implement, and maintain an asthma management program that connects with the community.

The CDC published [Strategies for Addressing Asthma in Schools](#), a compilation of information and resources for implementing programs in schools. It was designed for staff in state health departments as they manage asthma programs, but other individuals and groups with an interest in “asthma friendly schools” may also find it useful. It aligns with the [WSCC](#) model of school health described in Chapter One of this document.

Meeting the Needs of Students with Chronic Health Conditions

Topic: Anaphylaxis

Background and Rationale

Anaphylaxis is a serious, life-threatening allergic reaction. The most common anaphylactic reactions result from foods, insect stings, latex, and medications. When exposed, the immune system overreacts to the allergen by releasing chemicals that cause allergy symptoms. Some people are susceptible to a serious anaphylactic reaction that affects more than one part of the body at the same time. Anaphylaxis requires immediate medical treatment, including a prompt injection of epinephrine and a trip to a hospital emergency room. If it isn't treated properly, anaphylaxis can be fatal. Individuals with allergies or asthma or a family history of anaphylaxis are at higher risk. Once an individual has experienced anaphylaxis, the risk of having another anaphylactic reaction increases (AAAAI, 2017).

While it is recognized that all allergens cannot be completely eliminated from the school setting, schools must establish policies and emergency plans to protect the safety and well-being of students with life-threatening allergies. Students eat in the school cafeteria or purchase foods from a school store. Students may also be exposed to stinging insects while on the playground, athletic fields, or while participating on field trips. The school nurse must be prepared to address the needs of students with known severe allergic



reactions, as well as anticipate reactions from individuals who have never had a serious reaction before.

More than 170 foods have been reported to cause allergic reactions. Milk, egg, peanuts, tree nuts, wheat, soy, fish, and crustacean shellfish cause the most serious food allergy reactions in the United States. Approximately 15 million Americans have food allergies.



Key Point

About 5.9 million children, or 1 in 13 children under the age of 18, are affected by food allergies—that's roughly equivalent to two student in every classroom. The CDC reports that the prevalence of food allergies in children increased by 50% between 1997 and 2011 and peanut or tree nut allergies have more than tripled. About 40% of children with food allergies have experienced a severe allergic reaction such as anaphylaxis (FARE, 2017).

Teenagers and young adults with food allergies are at the highest risk of fatal food-induced anaphylaxis with most fatal food allergy reactions occurring when food is consumed outside the home. More than 15% of school-aged children with food allergies have had a reaction in school; however, approximately 20-25% of epinephrine administrations in schools involve individuals whose allergy was unknown at the time of the reaction (FARE, 2017).

In addition to dealing with food allergies, the school nurse may also need to provide emergency assistance for students or staff experiencing a severe reaction to an insect sting. People who have already experienced an allergic reaction to an insect sting have a 60% chance of a similar or worse reaction if stung again. Fire ants, yellow jackets, hornets, and wasps can sting repeatedly. Honeybees have barbed stingers that are left behind in the victim's skin. These stingers are best removed by a scraping action, rather than a pulling motion, to avoid squeezing more venom into the skin. In most people, an insect sting results in pain, swelling, and redness confined to the sting site. In some people, a large local reaction includes swelling that extends beyond the sting site. In either case, cleansing the area and applying ice is appropriate. However, an unusually painful or very large local reaction may persist for 2-3 days and may require antihistamines and corticosteroids to lessen the discomfort. An allergic reaction to an insect sting requires immediate medical attention. Symptoms of an allergic reaction may include hives, itching, and swelling in areas other than the sting site; abdominal cramping, vomiting, intense nausea or diarrhea; tightness in the chest and difficulty breathing; and a hoarse voice or swelling of the tongue or throat, or difficulty swallowing. Anaphylaxis is the most severe reaction and requires an immediate epinephrine injection (ACAAI, 2014).

A less common cause of anaphylaxis is latex allergy. Latex products such as balloons, rubber bands, rubber balls, and bandages may cause a reaction. Not all reactions to latex are due to having a true allergy. In some people, their immune system reacts as if latex were a harmful substance. IgE-Mediated Latex Allergy (Type I) is an allergy to natural rubber latex proteins. The body's immune system makes antibodies called immunoglobulin

E (IgE) antibodies which results in allergy symptoms. An allergic reaction can occur when latex proteins come in contact with the skin or mucous membranes or get into the lungs through breathing. Allergic reactions to latex can be severe and life threatening (AAFA, 2015). Children with spina bifida may be at higher risk for severe latex allergies due to related hospitalizations and procedures that result in increased sensitivity (SBA, 2015).

COMMON SYMPTOMS OF ANAPHYLAXIS	
Skin:	Flushing, hives, itching/tingling, pallor, and/or bluish hue;
Respiratory:	Shortness of breath, wheezing, and/or hacking cough;
Gastrointestinal:	Nausea, stomach cramps, vomiting, and/or diarrhea;
Circulatory:	Dizziness, fainting, drop in blood pressure, and/or a thready pulse;
General:	Lip/tongue swelling, voice change, metallic taste in mouth, drooling, a feeling of doom, agitation, panic, and/or facial swelling.

Regardless of the source, anaphylaxis may begin within seconds of exposure to an allergen and can result in death within minutes. The symptoms of anaphylaxis must be identified quickly so that an appropriate medication can be administered. Emergency services must be immediately notified to transfer the victim to an emergency medical facility. For this reason, all school personnel should be trained to recognize when a student may be experiencing anaphylaxis and know how to get timely medical assistance for the student.



Key Point

*The Food Allergy Research and Education Organization created a **common symptoms poster** which summarizes symptoms and actions.*

Key Point

*Kids with Food Allergies, a division of the Asthma and Allergy Foundation of America, provides an **anaphylaxis overview** with videos and other materials that can be used with school personnel or parents.*

Epinephrine (adrenaline) is the first-line treatment for anaphylaxis. Epinephrine works by counteracting the effects on the body caused by the allergen. Specifically, it increases blood pressure by constricting the blood vessels, relaxing the muscles that assist with breathing, and reducing tissue swelling. Epinephrine should be given quickly, at the first sign of anaphylaxis, in order to increase the chance of survival. Epinephrine is a fast-acting medication, but its effects may last only a few minutes; subsequently, it may be necessary to administer another dose of epinephrine if symptoms persist or recur. For this reason, emergency medical assistance should be summoned to transport the student to an emergency medical facility. Epinephrine is a safe drug, with the risks of anaphylaxis outweighing any risks of administering the medication (FARE, 2014). The Food Allergy Research and Education (FARE) organization provides an overview at [Epinephrine Options and Training](#).



Key Point

Antihistamines, known as H1 blockers, are prescribed to relieve mild allergy symptoms (e.g., itching, sneezing, hives, rashes). These drugs do not stop or control a severe reaction. Antihistamines do not treat anaphylaxis and have no life-saving capacity. If an anaphylactic reaction is occurring, give epinephrine immediately and call 911 (FARE, 2014).

The AAP recently released an [emergency care plan](#) (ECP) which can be used for all types of allergies that cause anaphylaxis. The AAP also developed [Guidance on Completing a Written Allergy and Anaphylaxis Emergency Plan](#) to help physicians and other healthcare providers understand the need for and use of the plan; however, the plan is not applicable for unknown first-time reactions.

To assist schools to meet the needs of students with food allergies, the CDC developed [Voluntary Guidelines for Managing Food Allergies in Schools](#). In addition, the CDC publishes a [Food Allergy FAQ](#) and a [Food Allergies Toolkit](#) which contains Power Point slides, resources for school and district administrators, and materials for members of the school health team. These and other materials designed to help schools develop policies and procedures to manage food allergies and anaphylaxis are available from the [National Association of School Nurses \(NASN\)](#), [Food Allergy Research and Education](#) and the [National School Boards Association \(NSBA\)](#).

Applicable Laws and Regulations

N.J.S.A. 18A:40-12.5 – Emergency Administration of Epinephrine

N.J.S.A. 18A:40-12.6-6D

This law requires each board of education or chief school administrator of a nonpublic school to develop a policy for the emergency administration of epinephrine via a pre-filled auto-injector mechanism to a pupil for anaphylaxis. It requires the parents or guardians of the pupil to provide to the board of education or chief school administrator of a nonpublic school written authorization for the administration of the epinephrine and written orders from the physician or advanced practice nurse that the pupil requires the administration of epinephrine for anaphylaxis.

The law requires the board or chief school administrator of a nonpublic school to inform the parents or guardians of the pupil in writing that the district and its employees or agents or the nonpublic school and its employees or agents shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector mechanism. The parents or guardians of the pupil must sign a statement indicating that they hold harmless the district and its employees or agents or the nonpublic school and its employees or agents against any claims arising out of the administration of the epinephrine via a pre-filled auto-injector mechanism. The permission is effective for the school year for which it is granted and is renewed for each subsequent school year upon fulfillment of the requirements.

The policy developed by a board of education or chief school administrator of a nonpublic school requires that the pupil's prescribed epinephrine be secured in an unlocked location easily accessible by the school nurse and designees to ensure prompt availability in the event of an allergic emergency at school or at a school-sponsored function. The location of the epinephrine shall be indicated on the pupil's emergency care plan. Backup epinephrine via a pre-filled auto-injector mechanism shall also be available at the school. The school nurse or designee must be promptly available on site at the school and school-sponsored functions in the event of an allergic reaction. The policy must also address the transportation of the pupil to a hospital emergency room by emergency services personnel after the administration of epinephrine, even if the pupil's symptoms appear to have resolved.

The policy must also permit the school nurse or trained designee to administer epinephrine via a pre-filled auto-injector mechanism to any pupil without a known history of anaphylaxis or any pupil whose parent or guardian has not met the requirements when the nurse or designee in good faith believes that the pupil is having an anaphylactic reaction.

Each public and nonpublic school must maintain in a secure but unlocked and easily accessible location a supply of epinephrine auto-injectors that is prescribed under a standing protocol from a licensed physician or an advanced practice nurse, and is accessible to the school nurse and trained designees for administration to a pupil having an anaphylactic reaction.

N.J.S.A. 18A:40-12.6 – Emergency Administration of Epinephrine

This law states that the school nurse has primary responsibility for the administration of epinephrine. The school nurse designates, in consultation with the board of education, or chief school administrator of a nonpublic school, additional employees of the school district or nonpublic school who volunteer to administer epinephrine via a pre-filled auto-injector mechanism to a pupil for anaphylaxis when the nurse is not physically present at the scene. In the event that a licensed athletic trainer volunteers to administer epinephrine, it shall not constitute a violation of the "Athletic Training Licensure Act," P.L.1984, c.203 (C.45:9-37.35 et seq.).

The school nurse determines that the designees have been properly trained in the administration of the epinephrine via a pre-filled auto-injector mechanism using standardized training protocols established by the NJDOE in consultation with the NJDOH.

The parents or guardians of the pupil must consent in writing to the administration of the epinephrine via a pre-filled auto-injector mechanism by the designees.

The board or chief school administrator of a nonpublic school informs the parents or guardians of the pupil in writing that the district and its employees or agents or the nonpublic school and its employees and agents shall have no liability as a result of any injury arising from the administration of the epinephrine to the pupil and the parents or guardians of the pupil must sign a statement acknowledging understanding that the district or nonpublic school has no liability as a result of any injury arising from the administration of



the epinephrine via a pre-filled auto-injector mechanism to the pupil and that the parents or guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of the epinephrine via a pre-filled auto-injector mechanism to the pupil.

Nothing in this section prohibits the emergency administration of epinephrine via a pre-filled auto-injector mechanism to a pupil for anaphylaxis by the school nurse or other employees designated pursuant to this section when the pupil is authorized to self-administer epinephrine pursuant to section 1 of P.L.1993, c.308 (C.18A:40-12.3), or when there is a coexisting diagnosis of asthma, or when a prescription is received from a licensed health care professional for epinephrine coupled with another form of medication, or when the epinephrine is administered pursuant to subsection f. of section 1 of P.L.1997, c.368 (C.18A:40-12.5).

N.J.S.A. 18A:40-12.3 – Self-Administration of Medication by Pupil

N.J.A.C. 6A:16-2.1(a)5 & 9

Pupils with asthma, life-threatening illnesses, or life-threatening allergic reactions are permitted to self-administer medications to address these conditions. In order to do so, the student's parent or guardian must provide the school with written authorization for the self-administration as well as a signed statement holding the school/district and its employees harmless against any claims arising out of the self-administration. Written verification from the student's physician that the student has asthma, a life-threatening illness, or is subject to a life-threatening allergic reaction is also required. The physician must certify that the student is capable of and has been instructed in the proper administration of the medication. The pupil is permitted to carry an inhaler or prescribed medications for allergic reactions, including a pre-filled auto-injector, provided the pupil does not endanger himself or others by misuse.

N.J.A.C. 6A:16-2.1(a)10&11

This section requires the development of an individualized healthcare plan (IHP) and individualized emergency healthcare plan (IEHP) for students with chronic medical conditions, including diabetes, asthma, and life-threatening allergies, requiring special health services. It also requires the school district to develop policies and procedures to manage food allergies in the school setting and to facilitate the emergency administration of epinephrine to students for anaphylaxis.



Key Point

*Please note: New Jersey's Guidelines for the **Management of Life-Threatening Food Allergies in Schools** and the **Training Protocols for the Emergency Administration of Epinephrine** are still available on the NJDOE website; however, the documents were written in 2008.*

Additional Points for School Nursing Practice

The certified school nurse recruits and trains volunteer delegates. The school nurse determines if a delegate candidate is acceptable for the task within each school building and as deemed necessary by the nursing services plan.

The school nurse or trained delegate must be promptly available on site at the school and school-sponsored functions in the event of an allergic reaction.



Key Point

The law also permits the school nurse or trained delegate to administer epinephrine via a pre-filled auto-injector to a student without a known history of anaphylaxis when the nurse or delegate believes the student is having an anaphylactic reaction.

The district should ensure that all substitute nurses have been trained and are well-versed in the school's anaphylaxis response procedures.

All substitute personnel (e.g., teachers, secretaries, custodians, food service workers) should be trained to recognize and appropriately respond in accordance with district policies and procedures.

Epinephrine should be stored according to the manufacturer's directions to maintain effectiveness in a clearly labeled, easily accessible, secure, but unlocked cabinet/location. For the student with known life-threatening allergies, the location of the epinephrine must be indicated on the student's emergency care plan.



Key Point

A 911 call for emergency medical services must be made following the administration of epinephrine even if the symptoms of anaphylaxis have resolved, as a second reaction can occur up to several hours later. The nurse or delegate should remain with the victim until emergency personnel arrive to assume care.

The school nurse, in consultation with the school physician, board of education or chief school administrator, determines what is an adequate stock supply of epinephrine to be available at all times within the school.

The AAP published [Epinephrine for First Aid Management of Anaphylaxis](#) in February 2017. It provides information to help identify patients at risk of anaphylaxis and new information about epinephrine and epinephrine auto-injectors.

The Asthma and Allergy Foundation of America website, [Kids with Food Allergies](#), has a section called [Living with Food Allergies](#) that provides information on the various kinds of epinephrine auto-injectors available.



The **Food Allergy Management and Education (FAME)** toolkit and manual was developed by the St. Louis Children's Hospital with guidance provided by leading allergists/health care professionals, national food allergy advocacy organizations, national school health organizations, national school educator organizations, school nurses, educators, registered dietitians, school nutritionists, attorneys, and parents/guardians of children with food allergies.

The Children's Hospital of Philadelphia (CHOP) provides **allergy resources** for use by schools, children, and families.

Meeting the Needs of Students with Chronic Health Conditions

Topic: Diabetes

Background and Rationale

As of 2015, 30.3 million people in the United States (9.4% of the population) have diabetes and more than 1 in 4 of them did not know they had the disease. Type 1 diabetes is usually diagnosed in children and young adults. With type 1 diabetes, the body does not make insulin and the immune system attacks and destroys the cells in the pancreas that make insulin. People with type 1 diabetes need to take insulin every day to stay alive. Type 2 diabetes usually is diagnosed in middle aged and older adults; however, it has become more common in younger individuals. With type 2 diabetes, the body does not make or use insulin well (NIDDK, 2017). The CDC's **Diabetes At a Glance 2016** provides an overview of diabetes as a public health problem.

As a school nurse, knowing how to care for students with diabetes is important because the rates of newly diagnosed cases of type 1 and type 2 diabetes are increasing among youth in the United States according to the report **Incidence Trends of Type 1 and Type 2 Diabetes Among Youths, 2002-2012** published in the New England Journal of Medicine in April 2017. The study, funded by the CDC and the NIH, found that from 2002 to 2012, the rate of newly diagnosed cases of type 1 diabetes in youth increased by about 1.8% each year while the rate of newly diagnosed cases of type 2 diabetes increased by 4.8% (NIH, 2017).

Type 1 diabetes (formerly called insulin dependent or juvenile diabetes) is caused by an autoimmune reaction that destroys the cells in the pancreas that make insulin, called beta cells. There may also be a genetic predisposition to develop type 1 diabetes. Diet and lifestyle habits do not cause type 1 diabetes. Students with type 1 diabetes require daily insulin (NIDDK, 2017).

Individuals are more likely to develop type 2 diabetes if they are age 45 or older, have a family history of diabetes, or are overweight. Physical inactivity, race, and certain health problems such as high blood pressure contribute. However, as childhood obesity rates continue to rise, so are the rates of type 2 diabetes in youth. More than 75% of children with type 2 diabetes have a close relative who also has diabetes. Certain habits, such as unhealthy eating patterns and a lack of exercise increase risk (CDC, 2017e).

Advances in technology and medical care have enabled young people with diabetes to attend school and participate in the full range of educational activities. However, the care of students with any chronic illness requires the knowledge and expertise of a multidisciplinary team working together to meet the health and academic needs of the student. The school nurse and other members of the school health team must work closely with the student, the family, and the medical home to develop a plan of care that allows the student to participate in school activities while learning to self-manage the condition. The ultimate goal is to have the student be safe and feel confident.

Because of the increased number of students presenting with diabetes, a number of national organizations have developed materials to assist schools and families. The NIH created [Diabetes in Children and Teens](#) to help young people, their families, and healthcare professionals better understand diabetes management. NIH also developed [Helping the Student with Diabetes Succeed: A Guide for School Personnel](#). Similarly, the CDC developed [Children and Adolescents with Diabetes](#) to educate parents and families. The American Diabetes Association developed a [Safe at School Campaign](#) to provide training and resources for school personnel and families about the need for care during the school day and at school-sponsored activities. The Joslin Center provides numerous [Resources for School Nurses](#) that includes a sample 504 plan and information on insulin pumps.

In 2009, the New Jersey Legislature recognized the difficulties students with diabetes have balancing food, medications, and physical activity during the school day. It further acknowledged that the school nurse is the most appropriate person in the school setting to provide care for a student with diabetes. In response, the NJDOE developed [Guidelines for the Care of Students with Diabetes in the School Setting](#) which provides quick reference guides, a Power Point, and sample individualized healthcare plans. The materials provide school nurses with a wealth of information on the management of diabetes as well as glucagon training information.

One of the most important roles for the school nurse is the development of a Diabetes Medical Management Plan. The American Diabetes Association created a generic [diabetes medical management plan](#) as well as a [school and childcare diabetes medical management plan](#). A [diabetes IHP](#) is also available on the NJDOE website. It consists of four parts:

DIABETES IHP
Part A: Contact Information must be completed by the parent/guardian.
Part B: Diabetes Medical Management Plan (DMMP) must be completed by the student's physician or advanced practice nurse and provides the medical "orders" for the student's care. This section must be signed and dated by the medical practitioner.
Part C: Individualized Healthcare Plan must be completed by the school nurse in consultation with the student's parent/guardian and healthcare provider. It focuses on services and accommodations needed by the student at school or during school-sponsored activities.
Part D: Authorizations for Services and Sharing of Information must be signed by the parent/guardian and the school nurse.



The NJDOE also published a [quick reference emergency guide](#).

The school nurse plays an important role educating school personnel about diabetes. All new personnel should be educated on diabetes basics and how the school addresses diabetic emergencies. All employees should be updated as part of the nurse's annual health presentation. Student-specific training is necessary for those employees who have responsibility for or supervise a student with diabetes. In general, school staff need to understand the difference between hyperglycemia and hypoglycemia and how the symptoms and responses differ. Coaches, club advisors, and those responsible for after-school care and activities should be trained. The law also requires schools to post a [diabetes reference guide](#) which identifies the signs and symptoms of hypoglycemia in students with diabetes.

The law specifically states that school bus drivers who transport students with diabetes will be provided with a notice of the pupil's condition, how to treat hypoglycemia, who to contact in an emergency, and parent contact information. This may require the school nurse to collaborate with the district transportation coordinator since school bus drivers may not be district employees. Additionally, some athletic coaches may not be district employees; thus, the school nurse must work with the athletic director and trainer to ensure that all coaches receive the appropriate training.

The Diabetes Medical Management Plan (DMMP) is provided to the school nurse from the physician or APN managing the student's care.

The plan must include:
Target blood sugar;
Treatment for hypoglycemia;
Treatment for hyperglycemia;
Frequency of glucose testing;
Insulin and glucagon orders;
Times of meals/snacks and exercise;
Guidance for participation in sports and exercise;
Accommodations for activities including trips and parties;
Medical issues that might impact learning;
Communication protocols (parents, healthcare providers, school nurse);
Permission to self-manage requires written certification from student's healthcare provider and must be addressed in the IHP; and,
Oversight of self-care by the school nurse outlined in the student's IHP.

The IHP documents and communicates the individual student's needs and the nursing management strategies to be implemented during the school day and is based on the medical orders found in the DMMP.

In addition to the information found in the DMMP, the IHP should also include:

- Emergency contact information for the student (e.g. parent, medical home);
- Level of self-care;
- Time and frequency of blood glucose monitoring and target range;
- Immediate action to take when outside of target range;
- Insulin/medication administration (e.g. injections, pump);
- Glucagon administration (e.g. self-administration, delegates);
- Meal and snack schedule;
- Instructions related to physical activity and sports;
- Recognition and treatment of hypoglycemia and hyperglycemia;
- Whether or not the student has a Section 504 Plan and/or an IEP; and,
- Emergency plans.

Should the student require a 504 plan, additional information might include:

- Location and timing of blood glucose monitoring and insulin administration;
- Identity of trained diabetes personnel;
- Location of diabetes supplies;
- Free access to water and restroom;
- Nutritional needs, meals, and snacks;
- Full participation in all school-sponsored activities;
- Education of direct-contact personnel;
- Access to blood glucose checks and treatment supplies during exams;
- Alternative times for academic exams if student is experiencing hypoglycemia or hyperglycemia;
- Absences without penalty for doctors' appointments and diabetes-related illness; and,
- Maintenance of confidentiality and the student's right to privacy.

Because diabetes requires life-long attention and management, the school nurse must work closely with the student and family to reduce absences, improve control, and monitor the child's social and emotional health. The school health team should provide emotional support and encourage physical activity and healthy eating. Students must be supported to carefully monitor glucose levels and take medication as prescribed. The goal of the student's IHP is to assist the student in achieving improved blood glucose control to prevent long-term complications of high blood glucose and complications of acute low blood glucose levels. Students with diabetes who check their blood glucose



levels in the classroom spend less time out of class. Self-checking blood glucose levels helps students learn and understand the appropriate responses to a blood glucose reading result. The school nurse should also work closely with the child's teachers to ensure understanding of symptoms and the need for routine care.

Applicable Laws and Regulations

N.J.S.A. 18A:40-12.11 – Diabetes

The Legislature stated that diabetes is a serious chronic disease that impairs the body's ability to use food, and must be managed 24 hours a day in order to avoid the potentially life-threatening short-term consequences of blood sugar levels that are either too high or too low, and avoid or delay the serious long-term complications of high blood sugar levels that include blindness, amputation, heart disease, and kidney failure. In order to manage their disease, students with diabetes must have access to the means to balance food, medications, and physical activity level while at school and at school-related activities. The school nurse is the most appropriate person in the school setting to provide care for a student with diabetes, because the school nurse is in a position to coordinate care and educate school staff in the monitoring and treatment of symptoms, develop an individualized health care plan and an individualized emergency health care plan, and consult and coordinate with a student's parents or guardians and healthcare provider to establish a safe, therapeutic environment.

N.J.S.A. 18A:40-12.12 – Definitions: Students with Diabetes

An individualized emergency healthcare plan is a document developed by the school nurse, in consultation with the parent or guardian of a student with diabetes and other appropriate medical professionals, which is consistent with the recommendations of the student's health care providers and which outlines a set of procedural guidelines that provide specific directions about what to do in a particular emergency situation and is signed by the parent or guardian and the school nurse.

An individualized healthcare plan is a document developed by the school nurse, in consultation with the parent or guardian of a student with diabetes and other appropriate medical professionals who may be providing diabetes care to the student, which is consistent with the recommendations of the student's healthcare providers and which sets out the health services needed by the student at school and is signed by the parent or guardian and the school nurse.

A school is an elementary or secondary public school located within this State.

A school employee is a person employed by a school district.

N.J.S.A. 18A:40-12.13 – Healthcare Plans for Students with Diabetes

The parent or guardian of a student with diabetes who seeks diabetes care while at school shall inform the school nurse who develops an individualized healthcare plan and an individualized emergency healthcare plan for the student.

The parents or guardians of the student must annually provide to the board of education written authorization for the provision of diabetes care as may be outlined in the individualized plans including authorization for the emergency administration of glucagon and, if requested by the student's parents or guardians authorization for the student's self-management and care of his diabetes.

If a request is made by a student's parent or guardian, the student's physician or advanced practice nurse must provide written certification to the board of education that the student is capable of, and has been instructed in, the management and care of his diabetes.

The individualized healthcare plan and individualized emergency healthcare plan developed must be updated by the school nurse prior to the beginning of each school year and as necessary in the event that there is a change in the health status of the student.

Each individualized healthcare plan must include, and each individualized emergency healthcare plan may include, the following information:

- The symptoms of hypoglycemia for that particular student and the recommended treatment;
- The symptoms of hyperglycemia for that particular student and the recommended treatment;
- The frequency of blood glucose testing;
- Written orders from the student's physician or APN outlining the dosage and indications for insulin administration and the administration of glucagon, if needed;
- Times of meals and snacks and indications for additional snacks for exercise;
- Full participation in exercise and sports, and any contraindications to exercise, or accommodations that must be made for that particular student;
- Accommodations for school trips, after-school activities, class parties, and other school-related activities;
- Education of all school personnel who may come in contact with the student about diabetes, how to recognize and treat hypoglycemia, how to recognize hyperglycemia, and when to call for assistance;
- Medical and treatment issues that may affect the educational process of the student with diabetes; and,
- How to maintain communications with the student, the student's parent or guardian and health care team, the school nurse, and the educational staff.

The school nurse assigned to a particular school coordinates the provision of diabetes care at that school and ensures that appropriate staff are trained in the care of students



with diabetes, including staff working with school-sponsored programs outside of the regular school day, as provided in the IHP/IEHP.

N.J.S.A. 18A:40-12.14 – Authorized Employees for Administration of Glucagon



Key Point

The school nurse has primary responsibility for the emergency administration of glucagon to a student with diabetes who is experiencing severe hypoglycemia.

The school nurse designates, in consultation with the board of education, additional employees of the school district who volunteer to administer glucagon to a student with diabetes who is experiencing severe hypoglycemia. The designated employees are only authorized to administer glucagon following training by the school nurse or other qualified health care professional, when a school nurse is not physically present at the scene. These activities do not constitute the practice of nursing and are exempted from all applicable statutory or regulatory provisions that restrict the activities that may be delegated to a person who is not a licensed health care professional. In the event that a licensed athletic trainer volunteers to administer glucagon to a student with diabetes, it does not constitute a violation of the "Athletic Training Licensure Act," P.L.1984, c.203 (C.45:9-37.35 et seq.).

N.J.S.A. 18A:40-12.15 – Management, Care of Diabetes by Student Permitted

Upon the written request of the parent or guardian and as provided in a student's individualized health care plan, a school district must allow the student to attend to the management and care of the student's diabetes as needed in the classroom, in any area of the school or school grounds, or at any school-related activity if the student has been evaluated and determined to be capable of doing so as reflected in the student's individualized health care plan. The student's management and care of his diabetes includes the following:

- Performing blood glucose level checks;
- Administering insulin through the insulin delivery system the student uses;
- Treating hypoglycemia and hyperglycemia;
- Possessing on the student's person at any time the supplies or equipment necessary to monitor and care for the student's diabetes;
- Complying with required procedures for medical waste disposal in accordance with district policies and as set forth in the individualized health care plan; and,
- Attending to the management and care of the student's diabetes.

N.J.S.A. 8A:40-12.16 – Notification to School Bus Driver

For each pupil with diabetes whom a school bus driver transports, the school district must provide the driver with a notice of the pupil's condition, how to treat hypoglycemia, who to contact in an emergency, and parent contact information.

N.J.S.A. 18A:40-12.17 – Posting of Reference Sheet

Designated areas of the school building must have posted, in plain view, a reference sheet identifying signs and symptoms of hypoglycemia in students with diabetes.

N.J.S.A. 18A:40-12.18 – Release for Sharing of Certain Medical Information

The school nurse must obtain a release from the parent or guardian of a diabetic student to authorize the sharing of medical information between the student's physician or APN and other health care providers. The release authorizes the school nurse to share medical information with other staff members of the school district, as necessary.

N.J.S.A. 18A:40-12.20 – Possession of Syringes Authorized

The possession and use of syringes consistent with the purposes of this act shall not be considered a violation of applicable statutory or regulatory provisions that may otherwise restrict or prohibit such possession and use.

N.J.S.A. 18A:40-12.21 – School Choice and Diabetes

A student's school choice shall not be restricted due to the fact that the student has diabetes.

N.J.A.C. 6A:16-2.1(a)2vii & (a)4ii – Glucagon

These rules require the local board of education to develop policies, procedures, and mechanisms to address the emergency administration of glucagon by volunteer delegates.

N.J.A.C. 6A:16-2.1(a)9 – Self-Administration of Medication

This rule requires the local board of education to develop policies to address the self-administration of medication by a student for asthma or other potentially life-threatening illness or life-threatening allergic reaction and the self-management and care of a student's diabetes.

N.J.A.C. 6A:16-2.1(a)10 – Individualized Health Care Plans

This rule requires the development of an individualized healthcare plan and individualized emergency healthcare plan for students with chronic medical conditions, including diabetes, asthma, and life-threatening allergies, requiring special health services.

N.J.A.C. 6A:16-2.3(b)3vii – Role of School Nurse

This rule establishes that the school nurse is responsible to direct and supervise the emergency administration of epinephrine and glucagon, and train school staff designated to serve as delegates.



Additional Points for School Nursing Practice

Students with hyperglycemia or hypoglycemia may have difficulty concentrating and may need to have information repeated.

Students need adequate time to check blood glucose levels, take medications, and eat.

During academic testing, students should check blood glucose before and during testing, if specified in their DMMP or 504 plan. Students should have access to food, liquids, and the restroom during the testing period. If a serious high or low blood glucose episode occurs during testing, the student should be given an opportunity to retake the examination.

Students with diabetes may experience patterns (e.g., decreased concentration at same time of day, frequent bathroom breaks) that may require changes to eating, activity, or medications. Teachers should note these concerns and discuss them with the school nurse.

Generally the goal in the treatment of **hypoglycemia** is to raise the blood glucose level to within a student's target range. Never leave a student experiencing or suspected of experiencing hypoglycemia alone. The student should be accompanied to the health office by a responsible individual capable of responding if the student becomes agitated, confused, or loses consciousness.



Key Point

Always follow the student's DMMP

Key Point

*The Children's Hospital of Philadelphia (CHOP) has links to various **diabetes care** items including meters and lancets as well as other tools to help students manage their condition.*

For students with hypoglycemia, the **Rule of 15** applies:

- Have the student eat or drink fast-acting 15 g carbohydrates such as 6-7 pieces of hard candy, 4 ounces fruit juice or regular soda (not diet), or 1 tablespoon of sugar; this amount may be reduced for younger, smaller students;
- Check the blood glucose level 10-15 minutes after treatment;
- Repeat treatment of 15 grams of sugar if blood glucose level remains low and recheck in 15 minutes; and,
- If symptoms continue or blood glucose levels do not increase, call parent/guardian as specified in DMMP (National Diabetes Education Initiative, 2016).

If the student is unconscious or cannot swallow, use Glucagon. Severe hypoglycemia is rare, but life threatening, if not treated promptly.

- Place the student on his side.
- Lift the student's chin to keep the airway open.
- Inject glucagon, if provided for in the student's DMMP.
- Never attempt to give food or put anything in the student's mouth.
- Have someone call 911 and then have them call the child's parent/guardian.
- The student should respond to the glucagon in 10 to 20 minutes.
- Remain with the student until help arrives.
- When the student is awake and able to swallow, give sips of juice or another quick acting form of glucose, followed by a snack while waiting for EMS.
- Be advised, the student may become nauseated and vomit after the glucagon injection (American Diabetes Association, 2015).

The law permits the school nurse to designate, in consultation with the board of education, additional employees of the school district who volunteer to administer **glucagon** to a student experiencing severe hypoglycemia (low blood sugar) when the nurse is not physically present. This can occur when the nurse is out of the building or when a nurse is not present such as at a school-sponsored event after school, at night, during the summer, or on weekends. Glucagon is a life-saving hormone that raises the blood glucose level. Since glucagon is an injected medication, volunteers must be trained to recognize the signs and symptoms of hypoglycemia and to mix, withdraw, and inject the medication into a student's arm, thigh, or buttock. Trained delegates should also be CPR-AED certified.



Key Point

The glucagon delegate must be a school employee who volunteers to provide the emergency care.

Key Point

The designated employee is authorized to administer glucagon, only after completing training by the school nurse or other qualified health care professional, and can administer glucagon only when a school nurse is not physically present at the scene.

The law requires that the school nurse designate, in consultation with the district board of education, employees who can be trained to administer glucagon in an emergency. The designated employee must demonstrate proficiency in handling a diabetic emergency including administering an injection and providing supportive care until emergency medical services arrives for transport and follow-up care.



Because the law requires the school nurse to update the student's IHP/IEHP at the beginning of each school year and as necessary to address any changes in the health status of the student, the trained delegate should be informed of any changes annually and as they occur. In addition, because a volunteer may not be called upon to actually administer the medication in an emergency, it is important to ensure that the individual's skills and knowledge are current.



Key Point

Since the school nurse delegates this emergency task, the nurse must assess the volunteer's skill, competency, and comfort level with the procedure and document accordingly. If the individual does not appear to be able to perform the procedure, the school nurse should discuss it with the individual and the building administrator.

The goal in the treatment of **hyperglycemia** is to lower the blood glucose level to within a student's target range. Generally, the action steps for hyperglycemia are:

- Verify status with a blood glucose check as specified in the DMMP;
- Check ketones as specified in the DMMP; generally a student should refrain from physical activity if positive for ketones;
- Allow free use of bathroom and access to water;
- Administer insulin as specified in the DMMP;
- Recheck blood glucose per DMMP;
- Notify the parent/guardian immediately when the conditions for contact are present as specified in the DMMP; and,
- Monitor the student in the health office.

A student may need to check their glucose level more often during times of stress, when ill, prior to or during academic testing, or when feeling symptomatic. Changes in meal times, medications, or activity levels may precipitate changes in the blood glucose level and more frequent testing is warranted. A student may also need to test during changes in school schedules such as extended day, early release for employment or activities, or during inclement weather.

Meeting the Needs of Students with Chronic Health Conditions

Topic: HIV/AIDs

Background and Rationale

Ryan White was diagnosed with AIDS following a blood transfusion in December 1984. He was 13 years old and given six months to live. When he tried to return to school, he

fought AIDS-related discrimination in his Indiana community. He rallied for his right to attend school and gained national attention. He died in April 1990, one month before his high school graduation and only months before Congress passed the legislation bearing his name in August 1990 - the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The [Ryan White HIV/AIDS Program](#) lives on as his legacy, providing help to families impacted by this disease. Ryan White was the first school-aged “face” of HIV/AIDS. Great strides have been made since then but there are still many misconceptions about HIV/AIDS.

The Human Immunodeficiency Virus (HIV) attacks and destroys the CD4 cells of the immune system. The loss of these infection-fighting cells makes it difficult for the body to fight infections and certain cancers. Without treatment, HIV can gradually destroy the immune system and advance to acquired immunodeficiency syndrome, better known as AIDS. Within 2 to 4 weeks after a person becomes infected with HIV, flu-like symptoms such as fever, chills, or rash develop, which may last a few weeks. HIV continues to multiply but at very low levels. Opportunistic infections and infection-related cancers occur later in the process. Without treatment with HIV medicines, the infection may advance to AIDS (USDHHS, 2017).

The NJDOH provides county and municipal [HIV/AIDS statistics](#) showing that more than 37,000 New Jersey residents were living with HIV/AIDS in 2016. While the data shows increased prevalence in urban areas of the state, school nurses across New Jersey need to understand how to care for students infected with HIV, regardless of the form of transmission. Students may have an HIV-infected parent or family member; thus, school nurses can assist students and their families to access care from community-based services. In addition, all public school students in New Jersey must be educated about HIV/AIDS. The school nurse should ensure that the health curriculum is medically accurate, current, and unbiased. Dealing with HIV/AIDS prevention requires a general and targeted approach to risk reduction, coupled with sensitivity and adherence to confidentiality laws.

HIV is spread through sexual contact with an infected partner, by blood-borne exposure, and vertical (mother to child) transmission. The person-to-person spread of HIV is called HIV transmission. HIV may be transmitted in blood, semen, pre-seminal fluids, rectal fluids, vaginal fluids and breast milk (USDHHS, 2017). HIV is most commonly spread through sexual contact with an infected partner. The virus can also be transmitted through infected blood and by sharing needles or syringes contaminated with the virus. Untreated women with HIV can also spread the virus to their babies during pregnancy, childbirth, or through breastfeeding. HIV is not spread by droplet or airborne means, tears or sweat, urine, or insects. It is not spread by casual contact, such as a handshake, hug, or a closed mouth kiss. It is not transmitted from contact by objects such as toilet seats or door knobs (CDC, 2017f). The CDC provides a detailed FAQ on HIV [transmission](#).

To date, the prognosis of HIV infected children is significantly improved due to anti-retroviral medication and risk reduction strategies. In 1996, the life expectancy of an HIV infected person was an average of 19 years from initial diagnosis. By 2011, life expectancy had increased to 53 years (Marcus, et al., 2016). The number of HIV infected infants



born annually in New Jersey has been reduced through widespread implementation of mandatory counseling, voluntary testing, and voluntary treatment of pregnant women with HIV infection.

Worldwide, in 2015 nearly 37 million people were living with HIV with approximately 1.8 million of them children under 15 years of age. More than 90% of HIV infections in children result from mother-to-child-transmission, where the virus is passed from a mother living with HIV to her baby during pregnancy, childbirth, or breastfeeding. Because children's immune systems are not fully developed, children living with HIV get sick more severely than adults. They may experience the same common pediatric infections as HIV-negative children, but they cannot fight these infections as effectively. Common infections in HIV-positive children include ear and sinus infections, sepsis, pneumonias, urinary tract infections, intestinal illness, skin diseases, and meningitis as well as tuberculosis, diarrhea, and respiratory illnesses (Elizabeth Glaser Pediatric AIDS Foundation, 2017). The worldwide scope of this disease may have implications for school nurses working in schools with high rates of students arriving from areas of the world with where HIV/AIDS is most prevalent.

Youth aged 13 to 24 accounted for 22% of all new HIV diagnoses in 2015 with 81% of those new cases occurring among gay and bisexual males. Young black/African American and Hispanic/Latino gay and bisexual males are especially affected; however annual HIV infections fell 18% among young gay and bisexual males from 2008 to 2014 (CDC, 2017g).



Key Point

Adolescents with HIV are less likely to be linked to care and have a suppressed viral load. Addressing HIV in youth requires providing them with the information and tools needed to reduce their risk, make healthy decisions, and get treatment and care (CDC, 2017g).

There are three stages of HIV:

- During stage 1 (acute HIV infection), people may experience a flu-like illness for a few weeks. During this stage, they are very contagious due to the large amount of virus in the blood; however, some people do not feel sick at all. To know whether someone has acute infection, either a fourth-generation antibody/antigen test or a nucleic acid (NAT) test is necessary.
- During stage 2 (clinical latency or dormancy), the person may be asymptomatic or have what is called chronic HIV infection. The HIV is still active but reproduces at very low levels and people may not have any symptoms or they may get sick during this time. This period can last a decade or longer, but some may progress through this phase faster. People who take medicine to treat HIV may be in this stage for several decades. People can still transmit HIV to others during this phase, although people on antiretroviral therapy (ART) may have a very low level of virus in their blood and are much less likely to transmit HIV than those who are not virally

suppressed. At the end of this phase, a person's viral load starts to go up and the CD4 cell count begins to go down. As this happens, the person may begin to have symptoms as the virus levels increase in the body, and the person moves into Stage 3.

- Stage 3 is the most severe phase and is known as acquired immunodeficiency syndrome or AIDS. Due to a damaged immune systems, individuals get an increasing number of severe illnesses, called opportunistic illnesses. Without treatment, people with AIDS typically survive about 3 years. Common symptoms of AIDS include chills, fever, sweats, swollen lymph glands, weakness, and weight loss. People are diagnosed with AIDS when their CD4 cell count drops below 200 cells/mm or if they develop certain opportunistic illnesses. People with AIDS can have a high viral load and be very infectious (CDC, 2017h).

An individual may also acquire HIV by participating in risky behaviors such as sharing drug needles with someone who has HIV, having unprotected anal or vaginal sex with an infected partner, or exposure to infected blood or body fluids. Susceptibility to HIV infection increases in adolescents with a history of sexually transmitted infections (STIs). In 2015, youth aged 13 to 24 accounted for 22% of all new HIV diagnoses in the United States. Most of those new diagnoses among youth (81%) occurred among gay and bisexual males. Young black/African American and Hispanic/Latino gay and bisexual males are especially affected. According to the CDC's 2015 YRBS, only 10% of high school students have been tested for HIV and among male students who had sexual contact with other males, only 21% have ever been tested for HIV. Nationwide, 21% of all students who are currently sexually active (had sexual intercourse during the previous 3 months) and 32% of male students who had sexual contact with other males, drank alcohol or used drugs before their most recent sexual intercourse. Additionally nearly half (43%) of all sexually active high school students and 49% of male students who had sexual contact with other males did not use a condom the last time they had sexual intercourse. Finally, one-third (33%) of male students who had sexual contact with other males reported sexual intercourse with 4 or more persons during their life, compared to 12% of all students who had ever had sexual contact (2017g).

School nurses need to understand the behaviors that place adolescents at risk and the prevention strategies that can reduce or eliminate risk. The data has significant implications for school nurses who routinely provide informal and individualized health education to students who seek care and advice. School nurses must provide medically accurate and unbiased information. The nurse should be prepared to provide information on community-based agencies and organizations

Applicable Laws and Regulations

N.J.A.C. 8:61-2.1 – Attendance at School by Students or Adults with HIV Infection N.J.A.C. 6A:16-2

NJDOH regulations state that no student with HIV infection shall be excluded from school for reasons of HIV infection. Exclusion of an HIV-infected student can only be for reasons



that would lead to the exclusion of any other student. Students with HIV infection cannot be restricted from school services including transportation, extra-curricular activities and athletic activities, or assigned to separate services such as home instruction for reason of HIV infection or living with or being related to someone with HIV infection.

The regulations further require that any person be removed from the school setting if the person has uncovered weeping skin lesions.

Any public or nonpublic school and day care facility, regardless of whether students or adults with HIV are present, must adopt written policies and routine procedures for handling blood and body fluids and make available training and appropriate supplies to all school personnel. Additionally, any public or nonpublic school and day care facility must adopt written policies and procedures for post exposure evaluation and follow up for any employee exposed to blood or body fluids. District boards of education must develop written policies and procedures for post exposure management, in conformance with OSHA.

In order to share information that identifies a student as having HIV infection or AIDS, employees of a district board of education or school must have prior written informed consent of the student aged 12 or greater, or of the student's parent or guardian as required by N.J.S.A 26:5-C-5 et seq., except as may be authorized or required by other laws.

N.J.A.C. 6A:16(a)7 – Handling Blood and Bodily Fluids

These regulations require district boards of education to develop and implement written policies and procedures regarding sanitation and hygiene when handling blood and bodily fluids. Some of these requirements have changed. Current information on policies and procedures can be found in Chapter Thirteen: Blood Borne Pathogens and Universal Precautions.

N.J.A.C. 6A:16-2.2(k) – Student's HIV/AIDS Status and Medical Exams

Information concerning a student's HIV/AIDS status is not required as part of the medical examination or health history pursuant to N.J.S.A. 26:5C-1 et seq.

N.J.A.C. 6A:16-2.4 – Required Student Health Records

In order to share information that identifies a student as having HIV infection or AIDS, employees of a district board of education or school must have prior written informed consent of the student aged 12 or greater, or of the student's parent or guardian as required by N.J.S.A 26:5-C-5 et seq., and only for the purpose of determining an appropriate educational program for the student.

The consent form should specify approved reasons for disclosure, the type of information to be disclosed, specific individuals to be informed by name and by title, and the date on which the consent expires. Generally, school health record disclosure consent forms should have an effective period no greater than one year. Even with such consent, information can be shared only for purposes of establishing an appropriate educational program for the student.



Key Point

The standards for maintaining confidentiality of records which identify the HIV status of an individual are established in N.J.S.A.26:5C, and exceed those established for district educational records or general health records. Identifying records could include the written consent form, referral letters from healthcare providers, child study team evaluations, or medication records. Identifying information could be obtained either formally or informally. Any information that identifies an individual as HIV positive can be shared only with specific written consent from the parent/guardian or student age 12 or greater.

N.J.S.A. 9-17A-4 – Consent by Minor to Treatment

This law permits minors to seek medical treatment. The consent to the provision of medical or surgical care or services by a hospital, public clinic, or the performance of medical or surgical care or services by a physician, licensed to practice medicine, when executed by a minor who is or believes that he may be afflicted with a venereal disease (STI) or who is at least 13 years of age and is or believes that he may be infected with HIV or have AIDS, or by a minor who, in the judgment of a treating physician, appears to have been sexually assaulted, shall be valid and binding as if the minor had achieved his or her majority, as the case may be. Any such consent shall not be subject to later disaffirmance by reason of minority. In the case of a minor who appears to have been sexually assaulted, the minor's parents or guardian shall be notified immediately, unless the attending physician believes that it is in the best interests of the minor patient not to do so; however, inability of the treating physician, hospital, or clinic to locate or notify the parents or guardian shall not preclude the provision of any necessary emergency medical or surgical care to the minor.



Key Point

HIV status is confidential, unless written consent is obtained from the parents or student aged 12 or older.

Key Point

HIV is considered a serious public health threat and minors are not always willing to consult with a parent or guardian with regard to obtaining medical attention for HIV. According to N.J.S.A 9:17 A-4, minors aged 13 years or older who believe they are or may be infected with HIV or have AIDS are eligible for medical care and treatment, without the consent of a parent or guardian. This provides infected individuals who are minors, and their partners, the opportunity to be informed of possible exposure in a timely and professional manner; to be informed of and directed to HIV counseling and testing resources; and, to receive counseling about appropriate risk-reduction behavior.



Additional Points for School Nursing Practice

The NJDOH provides [HIV testing information](#) including the availability of the Rapid HIV Test which tests for HIV antibodies. It involves a finger stick and a swab of the oral mucosa. Results are available in 15-20 minutes.

Students with HIV may require early intervention and accommodations for learning. These students may have learning difficulties and health issues that require a Section 504 plan, in accordance with the Rehabilitation Act of 1973.

Maintaining confidentiality can be difficult considering that an infected student might require accommodations for medication administration, the use of the bathroom, and access to special fluids, nutritional supplements, or food.

The school nurse should confer with the student, his/her parents/guardians, and medical home to address attendance issues due to the student's medical condition.

The school nurse should educate students and school personnel about standard precautions of gloving with any exposure to body fluids or blood. Many school nurses provide small emergency kits to classrooms. All students and school personnel should be taught proper hand washing techniques to prevent the transmission of all communicable illnesses.

The school nurse, as part of the school health team, should support HIV prevention education as part of the district's health education programs. Specifically, New Jersey's [Student Learning Standards for Comprehensive Health and Physical Education](#) require all students to develop health literacy. K-12 students are expected to acquire developmentally appropriate knowledge and skills to support a healthy active lifestyle. Students learn how to access services and prevent diseases and injuries as well as how to reduce risk factors and communicate about their health. The school nurse plays an important part in health education as a classroom teacher and healthcare professional, ensuring that all students have access to medically accurate information.

Encourage athletes to participate in sports despite their HIV status. The AAP recommends all HIV-infected children and adolescents be encouraged to participate as much as their health will allow. The confidentiality of a child or adolescent's HIV-infection status should be respected, with disclosure given only with the consent of the parent(s) or legal guardian(s). In the event of possible exposure to body fluids, universal precautions should be followed, regardless of an athlete's HIV status (AAP, 2015).

Students with HIV should receive all immunizations against common childhood illness, unless medically contraindicated. The United States Department of Health and Human Services (USDHHS) document, [Preventing Vaccine-Preventable Diseases in HIV-Infected Children and Adolescents](#), provides specific guidance and recommendations.

The [Elizabeth Glaser Pediatric AIDS Foundation](#) provides information for individuals and families and supports research.



Key Point

Pre-exposure prophylaxis, or PrEP, is a way for people who do not have HIV but who are at substantial risk of getting it to prevent HIV infection by taking a pill every day. The pill (brand name Truvada) contains two medicines (tenofovir and emtricitabine) that are used in combination with other medicines to treat HIV. When someone is exposed to HIV through sex or injection drug use, these medicines can work to keep the virus from establishing a permanent infection. When taken consistently, PrEP has been shown to reduce the risk of HIV infection in people who are at high risk by up to 92%. PrEP is much less effective if it is not taken consistently. PrEP is a powerful HIV prevention tool and can be combined with condoms and other prevention methods to provide even greater protection than when used alone. People who use PrEP must commit to taking the drug every day and seeing their health care provider for follow-up every 3 months. (CDC, 2017i).



Key Point

Post exposure prophylaxis (PEP) is the use of antiretroviral drugs after a single high-risk event to stop HIV seroconversion. PEP must be started as soon as possible to be effective—and always within 72 hours of a possible exposure (CDC, 2017j).

Meeting the Needs of Students with Chronic Health Conditions

Topic: Lyme Disease

Background and Rationale

Lyme disease was first reported in 1977 in Old Lyme, CT. In 2015, 95% of confirmed Lyme disease cases were found in 14 states. New Jersey was ranked second in the nation with 4855 cases of [Lyme disease](#). Spread by a black-legged tick that can be as small as a poppy seed, it often impacts young children, likely due to greater exposure and lack of awareness of the importance of finding ticks (CDC, 2017k). Lyme disease is a bacterial illness that some people get after being bitten by black-legged ticks infected with the organism *Borrelia burgdorferi*. Black-legged ticks can also spread other diseases (co-infections) including babesiosis, Powassan, *Borrelia miyamotoi*, and anaplasmosis.

School nurses play an important role in the prevention of tick-borne diseases, and may even be asked to “remove” a tick. They also play a critical role in the early identification of potential Lyme disease cases. Students with Lyme disease may require medications during the school day as well as health and learning accommodations. Depending on the severity and stage of the illness, the school nurse may need to develop an IHP/IEHP or the child may be eligible for a 504 plan or an IEP.

New Jersey’s school nurses need to know the [symptoms of Lyme disease](#). For example, children with Lyme disease may present with non-specific fatigue, joint pain, or skin



rashes. Some children may present with flu-like symptoms including headaches or sleep disorders. They may visit the school health office with a myriad of “complaints” and symptoms. The school nurse’s assessment of these visits is critical to the identification of the disease.

Ticks can attach to any part of the human body but are often found in hard-to-see areas such as the groin, armpits, and scalp. Most people are infected by the bite of an immature tick called a nymph. They are tiny, less than 2 millimeters in length, and feed during the spring and summer months when children are more likely to be outdoors. Adult ticks can also transmit Lyme disease, are about the size of a sesame seed, and are most active during the cooler months of the year (CHOP, 2017).

Once infected, a range of nonspecific symptoms may occur. If left untreated, the infection can spread to other parts of the body, potentially causing long-term medical issues and permanent damage. Symptoms usually occur within the first 30 days after a tick bite and may include a circular-shaped, “bull’s-eye” rash called erythema migrans. It can be pink or clear in the center and red on the surrounding skin. The rash can last up to several weeks, may vary in size and location, may itch, and may mimic other skin problems such as hives or eczema. The individual may also experience flu-like symptoms such as fever, chills, muscle and joint aches, fatigue, and swollen glands (CHOP, 2017).

If the infection spreads to other parts of the body, the student may experience severe headaches and neck stiffness, additional bull’s eye rashes, arthritis in large joints, Bell’s palsy, heart palpitations or an irregular heart beat, dizziness, shortness of breath, shooting pains and numbness, memory loss, and eye inflammation (CHOP, 2017).

Oral antibiotics are commonly used to treat Lyme disease in the early stages. Doxycycline, amoxicillin, or cefuroxime are typically given as a four week course. If symptoms have not resolved after an initial four week course of antibiotics, a second four week course of antibiotics is sometimes necessary. Individuals with neurologic or cardiac involvement may require IV antibiotics. Children with cardiac, joint, or brain involvement from Lyme disease may need additional follow-up with pediatric specialists (CHOP, 2017). The overall **treatment** of Lyme disease includes antibiotics and supportive measures; however, some students may require in-school antibiotic intravenous therapy which should be coordinated with community health services providers and the student’s medical home. In such cases, an IHP should be developed based on the child’s needs and medical orders. School nurses should consider initiating a 504 plan for students experiencing neurocognitive problems (Lyme Disease Challenge, 2017). Lyme disease should be considered in children who exhibit drastic changes in mood, school performance, or general health. Children with Lyme disease may exhibit difficulties with spatial relationships, tracking, memory, communication, and persistence (Cook, 2009).

Applicable Laws and Regulations

N.J.S.A. 18A:35-5.1 – Lyme Disease Curriculum Guidelines

The Commissioner of Education, in consultation with the Commissioner of Health, shall develop curriculum guidelines for the teaching of information on the prevention of Lyme disease within the public school health curriculum. The guidelines shall emphasize disease prevention and sensitivity for victims of the disease. The Commissioner of Education shall periodically review and update the guidelines to insure that the curriculum reflects the most current information available.



Key Point

Instruction about Lyme disease should be addressed in a locally-developed curriculum that is aligned with the New Jersey Student Learning Standards for Comprehensive Health and Physical Education (2.1 Diseases and Health Conditions) and the National Health Education Standards (Standards 1 and 7). Teachable moments include field trips, outdoor play and sports programs, and community-based environmental activities.

N.J.S.A. 18A:35-5.3 – Training Teachers

The Commissioner of Education, in consultation with the Commissioner of Health, shall also provide curriculum guidelines for the training of all teachers who instruct students with Lyme disease which emphasizes the special needs and problems of students with the disease, in order to provide information about how best to teach those students.



Key Point

Each school district shall annually provide training to all teachers who instruct students with Lyme disease should emphasize the unique needs of the students and how best to teach them.

Additional Points for Nursing Practice

The **prevention of tick-borne disease** requires a collaborative district and community prevention effort. The district board of education should develop policies and procedures for environmental controls on school grounds. In addition, the district should have specific policies about the use of insect repellants and tick checks on school-sponsored field trips. In general, the best method for preventing tick borne disease is to avoid tick-infested areas, particularly in the spring and summer when nymphal ticks are feeding. Ticks prefer a moist, shaded location with leaf litter and low-lying vegetation in wooded or overgrown grassy areas. Since tick-borne diseases can also impact employees who maintain school grounds, district boards of education should support efforts to decrease the tick population by reducing or eliminating tall grass, brush, and leaf litter and discouraging deer activity near the school and on school grounds.



School nurses should advise parents/guardians to check their children for ticks under the arms, in and around the ears, inside the belly button, behind the knees, between the legs, around the waist, and in their hair. Individuals should bathe or shower as soon as possible after coming indoors. Parents should examine their child's gear and clothes because ticks can be brought into the home on clothing and pets, then attach to a person later. Dry clothes should be tumbled in a dryer on high heat for 10 minutes to kill ticks on clothing after coming indoors. If the clothes require washing first, hot water is recommended as cold and medium temperature water will not kill ticks effectively. If the clothes cannot be washed in hot water, they can be tumble dried on low heat for 90 minutes or high heat for 60 minutes.

School nurses need to know **how to remove a tick**. If a tick is found on a person, remove it immediately as per the school physician's protocol. Notify the parent/guardian and recommend that the student's medical home be contacted for evaluation.

- Use fine-tipped tweezers to grasp the tick as close to the skin's surface as possible and pull upward with steady, even pressure.
- Don't twist or jerk the tick as this can cause the mouth-parts to break off and remain in the skin. If this happens, remove the mouth-parts with tweezers. If the mouth cannot be removed easily with clean tweezers, leave it alone. Contact the child's parent for evaluation by the medical home.
- After removing the tick, thoroughly clean the bite area and your hands with an antiseptic or soap and water.
- Place the tick in a sealed bag/container for identification. Never crush a tick with your fingers.
- The child's medical home should monitor the child for signs and symptoms of Lyme disease for 30 days and specifically for any skin lesion at the site of the bite.



Key Point

Testing of individual ticks is not recommended; however, there are companies that provide tick testing for a fee. The analysis of a submitted tick is not a definitive test for Lyme disease itself and it does not rule out the possibility that the individual may have other undetected tick bites. The local health department may offer useful tick identification services and information.

School nurses should document care on the Health History and Appraisal Health Form, A-45. All referrals, healthcare provider documentation, and follow-up should also be recorded on the student's health record.

CDC Recommendations for Tick Bite Prophylaxis

NJDOH Lyme FAQ

Meeting the Needs of Students with Chronic Health Conditions

Topic: Other Chronic Health Conditions Impacting Learning

Background and Rationale

School nurses provide care and support for students with a myriad of health conditions. Students may require the administration of medication in response to symptoms or to prevent symptoms from occurring. They may need assistance with routine care. The school nurse functions as a care giver, health educator, and counselor for many of students and families. Unlike diabetes or asthma, the health conditions included in this section are not specifically referenced in New Jersey education law or code. Other laws or regulations that address the conditions may be summarized below. This section provides a brief overview of some of the more common chronic health conditions. Clearly, the school nurse should develop an IHP/IEHP for students receiving care and accommodations. In some cases, a child may need a 504 Plan or referral to the Child Study Team for evaluation.

Attention Deficit Hyperactivity Disorder

Attention deficit hyperactivity disorder (ADHD) is a behavioral condition that makes focusing on everyday requests and routines challenging. People with ADHD typically have trouble getting organized, staying focused, making realistic plans, and thinking before acting. They may be fidgety, noisy, and unable to adapt to changing situations. Children can be defiant, socially inept, or aggressive. The stereotype of someone with ADHD is a hyperactive little boy. However, parents, teachers, and others often overlook ADHD in girls because their symptoms differ from those of boys. Women and girls with untreated ADHD are at risk for low self-esteem, underachievement, depression, and anxiety (APA, 2017).

ADHD is usually diagnosed in childhood and often lasts into adulthood. It is not uncommon for children to have difficulty focusing. For some children, these behaviors are transitional but not for children with ADHD. Children with ADHD may experience difficulties in school and at home. They may have difficulty paying attention or sitting still in class and may squirm, daydream, make careless mistakes, take unnecessary risks, or have trouble getting along with others.

There is no clear cut cause for these disorders. They are not caused by eating too much sugar, watching too much television, parenting, or social and environmental factors such as poverty or family chaos. Determining if a child has ADHD requires a comprehensive history and medical examination including hearing and vision tests. Teachers, counselors, and parents may be asked to complete a checklist of observed behaviors. The child may be referred to a child psychologist or developmental pediatrician for additional evaluation and treatment recommendations (CDC, 2017).



Treatments for ADHD may include:

- Behavior therapy, including training for parents, focusing on strengthening positive behaviors and eliminating problem behaviors;
- Medications including stimulants and non-stimulants; and,
- School accommodations and interventions.

The [AAP treatment guidelines](#) state that for children 6 years of age and older, both behavior therapy and medication are good options, preferably both together. For young children (under 6 years of age) with ADHD, behavior therapy is recommended as the first line of treatment, before medication is tried. Children and Adults with Attention Deficit Disorder (CHADD) developed [Managing Medications](#) which includes a chart of medications and side effects. [Facts about ADHD](#), published by the CDC, includes information on symptoms, diagnosis, and treatments. The AAP also provides an [ADHD Guide for Parents](#).

Applicable Laws and Regulations

There are no New Jersey education laws or regulations that specifically address school nursing services and ADHD.

Additional Considerations for School Nursing Practice

School nurses need to establish a relationship with students with these conditions and their families. Effective communication with the student, the family, and the medical home, will enable the school nurse to develop and implement an IHP or 504 plan that meets the needs of the student.

The school nurse, working with school counselors and the school psychologist, need to communicate with the parents/guardians to determine if they have been trained in behavioral therapy so that similar strategies can be used during the school day. Medication controls symptoms but behavior therapy changes behavior.

If the student requires a dose of medication during the school day, the school nurse must store the medication safely and administer it as prescribed. Some medications may not require a dose during the school day; however, the school nurse needs to know the kind of medication, dose, and timing of the prescribed medication for the condition. The school nurse should discuss with the student and family any possible side effects that may occur during the school day.

Common psychostimulant medications used to treat the conditions include methylphenidate (Ritalin, Concerta, Metadate, Focalin); mixed salts of a single-entity amphetamine product (Adderall, Adderall XR); and dextroamphetamine (Dexedrine, Dextrostat). Methylphenidate, amphetamine and mixed salts of amphetamine are now available as both short- and long-acting preparations. Short-acting preparations generally last about 4 hours; long-acting preparations are more variable in duration—with some preparations lasting 6–8 hours and newer preparations lasting 10–12 hours (CHADD, 2017).

Atomoxetine (Strattera) is neither a stimulant nor an antidepressant. It alleviates inattention and hyperactivity/impulsivity symptoms of ADHD by affecting specific aspects of the norepinephrine system. Atomoxetine has been tested on more than 1,600 children, adolescents, and adults. It is a prescription medication, but it is not a controlled substance like a stimulant. This allows medical professionals to give samples and to place refills on the prescriptions. It does not start working as quickly as stimulants do. Reports suggest that the full effects are often not seen until the individual has taken atomoxetine regularly for 3–4 weeks (CHADD, 2017).

Antidepressants that have active effects on the neurotransmitters norepinephrine and dopamine can have a positive effect on ADHD symptoms. Antidepressants that only affect the serotonin system—serotonin selective reuptake inhibitors (SSRIs), such as fluoxetine (Prozac), sertraline (Zoloft) and citalopram (Celexa)—have not been shown to be effective for treating primary symptoms of ADHD but may be effective against co-existing conditions. Research has shown that long-acting clonidine (Catapres) and guanfacine (Tenex), which are sometimes prescribed to reduce excessive hyperactivity or severe insomnia in children with ADHD, can also improve attention span in children with ADHD (CHADD, 2017).

For more information on medications see, CHADD’s [managing medications](#) chart.



Key Point

Medication does not cure ADHD; when effective, it eases ADHD symptoms during the time it is active.

Students may be monitored both on and off medication. Observations may be collected from parents, teachers, and coaches.

Educational adaptations such as preferential seating, modified work assignments, testing modifications, or behavior plans may be implemented. These may be incorporated into the students’s 504 plan.

Autism Spectrum Disorder

Autism Spectrum Disorder (ASD) is a developmental disorder that affects an individual’s social interactions, communication, and behavior. Signs of ASD begin during early childhood and typically last throughout a person’s life. People with ASD may communicate, interact, behave, and learn in different ways. Some people with ASD need a lot of help in their daily lives, others need less, while some are considered gifted. Individuals with ASD may have restricted and repetitive behavior, interests, and activities. These characteristics fall across a “spectrum” ranging from mild to severe (Autism New Jersey, 2017).

According to the National Institute of Neurological Disorders and Stroke (NINDS) at NIH, ASD may make communication challenging. For example, children with ASD may fail to



respond to their names or avoid eye contact, find it difficult to talk about their feelings, and have difficulty understanding others' feelings. Individuals with ASD may have difficulty interpreting non-verbal cues such as gestures or body language. Some people with ASD require routine; therefore, any changes to their daily routine can result in emotional outbursts (NINDS, 2017a).

Certain genetic disorders may be associated with an increase risk for autism, including Fragile X syndrome and tuberous sclerosis. Research continues to look for a genetic mutation association. Individuals with ASD also have a higher risk of epilepsy. Children whose language skills regress before age 3 appear to have a risk of developing epilepsy or seizure-like brain activity. About 20 to 30 percent of children with ASD develop epilepsy by the time they reach adulthood. Additionally, people with both ASD and intellectual disability have the greatest risk of developing seizure disorder (NINDS, 2017a).

School nurses who care for students with ASD need to work closely with the family, other school personnel, and the child's medical providers to ensure a safe environment.

Symptoms may improve with age and behavioral treatment; however adolescents with ASD may become depressed or experience behavioral problems. Their treatment may need some modification as they transition to adulthood. The school nurse may need to modify the student's IHP/IEHP or 504 plan to reflect changes in treatment and behavior as a child ages. Medication does not cure ASD; however, students may be prescribed medications to deal with related issues such as anxiety, depression, and obsessive-compulsive disorder. Antipsychotic medications are used to treat severe behavioral problems. Seizures can be treated with one or more anticonvulsant drugs. Medication used to treat people with attention deficit disorder can be used effectively to help decrease impulsivity and hyperactivity in people with ASD (NINDS, 2017a).

Applicable Laws and Regulations

P.L. 2007, c.174 – Autism Medical Research and Treatment Fund

The [Governor's Council for Medical Research and Treatment of Autism](#) was created by State appropriation in 1999 and issues research, clinical and educational enhancement grants. It seeks to advance and disseminate the understanding, treatment, and management of ASD by coordinating biomedical research, clinical innovation, and professional training. The Council's initiatives are funded by a one dollar surcharge from motor vehicle violations and fines, which results in approximately \$4 million each year dedicated to autism research, treatment, and education.

The NJDOH publishes information for professionals and the public on autism and maintains the New Jersey Autism Registry. All licensed healthcare providers must register any child who is diagnosed with an autism spectrum disorder (ASD), lives in New Jersey, and is 0-21 years of age. NJDOH also publishes a list of organizations and agencies that provides [autism information and services](#).

Additional Points for School Nursing Practice

[Autism NJ](#) provides education, training, and support for families along with advocacy and policy efforts.

Students with ASD often have a range of healthcare issues in addition to the diagnosis of ASD. These co-morbid conditions may include seizures, gastrointestinal problems, sleep problems, anxiety, and attention issues as well as toileting and feeding issues.

The student with ASD may need to take medication at school. An IHP should be created that takes into account the student's history, diagnosis, and healthcare needs. The school nurse should work closely with the family, the child's medical providers, and other school health team members to develop an IHP that fully addresses issues such as the child's routine, communication styles, social interactions, and the student's ability to self-manage.

Autism Speaks publishes numerous resources for healthcare providers, educators, and families including:

- [Autism and the Classroom](#)
- [Autism and Health](#)
- [Autism Tool Kits](#)

Cerebral Palsy

Cerebral palsy (CP) is a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination. It is caused by damage to the developing brain resulting in the inability to control movement and maintain posture and balance. The damage may occur before, during, or after birth (NINDS, 2017b). Children with CP may lack muscle coordination, have stiff or tight muscles or extremity weakness, have difficulty swallowing or speaking, experience shaking or random involuntary movements, and have difficulty with activities of daily living such as getting dressed or writing. The NIH website [Cerebral Palsy: Hope Through Research](#) provides information on treatment, and ongoing research. The CDC also provides information on [cerebral palsy](#).

Some students with cerebral palsy are able to participate in a regular education program with some modifications while others may have significant impairments that require 1:1 care. The student should have an IHP or 504 plan and may also have an IEP. The school nurse serves as an important liaison between the school and the child's family and medical home.



Applicable Laws and Regulations

N.J.S.A. 26:5A-1 – Reports by Physicians of Cerebral Palsy Cases

This law requires physicians to report to the local board of health each case of cerebral palsy now under his care, if his patient is under eighteen years of age, and all new cases of cerebral palsy, regardless of the age of the patient.

Additional Points for School Nursing Practice

The school nurse should develop an IHP/IEHP and/or 504 plan for the student focusing on the management of primary health conditions, prevention and management of complications, control of pain, optimization of mobility and fall prevention, individualized crisis and emergency management, and staff training.

The Nemours Children's Health System publishes a [Special Needs Fact Sheet: Cerebral Palsy](#) that provides information for parents and teachers about classroom adaptations, 504 plans, and camps for students with special needs.

It is not unusual for children with CP to have digestive disorders including constipation or reflux. The IEP should address any nutritional issues that may arise during the school day due to drooling or difficulty swallowing. School food service personnel and other school personnel who supervise the cafeteria should be educated about CP and informed if the child needs more time or assistance with meals.

The [United Cerebral Palsy Resources](#) webpage provides information for parents and caregivers on issues such as assistive technology devices and health and wellness and includes information on [Disability Etiquette](#).

Cystic Fibrosis

Cystic fibrosis is an inherited disease characterized by the buildup of thick, sticky mucus that can damage many of the body's organs, particularly the respiratory and digestive systems. The abnormal mucus leads to severe problems with breathing and bacterial infections in the lungs causing chronic coughing, wheezing, and inflammation. This leads to permanent lung damage, including the formation of scar tissue (fibrosis) and cysts in the lungs. Most people with cystic fibrosis also have digestive problems. The disease can also block the ducts of the pancreas, reducing the production of insulin and preventing digestive enzymes from reaching the intestines to aid digestion. This can lead to diarrhea, malnutrition, poor growth, and weight loss. In adolescence or adulthood, a shortage of insulin can cause a form of diabetes known as cystic fibrosis-related diabetes mellitus. The disease may also affect the sweat glands and the reproductive system (NHLBI, 2013). The [Cystic Fibrosis Foundation](#) provides information on research and treatments as well as information on [cystic fibrosis and schools](#). Treatment aims to prevent and control lung infections and loosen and remove thick, sticky mucus from the lungs. This may involve chest physical therapy, exercise, and medications such as anti-inflammatories, antibiotics, and bronchodilators. Some individuals may require the use of oxygen.

CF can cause digestive problems such as bulky stools, intestinal gas, a swollen belly, severe constipation, and pain or discomfort. Digestive problems can lead to poor growth and development in children. Nutritional therapy focuses on ensuring a well balanced diet rich in calories, fat, and protein. Students with CF may take pancreatic enzymes to aid digestion and vitamin supplements A, D, E, and K to replace the fat soluble vitamins that cannot be absorbed. Students with CF may need supplemental shakes and a high-salt diet (or supplement) especially before exercising. Some individuals with CF may also need medications to reduce stomach acid (NHLBI, 2013).

Applicable Laws and Regulations

New Jersey law requires [newborn screening](#) for cystic fibrosis along with 55 other conditions.

Additional Points for School Nursing Practice

Children with cystic fibrosis may follow a special diet that includes high-calorie, high fat foods supplemented with pancreatic enzymes and vitamins. The student may need to store these items in the school health office.

Children with cystic fibrosis may experience bouts of coughing and should be allowed free access to water. Students should keep tissues handy and be taught how to dispose of them properly.

Dehydration is a real problem for some students with cystic fibrosis. When they sweat, they lose more salt. The physical education teacher, athletic trainer, and coaches must ensure that students with CF are properly hydrated.

School nurses should consider the following when developing the student's IHP or 504 plan:

- The potential for ineffective airway clearance and ways to address this problem during the school day, on school transportation, and at school-sponsored activities;
- The potential for nutritional imbalance and strategies to support healthy eating while at school;
- The risk for acute infection especially during high incidence of respiratory infections in school;
- The risk of activity intolerance, especially related to sweating and dehydration;
- The risk for non-compliance with treatment, particularly as the student moves through developmental transitions; and,
- The risk for disturbed body image and related social and emotional issues.

NASN Sample IHP for Cystic Fibrosis



Seizure Disorders and Epilepsy

Epilepsy is a neurological condition defined by recurring unprovoked seizures. It is a common disorder of the nervous system and affects people of all ages, races, and ethnic backgrounds. A seizure is a single occurrence while epilepsy is two or more unprovoked seizures. Seizure disorders occur when a disturbance in the brain produces changes in awareness or sensation, involuntary body movements, or changes in behavior lasting from a few seconds to a few minutes (Johns Hopkins Medicine, 2017).

The CDC reports that 1.2% of the total US population, including 470,000 children, have active epilepsy. According to the latest estimates, about 0.6% of children aged 0-17 years have active epilepsy, or in a school with 1000 students, about 6 children would have epilepsy. Epilepsy and related seizures may result from a stroke, brain tumor, central nervous system infection, or traumatic head/brain injury (CDC, 2017m).

The Johns Hopkins Epilepsy Center describes the three stages of a seizure as:

- The aura, meaning the start of a partial seizure;
- The ictus, meaning the stroke or attack; the actual physical seizure; and,
- The postictal phase, meaning after the attack; includes the aftereffects of the seizure, such as arm numbness, loss of consciousness, or partial paralysis.

Seizures that last too long or several seizures occurring close together are serious and require an immediate medical response. Convulsive **status epilepticus** involves repeated tonic-clonic seizures making it difficult to determine when one ends and another begins. This requires urgent, immediate medical care by trained professionals and testing to determine the cause of the seizure which might include an infection, tumor, or stroke. A person experiencing focal impaired awareness (complex partial) seizures might be confused but they are not “unconscious,” like in a tonic-clonic seizure. The symptoms are more subtle, requiring the school nurse to carefully observe and assess. Early recognition and treatment are keys to the best possible outcome (Schachter, et al. 2013).

Seizure triggers in children include but are not limited to fevers, missed medications, flashing or flickering bright lights, brain disorders, stress, lack of sleep, hormonal changes, certain foods, or certain mental processes such as reading or math (Epilepsy Foundation, 2014).

Treatments may include medication, surgery, specialized diets, and noninvasive brain stimulation. The school nurse and other caregivers must be able to describe the seizure and document the following information:

- What time did the seizure start and stop?
- Where in the body did the seizure start?
- Did the seizure stay in that part of the body or did it move to other areas?
- What type of movement occurred (e.g., jerking, twitching, stiffness)?

- Is there anything that might have triggered the child's seizure?
- Did the child experience anything unusual before the seizure started?
- Has there been a change in how often seizures occur or in the type of seizure activity? (Boston Children's Hospital, 2017).

Parents need to help their child live an active normal life. Epilepsy may impact how well they do in school, what sports they can play, and how they are treated by friends. It is important to be honest with the child and establish routines and set clear rules and limits. As the child matures, issues such as puberty, dating, substance use, driving, and independence must be addressed (AAP, 2014).

The school nurse plays an important role helping students prepare for self-management and independence. This includes responsibilities such as keeping track of medications, refilling prescriptions, making doctor appointments, and asking questions of the medical team (AAP, 2014).

Applicable Laws and Regulations

There are currently no New Jersey laws or regulations that specifically address seizure disorders or the administration of any medication for seizures by non-medical school personnel. While the NJBON provides a delegation algorithm, school law and regulations do not specifically allow non-medical school employees to administer any emergency medication except glucagon or epinephrine. Note that N.J.A.C. 6A:16 defines medications. The definition does not include herbal remedies. Authorization for medication administration must be in writing from a physician licensed in medicine, dentistry or osteopathy, or from an advanced practice nurse.



Key Point

Some rescue medications must be administered rectally. This requires the student to be partially undressed, sometimes in locations where privacy is an issue. The school nurse may not always be available to administer the medication when a seizure occurs on the school bus or athletic field. To date, New Jersey law does not address the administration of seizure medications by volunteer delegates. The administration of rescue medications must be addressed as part of the child's IHP/IEHP and IEP.

The Epilepsy Foundation provides a list of [epilepsy and seizure medications](#).

The school nurse should provide training to school personnel on how to handle a seizure. The Epilepsy Foundation provides training materials and video on [seizure first aid and safety](#) and provides a separate [school nurse training program](#).

The AAP clinical report, [Rescue Medications for Epilepsy in Education Settings](#), provides an excellent overview of the medical and legal issues surrounding the administration of seizure rescue medications such as rectal Diazepam (Diastat). Please be advised that



Midazolam, as discussed in the article, is not currently FDA approved for intranasal use and therefore should not be administered by school nurses.

Sickle Cell Disease

Most people with [sickle cell disease](#) (SCD) are of African ancestry or identify themselves as Black. About 1 in 13 African American babies is born with sickle cell trait and about 1 in every 365 Black children is born with sickle cell disease. People with Hispanic, Southern European, Middle Eastern, or Asian Indian backgrounds may also have the disease. There are approximately 100,000 Americans with SCD (NHLBI, 2017).

Sickle cell disease is a group of inherited red blood cell disorders. The red blood cells become hard and sticky and look like a “C” shaped farm tool called a “sickle.” There are not enough healthy red blood cells to carry oxygen through the body. The sickled cells get stuck in small blood vessels and clog blood flow, which can cause pain, infections, acute chest problems, and stroke (NHLBI, 2017). People who inherit one sickle cell gene and one normal gene have sickle cell trait (SCT). People with SCT usually do not have any of the symptoms of sickle cell disease (SCD), but they can pass the trait on to their children (CDC, 2017n).

Individuals with sickle cell disease have limited treatment options. Hydroxyurea can decrease several complications of SCD. L-glutamine has been approved by the FDA to reduce the number of sickle cell crises in adults and children older than age five. Another treatment, which can actually cure SCD, is a stem cell transplant (also called a bone marrow transplant). This procedure infuses healthy cells into the body to replace damaged or diseased bone marrow. Although transplants of bone marrow or blood from healthy donors are increasingly being used to successfully cure SCD, they require a matched donor (a person with similar, compatible bone marrow), and transplants can sometimes cause severe side effects, including occasional life-threatening illness or death (CDC, 2017o).

Children with sickle cell disease may have anemia, which leads to a lack of energy, breathlessness, and pale color of the skin and lips. A child experiencing a sickle cell crisis may have severe pain, leading to hospitalization. Infections, extreme physical activity, and other stress-producing activities may precipitate a crisis. Swelling of the hands and feet is one of the first symptoms of SCD. When accompanied by fever, it is a sign that the sickle cells are getting stuck in the blood vessels and blocking the flow of blood in and out of the hands and feet. The most common treatments for swelling in the hands and feet are analgesics and an increase in fluids. Pain is the most common complication of SCD. It can start suddenly, be mild to severe, and last for any length of time (CDC, 2017o). The CDC provides an overview of [sickle cell treatments](#).

The CDC also produced [Tips for Supporting Students with Sickle Cell Disease](#) which provides an excellent overview of the disease and symptoms that may occur during the school day. It details information for nurses, teachers, and administrators as well as families.

Applicable Laws and Regulations

N.J.S.A. 26:5B-3 – Hereditary Disorder

New Jersey defines a hereditary disorder as any human ailment, disease, or deformity resulting from a specific genetic condition and for which treatment is available, and includes Cooley's anemia, cystic fibrosis, sickle cell anemia, hemophilia, Huntington's Disease, and inborn errors of metabolism such as galactosemia and phenylketonuria.

N.J.S.A. 26:5B-5&6 – Sickle Cell Anemia

Sickle cell anemia is an inherited blood disorder characterized primarily by chronic anemia and periodic episodes of pain. The clinical course of sickle cell anemia does not follow a single pattern, for the symptoms can range from mild to very severe. All newborn infants born in New Jersey and in most other states are screened for sickle cell anemia; however, there is currently no known means of prevention or cure for the disease, although promising new methods of treatment have emerged from clinical studies in recent years, including drug therapy, bone marrow transplants from matched siblings, and umbilical cord blood transplants.

The Department of Health, in consultation with the Medical Society of New Jersey and Rutgers, The State University, was required to prepare, and make available on its Internet website information in English and Spanish which is designed to be easily understandable by the general public. The materials focus on genetic risk factors associated with, and the symptoms and treatment of, sickle cell anemia. The NJDOH is required to make booklets available to all licensed health care facilities engaged in the diagnosis or treatment of sickle cell anemia, as well as to health care professionals, community health centers, members of the public, and social services agencies upon their request.

New Jersey requires [newborn screening](#) for sickle cell disease along with 55 other conditions. The NJDOH makes [Sickle Cell Disease: A Family Guide](#) available on its website.

Additional Points for School Nursing Practice

As with any chronic illness, students with sickle cell disease should have an IHP/IEHP and/or 504 plan. For example, students may need an extra set of books for home, more frequent bathroom breaks, access to water throughout the school day, or extra layers of clothing. The school nurse should work closely with the student's family and the medical home to develop a plan of care that addresses how to deal with pain, fever, weakness or fatigue, changes in classroom temperature, and other issues that may impact the child's ability to learn.

Because children with sickle cell disease may experience a blockage leading to a stroke, the school nurse should discuss possible symptoms with teachers and emphasize the need for emergency care should the student exhibit the signs.

Pain may occur anywhere in the body but most commonly in the arms, legs, abdomen, and back. It may last a few hours, days, weeks, or longer. The child's pain may ease or get worse over time or may become so severe that a child needs to be hospitalized.



Howard University Sickle Cell Disease Information

The Sickle Cell Information Center provides [Information for Teachers and Students](#), including multilingual resources.

Spina Bifida

[Spina bifida](#) is a condition that affects the spine, is usually apparent at birth and can happen anywhere along the spine. When the neural tube does not close all the way, the backbone that protects the spinal cord does not form and close as it should. This often results in damage to the spinal cord and nerves. Genetic and environmental factors may influence its occurrence (CDC, 2016).

The extent of the condition may range from mild to severe. This depends on the size and location of the defect and whether the spine and nerves are affected. The Spina Bifida Association (SBA) provides information on the various [types of spina bifida](#). Approximately 80% of people with spina bifida have hydrocephalus. The most common treatment for hydrocephalus is to insert a [shunt](#) to drain excess fluid from the head to another place where the body can remove it naturally (SBA, 2015).

Students with spina bifida present with a myriad of individual issues that require the school nurse and other care providers to work together to support a safe and healthy environment for the child. The school nurse plays an important role developing the IHP/IEHP and implementing the plan of care. The school nurse communicates with the medical home, school staff, the student, and the family and updates the plan as the student matures and as care changes.

The SBA has numerous [info sheets](#) that address topics such as adaptive physical education, continence, precocious puberty, latex allergies, anxiety and depression. The SBA also provides a guide for educational issues and testing and a quick reference sheet for educators.

Applicable Laws and Regulations

There are no New Jersey education laws or regulations that specifically address spina bifida. Applicable federal laws and rules regarding eligibility for special education and related services may apply.

Additional Points for School Nursing Practice

Some children with spina bifida may be incontinent and at higher risk for urinary tract infections. Some children will require catheterization. It is important to develop a plan for toileting that works and is as simple as possible. This can lead to increased health, participation, and independence, and help the child to avoid embarrassment.

[Beyond Crayons](#) is a special program that promotes a healthy school environment for students with spina bifida.

As the school nurse works with the student's family and medical home to develop the IHP/IEHP and/or the 504 plan, the following questions should be considered:

- What is the level of the lesion? What type of spina bifida does the student have?
- Does the student have Arnold Chiari Type 1 Malformation? Were there any interventions? For more information, review the NIH fact sheet on [Chiari Malformations](#).
- Does the student have a shunt? Have there been any revisions?
- Does the student have a latex allergy? Is an epinephrine needed and available?
- What medications does the student take (in and out of school)?
- Does the student have a history of seizures?
- Does the student have mobility issues? Does the student need to be lifted? Is special equipment needed?
- What is the student's bladder management program?
- What is the student's bowel management program?
- Any skin breakdown concerns?



Key Point

Many people with spina bifida are allergic to products that contain latex or natural rubber. A person with this type of allergy should wear a bracelet to alert other people of the allergy.

The [CHOP Spina Bifida](#) webpage provides information in English and Spanish on the condition along with 12 brief videos that explain how the condition is diagnosed and pre-natal and postnatal treatments.





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CHAPTER SIX: Preparing for Emergencies and Crisis

Topic: Injury Prevention and First Aid

Background and Rationale



Schools have a unique role in preventing injuries to children and youth. Children can be injured walking or biking to school or while riding a school bus. Once they arrive, students can be injured on the school campus. Schools need to specifically prepare to prevent injuries in the classroom, on playgrounds, in the gymnasium, and on the athletic field. Promoting the health and safety of children and youth is an

important responsibility and one that the school nurse should embrace as the school's resident healthcare professional. While the school nurse is most often called upon to provide direct care to an injured individual, the school nurse should also educate students, their families, and school personnel about safety issues. The school nurse plays an important role in the development of safe school policies and practices, including mandated school safety and security initiatives. This chapter discusses ways school nurses can be involved in assuring the health and safety of students and school personnel.

According to the CDC's [National Action Plan for Child Injury Prevention](#), childhood unintentional injuries are the leading cause of death among children ages 1 to 19 years. Each year, an estimated 8.7 million children from birth to age 19 are treated in emergency departments for unintentional injuries and more than 9,000 die as a result of their injuries. These injuries include drownings, falls, fires or burns, poisoning, suffocation, and transportation-related injuries. Injuries claim the lives of 25 children every day (CDC, 2012).

Student injuries and emergencies are not confined to the playground or athletic field. Given that so many children with special healthcare needs attend school, schools and school nurses, in particular, must be prepared for all kinds of life-threatening emergencies. The school health team should work with the district board of education to ensure that every school is prepared to handle individual student emergencies occurring at school. According to the AAP, schools that are prepared for an emergency in an individual are more likely to be prepared for complex events such as community disasters (AAP, 2008).

One of the core roles of the school nurse is to provide quality health care to students and staff with actual and potential health problems including those who have been injured



Medical Emergencies Occurring in School

The district board of education is required to develop, approve, and enact policies and procedures to deal with illness or injuries occurring during the school day or as part of school-sponsored activities. When an emergency occurs:

1. The school nurse assesses the situation, activates the appropriate protocol(s) and determines whether EMS needs to be activated. Should a school nurse or other medical professional not be available, call 911 to activate EMS.
2. Once EMS is activated, the caller should inform the EMTs of the school's entrance point. Make sure there is a designated greeter to direct the EMTs to the emergency.
3. When possible, remove other students and staff members from the scene.
4. All emergency-response interventions should be promptly and accurately recorded and passed on to the EMTs.
5. For children with special healthcare needs, the IHEP is activated and information is made available to the EMTs.
6. Any student who receives emergency epinephrine must be transported to the emergency department.
7. Parents, legal guardians, or designated emergency contact persons are informed as quickly as possible about the child's injury or sudden illness at school after EMS is notified. Do NOT wait to reach the child's parents before activating EMS.
8. Notification systems must be in place through a designated spokesperson to inform the school staff, students, the media, and the community at large of the outcome of an individual student's emergency situation in an appropriate manner that respects the student's confidentiality and dispels false rumors.
9. The description and disposition of the situation must be documented on district required forms and the student's school health record, as appropriate. This information can be used to (1) identify patterns of injury; (2) prevent another such injury or illness; (3) inform parents of the nature and management of the injury; (4) share information with the child's medical home; share information with local and state child fatality review teams charged with investigating death and near-death events; and (5) provide information for liability and insurance purposes.

After the Event

10. Study the records of the situation and provide feedback to school staff and EMS. Identify areas in need of improvement and design education programs to address potential or identified shortcomings.
11. After an emergency intervention, the IHP/IEHP should be reviewed and adjusted as needed.
12. Initiate mental health interventions, as appropriate, for all affected students and staff. Identify, in advance, community providers who can assist with such efforts.
13. Check and restock equipment and medications used during the emergency.

Adapted from the AAP's Medical Emergencies in Schools, 2008

(Cosby, Miller, & Youngman, 2013). The school nurse must be able to assess and intervene in any emergency situation arising in the school setting. It is incumbent upon the district board of education to ensure that appropriate policies are in place and resources available to support emergency interventions in the school-setting. The school physician plays an important role developing standing orders and protocols to address routine first aid as well as emergency situations that may result in multiple injuries, such as those occurring as part of school violence or transportation incidents.

The school nurse must be prepared to work with emergency services personnel during casualty situations such as school shootings, bus accidents, or other incidents that may impact both adults and students. School nurses must also be prepared to address injuries related to floods, tornados, toxic chemical spills, fires, and explosions. School nurses should continuously update their knowledge and skills about emergency responses and work, in advance, with emergency responders to “practice” or simulate possible conditions during such emergencies.

School emergencies can involve students, adults, staff members, volunteers, or attendees at special events. Because injuries are the most common life-threatening emergencies encountered by children and adolescents inside or outside schools, all school personnel should know the general principles of basic first aid and cardiopulmonary resuscitation (CPR). The National Federation of State High School Associations (NFHS) and the American Red Cross (ARC) offer first aid courses specifically for athletic coaches and officials. The [New Jersey Student Learning Standards for Comprehensive Health and Physical Education](#) require all students to understand safety principles and risk reduction with a focus on the prevention of intentional and unintentional injuries and the application of basic first aid including CPR and the use of an AED.

There are numerous resources to support safe schools and prevent injuries. As part of its injury prevention initiatives, the CDC created [Protect the Ones You Love: Child Injuries are Preventable](#) to provide parents and caregivers with strategies to protect children from injuries. The CDC also produces the [Heads Up](#) program to address head injuries with information specifically for parents, youth and school sports programs, healthcare providers, schools, and school nurses.

The [Children’s Safety Network](#) works to equip states and jurisdictions to strengthen their capacity, utilize data, and implement effective strategies to make major reductions in injury-related deaths, hospitalizations, and emergency department visits. [New Jersey](#) specific information and data is provided.

The AAP Healthy Children website promotes [safety prevention](#) with tips for parents and caregivers. The AAP’s [Council on Injury, Violence, and Poison Prevention](#) provides policy information and resources for pediatricians and other healthcare providers on topics such as firearms, vehicle safety, and childhood trauma.

The [Center for Child Injury Prevention Studies](#) at CHOP focuses on injury biomechanics and technological solutions. It looks at how humans behave in relation to safety technology, promotion, and education. The project’s [injury prevention blog](#) shares timely comments and resources on child safety issues.



The [Safe Kids Worldwide](#) campaign educates parents and healthcare professionals about child safety issues and solutions. The [Safe Routes](#) program promotes walking and biking and sponsors Walk to School Day in October and Bike to School Day in May.



Key Point

School nurses and emergency services personnel must work together during large scale emergencies. Many school districts and communities engage in emergency drills to improve preparedness for such incidents.

Applicable Laws and Regulations

N.J.A.C. 6A:16-5. — School Safety and Security Plans

These rules require each school district to develop and implement comprehensive plans and procedures that provide for safety and security in the public elementary and secondary schools of the school district. A [school security checklist](#) is provided.

N.J.A.C. 6A:16-2.1(a) — Health Services Policy and Procedural Requirements

Each district board of education is required to develop and adopt written policies, procedures, and mechanisms for the provision of health, safety, and medical emergency services, and inform staff, as appropriate.

N.J.A.C. 6A:16-2.1(a)4 — Provision of Health Services in Emergency Situations

This section requires that the district board of education implement policies and procedures for the emergency administration of epinephrine and glucagon and the use of an AED for a sudden cardiac event. It also requires the local board to develop policies and procedures to address the provision of care for any student who becomes ill or injured at school or a school-sponsored activity, including parental notification and transportation of the pupil requiring immediate care.

N.J.A.C. 6A:16-2.3(a)4i — School Physician: Standing Orders for Emergency Care

The school physician is responsible for the development and implementation of school district policies and procedures related to health, safety, and medical emergencies. The school physician establishes standards of care for emergency situations and medically related care involving students and school staff. The orders must be adopted by the district board of education and reviewed and reissued before the beginning of each school year.

N.J.A.C. 6A:32-2.7(a) & (b) — School Contact Directory

Each district board of education is required to compile and maintain a school contact directory for official use that is separate and distinct from the student information directory. School personnel provide information from the school contact directory for official use only to judicial and law enforcement personnel and to medical personnel currently providing services to the student in question. Upon request from a court, other judicial

agency, law enforcement agency, or medical service provider currently providing services to the student in question, school personnel shall promptly verify the enrollment of a student and provide the requester with all information about the student that is contained in the school contact directory for official use. To exclude any information from the school contact directory for official use, the parent, adult student, or emancipated minor shall notify the district board of education in writing.

N.J.S.A. 18A:35-4.28 — Instruction in CPR and the Use of an AED

The board of education of a public school district that includes grades 9 through 12, or the board of trustees of a charter school that includes grades 9 through 12, must provide instruction in cardiopulmonary resuscitation and the use of an automated external defibrillator to each student prior to graduation as part of the district's implementation of the Core Curriculum Content Standards in Comprehensive Health and Physical Education. The board of education or board of trustees may select a no-cost, non-certification instructional program to meet this requirement. This requirement became effective with the 2014-2015 grade nine class.

Additional Points for School Nursing Practice



Key Point

Do not delay in getting emergency medical care if you cannot reach a child's parent/guardian.

When calling 911, stay on the phone and follow instructions. Give the address of the school and clear directions to the location of the incident or injured individual. The emergency medical team should be met and escorted to the location of the emergency.



Key Point

GPS may help emergency service personnel locate an injured individual, especially if the illness or injury occurs during a school-sponsored trip or off-site athletic event. Administrators, school nurses, and other school personnel supervising these activities should activate GPS on their cell phones for use in emergency situations.

When a student becomes ill or injured and requires emergency services, provide EMS with the name, age, and sex of the student; a copy of the student's IHP/IEHP, if available; a description of the child's injury or symptoms; and the name and contact information of the student's parent/guardian. Include the name of the student's healthcare provider/medical home, if known.

Call the student's parent or legal guardian and describe the medical emergency and what you are doing to care for the student. Inform the student's parent/guardian of the location of medical facility.



Key Point

The school nurse should never use a personal or school vehicle to transport a critically ill or injured student. The nurse cannot provide emergency medical care to a student while driving. In addition, when the nurse leaves the building to care for an ill or injured student, there may be no one to provide care for the students remaining at school. If a student requires emergency care and transport, 911 should be activated and EMS should assume care for the student. Once emergency medical services respond, they are “in charge” of the ill or injured student’s care.

New Jersey Emergency Medical Services for Children

[Ready Together New Jersey](#) is a handy reference guide for emergency preparedness.

School nurses may find it helpful to take a first aid course since many school nurses come from a clinical setting where resources are readily available. Learning to adapt to the school environment may be difficult for some nurses who are accustomed to working with other healthcare professionals. Resources include:

[National Safety Council Training](#)

[American Red Cross Training](#)

[NJ ARC first aid and CPR classes](#)

[American Heart Association CPR in Schools](#)



Emergency situations may warrant the school nurse contacting numerous school and district personnel. The school district should make available to the school nurse the following contact information:

- School building administrator(s);
- School safety and security officer/school resource officer;
- EMS providers, police, and fire department;
- School physician;
- County or local health department;
- Other district school nurses;
- Central office personnel: superintendent, human resources, grounds and facilities);
- School counselor, psychologist, and student assistance professional;
- Poison Control;
- All classrooms, offices, and facilities in the building and on the school campus; and,
- A list of all school personnel and volunteers.

In preparation for an emergency, the school nurse should have access to:

- A detailed map of the school and campus, denoting the locations of AEDs, epinephrine auto-injectors and other emergency devices;
- The schedule/location of students or staff who have mobility or health issues and that may require assistance to evacuate the building;
- A list of all students with hearing or communication issues; and,
- A list of school personnel who are certified in CPR, are EMTs or paramedics, or who are volunteer delegates for epinephrine and/or glucagon administration.

Because sudden cardiac death is not limited to student athletes, New Jersey has enacted a series of laws to detect and prevent it. Student athletes are required to complete a cardiac assessment and history as part of the pre-participation physical exam (see Chapter 3 of this document). Additionally, effective September 2014, all public and nonpublic schools must have an AED available. School districts are also required to disseminate a pamphlet on sudden cardiac arrest to parents/guardians (see Chapter 12 of this document).

The NJDOE requires all candidates for school nurse certification to hold CPR and AED certification.



Preparing for Emergencies and Crisis

Topic: CPR/AEDs and Cardiac Emergencies

Background and Rationale

Sudden cardiac death in children and youth is rare. When it occurs, it is usually due to an undetected cardiac anomaly leading to a life-threatening arrhythmia, an electrical disturbance of the heart that compromises blood flow to vital organs. Pediatric sudden cardiac arrest (SCA) can cause death if not treated within minutes. About 100 cardiac deaths are reported in the U.S. each year and the chance of sudden death occurring in any individual high school athlete is about one in 200,000 per year. Sudden cardiac death is more common in males than in females; in football and basketball than in other sports; and, in African American individuals than other racial and ethnic groups (NJDOE, 2014).

In children, SCA occurs most commonly between ages 10-19. Multiple risk factors may include:

- Athletic activity;
- Known congenital heart disease or structural heart abnormalities;
- Known abnormal heart rhythms associated with congenital heart disease;
- Known abnormal heart rhythms that are very rapid, even with a normal heart;
- Undiagnosed cardiac conditions;
- Obesity and hypertension;
- Exposure to drugs, medications, toxins and infectious agents, including cocaine, inhalants, recreational or club drugs, and some prescription medications;
- A sudden blow to the chest directly over the heart (commotio cordis);
- A family history of known heart abnormalities and sudden death before 50 years of age;
- Unexplained fainting or seizures; and,
- Conditions such as long QT syndrome, Brugada syndrome, catecholaminergic polymorphic ventricular tachycardia (CPVT), hypertrophic cardiomyopathy (HCM), arrhythmogenic right ventricular cardiomyopathy (ARVC) or other familial cardiomyopathies (CHOP, 2017).

Applicable Laws and Regulations

N.J.A.C. 6A:16-2.1(a)4vi — Emergency Action Plan for Cardiac Event

Each district board of education must establish and implement an emergency action plan for responding to a sudden cardiac event, including the use of an AED.

N.J. S.A. 18A:40-41b — Janet's Law: AEDs

Janet's Law requires every district/school (public and nonpublic) to have an AED available in an unlocked location on school property with an appropriate identifying sign. The AED must be accessible during the school day. It must also be available during any school-sponsored athletic event or team practice, and must be within reasonable proximity of the school athletic field or gymnasium, as applicable.

The law also requires every district/school to have a team coach, licensed athletic trainer, or other designated staff member present for athletic events or team practices who is trained in CPR and the use of an AED. This requirement can be satisfied by having a state-certified emergency services provider or other certified first responder on site at the event or practice.

Every school/district must establish and implement an emergency action plan for responding to a sudden cardiac event, including the use of an AED. The emergency action plan must contain, among other things, a list of no less than five (5) school employees, team coaches, or licensed athletic trainers who hold current certifications in CPR and the use of an AED from the American Red Cross, American Heart Association, or other training program recognized by the NJDOH. The list must be updated, as necessary, at least once per semester of the school year.

The Emergency Action Plan must include who responds to the victim and who calls 911; who gets the AED and who operates it; who performs CPR; and, who assists responders to get to the victim.

Janet's Law FAQ**P.L. 2012, Chapter 6 — AEDs and Liability**

The New Jersey Legislature enacted this law to encourage greater acquisition, deployment, and use of AEDs. The law expands immunity from civil liability of persons who acquire AEDs and grants immunity from civil liability to lay persons who use the AED in good faith in emergency situations.

AEDs may be used by lay persons without any training to provide defibrillation within the first minutes of cardiac arrest of victims. The law details specific requirements which must be in place to ensure the safe use of an AED.

It requires persons/entities that purchase AEDs to assure that they have trained people on duty, that appropriate protocols are established, and that the AED is maintained according to the manufacturer. It also requires that the owner notify EMS/police of the location of all AEDs.

N.J.S.A. 18A:40-41i — Mandated CPR Certification for Coaches

A person who coaches a school district or nonpublic school athletic activity must hold a current certification in cardio-pulmonary resuscitation from the American Red Cross, American Heart Association, or other training program recognized by the NJDOH.



N.J.S.A. 18A:35-4.28 — Instruction in CPR and AEDs

This law requires public school districts and charter schools that include grades 9 through 12 to provide instruction in cardiopulmonary resuscitation and the use of an AED to each student prior to graduation as part of the district's implementation of the Core Curriculum Content Standards in Comprehensive Health and Physical Education. The board of education or board of trustees may select a no-cost, non-certification instructional program to meet this requirement.

Additional Points for School Nursing Practice

The American Heart Association provides information and resources to develop a [cardiac emergency response plan](#).

[Cardiac Emergency Response Planning for Schools](#) can be found in the September 2016 edition of the NASN School Nurse.

The [Sudden Cardiac Arrest Foundation](#) provides information and resources.

Under Janet's Law, the school and district must identify no less than five school staff who are certified in CPR and the use of AEDs. The district should ensure that the school nurse has a list of all personnel who are licensed healthcare professionals, EMTs or paramedics, or CPR/AED trained. These emergency contacts can be added to the nurse's school-issued cell phone.

The school district must ensure that the AED is maintained in accordance with the manufacturer's specifications.

While CPR-AED certification is required for school nurse certification, the school nurse has a professional responsibility to maintain current CPR/AED certification. Many school districts also offer CPR/AED courses for all school personnel.

Preparing for Emergencies and Crisis

Topic: Do Not Resuscitate (DNR) Orders

Background and Rationale

Medical advances enable an increasing number of students with complex life-threatening medical conditions to attend school. School nurses may receive Do Not Resuscitate (DNR) orders from a child's parent/guardian and the child's medical home. DNR directives (sometimes called Do Not Attempt Resuscitation or DNAR) may present difficult issues for school nurses and educators, logistically and emotionally. Requesting that life-supporting procedures such as CPR or the use of an AED be withheld when a child experiences a cardiac or respiratory emergency is a difficult decision that has medical, emotional, legal, and ethical issues for the nurse, the school health team, and the school district.

Each student with a DNR order should have an IHP/IEHP developed by the certified school nurse with input from the child's parents/guardians, the student's healthcare pro-

vider, the palliative care team, school administrators, local emergency medical services, the family's funeral director, and the student, when appropriate. The DNR order should clearly specify what life-supporting measures are to be withheld (e.g., CPR, intubation, ventilation, AED, medication). DNR orders should be evaluated individually at the district level with input from the school district's legal counsel to ensure compliance with state and local laws. A DNR order can be revoked at any time (NASN, 2014).

In 2000, the AAP recommended that pediatricians and parents of children at increased risk of dying in school who desire a DNR order meet with school officials. This meeting should include school nurses, school counselors, teachers, administrators, and EMS personnel. When appropriate, the child should be involved. The goal is to reach an agreement about in-school medical interventions. Concerted efforts to accommodate all points of view help avoid confrontation and possible litigation (AAP, 2000). This recommendation stands today as sage advice for school administrators and school nurses.

The [New Jersey Hospital Association DNR Guidelines](#) provide information on out-of-hospital DNR orders and how to obtain a DNR bracelet recognized by EMS providers.

Applicable Laws and Regulations

N.J. A.C. 6A:16-1.3 – Do Not Resuscitate Orders

A Do Not Resuscitate order or DNR order is a written directive signed by the parent or guardian of a student who, after consultation with the pediatrician and other advisors, declines emergency administration of cardiopulmonary resuscitation (CPR) and the use of an AED to the student.



Key Point

The NJDOE defines DNR orders addressing the use of CPR and AEDs but does not reference other palliative care issues that may arise.

N.J.A.C. 6A:16-2.1(a)3 – Policy and Procedural Requirements

Districts boards of education must develop policies and procedures for the review of DNR orders received from a student's parent or medical home.



Key Point

The regulations do not specify who conducts the "review." The school physician reviews reports and orders from the student's medical home and thus would be involved in "approving" any specific palliative care measures. An additional review by the school board's attorney is advised.



Additional Points for School Nursing Practice

The **Initiative for Pediatric Palliative Care** is a collaborative that includes children's hospitals, pediatric units, hospice, home care providers, and other nursing and medical associations to promote family centered care for children living with life-threatening conditions.

When this issue arises, the school nurse should educate school personnel about the difference between end-of-life issues versus routine or acute care issues that may still require medical management and attention.

The school nurse should educate personnel about ways to comfort the student, other students, and family members.

The student's emergency contacts must be kept current and include the parent/guardian, medical home or attending physician, and EMS providers.

School personnel need to understand cultural and religious issues related to the DNR order and how the actual event may impact students and school staff. The school district's crisis team should be informed when the DNR order is approved.

The school administrator and school nurse should designate, in advance, a place in the school where student and family privacy can be maintained.

The school administrator and school nurse should discuss, in advance, how the student's death will be addressed with students, staff, and the school community.

Preparing for Emergencies and Crisis

Topic: Drug Overdose: Administering Naloxone

Background and Rationale

Drug overdose deaths and opioid-involved deaths continue to increase with the majority of drug overdose deaths (more than six out of ten) involving an opioid (Rudd, et al. 2016). Since 1999, the number of overdose deaths involving opioids, including prescription opioids and heroin, quadrupled. From 2000 to 2015 more than 500,000 people died from drug overdoses while 91 Americans die every day from an opioid overdose (CDC, 2017). Opioids include illegal drugs such as heroin, as well as prescription medications used to treat pain such as morphine, codeine, methadone, oxycodone (OxyContin®, Percodan®, Percocet®), hydrocodone (Vicodin®, Lortab®, Norco®), fentanyl (Duragesic®, Fentora®), hydromorphone (Dilaudid®, Exalgo®), and buprenorphine (Subutex®, Suboxone®). Opioids bind to specific receptors in the brain, spinal cord, and gastrointestinal tract and minimize the body's perception of pain. However, stimulating the opioid receptors or "reward centers" in the brain can also trigger other systems of the body, such as those responsible for regulating mood, breathing, and blood pressure (SAMHSA, 2016).

The safe and effective management of opioid pain reliever (OPR) overdoses in schools should be included in the school's emergency preparedness and response plan. The

school nurse should provide leadership in all phases of emergency preparedness and response, including the management of drug-related emergencies in the school setting (NASN, 2015).

Opioid overdose-related deaths can be prevented when naloxone is administered in a timely manner. As a narcotic antagonist, naloxone displaces opiates from receptor sites in the brain and reverses respiratory depression that usually is the cause of overdose deaths. It is not effective in treating overdoses of benzodiazepines (such as Valium®, Xanax®, or Klonopin®), barbiturates (Seconal® or Fiorinal®), clonidine, Elavil®, GHB, or ketamine. It is also not effective in treating overdoses of stimulants such as cocaine and amphetamines (including methamphetamine and Ecstasy). However, if opioids are taken in combination with other sedatives or stimulants, naloxone may be helpful (SAMHSA, 2016).

The New Jersey Department of Human Services (NJ DHS) [Division of Mental Health and Addiction Services](#) developed a [Naloxone Fact Sheet](#) and other materials to assist with community-wide responses to the opioid epidemic. The NJDOH Office of Emergency Services developed a presentation, [EMS Response to an Opioid Overdose](#), to assist with training community emergency services providers.

At the national level, the Substance Abuse and Mental Health Services Administration (SAMHSA), working with the Association of State and Territorial Health Officials (ASTHO), developed an [Opioid Overdose Toolkit](#) and NASN developed a [Naloxone in Schools Toolkit](#). The toolkits may be useful when developing policy, protocols, and training.

Schools must anticipate and prepare for a variety of emergencies. A school nurse is often the first health professional responding to an emergency in the school setting. When administered quickly and effectively, naloxone has the potential to immediately restore breathing to a victim experiencing an opioid overdose.

Applicable Laws and Regulations

New Jersey P.L. 2013, c.46 — Overdose Prevention Act

The law states that a healthcare professional or pharmacist who, acting in good faith, directly or through a standing order, prescribes or dispenses an opioid antidote to a patient capable, in the judgment of the healthcare professional, of administering the opioid antidote in an emergency, shall not, as a result of the professional's acts or omissions, be subject to any criminal or civil liability, or any professional disciplinary action.

A healthcare professional prescribing or dispensing an opioid antidote to a patient shall ensure that the patient receives patient overdose information. This information shall include, but is not limited to: opioid overdose prevention and recognition; how to perform rescue breathing and resuscitation; opioid antidote dosage and administration; the importance of calling 911 emergency telephone service for assistance with an opioid overdose; and, care for an overdose victim after administration of the opioid antidote.



The law also affords immunity from arrest for use/simple possession offenses to the overdose victim, and to the person who sought medical assistance.

New Jersey P.L.1963, c.140 — Good Samaritan Law

The Good Samaritan Law encourages people to provide voluntarily emergency care to any person in need with the protection from law suits and criminal charges.



Key Point

Bills (S1830 and A542) were introduced during the 2018 legislative session and would require the NJDOE, in consultation with NJDHS and appropriate medical experts, to develop guidelines for school policies dealing with the emergency administration of opioid antidotes at school and during school-sponsored activities. To date, the bills have not been approved.

Key Point

*Pharmacies are permitted to dispense opioid antidotes without an individual prescription. The **NJDOH Naloxone Distribution and Training** provides information for medical practitioners and pharmacists.*

Additional Points for Nursing Practice

All New Jersey schools must develop emergency preparedness and response policies and procedures for suspected opioid overdose situations that include Naloxone administration. As first responders, school nurses have the education and knowledge needed to identify emergent situations, manage the emergency until relieved by EMS, communicate the assessment and interventions to EMS, and follow up with the healthcare provider.

Opioids in high doses can cause respiratory depression and death. An opioid overdose can be simply identified by a combination of three signs and symptoms referred to as the “opioid overdose triad” which includes pinpoint pupils, unconsciousness, and respiratory depression (WHO, 2014).

Naloxone displaces the opioid from the opioid receptor in the nervous system, leading to the lessening of respiratory depression and impending death. There are five essential steps for first responders:

1. Call for help. Dial 911.
2. Check for signs of opioid overdose.
3. Support breathing.
4. Administer Naloxone.
5. Monitor the response (SAMHSA, 2016).

Naloxone is approved by the FDA and has been used for decades by EMS personnel to reverse opioid overdose and resuscitate individuals who have overdosed on opioids. It can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection. The dose should be titrated to the smallest effective dose that maintains spontaneous normal respirations. The duration of effect of naloxone is 20 to 90 minutes, depending on the dose and route of administration and overdose symptoms. The goal of naloxone therapy is to restore adequate spontaneous breathing, but not necessarily complete arousal (SAMHSA, 2016).

Naloxone can be used in life-threatening opioid overdose circumstances in pregnant women. The FDA has approved injectable naloxone, intranasal naloxone (called Narcan® Nasal Spray), and a naloxone auto-injector (called Evzio®1). Naloxone kits include a syringe and naloxone ampules or vials or a prefilled naloxone syringe and a mucosal atomizer device to enable intranasal delivery. The Narcan Nasal Spray is a pre-filled, needle-free device that requires no assembly, which can deliver a single dose into one nostril. The Evzio auto-injector is injected into the outer thigh to deliver naloxone to the muscle (intramuscular) or under the skin (subcutaneous). Once turned on, the device provides verbal instruction to the user describing how to deliver the medication, similar to automated defibrillators (SAMHSA, 2016).

CDC Drug Overdose Data

Key Substance Use and Mental Health Indicators in the US: Results from the 2016 National Survey on Drug Use and Health

Preparing for Emergencies and Crisis

Topic: School Safety and Crisis Management

Background and Rationale

Over 1.3 million children attend New Jersey's PreK-12 schools. Parents/guardians have a reasonable expectation that their children will attend safe schools that are prepared to deal with any emergency that arises. However, schools are often ill-prepared to address natural disasters such as a dangerous flood, violent storm, or even an earthquake. In addition, today's schools must be prepared for man-made disasters such as hazardous waste spills, acts of terrorism, school shootings, and even pandemics.

Disasters can be especially traumatic for children and youth. The devastation to the child's home and community can be long-lasting and distressing. Because the entire community may be impacted, the child's sense of security and normalcy is severely affected. Immediate response efforts should emphasize teaching and reinforcing effective coping strategies, fostering supportive relationships, and helping children understand their reactions. The school nurse, as part of the school health team, is a critical part of this process. The school nurse has an important role helping students, staff, and families cope with devastation and tragedy. The National Association of School Psychologists (NASP) created [school safety and crisis resources](#) to help advance planning and policy



development (NASP, 2015). Many of these materials are applicable to a variety of situations.

New Jersey's schools must adopt a school safety and security plan that outlines proactive measures to protect the safety and security of all students and staff members. Each plan must be designed locally with the help of law enforcement, emergency management, public health officials, and all other key stakeholders. All plans must be reviewed and updated on an annual basis. These plans include procedures to respond to critical incidents including but not limited to bomb threats, fires, gas leaks, and active shooters. The format and content of school safety and security plans has been established by the Domestic Security Preparedness Task Force and the Commissioner of Education. The NJDOE Office of School Preparedness and Emergency Planning developed [School Security and Safety Resources](#) to assist with the development of school policies and procedures. The materials address issues such as cybersecurity, fire safety, and Zika planning and provide information on emergency go-kits.

In 2013, [The Guide for Developing High-Quality School Emergency Operations Plans](#) was developed by the federal government to address the myriad of issues facing schools today. It focuses on five key areas: prevention; protection; mitigation; response; and, recovery. The Guide outlines specific planning principles when developing a district and school plan.

- Leadership must support planning.
- District and school leaders use assessments to customize plans to the building level.
- All threats and hazards are considered.
- The functional needs of the whole school community are included. The "whole school community" includes children, individuals with disabilities and others with access and functional needs, those from religiously, racially, and ethnically diverse backgrounds, and people with limited English proficiency.
- All settings and all times are considered, including incidents that may occur during and outside the school day as well as on and off campus (e.g., sporting events, field trips).
- A collaborative process is used to create and revise the plan (FEMA, 2013).

The school health team, including the school nurse, should play an important part in developing the school safety and security plan. This process should also include the [school resource officer](#) (if one is employed) as well as law enforcement, community emergency services providers, community healthcare and social service providers, and others charged with protecting the community and its citizens.

Applicable Laws and Regulations

N.J.A.C. 6A:16-5.1 — School Safety and Security Plans

These regulations require the development of a comprehensive plan with accompanying procedures and mechanisms that is collaboratively developed in consultation with local law enforcement agencies, health and social services provider agencies, emergency management planners, and school and other community resources. The plans, procedures, and mechanisms are reviewed annually and updated as appropriate. The district board of education must disseminate to its employees a copy of the school safety and security plan and must be notified, in writing, of any updates or changes to the plan. Additionally, new district board of education employees must receive a copy of the school safety and security plan within 60 days of the effective date of their employment.

The district board of education must develop and provide an in-service training program for all district board of education employees to enable them to recognize and appropriately respond to safety and security concerns, including emergencies and crises, consistent with the district board of education's plans, procedures, and mechanisms. New employees must be trained within 60 days of the effective date of employment. The training program must be reviewed and updated annually, as appropriate.

N.J.S.A. 18A:41-1 — School Security Drill

A school security drill is an exercise, other than a fire drill, to practice procedures to respond to an emergency situation including, but not limited to, a non-fire evacuation, lockdown, or active shooter situation.

N.J.S.A. 18A:41-7 — Provision of Training on School Safety & Security

A local board of education and chief school administrator of a nonpublic school must ensure that all full-time teaching staff members in the district or nonpublic school are provided with training on school safety and security that includes instruction on school security drills and uses the drill guide and training materials available on the [NJDOE school security website](#). Each teaching staff member must be provided with the training within 60 days of the commencement of that staff member's employment.

N.J.S.A. 18A:41-1 — Fire and School Security Drills

Every principal of a school of two or more rooms, or of a school of one room when located above the first story of a building, must have at least one fire drill and one school security drill each month within the school hours, including any summer months during which the school is open for instructional programs, and must require all teachers of all schools, whether occupying buildings of one or more stories, to keep all doors and exits of their respective rooms and buildings unlocked during the school hours, except during an emergency lockdown or an emergency lockdown drill. Where school buildings have been provided with fire escapes, they are to be used by a part or all of the pupils performing every fire drill.



Additional Points for School Nursing Practice

It is important that all school personnel understand the **terminology** used during an emergency or crisis and fully understand their role when an event occurs.

The role of the school nurse in emergency management is to prevent or mitigate risk by identifying and reducing hazards in school, preparing for emergencies by developing plans for emergency responses, responding to emergencies, and working with the school and community to recover after a disaster or crisis (NASN, 2014).



Key Point:

Prevention is the best response to potential violence. This must start with the development of a school safety committee. Ideally, the school safety committee is part of the larger school health advisory committee that addresses all policies and procedures that impact the health and safety of the school community. However, if the district convenes a separate school safety committee, the school nurse and other members of the school health team should have prominent roles. If they are not included, they should advocate for a seat at the table.

The school nurse must ensure that the emergency response team is aware of the needs of students with significant health problems. For example, students who rely on electrical devices during the school day may need immediate attention during an electrical outage. Students with special needs may not be able to move without assistance or may not hear or see emergency announcements.

Make sure that all IHP/IEHPs are current and readily available for use during a crisis. Be sure necessary procedures are included as well as any potential need for medications, food, or special supplies.

Determine how to access electronic records if a power outage occurs. Be sure all electronic devices, such as lap top computers or cell phones, are fully charged daily.

A lockdown drill may be different from an evacuation drill. School nurses should have contingency plans for all possibilities.

In some districts, school nurses work at more than one school. When a community emergency occurs that restricts access or transportation to one or more school buildings in the district, (e.g., train derailment, flood, chemical spill), the school district should develop contingency plans to ensure access to emergency materials and information when a nurse is not able to be present at the scene. Planning for these “what-ifs” should include the school nurse and school physician as well as local police, fire, and EMS providers.

Students may be present in the health office at the time of a violent episode or active shooter situation and the school nurse is responsible for the students in the health office at that time. The school nurse, any support staff working in the health office, and substitute school nurses must know the layout of the office as well as any means of escape or areas to hide.

During a crisis, school nurses are often expected to render emergency first aid and triage injuries and may be asked to work with EMS to provide care. School nurses should prepare an emergency “Go-Bag” for use during a crisis. This should include a list of all students and staff, a list of those with health concerns, a medication list, a cell phone and important phone numbers, and a flashlight. The bag should also include first aid supplies to deal with potentially more serious injuries (Selekman & Melvin, 2017).

The school district should provide the school nurse with a list of school personnel who are licensed healthcare professionals, CPR/AED certified or EMS providers.

Responses to traumatic events are varied and psychological follow-up should be encouraged. The school nurse, as a member of the school’s crisis team, should work with counselors, psychologists, social workers, and community mental health providers to provide care and support to those impacted by the disaster or crisis.

Planning and preparation are the most important aspect of preventing tragic outcomes with regard to school safety and security. When prevention fails, the goal changes to mitigation. Development of simple and clear protocols may make all the difference.

For additional information, educational materials, and sample forms and policies, the CDC created [Caring for Children in a Disaster](#).

The CDC does extensive work in violence prevention. Here are three resources:

- [Violence Prevention](#)
- [Youth Violence Prevention](#)
- [Violence and Environmental Design](#)

NEA Healthy Futures developed the [School Crisis Guide](#).

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CHAPTER SEVEN: Documenting Care and Services

Topic: Mandated School Health Records

Background and Rationale



School health records have evolved. It is no longer sufficient to simply keep records of immunizations and screenings. The complex nature of children's health requires school nurses to develop and implement individualized plans of care requiring detailed information. School nurses must be prepared for emergencies, document changes, and confer with parents and healthcare providers to ensure conti-

nuity of care. The old saying, *If it's not documented, it wasn't done*, still applies. School nurses must adapt documentation systems to meet the needs of today's students and to ensure all legal parameters are met.

The laws and rules that govern documentation and confidentiality create a complex web that involves the rights of parents, students, school health staff, and other school personnel. Nursing standards of practice also apply and may be misunderstood by education professionals. Today's students, and the health issues they bring with them, require schools to develop data systems that inform care, provide current and accurate information, and maintain confidentiality. Electronic health records enable continuity of care but also create new privacy concerns.

N.J.A.C. 6A:32 defines a student record as information related to an individual student gathered within or outside the school district and maintained within the school district, regardless of the physical form in which it is maintained. Information recorded by certified school personnel solely as a memory aid and not for the use of a second party is excluded from this definition. The student health record is defined as documented information relevant to the health of the student to manage the routine and emergency care of the student while school is in session. New laws, however, require that schools address the needs of students during all kinds of school-sponsored activities, including those occurring at night, on weekends, and even during the summer. These new laws present documentation dilemmas as well.

Health records go beyond those required for every student. School nurses are expected to collect and analyze specific data, submit state reports, work with other school per-



sonnel to develop plans to address health emergencies, and develop action plans to address the myriad of health conditions presenting in today's schools. Technology presents a new set of issues for the school nurse, especially regarding access and confidentiality. As statewide data systems develop, school nurses must advance their technology skills and at the same time, deal with a myriad of requirements that preceded the use of technology. In addition, many school health requirements were established by law many years ago and have yet to be updated. The authority for children's health, and subsequently school health, falls across several state agencies. Finally, decisions about school management software are often made without considering the complex needs of school health services.

At the same time, state agencies have developed integrated systems to address complex health data and information. For example, the [New Jersey Immunization Information System \(NJIIIS\)](#) is an adjunct to official school health record systems implemented in many schools. It began operating in 1997 and contains over 2,895,143 demographic records of children whose parents have previously consented to participate in the system. Most children are already enrolled in the system through the Electronic Birth Certificate (EBC) record process. Each year approximately 80,000 more newborns are enrolled into the system.

Unfortunately, student health records have not reached this level of sophistication in New Jersey. The selection of student data systems remains a local issue and some of those systems do not "speak" to each other. While the required student health record, the Health History and Appraisal Form (A45), can be adapted for electronic use, some schools continue to use only a paper version. Thus, school nurses are constantly moving from a tech environment to a paper one, and back again.

Student health records provide a means for documenting and monitoring the continuing health status of each student and can be used to alert parents and educators to new, chronic, or unresolved problems that can affect the learning process. Documentation of health information is an expectation of professional school nursing practice. In 2017, NASN and ANA published the third edition of [School Nursing: Scope and Standards of Practice](#). Based on ANA's *Nursing: Scope and Standards of Practice* (2015) for all registered nurses, the School Nursing Standards are authoritative statements of the duties that school nurses should competently perform. NASN also addresses [school health documentation](#).

School nurses are responsible for the documentation, maintenance, and release of student health information. They must comply with restrictions for sharing information as required by federal and state statutes and regulations. Documentation in school nursing practice must promote high quality school nursing services, advance efficient and effective school health programs, and create a legal record of nursing services provided to students (Scott & Bubert, 2013). Other important objectives for health documentation include providing a historical record of care, facilitating care team communication, developing aggregated reports of student needs, supporting care planning and delegation, and describing emergency care planning (Johnson & Guthrie, 2012).

One of the primary roles of the certified school nurse is the development and implementation of the Individualized Healthcare Plan (IHP) and Individualized Emergency Healthcare Plan (IEHP). Asthma action plans and diabetes management plans are similar documents that outline the care necessary to manage a child's health condition while in school. NASN sees the [individualized healthcare plans](#) as an extension of the nursing process and a key role for the certified school nurse.

Health information in any form must be confidential, secure, accessible only by authorized staff, and protected from loss, alteration, or destruction. As an educational record, school health records must be transferrable to new school sites when a student progresses to other buildings within a district or moves outside of the district. Electronic student record systems should make this easier; however, New Jersey school districts are not required to use the same student data management system. Nonetheless, there are numerous benefits to using electronic health systems software, including time and space savings; efficient data management; analysis of student health data; continuity of care; and the ability to access, aggregate, and report school health office data quickly and easily. However, these benefits require the local school district to adopt and implement policies and practices that assure accuracy and confidentiality in the storage, maintenance, and transfer of student health information. NASN believes that the use of [electronic health records](#) (EHRs) helps school nurses provide efficient and effective care. Electronic health records allow schools to integrate health and educational data to help identify students at risk for poor health or academic struggles.

Dealing with confidentiality laws and regulations that may seem contradictory can be a challenge. NASN provides background and resources on [HIPAA and FERPA](#). Understanding these two laws is critical to any collaboration between public health and education. ASTHO created a [toolkit](#) to help public health agencies and schools work as partners in protecting children and adolescents from health threats. Sharing data between schools and public health agencies is an important part of this collaboration. ASTHO also provides a [HIPAA and FERPA comparison chart](#).

Documentation on school health records must be clear and accurate. Unlike some states, New Jersey does not yet have formally adopted codes and abbreviations for use with paper or electronic student health records. Documentation must include information on school nurse interventions and student responses and school nurses should use accepted nursing nomenclature and abbreviations. Medical abbreviations should be consistent with nursing/medical nursing languages, terms, and descriptions. Documentation should be consistent with nursing standards using nursing/medical terms as appropriate (Wolfe, 2017). School nurses must constantly speak two languages—education and health—and know when each is appropriate and required.

In addition to mandated student health records, school nurses are expected to complete numerous forms and reports such as immunization or TB reports. School nurses are also responsible for the development and implementation of an IHP/IEHP or 504 plan for a student with health issues such as allergies, diabetes, or asthma. Additionally, the school nurse and the school physician must be involved with the development of the district's



nursing services plan. The nursing services plan addresses the nursing services to be provided throughout the school district based on the needs of its students, potential emergency situations, basic nursing services requirements, and the assignment of medical staff to provide the services. This requires an understanding of student health issues and the care that is needed as outlined in a student's IHP, IEHP, 504 plan or IEP. The nursing services plan makes visible the care required and needed and the school health services staffing across district schools to deliver that care.

Applicable Laws and Regulations

N.J.A.C 6A:32-7 – Student Records

These regulations specifically address all student records including health records. The rules address access to student records, confidentiality, and information contained in a school contact directory. District boards of education are required to compile and maintain student records and regulate access, disclosure, or communication of information contained in educational records in a manner that assures the security of such records.

These regulations state that access to and disclosure of a student health record shall meet the requirements of the [Family Education Rights and Privacy Act, 34 C.F.R. Part 99 \(FERPA\)](#).

Federal laws addressing access to health services for students with disabilities include the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) and [Section 504 of the Rehabilitation Act \(1973\)](#) as amended through the [Americans with Disabilities Amendment Act \[ADAA\] in 2008](#). The USDE developed a [Section 504 FAQ](#) that provides useful information.

N.J.A.C. 6A:32-7.5 – Access to Student Health Records



Key Point

These regulations state that only authorized organizations, agencies or persons as defined in this section shall have access to student records, including student health records.

Each district board of education shall control access to, disclosure of, and communication regarding information contained in student health records to assure access only to people permitted by Federal and State statute and regulations. Authorized organizations, agencies, and persons shall include only the following:

- A student who has the written permission of a parent and the parent of a student under the age of 18 whether the child resides with the parent, except per N.J.S.A. 9:2-4; The place of residence shall not be disclosed and access shall not be provided if denied by a court;
- Students at least 16 years of age who are terminating their education in the school district because they will graduate secondary school at the end of the term or no longer plan to continue their education;

- An adult student and parent who has the written permission of an adult student, except that the parent shall have access without consent of the student as long as the student is financially dependent on the parent and enrolled in the public school system or if the student has been declared legally incompetent by a court of appropriate jurisdiction. The parent of the financially dependent adult student may not disclose information contained in the adult student's record to a second or third party without the consent of the adult student;
- Certified educational personnel who have assigned educational responsibility for the student and who are employed by agencies listed below shall have access to the general student record but not to the student health record except under conditions permitted in N.J.A.C. 6A:16-2.4:
- An approved private school for the disabled;
- A State facility;
- Accredited nonpublic schools in which students with educational disabilities have been placed according to N.J.S.A. 18A:46-14; or,
- Clinics and agencies approved by the NJDOE.

To fulfill its legal responsibility, a district board of education shall have access through the chief school administrator or his or her designee to information contained in a student's record. Information shall be discussed in executive session unless otherwise requested by the parent or adult student.

Secretarial and clerical personnel under the direct supervision of certified school personnel shall be permitted access to portions of the record to the extent necessary for the entry and recording of data and the conducting of routine clerical tasks. Access shall be limited only to student files in which such staff are directed to enter or record information, and shall cease when the specific assigned task is completed.



Key Point

Nothing in this section shall be construed to prohibit school personnel from disclosing information contained in the student health record to students or adults in connection with an emergency, if such knowledge is necessary to protect the immediate health or safety of the student or other persons.

N.J.S.A. 18A:40-4 – Records of Medical Examinations and Screenings

This law requires school districts to keep a record of the results of required medical examinations and screenings. The student health record is the property of the board of education and must be forwarded to any public school to which the pupil is transferred, if such school is known.



N.J.A.C. 6A:16-2.4 (a) – Content of Health Records

These rules require each school district to maintain a health record for each student that includes the findings of health histories, medical examinations, and health screenings as well as documentation of immunizations against communicable diseases or exemption from these immunizations.

N.J.A.C. 6A:16-2.4(b) – Confidentiality and Consent

These rules address confidentiality and informed consent regarding students with HIV/AIDS and substance abuse issues.

N.J.A.C. 6A: 16-2.4 (d) – Access to Records

These rules require the school district to provide access to the student health record to licensed medical personnel not holding educational certification who are working under contract with or as employees of the school district only to the extent necessary to enable the licensed medical personnel to perform his or her duties. It also allows secretarial or clerical personnel under the supervision of the certified school nurse to access portions of the student health record necessary for entry and recording of data and for conducting routine clerical tasks.

N.J.A.C. 6A:16-2.1(a)10 – Individualized Healthcare Plans

The individualized emergency healthcare plan (IEHP) is defined in code as a plan written by the certified school nurse that specifies the delivery of healthcare accommodations and services needed by a student in the event of an emergency. These rules require the development of an IHP/IEHP for students with chronic medical conditions, including diabetes, asthma, and life-threatening allergies, requiring special health services.

N.J.A.C. 6A:16-2.4(b)3iii – Maintaining Records

These regulations state that the school nurse is responsible for maintaining student health records.

N.J.A.C. 6A:2.3(b)3xii-xiii – Individualized Healthcare Plans

The school nurse is required to write and update, at least annually, the IHP/IEHP for students' medical needs, and instructing staff as appropriate. The school nurse is also required to write and update, at least annually, any written healthcare provisions required under Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a), for any student who requires them.

N.J.A.C. 6A:32-7.4 – Maintenance and Security of Student Records

The chief school administrator or designee is responsible for the security of student records maintained in the school district and for the development of procedures for assuring that access to such records is limited to authorized persons. School districts may store all documents either electronically or in paper format.

Student health records, whether stored on paper or electronically, must be maintained separately from other student records, until such time as graduation or termination

whereupon the health history and immunization record shall be removed from the student's health record and placed in the student's mandated record.

This section also addresses authorized organizations, agencies, and persons who may have access to student records.

N.J.A.C. 6A:32.7.4(e) – Maintenance of Records

The New Jersey public school district of last enrollment, graduation, or permanent departure of the student from the school district shall keep for 100 years a mandated record of a student's name, date of birth, name of parents, gender, health history and immunization, standardized assessment results, grades, attendance, classes attended, grade level completed, year completed, and years of attendance.

N.J.A.C. 6A:32-7.4(f) – Emergency Information

Nothing in this section shall be construed to prohibit school personnel from disclosing to students or adults in connection with an emergency the information contained in the student health record if the release is necessary to protect the immediate health or safety of the student or other persons.

N.J.A.C. 6A:32.7.8(a) – Records Retention

A student record is considered to be incomplete and not subject to the provisions of the Destruction of Public Records Law, N.J.S.A.47:3-15 et seq., while the student is enrolled in the school district. The school district shall retain the student health record and the health history and immunization record according to the school district records retention schedule as determined by the New Jersey State Records Committee.

Records Retention

Student Records Retention

School Records Retention

N.J.A.C. 8:57-4.7 – Records Required

This section requires schools to maintain an official State of New Jersey Immunization Record for every pupil that include the date of each immunization. The immunization record shall be separated from the child's educational record and other medical records for the purpose of the immunization record audit. Any computer-generated document or list shall be considered a supplement to, and not a replacement for, the official New Jersey Immunization Record.



Key Point

The official immunization records referenced above include the Health History and Appraisal Form A-45 (available online for printing) or the Standard School/Child Care Center Immunization Record Form IMM-8 (available by calling the NJDOH at 609-826-4861).



If a child withdraws, is promoted, or transfers to another school, the immunization record or certified copy along with any statements pertaining to exemptions shall be sent to the new school or shall be given to the parent or guardian upon request, within 24 hours of such a request. When a child graduates from secondary school, the immunization record or certified copy shall be sent to an institution of higher education or given to the parent or guardian, upon request.

Additional reporting requirements for the NJDOH can be found in Chapter Four of this manual.

N.J.A.C. 6A:16-2.1(b) – Nursing Services Plan

The NJDOE defines the nursing services plan as a plan that describes in detail the nursing services to be provided throughout the school district based on the needs of its students, potential emergency situations, basic nursing services requirements, and the assignment of medical staff to provide the services. Each district board of education is required to annually adopt the school district's nursing services plan at a regular meeting. The regulations also require the school physician to consult with the school district certified school nurse(s) to obtain input for the development of the school nursing services plan.

N.J.A.C. 6A:16-2.1(a)4viii – Cardiac Action Plan

This requires the school district to establish and implement an emergency action plan for responding to a sudden cardiac event, including the use of an AED. Details of this requirement can be found in Chapter Six of this document.

Additional Points for School Nursing Practice

Use of the [New Jersey Health History and Appraisal form \(A-45\)](#) is mandated. The NJDOE also includes other [Student Health Forms](#) on its website. The A-45 is periodically updated by the NJDOE and NJDOH to reflect new requirements.

In choosing an electronic medical records system for the health office, school nurses should review NASN's [Selection of Electronic Documentation System for School Health](#).



Key Point

If the health office still uses a daily log, it is simply a sign-in sheet. It is evidence that a student visited the health office. Students should not be asked to record on this sheet the reason for their visit as this is a breach of confidentiality.

Key Point

Asking students to disclose their chief complaint or health information in the presence of other students is a breach of confidentiality.



Key Point

Care delivered to a student must be documented on the student's health record which is maintained in the student's health folder. Documentation on the health record requires the same standards of practice as required by the state Nurse Practice Act and must be handled as privileged information.

School nurses can ensure that confidentiality is respected by revealing only necessary health concerns, and only to those individuals whose knowledge may affect the student's health. FERPA makes it clear that school officials with legitimate educational interests may be given access to personally identifiable information about students. In New Jersey "school official" means a person employed by the school district in an academic, administrative, or support role, or a person employed by or under contract to the district to perform a specific task. A school official is determined to have "legitimate educational interest" if the information requested is (1) necessary for that official to perform appropriate tasks that are specified in his or her position description or by a contract agreement; (2) used within the context of official agency or school business and not for purposes extraneous to the official's areas of responsibility or to the agency or school; and (3) consistent with the purposes for which the data are maintained. School officials do not have the authority to share this information with anyone not given access to the information.

Nothing in FERPA prohibits a school from disclosing information in aggregate or in another form that is not personally identifiable. Personally identifiable information includes:

- The student's name;
- The name of the student's parent or other family member;
- The address of the student or student's family;
- A personal identifier, such as the student's social security number or student number;
- A list of personal characteristics that would make the student's identity easily traceable; and,
- Other information that would make the student's identity easily traceable.
- School nurses should become familiar with the requirements set forth in [FERPA](#).



Key Point

Sharing a school-wide health concerns list with personal identifiers violates FERPA and is not considered best practice.



Certain school personnel may need information about a student's health condition in order to respond appropriately to symptoms or problems. These students must have an IHP or IEHP that lists the potential symptoms and the required response to those symptoms. The school nurse works with the student's parents to determine which school personnel should be specifically informed about the child's medical issues. This is best accomplished in the privacy of the health office where school staff can ask questions to help them better understand the child's condition and their potential responses.

The school nurse should provide general information (not student-specific) to all school personnel about health issues and conditions that may require emergency care.

Substitute personnel, including but not limited to nurses, teachers, and paraprofessionals, may need generic information about student health issues and specific information as necessary for emergency care as outlined in the child's IHP/IEHP or 504 plan.

Personally identifiable student health information must be protected and kept confidential through all methods of transmission. This includes phone conversations, paper, email, faxes, school data software, and electronic communications. This may be difficult when the school nurse does not have a dedicated private space for conversations or a dedicated fax machine. All school personnel, including school administrators, need to understand that health information is confidential.



Key Point

The school nurse must work with the district information technology department to assure that student health information is password protected so that non-nursing staff cannot access the information. Do not assume that the district technology staff understand the legal implications of this issue.

The nursing services plan was created to assist school districts to determine appropriate staffing levels for school health services. There is no required due date for the plan; however, it must be presented to local board of education for approval. School nurses play an important role in collecting and analyzing data that can be used to develop and support the plan. It is incumbent upon the school nurse to educate administrators about acuity levels (e.g., medically fragile, medically complex). It is also important to address how attending to the needs of students with chronic health conditions might impact health programs and services for all students in the school and district. The school nurse must ensure that all students who have chronic health conditions have an IHP and and IEHP, as appropriate.



Key Point

New Jersey does not have a standardized form or coding system to determine acuity levels; therefore, each local school district develops its own process and form for the nursing services plan.

The [American School Counselor Association FAQ](#) provides additional perspective on the concept of confidentiality in the school setting.

Common Medical Abbreviations and Acronyms

References

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CHAPTER EIGHT: Supporting Students with Special Learning Needs

Topic: The School Nurse and Special Education

Background and Rationale



Children and youth with special learning needs require the coordination of many disciplines in order to ensure they receive educational programs and services that meet their needs. The school nurse plays an important role as part of this multi-disciplinary approach to identify students in need and provide them with appropriate accommodations to help them learn.

This chapter provides an overview of

federal and state special education requirements, and is limited to the role of the school nurse in the identification, evaluation, and intervention process.

The USED plays a major role in the oversight and funding of programs and services for students with disabilities. The Individuals with Disabilities Education Act (IDEA), enacted in 1975, requires that students ages 3-21 be provided a free and appropriate public school education in the least restrictive environment. IDEA governs how states and public agencies provide early intervention, special education, and related services to more than 6.5 million eligible infants, toddlers, children, and youth with disabilities. Children and youth ages three through 21 receive special education and related services under IDEA Part B. IDEA authorizes formula grants to states to support special education and related services and early intervention services and discretionary grants to state educational agencies, institutions of higher education, and other nonprofit organizations to support research, demonstrations, technical assistance and dissemination, technology development, personnel preparation and development, and parent-training and information centers.

Congress reauthorized IDEA in 2004 and most recently amended IDEA through Public Law 114-95, the Every Student Succeeds Act (ESSA) in December 2015 (ED, 2017) stating: “Improving educational results for children with disabilities is an essential element of our national policy of ensuring equality of opportunity, full participation, independent living, and economic self-sufficiency for individuals with disabilities” (ED, 2017). IDEA provides eligible students with specially designed instruction and related services. Congress amended the related services list to clearly delineate between school health



services and school nursing services. School nursing services must be provided by a “qualified school nurse.”

A student may qualify for special education services under any one of 13 federally defined disability categories. The disability categories are defined in detail in [Chapter 14](#) of New Jersey Administrative Code and summarized in the chart below.

Students may qualify for special education services under any one of 13 federally defined disability categories:	
1.	A specific learning disability (SLD) includes learning issues that affect a child’s ability to read, write, listen, speak, reason or do math.
2.	An other health impairment covers conditions that limit a child’s strength, energy or alertness.
3.	Autism Spectrum Disorder (ASD) is a developmental disability that affects a child’s social and communication skills and behavior.
4.	An emotional disturbance may include anxiety disorder, schizophrenia, bipolar disorder, obsessive-compulsive disorder and depression.
5.	A speech or language impairment includes communication problems such as stuttering, impaired articulation, language impairment or voice impairment.
6.	A visual impairment includes both partial sight and blindness.
7.	Deafness is severe hearing impairment. Students are unable to process language through hearing.
8.	A hearing impairment includes hearing loss not covered by the definition of deafness. This type of loss can change or fluctuate over time.
9.	Deaf-blindness includes both hearing and visual impairments.
10.	An orthopedic impairment is defined as any impairment to a child’s body, no matter what the cause.
11.	Intellectual disability is defined as having below-average intellectual ability and may include poor communication, self-care and social skills.
12.	A traumatic brain injury is caused by an accident or some kind of physical force.
13.	Multiple disabilities means that a student has more than one condition covered by IDEA.

Chapter 14 defines the child study team (CST) as a school psychologist, a learning disabilities teacher-consultant, and a school social worker. School nurses are considered specialists in the area of disability and may be asked to assist with the process. The team is charged with developing the individualized education program (IEP), a written plan that details those individually designed instructional activities and related services necessary to achieve specific goals and objectives. A case manager coordinates the development, monitoring, and evaluation of the IEP. The case manager facilitates communication be-

tween home and school and coordinates the annual review and reevaluation process. The school nurse may be called upon to assist the case manager to understand medical or health issues or communications (NJDOE, 2017).

The [New Jersey Tiered System of Support](#) (NJTSS) is a framework of academic and behavioral supports and interventions to improve student achievement based on the core components of multi-tiered systems of supports (MTSS) and the three-tier prevention logic of Response to Intervention (RTI). With a foundation of strong district and school leadership, a positive school culture and climate, and family and community engagement, NJTSS builds upon intervention and referral services (I&RS) and gives schools a structure to meet the academic, behavioral, health, enrichment, and social-emotional needs of all students (NJDOE, 2014). District boards of education are required to implement in each school building in which general education students are served a coordinated system for planning and delivering intervention and referral services. I&RS helps school staff and parents address learning, behavior, and health problems using a collaborative team-based approach that focuses on early identification and intervention. However, I&RS is not part of the special education evaluation process. Students do not have to be evaluated by the I&RS committee first before being referred to the CST for evaluation.



Key Point

*In February 2014, the New Jersey State Board of Education re-adopted N.J.A.C. 6A:16, with amendment to the regulations at N.J.A.C. 6A:16-8 that establish intervention and referral services (I&RS) and outline the functions of this system in each school building. The I&RS manual is being updated to reflect these changes and will be posted to this **website** upon completion.*

The USED's Office for Civil Rights (OCR) does not enforce IDEA; however, OCR does enforce the Rehabilitation Act of 1973, Section 504 and Americans with Disabilities Act of 1990, Title II rights of IDEA-eligible students with disabilities (ED, 2017). Section 504 requires certain legal mandates that address the health needs of students. Further, the law mandates that students be assessed by qualified individuals in any areas that may impact learning.

Both IDEA and Section 504 have significant implications for school nursing as a profession and for students and their families. Students may have a disability that impacts learning but does not meet the criteria for eligibility under the IDEA. Those students may be eligible for services under [Section 504](#) of the Rehabilitation Act of 1973. A student who qualifies for a 504 plan has the right to extra protections against discrimination at school based on the identified disability. Thus, the student is entitled to accommodations within the general curriculum. Students are eligible for Section 504 protection if they have a physical or mental impairment that substantially limits one or more major life activities or if they have a record of, or are regarded as, having such impairment. School is considered a major life activity. However, learning is not the only major life activity to be considered in determining a student's eligibility for protection under Section 504. For



example, if a condition such as asthma substantially limits another major life activity of a student, s/he may be eligible for services under Section 504 (ED, 2015).

New Jersey school districts are required to convene a multidisciplinary team to evaluate the student and determine eligibility for [Section 504](#). It is highly recommended that the school nurse be part of the team. Once the student's eligibility is determined, the team must develop and implement a Section 504 accommodation plan which describes the nature of the student's disability and the major life activity it limits. Additional information can be found on the NJDOE's webpage dedicated to [Section 504](#).

One of the most important roles for the school nurse is the development of an IHP/IEHP for students with special healthcare needs. In addition, the school nurse is uniquely qualified to help child study team members and parents better understand medical evaluations and issues. The student has a right to a nondiscriminatory comprehensive evaluation by a qualified professional. The school nurse may be the only school employee with knowledge of medical terminology, testing, diagnosis, and treatment.

Medically fragile students may require clinical nursing services in order to attend school. These students may require 1:1 nursing care that requires a constant presence on the school bus, in the classroom, and at all school activities. The school nurse is charged with delivering school health services for the entire school population and cannot provide intensive services to one student, all day. New Jersey law (see below for more detail) clarifies this by defining medically fragile and clinical nursing services.

School nurses should also be aware of the Special Education Medicaid Initiative (SEMI) and Medicaid Administrative Claiming (MAC), both school-based federal Medicaid Title XIX reimbursement programs. The purpose of the [SEMI and MAC](#) programs is to recover a portion of costs for certain Medicaid covered services or activities provided to Medicaid-eligible students enrolled in participating New Jersey local education agencies, ages 3-21. The SEMI and MAC [handbook](#) was recently updated.

Another program, [Early and Periodic Screening, Diagnostic and Treatment \(EPSDT\)](#), provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The Department of Children and Families (NJDCF) oversees the [EPSDT](#) program in New Jersey. The program is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental services.

- Early means assessing and identifying problems early;
- Periodic means checking children's health at periodic, age-appropriate intervals;
- Screening means providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems;
- Diagnostic means performing diagnostic tests to follow up when a risk is identified; and,
- Treatment means control, correct, or reduce any health problems found.

Applicable Laws and Regulations

The [New Jersey Special Education Regulations: N.J.A.C. 6A:14](#) are based on federal requirements and should be reviewed in their entirety. Key areas for school nurses are summarized below.

N.J.A.C. 6A:14-3.1(c) – Specialists

Specialists in the area of disability include, but are not be limited to, child study team members, as well as speech-language specialists, occupational therapists, physical therapists, audiologists, school nurses, advance practice nurses, and physicians who are appropriately certified and/or licensed to carry out activities under this chapter. Where an educational certificate and a license are required to carry out activities under this chapter, the professional shall be appropriately certified and licensed.

N.J.A.C. 6A:14-3.3(g) & (h) – Audiometric Screening Required

These rules require an audiometric screening and a vision screening for every student referred to the child study team for a special education evaluation.

N.J.A.C. 6A:14-3.4(a)1 – Comprehensive Child Study Examination

N.J.A.C. 6A:14-3.4(j)

This section describes the school nurse's role in the identification of students with disabilities. The comprehensive child study evaluation uses cognitive, behavioral, physical, and developmental data to determine how best to provide a student with educational programs and services in the least restrictive environment. School nurses deliver "related services" as defined by IDEA.

Upon receipt of a written referral to the child study team, the school nurse shall review and summarize available health and medical information regarding the student and shall transmit the summary to the child study team for the meeting, so it can consider the need for a health appraisal or specialized medical evaluation.

N.J.A.C. 6A:14-3.5(c) – Disabilities Defined

This section defines the disabilities eligible for services.

N.J.A.C. 6A:14-3.9(a) – Related Services

This section defines related services as including, but not limited to, counseling, occupational therapy, physical therapy, school nursing services, recreation, social work services, medical services, and speech-language services.

N.J.A.C. 6A:14-3.9(a) 8 & 9 – Nursing Services as a Related Services

Nursing services shall be provided as a related service only to the extent such services are designed to enable a child with a disability to receive a free, appropriate public education as described in the individualized education program of the child. Medical services shall be provided as a related service for diagnostic and evaluation purposes only.



N.J.S.A. 18A:40-3.2 – Clinical Nursing Services for Medically Fragile Students

This law states that school nursing is a separate and distinct specialty within the nursing and educational professions and that competence in specified areas of health and education is needed in order for school nurses to act as health advocates for school-age children. It specifically addresses the needs of “medically fragile students” who require clinical nursing services.

The law states that medically fragile students are often diagnosed with medical conditions and life-threatening diseases, including cerebral palsy, seizure disorder, and other neurological diseases that require mechanical ventilation and emergent intervention by providers of clinical nursing services while attending school. Medically fragile students who require clinical nursing services while attending school should expect and receive the same level of care they receive at home. Maintaining a continuity of care for medically fragile students creates a safer environment at school, fosters learning, and gives parents confidence that their children’s medical needs are being met by qualified health care providers. Currently, there are no standards of practice in place for providers of clinical nursing services. As a result, the quality of care medically fragile students receive in school is often inadequate to meet their health care needs. Therefore, it is in the public interest that, in order to guarantee the health and safety of medically fragile students while attending school, providers of clinical nursing services for such students meet the same qualifications as providers of clinical nursing services certified to participate in the State’s Medicaid and NJ FamilyCare programs, and that parents should be given the option to choose the provider who will render clinical nursing services to their children while attending school, if the cost remains neutral to the school district.



Key Point

The law reiterates that nursing services provided in the public schools must be delivered by an individual 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.

Special education students and those with medical needs requiring specialized care shall have that care rendered by an appropriate provider as appointed by the State Board of Education. No person shall be issued such certificate unless the person is licensed as a registered nurse pursuant to the provisions of P.L.1947, c.262 (C.45:11-23 et seq.) and meets all of the requirements prescribed by the board for a nursing endorsement. A school district may supplement the services provided by the certified school nurse with non-certified nurses, provided that the non-certified nurse is assigned to the same school building or school complex as the certified school nurse.

A medically fragile student requiring clinical nursing services shall have those services rendered by a provider of clinical nursing services as defined in this subsection. Nothing in this section shall be construed to exclude a licensed healthcare service firm that is ap-

proved to provide private duty nursing under the Medicaid Program and is in compliance with State Board of Education regulations. The parent or legal guardian of a medically fragile student shall have the option to choose a provider to render clinical nursing services to the student, and the State Board of Education shall allow the provider chosen by the parent or legal guardian to render such services to the student only if the cost to the school district remains neutral.

The law defines the following:

- A medically fragile student is a school-aged child who suffers from a life-threatening medical condition, and as a result of such condition, requires more individualized and continuous care than is available from a school nurse.
- Clinical nursing services are specific health care services, based on a medically fragile student's individualized education plan and a physician's or advanced practice nurse's orders, as provided by a registered nurse or licensed practical nurse with specialized pediatric training who attends to the student.
- A provider of clinical nursing services is an agency that renders clinical nursing services and is approved to provide private duty nursing under the Medicaid program pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.) or the NJ FamilyCare Program pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

N.J.A.C. 6A:16-8 – Intervention and Referral Services

These rules require district boards of education to establish and implement in each school building in which general education students are served a coordinated system for planning and delivering intervention and referral services designed to assist students who are experiencing learning, behavior, or health difficulties, and to assist staff who have difficulties in addressing students' learning, behavior, or health needs.

Additional Points for School Nursing Practice

The Statewide Parent Advocacy Network (SPAN) developed an [Overview of IDEA and 504](#) that provides basic information on federal and state requirements.

School nurses may find the [NASN Section 504 and IDEA](#) paper helpful.

Kids Health by Nemours provides an overview of [504 plans](#) and [IEPs](#) for parents.

The school nurse should establish a relationship with the child's parents, and as appropriate, the child's medical home. The school nurse can become a consistent source of information and support during the evaluation process.

The school nurse retains responsibility for ensuring that all students, including those who are medically fragile and receiving specialized nursing care, are in compliance with required immunizations and any other public health requirements. The school nurse must work closely with the assigned provider to ensure that care is appropriately documented and included as part of the student's health record. The school nurse should inform the



nurse providing specialized services about school policies regarding infection control, communicable disease reporting, and confidentiality.

During the CST evaluation process, the school nurse collects subjective health information by conducting a complete health history review. This should include the student and parents as well as the educational staff's perceptions about how the student's health impacts learning. As requested, the school nurse coordinates a medical examination by the child's medical home or the school physician and summarizes the medical information and other pertinent health data. The school nurse should describe any anticipated health services or potential health outcomes.

The student must have an IEP in order for the district to receive reimbursement through SEMI. The services must be included in the student's IEP. Changes to the IEP require a meeting of the CST. The school nurse may be responsible for calculating and submitting hours and services to the district financial office for district reimbursement. Evidence of services administered to the student must be documented on the student's health record, form A-45. Records of cost recovery attempts are retained by the school district.



Key Point

School districts that participate in Medicaid-based programs must maintain all service and financial records, supporting documents, and other recipient records relating to the delivery of services reimbursed by Medicaid for at least seven (7) years from the date of service. Parental consent forms must also be maintained in the district for at least seven years after a student has withdrawn from the district. All records must be retrievable and made available upon audit

For students with disabilities transitioning from high school to community, preparations must start by age 16. The school nurse can teach functional skills such as taking medications or reporting asthma symptoms to an employer.

The school nurse should document that a 504 Plan is in effect. The IHP/IEHP and the 504 Plan should align.

Students identified as eligible for services under IDEA may be enrolled in a special class or program in another school district or in a special education program in a receiving school, including educational services commissions; jointure commissions; regional day schools; county special services school districts; the Marie H. Katzenbach School for the Deaf; approved private schools for the disabled that may or may not provide residential services; and, public colleges that have programs for students with disabilities.

Records of all out-of-district special education placements must be retained by the resident school district. Upon admission to an out-of-district program, a copy of the form A-45 must be sent to the receiving school. When out-of-district placement is terminated, form A-45 must be returned to the resident school.

Student Transportation

Transportation is considered a related service under IDEA and may include:

- Travel to and from school;
- Travel between schools;
- Travel in and around school buildings; and/or,
- Specialized equipment (such as special or adaptive buses, lifts, ramps), if required to provide transportation to special education for a child with a disability.

The school nurse, in collaboration with the CST, must communicate the needs of the student and assist with necessary training and/or education for transportation staff relevant to the student's care. The student's IHP/IEHP should detail any accommodations or health and safety issues related to the student's health condition that must be addressed during transportation.

When planning transportation for students with disabilities, the school district should consider the following questions:

- Can the student be safely transported, given the transportation environment (including the length of the ride), without undue risk to the student or others?
- Are there any medical, health, physical, or behavioral concerns that may expose the student to unreasonable risk, given the anticipated transportation environment?
- Can assistive or adaptive equipment identified as necessary to accommodate the student during the transportation process be safely secured and transported, and are adequate instructions available regarding its use?
- Will the necessary transportation services (such as the length of ride) impact on the student's ability to benefit from the planned program?
- Are there any questions regarding the safe and appropriate use of assistive or adaptive equipment (including mobile seating devices, ventilators, or oxygen equipment)?
- Is an attendant or other qualified personnel required and available?
- Is a responsible adult available for pick-up and delivery of the student?
- How will medication be transported between home and school? Will the student require the administration of any routine or emergency medications during transport?
- How will the school district handle transportation during inclement weather?
- If the child has specialized equipment, who has been trained and is authorized to operate it?



The NJDOE outlines [Training Requirements for School Bus Drivers and Bus Aides](#) and [transportation training for students with special needs](#). The school nurse may be responsible for training school bus drivers and ancillary personnel about emergency responses, blood borne pathogens, and first aid. Some school districts require bus drivers to be certified in CPR. Student-specific information should be shared with permission of the student's parents and only to ensure the child's safety.

Supporting Students with Special Needs

Topic: Home Instruction

Background and Rationale

The NJDOE defines home instruction (sometimes called homebound instruction) as the provision of one-to-one or small group instruction in the student's place of residence or other appropriate setting due to a health condition, need for treatment, court order, or exclusion from general education for disciplinary or safety reasons. Home instruction refers to the public school's obligation to provide educational programming in the home to students who are absent from class due to a serious health condition or who have been placed on homebound instruction based upon an individualized assessment of a disability. Home instruction is unrelated to "home schooling," which refers to the option parents have to provide educational programming for their children at home (NJDOE, 2014).

Applicable Laws and Regulations

N.J.A.C. 6A:16-10.1 – Home Instruction Due to Chronic Health Condition

The district board of education is required to provide instructional services to an enrolled student, whether a general education student in kindergarten through grade 12 or special education student age three to 21, when the student is confined to the home or another out-of-school setting due to a temporary or chronic health condition or a need for treatment that precludes participation in their usual education setting, whether general education or special education.

To request home instruction due to a temporary or chronic health condition, the parent/guardian must submit to the school district a request that includes a written determination from the student's physician documenting the projected need for confinement at the student's residence or other treatment setting for more than 10 consecutive school days or 20 cumulative school days during the school year.

The school district forwards the written determination to the school physician. The school physician may contact the student's physician to secure additional information concerning the student's diagnosis or need for treatment, and either verifies the need for home instruction or provides the district board of education reasons for denial.

The school district notifies the parent/guardian concerning the school physician's verification or reasons for denial within five school days after receipt of the written determination by the student's physician.

Once eligibility is verified, the school district must provide instructional services within five school days after receipt of the school physician's verification or, if verification is made prior to the student's confinement, during the first week of the student's confinement to the home or out-of-school setting.

The school district is responsible for the costs of providing instruction in the home or out-of-school setting either directly, through online services including any needed equipment, or through contract with another district board of education, educational services commission, jointure commission, or approved clinic or agency.

Home or out-of-school instruction must meet specific instructional standards to ensure student progress. For a student with disabilities, the home instruction must be consistent with the student's IEP. For a general education student, when the provision of home instruction will exceed 60 calendar days, the school physician shall refer the student to the child study team for evaluation.

During all periods of instruction delivered in a student's home, the student's parent or other adult who has been designated by the parent must be present.

N.J.A.C. 6A:16-10.2 – Home or Out-of-School Instruction for Reasons Other than a Temporary or Chronic Health Condition

The district board of education shall provide instructional services to an enrolled general education student at the student's home or other suitable out-of-school setting:

- If the student is mandated by State law and rule for placement in an alternative education program, but placement is not immediately available;
- If the student is placed on short-or long-term suspension from participation in the general education program; or,
- If a court order requires the student to receive instructional services in the home or other out-of-school setting.

In addition to the general rules for home instruction due to a health condition, instruction must be provided by a certified teacher. One-on-one instruction must be delivered for no fewer than 10 hours per week on three separate days of the week and no fewer than 10 hours per week of additional guided-learning experiences that may include the use of technology to provide audio and visual connections to the student's classroom.

N.J.A.C. 6A:32-8.1(f) – Absences and Home Instruction

A student who has been placed on home instruction shall have his or her attendance status recorded on the regular register for the program in which the student is enrolled. For the period beginning the first day the student is unable to attend school and ending the day before the first instructional day at the student's place of confinement, the student shall be marked absent. No absences shall be recorded for the student while on home instruction, providing the hours of instruction are no less than required by N.J.A.C. 6A:14-4.8 and 4.9. The number of possible days of enrollment for a student on home



instruction shall be the same as for other students in the program in which the student is enrolled.

Additional Points for School Nursing Practice

Based on information about a student's health condition or injury and the potential for absenteeism during recovery, the school nurse may recommend that home instruction be considered.

The school nurse should work with the parent/guardian, the student's medical home, and other school health team members to ensure a safe transition for the student's return to school.

The school nurse may provide the school physician with additional information about the student's medical history, attendance records, and other pertinent information to assist in the review and verification process.

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CHAPTER NINE: Promoting Social, Emotional, and Mental Health

Topic: Creating a Positive School Climate and Culture

Introduction



A school's climate and culture is a reflection of every employee and every student. It represents the values of the organization, in action, every day and in every interaction. A school's climate considers equity, culture, access, trust, and respect. School policies and practices promote a whole child approach, an environment that is safe, healthy, challenging, supportive, and engaging for all. Students and

staff feel connected to the school and community. School climate is the quality and character of school life. It also reflects norms, goals, values, interpersonal relationships, teaching and learning practices, and organizational structures. A sustainable, positive school climate supports learning as well as youth development (NSCC, 2007).

Without a warm and welcoming school climate, students and staff will not feel part of the "school community." This feeling impacts the ability of teachers and staff to connect with students, with each other, and with families subsequently contributing to student well-being, engagement, and academic achievement. Actual and perceived relationships that create a sense of community, safety, and security amongst adults and students within a building are part of this equation. School climate and school connectedness are linked. A school's climate correlates to how engaged students are in the classroom, how welcomed they are by their peers, and how invested their family is in helping them achieve (NASP, 2017).

School climate is the quality and character of school life, including the norms, goals, values, interpersonal relationships, teaching, learning and leadership practices, and organizational structures. Climate supports people to feel socially, emotionally and physically safe. This is reflected in the school's policies and practices and impacts the school board, superintendent's office, principals, teachers and other building staff, parents, students, and community members (NSCC). While school nurses may not be directly involved with the development of school climate policy, it is important that they participate in activities and develop strategies to support a safe and positive climate for students,



staff, and families. School nurses must understand the relationship between school climate and connectedness and the care they deliver in the health office and on campus.

School connectedness supports **protective factors**. Young people who feel connected to their school are less likely to engage in many risk behaviors including early sexual initiation; alcohol, tobacco, and other drug use; and violence and gang involvement. Young people who are at increased risk for feeling alienated or isolated from others may have difficulty connecting with other students and adults in school. Those at greater risk for feeling disconnected include students with disabilities, students who are lesbian, gay, bisexual, transgender, or question their sexual orientation, and students who are homeless (CDC, 2009).

School nurses must take an active role to create and promote a safe and supportive school environment. The school health office must be viewed as a safe place for all students and staff, where communications are valued and kept confidential. School nurses cannot be perceived by students, staff, or parents as judgmental. Because school nurses provide services for every student, health care must be culturally sensitive. School nurses must learn about and respect the beliefs, traditions, and values of students and their families. As a member of the school health team, school nurses serve as a role model for other school personnel. It is important for the school nurse to participate in school climate assessments and offer assistance to develop policies and practices in response to the results.

The National Center on Safe Supportive Learning Environments includes school nurses as **school support staff**. As a member of the school health team, school nurses build relationships with students and families that help them navigate health and academic supports, support school connectedness, and create safe environments where students and families feel respected. The **Collaborative for Academic, Social and Emotional Learning (CASEL)** also provides resources and research on the impact of social and emotional learning. Because the school health work is not limited to a single classroom or grade level, the school nurse brings a broader perspective to the creation of a safe and supportive learning environment.

The **Center for Supportive Schools** created **Campaign Connect-New Jersey (CC-NJ)** to support New Jersey schools in becoming safer, more supportive, engaging, and inspiring by providing them with the training, tools, and resources to facilitate a team of stakeholders through a data-informed, relationship-driven cycle of continuous school improvement. Campaign Connect is grounded in research that when students are immersed in safe, supportive, engaging, and inspiring environments where they feel connected to their school community through healthy relationships with adults and peers, they believe that people in their schools value them and want them to succeed. This belief is an important prerequisite to greater academic achievement, reduced bullying, lower dropout rates, improved grades, fewer discipline referrals, and fewer high-risk behaviors.

School nurses address the physical, social, emotional, and mental health of every student. They frequently interact with families and the community which provides them with

unique insights into how the school is perceived. Absenteeism, poor academic performance, and risk-taking behaviors may be observed by the school nurse and may reflect a lack of connectedness to the school environment.

District boards of education are required to develop standards, policies, and procedures for positive student development and student behavioral expectations on school grounds and, as appropriate, for conduct away from school grounds. The goal is to foster the health, safety, and social and emotional well-being of students and support the establishment and maintenance of civil, safe, secure, supportive, and disciplined school environments conducive to learning. School nurses must understand their role in promoting a healthy and safe school where student feels respected and connected.

A school's climate impacts every sector of the school community. This chapter addresses multiple issues that may impact a student's health and well-being. These issues impact student conduct as well as the social and emotional health of students and staff. These issues may be interrelated and thus, the work of a collaborative school health team becomes paramount. New Jersey often requires the creation of district or school teams to address one aspect of student health and well-being. The school health team, when properly configured and empowered, can address all health issues, policies, and practices through a multi-disciplinary lens. The school nurse should assume a leadership role on the school health team, keeping in mind the importance of a whole child approach.

The Robert Wood Johnson Foundation and the American Institutes for Research convened school climate practice leaders to develop **Ten Key Ideas for the Social and Emotional Learning and School Climate Community**

Promoting Social, Emotional, and Mental Health

Topic: Alcohol and Other Drug Use and Abuse

Background and Rationale

Substance use has harmful effects on school performance. Students under the influence of substances are not ready to learn and are at risk of long-term impairment of cognitive ability and memory. Data from the Centers for Disease Control's (CDC) Youth Risk Behavior Surveillance System (YRBSS) show a negative association between health-risk behaviors and academic achievement among high school students (CDC, 2015). Addiction to tobacco, alcohol, illegal, and prescription drugs nearly always originates during adolescence. The younger people are when they have their first drink or drug, the more probable it is that dependence on drugs or alcohol will occur. Notwithstanding addiction, even experimenting with drugs and alcohol can lead to patterns of risk-taking behaviors including unsafe sex, driving while intoxicated, and/or other perilous, unsupervised activities. With patterns of repeated substance use, serious social and health risk outcomes can occur. These include school failure, family/friend relationship issues, loss of interest in normal activities, and impaired memory. These teens are at an increased risk of contracting an infectious disease (like HIV or hepatitis C) via risky sexual behavior or sharing contaminated injection equipment. They may experience mental health problems and



substance use disorders leading to overdose and death (NIDA, 2014). More detailed information and current data can be found in the June 2016 edition of the MMWR [Youth Risk Behavior Surveillance — United States, 2015](#).

The school nurse plays a unique role in the prevention of substance abuse as well as the detection and care of students found to be under the influence. NASN developed a practice paper, [Drugs of Abuse](#), that provides information on youth using prescription drugs for non-medical use. The AAP-COSH and AAP's Committee on Substance Abuse issued [The Role of Schools in Combating Illicit Substance Abuse](#) which addresses the effects of substance abuse, screening programs, education programs, and the relationship between the medical home and drug rehabilitation programs.

New drugs appear every day and the school nurse needs current information on over-the-counter, prescribed, and illicit substances. Changes in laws occur so rapidly that school policies may lag behind. The [DEA Drug Schedule](#) to provide information on a drug's acceptable medical use and the likelihood of dependency.

Students spend the majority of their day in a school environment. The school environment supports the physical, social, and psychological needs for many adolescents; therefore, schools naturally assume a critical role in substance abuse education, prevention, identification, referral for treatment, and long-term management of a substance use disorder. School nurses have a unique knowledge of adolescent brain development and the ever-changing challenges that adolescents face, along with the complexities of addiction disorders. School nurses should work with the replace with student assistance coordinator to ensure confidential care for the student with substance use issues.

It is the obligation of the district board of education to develop and implement policies and procedures that create a safe and healthy educational environment and to ensure that adequate measures are in place for the education, prevention, identification, intervention, and treatment for substance abuse. The role of the school nurse should be clearly identified within those policies. The school nurse must clearly understand the laws, rules, and policies that address this important issue.

Applicable Laws and Regulations

Sections of the following laws have been summarized. To access the full text, please go to [Title 18A](#).

Overdose Prevention Act (NJ P.L. 2013, c46)

The law states that a health care professional or pharmacist who, acting in good faith, directly or through a standing order, prescribes or dispenses an opioid antidote to a patient capable, in the judgment of the health care professional, of administering the opioid antidote in an emergency, shall not, as a result of the professional's acts or omissions, be subject to any criminal or civil liability, or any professional disciplinary action.

A health care professional prescribing or dispensing an opioid antidote to a patient shall ensure that the patient receives patient overdose information. This information shall in-

clude, but is not limited to: opioid overdose prevention and recognition; how to perform rescue breathing and resuscitation; opioid antidote dosage and administration; the importance of calling 911 emergency telephone service for assistance with an opioid overdose; and care for an overdose victim after administration of the opioid antidote.

The law also affords immunity from arrest for use/simple possession offenses to the overdose victim and to the person who sought medical assistance.

N.J.S.A. 18A:40A-1-25 – Alcohol, Tobacco, and Other Drug (ATOD) Abuse

These laws require local boards of education to develop a comprehensive substance abuse program that includes instructional components for K-12 students, inservice training for school personnel, identification of students under the influence, and related medical evaluations and referrals.

N.J.S.A. 18A:40A-7.1 – Confidentiality

This law states that if a public or private elementary or secondary school pupil participating in a school-based drug and alcohol abuse counseling program provides information during the course of a counseling session in that program which indicates that the pupil's parent or guardian or other person residing in the pupil's household is dependent upon or illegally using a substance that information must be kept confidential and may be disclosed only under the circumstances which the law describes in detail.

N.J.S.A. 18A:40A-10 – Referral Program in Schools

This requires each local board of education to establish a comprehensive substance abuse intervention, prevention, and treatment referral program in the public elementary and secondary schools of the district. Treatment is not at the expense of the local board of education. Each school district must develop a clear written policy statement which outlines the district's program to combat substance abuse and which provides for the identification, evaluation, referral for treatment and discipline of pupils who are substance abusers. Copies of the policy statement shall be distributed to pupils and their parents at the beginning of each school year.

N.J.S.A. 18A:40-12 – Reporting of Pupils Under Influence: Examination and Referral

This law states that whenever it appears to any teaching staff member, school nurse, or other educational personnel of any public school that a pupil may be under the influence of substances (other than anabolic steroids) it must be immediately reported to the school nurse or medical inspector or to a student assistance coordinator, and to the principal or, in his absence, to his designee. The administrator or his designee must immediately notify the parent or guardian and the superintendent of schools. An immediate examination of the pupil by a doctor selected by the parent or guardian, or if that doctor is not immediately available, by the medical inspector, if he is available must be arranged. If a doctor or medical inspector is not immediately available, the pupil must be taken to the emergency room of the nearest hospital for examination accompanied by a member of the school staff designated by the principal and a parent or guardian of the pupil, if



available. The pupil must be examined as soon as possible for the purpose of diagnosing whether or not the pupil is under such influence.

A written report of that examination must be furnished within 24 hours by the examining physician to the parent or guardian of the pupil and to the superintendent of schools or administrative principal. If it is determined that the pupil was under the influence of a substance, the pupil shall be returned to the pupil's home as soon as possible. The pupil may not resume attendance at school until a written report certifying that the pupil is physically and mentally able to return, prepared by a personal physician, the medical inspector, or the physician who examined the pupil, is submitted to the principal.

In addition, the pupil must be interviewed by a student assistance coordinator (SAC) or another appropriately trained teaching staff member for the purpose of determining the extent of the pupil's involvement with these substances and possible need for treatment. If it is determined that the pupil's involvement with and use of these substances represents a danger to the pupil's health and well-being, the SAC or other teaching staff member shall refer the pupil to an appropriate treatment program which has been approved by the Commissioner of Health.

N.J.S.A. 18A:40A-23 – Random Testing of Certain Students

This law allows a board of education to adopt a policy, which is consistent with the New Jersey Constitution and the federal Constitution, for the random testing of the district's students in grades 9-12 who participate in extracurricular activities, including interscholastic athletics, or who possess school parking permits, for the use of controlled dangerous substances as defined in N.J.S.2C:35-2 and anabolic steroids. The testing shall be conducted by the school physician, school nurse, or a physician, laboratory or health care facility designated by the board of education and the cost shall be paid by the board. Any disciplinary action taken against a student who tests positive for drug use or who refuses to consent to testing shall be limited to the student's suspension from or prohibition against participation in extracurricular activities, or revocation of the student's parking permits.

N.J.S.A. 18A:40A-24 – Public Hearing Prior to Adoption of Drug Testing Policy

This requires each board of education to hold a public hearing prior to the adoption of its drug testing policy. The policy must contain specific elements further outlined in the law and must be in written form and distributed to students and their parents or guardians at the beginning of each school year.



Key Point

N.J.A.C. 6A:16-4.4(c) addresses the collection of specimens for alcohol or other drug testing in a State-licensed collection station or clinical laboratory and limits the handling of the specimens to a school physician, a physician, other than the school physician, licensed to practice medicine or osteopathy, a certified school nurse or noncertified nurse, pursuant to N.J.A.C. 6A:9B-12.3 and 12.4 or the staff of a State-licensed clinical laboratory or health care facility, as designated by the district board of education.

N.J.A.C. 6A:16 – Programs to Support Student Development

Subchapters 3 and 4 specifically address mandated substance abuse policies and programs. Subchapter 5 addresses reporting requirements and Subchapter 6 addresses the role of law enforcement. The regulations are summarized for the purposes of this document. The full text may be accessed by clicking on the link above. School nurses should review the content of this chapter frequently for any changes or updates.

N.J.A.C. 6A:16-3.1 – Comprehensive Programs.

Each district board of education must establish a comprehensive program of prevention, intervention, referral for evaluation, referral for treatment, and continuity of care for student alcohol, tobacco, and other drug abuse in the school district's public elementary and secondary schools. This section details the purposes of the programs and services and established training for all school personnel. It also describes the role of the student assistance coordinator (see Chapter Two of this document).

N.J.A.C. 6A:16-3.2 – Confidentiality

Confidentiality includes information provided by the student while participating in a school-based drug/alcohol counseling program about the student's parent or other person residing in the student's household who is using illegal substances. It also requires the school to comply with federal laws regarding confidentiality.

N.J.A.C. 6A:16-4.1 – Suspicion of Being Under the Influence

This section requires local boards of education to adopt policies and procedures for students who consume or who are suspected of being under the influence alcohol or other drug-related situations on school grounds, including on school buses or at school-sponsored functions alcohol and other drug, including anabolic steroids for assessment, intervention, referral for evaluation, referral for treatment, and discipline of students. Policies and procedures need to address students who are using, processing, or distributing alcohol and other drugs, including the staff's role of handing the substances and follow up consequences, screening, and referral for treatment. Clear mandatory procedures for supporting ameliorated students must include medical evaluation by a health care provider to determine the student's physical and mental capacity to perform at school.

N.J.A.C. 6A:16-4.2 – Policy Review

This section requires an annual review of policies and procedures which must be disseminated to staff, students, and parents via the district's website or other appropriate means.

N.J.A.C. 6A:16-4.3 – Reporting, Notification, and Examination

These rules establish the procedures to be followed when a staff member suspects a student of being under the influence. Students who are suspected of being under the influence of alcohol or other drugs must be reported to the principal/designee and the certified school nurse. Additional notification needs to include the parent or guardian and chief school administrator. A medical examination must be immediately conducted and a report submitted by the examining physician before the student can be cleared to care to return to school.



N.J.A.C. 6A:16-4.4 – Random Testing

School district boards of education are permitted, but not required, to adopt policies for the random testing for alcohol or other drug use of students in 9th through 12th grade who participate in extra-curricular activities, including interscholastic athletics, or who possess parking permits, with parental consent.

N.J.A.C. 6A:16-5.3 – Reporting of Alcohol and Other Drug Abuse

This rule requires school staff that report a student being under the influence of alcohol or other drugs to notify the principal and file with the principal a report describing the incident. The report shall be on a form adopted by the district board of education and include all of the information necessary for accurately reporting on the Electronic Violence and Vandalism Reporting System (EVVRS).

N.J.A.C. 6A:16-6.1&6.2 – Law Enforcement

These rules address the development and adoption of policies and procedures for school staff and law enforcement authorities in all matters that relate to the unlawful possession, distribution, and disposition of controlled dangerous substances, including anabolic steroids, drug paraphernalia, and alcoholic beverages.

N.J.A.C. 6A:16-6.3 – Reporting

These rules require any staff member who, in the course of his or her employment, has reason to believe that a student or staff member has unlawfully possessed or in any way been involved in the distribution of a controlled dangerous substance, including anabolic steroids, or drug paraphernalia shall report the matter as soon as possible to the principal or, in the absence of the principal, to the staff member responsible at the time of the alleged violation. Either the principal or the responsible staff member shall notify the chief school administrator, who in turn shall notify as soon as possible the appropriate county prosecutor or other law enforcement official designated by the county prosecutor to receive such information.

N.J.A.C. 6A:16-6.4 – Reporting

A school employee who seizes or discovers alcohol, other drugs or an item believed to be a controlled dangerous substance, including anabolic steroids or drug paraphernalia, must immediately notify and submit to the principal/designee, the alcohol, other drug or item.

N.J.A.C. 6A:16-6.5 – Confidentiality

This regulation addresses the confidentiality of a student's or staff member's involvement in alcohol or other drug abuse intervention and treatment programs.

The Department of Law and Public Safety published the [New Jersey School Search Policy Manual and Companion Reference Guide](#) to assist school administrators and teachers as well as law enforcement officials. It includes a specific section on [Urinalysis Drug Testing](#) and addresses both suspicion-based and random alcohol/drug screening.

P.L.2017, CHAPTER 167, approved July 21, 2017

This law requires school districts and nonpublic schools that participate in interscholastic sports or cheerleading programs to distribute an opioid abuse and addiction fact sheet annually to the parents or guardians of student-athletes and cheerleaders, and to obtain a signed acknowledgement of the receipt of the fact sheet by the student and his parent or guardian.

NJDOE Opioid Fact Sheet Memo: January 2018

Additional Points for School Nursing Practice

The Association of Student Assistance Professionals of New Jersey (ASAP-NJ) provides numerous [resources](#) including a physician clearance letter, forms, training presentations, and activity checklists.

**Key Point**

The certified school nurse has an important role in the identification and assessment of a student suspected of being under the influence. The school nurse must monitor the student's vital signs and assess the student's general health for any emerging issues. The school nurse must follow district policies and procedures.

Key Point

*The medical examination and clearance must be completed and received by the school from a health care provider within 24 hours. Parental failure or refusal to comply with the medical examination procedure is in violation of child neglect laws and the Division of Child Protection and Permanency needs to be notified. See the **CDF reporting laws** for more information.*

Depending on school district policy, a student may be, but is not required to, provide a urine sample if the school suspects or has evidence that he/she is using drugs. Justification may include a school official observing the student use, the student showing physical symptoms of being under the influence, or exhibiting patterns of abnormal or erratic behavior.

**Key Point**

A drug screening is not a state requirement for a student who is suspected of being under the influence of alcohol or controlled dangerous substances; however, a medical examination by a health care provider is mandatory.

As with other required medical examinations, if a student does not have a medical home, the school district must provide the examination at the school physician's office or other comparably equipped facility.



Key Point

Random substance use testing policies are at the discretion of the individual school district. Students are selected regardless of their drug use history and include students who are required to do a drug test as a condition of participation in an extracurricular activity.

Pursuant to **Chapter 13 Urinalysis Drug Testing**, district boards of education that adopt random testing procedures should:

- Solicit parental input with public hearings or presentations;
- Document findings that demonstrate the necessity and appropriate implementation of the drug screening process;
- Limit the purpose of the program to deter substance abuse, not to punish users;
- Minimize the invasiveness of the process with the collection and handling of urine samples and the consideration of students' privacy;
- Preserve the chain of custody and assure accuracy of drug testing results;
- Preserve the confidentiality of students' positive tests; and,
- Allow for the disclosure of prescribed medication to medical personnel after a positive test.

School districts need to adopt policies to address the use of medical marijuana. Please see Chapter Five of this document for more information.

The [SAMHSA 2016 Survey](#) is national report that summarizes key findings from the 2016 National Survey on Drug Use and Health (NSDUH) for indicators of substance use and mental health among people aged 12 years old or older in the civilian, non-institutionalized population of the United States.

Promoting Social, Emotional, and Mental Health

Topic: Tobacco Use and E-Smoking Devices

Background and Rationale

The CDC's [Youth Risk Behavior Surveillance — United States, 2015](#) published in the June 2016 MMWR found that nationwide, 32.3% of students had ever tried cigarette smoking (even one or two puffs). This was higher among Hispanic males and females. The prevalence of having ever tried cigarette smoking also decreased significantly from 2013 (41.1%) to 2015 (32.3%). Nationwide, 6.6% of students had smoked a whole cigarette for the first time before age 13 years. The prevalence of having smoked a whole cigarette before age 13 years also decreased significantly from 2013 (9.3%) to 2015 (6.6%). Nationwide, 10.8% of students had smoked cigarettes on at least 1 day during the 30 days

before the survey. The prevalence of current cigarette use increased during 1991–1997 (27.5%–36.4%) and then decreased during 1997–2015 (36.4%–10.8%). The prevalence of current cigarette use also decreased significantly from 2013 (15.7%) to 2015 (10.8%). Daily cigarette smoking increased during 1991–1999 (9.8%–12.8%) and then decreased during 1999–2015 (12.8%–2.3%). The prevalence of having currently smoked cigarettes daily also decreased significantly from 2013 (4.0%) to 2015 (2.3%). The YRBSS provides other data about student tobacco use, including cigarette and cigar smoking, the use of smokeless tobacco products, and the use of electronic vape products (Kann, et al., 2016). The school nurse plays an important role in the identification of early tobacco users as well as school and community prevention efforts.

Tobacco use is a primary public health issue. The CDC’s [Office on Smoking and Health](#) provides resources for health professionals as well as a snapshot of [New Jersey’s](#) tobacco prevention efforts. It estimates that for every dollar spent on tobacco prevention, states can reduce tobacco-related health care expenditures and hospitalizations by up to \$55.

Tobacco can be smoked, chewed, or sniffed and contains nicotine, the ingredient that can lead to addiction. Tobacco smoking can lead to lung cancer, chronic bronchitis, and emphysema. Tobacco use increases the risk of heart disease, which can lead to stroke or cardiac insufficiency and infarct. Additionally, tobacco smoking has been linked to other cancers, leukemia, cataracts, and pneumonia. Smokeless tobacco increases the risk of mouth cancers. Furthermore, secondhand smoke can lead to lung cancer and heart disease as well as other health effects in adults and children. Currently, among youth in this country, 5.6 million of today’s Americans younger than 18 will die early from a smoking-related illness. That’s about 1 out of every 13 Americans aged 17 years or younger currently alive today (CDC, 2014). E-cigarettes have deliberately been designed to appeal to even younger users.

School nurses may identify early users of tobacco products during health office visits and screenings. The school nurse is uniquely positioned to offer health counseling and education to these students who have already begun to use tobacco products. Because tobacco use has many long term effects, it is often difficult to convince young users of the need to forego tobacco use now to prevent health problems later in life. Young people may feel that they can quit any time and thus fail to grasp that even when they do quit, residual damage may have already occurred. School nurses must also recognize that some students live in homes where tobacco use is acceptable. The school nurse may educate families about the impact of secondhand smoke on children, particularly those already diagnosed with allergies, asthma, or other respiratory illnesses. As part of the school health team, school nurses can promote and provide smoking cessation programs for students and staff and support quality health education programs that address tobacco use prevention beginning in elementary grades. Finally, school nurses can impact school policies and practices that restrict and ban the use of tobacco products on school property.



Applicable Laws and Regulations

An overview of federal, state, and local [Tobacco Control Laws](#) can be found at NJGASP.

P.L.2017, C118 – Minimum Age Sale and Distribution

This law changed the minimum age for the sale and distribution of tobacco products and electronic smoking devices from 19 to 21 and enacts penalties for businesses that are non-compliant. As of November 1, 2017, the legal age for purchasing tobacco products and electronic smoking devices in New Jersey is 21 years of age.

The [Family Smoking Prevention and Tobacco Control Act](#) gave the Food Drug Administration (FDA) authority to regulate the manufacturing, distribution, and marketing of tobacco products.

New Jersey Smoke Free Air Act

Smoke Free Air Act

N.J.S.A. 18A:36-32 – Vending Machines

Cigarette vending machines are prohibited on any property owned by a school board and used for school purposes.



Key Point

Smoking is not permitted on school buses and vehicles even if students are not present in the vehicle. This applies to public, private, or professional training school buses.

N.J.A.C. 8:6 Smoke Free Air

N.J.A.C. 8:6-7.2 – Smoking Prohibitions

Smoking is prohibited in school buildings and on school grounds. School buildings and school grounds means and includes, with respect to public and nonpublic elementary and secondary schools:

- Land, portions of land, structures, buildings, and vehicles, owned, operated or used for the provision of academic or extracurricular programs sponsored by a school or a community provider and structures that support these buildings, such as school wastewater treatment facilities, generating facilities, and other central service facilities including, but not limited to, kitchens and maintenance shops;
- Athletic stadiums, swimming pools, any associated structures or related equipment tied to such facilities including, but not limited to, grandstands and night field lights, greenhouses, garages, facilities used for non-instructional or non-educational purposes, and any structure, building or facility used solely for school administration; and,

- Playgrounds, and recreational places owned by local municipalities, private entities, or other individuals during those times when the school district has exclusive use of a portion of such land.

N.J.S.A. 26:3D-56-58 – Smoking and Use of Electronic Smoking Devices in Indoor Public Places

The Legislature found that tobacco is the leading cause of preventable disease and death in the State and the nation and that tobacco smoke constitutes a substantial health hazard to the nonsmoking majority of the public. It established that electronic smoking devices have not been approved as to safety and efficacy by the federal Food and Drug Administration. The law prohibits smoking in an indoor public place or workplace and prohibits smoking in any area of any building of, or on the grounds of, any public or nonpublic elementary or secondary school, regardless of whether the area is an indoor public place or is outdoors.



Key Point

Smoking is also banned during K-12 school activities that take place off school premises.

N.J.A.C. 6A:16 – Programs to Support Student Development

Subchapters 3 and 4 specifically address mandated substance abuse policies and programs including tobacco use. Subchapter 5 addresses reporting requirements and Subchapter 6 addresses the role of law enforcement. Some sections have been summarized for the purposes of this document and may be accessed in their entirety by clicking on the link above.

N.J.A.C. 6A:16-3.1 – Comprehensive Alcohol, Tobacco, and Other Drug Programs

These rules require each district board of education to establish a comprehensive program of prevention, intervention, referral for evaluation, referral for treatment, and continuity of care for student alcohol, tobacco, and other drug abuse in the school district's public elementary and secondary schools. The purpose of the prevention component of the program is to keep students from using alcohol, tobacco or other drugs and reduce the factors that place students at risk for involvement with alcohol, tobacco or other drugs through school and community-based planning processes.

N.J.A.C. 6A:16-3.1(a)8 – Tobacco Use on School Grounds or Buses

Each district board of education shall make and enforce rules to prohibit any person from smoking or carrying lighted tobacco at any time on school grounds or on school buses or other vehicles owned or contracted by the board of education.



Additional Points for Nursing Practice

NJDOH Tobacco Control

Tobacco Free NJ provides resources for tobacco control and prevention initiatives.

E-cigarettes are popular among teens and are now the most commonly used form of tobacco among youth in the US which is raising public health concern. They are easily available, promoted by alluring advertisements, and come in various e-liquid flavors. Young people believe they're safer than regular cigarettes (NIDA, 2017). E-cigarettes are battery-operated devices that deliver nicotine and flavorings without burning tobacco. Puffing activates the battery-powered heating device which vaporizes the liquid in the cartridge which typically delivers nicotine, flavorings, and other additives to users via an inhaled aerosol. These devices are referred to by a variety of names, including "e-cigs," "e-hookahs," "mods," "vape pens," "vapes," and "tank systems." E-cigarette aerosol contains harmful and potentially harmful constituents including nicotine. Nicotine exposure during adolescence can cause addiction and harm the developing adolescent brain (USDHHS, 2016).

The Surgeon General's fact sheet: **Preventing Youth Tobacco Use**

The CDC website provides a wealth of information on tobacco use and prevention including information on **Second Hand Smoke and smokeless tobacco use**.

Smoking Cessation Tips

Campaign for Tobacco Free Kids

From the CDC: **E-Cigarettes Ads and Youth and Smokeless Tobacco Products**

From the Surgeon General: **E-Cigarette Risks**

Promoting Social, Emotional, and Mental Health

Topic: Anabolic Steroids

Background and Rationale

Anabolic steroids are synthetic variations of the male sex hormone testosterone. Steroids can be prescribed to treat various medical conditions; however, some athletes and bodybuilders abuse these drugs to boost performance or improve their physical appearance. Individuals who abuse anabolic steroids usually take them orally, inject them into a muscle, or apply a cream, gel, or patch. The abuse of anabolic steroids may lead to short-term effects such as extreme mood swings or "roid rage" that may lead to violence (NIDA, 2016a).

Healthy People 2020 established a national goal to reduce steroid use by 10% among adolescents in eighth, tenth, and twelfth grades. The nonprofit research organization **Child Trends** reported that for students in grades eight and ten, steroid use increased between 1991 and 2000 (peaking at 1.7% and 2.2% respectively), and then decreased between 2000 and 2014, to less than one percent. For twelfth-graders, use peaked slightly

later, between 2001 and 2004, at 2.5% before declining and was at 1.5% in 2014 (Child Trends, 2014).

In the June 2016 MMWR, the CDC summarized the results of the [Youth Risk Behavior Surveillance — United States, 2015](#). The YRBSS is self-reported data focusing on health risk behaviors. Nationwide, 3.5% of students had taken steroid pills or shots without a doctor's prescription one or more times during their life and the prevalence of having ever taken steroids without a doctor's prescription was higher among male (4.0%) students and in particular, higher among 12th-grade male students. The prevalence of having ever taken steroids without a doctor's prescription did not change significantly from 2013 (3.2%) to 2015 (3.5%). Across 24 states, the prevalence of having ever taken steroids without a doctor's prescription ranged from 1.4% to 6.3% (median: 3.8%) but across 12 large urban school districts, the prevalence ranged from 2.5% to 8.7% (median: 3.5%) (Kann, et al., 2016). This information has significance for school nurses who work with young adolescents and in particular, those participating in school and community athletic programs. The school nurse may be the first to recognize some of the changes and side effects of steroid use in males such as aggression, mood swings, and breast enlargement. Girls who abuse anabolic steroids may exhibit menstrual irregularities, changes in mood, and increased facial or body hair. Both may exhibit increased blood pressure, acne, and swelling due to fluid retention.

The use of anabolic steroids differs from the abuse of other illicit substances. Steroid use is driven by the desire of abusers to change their appearance and performance, characteristics of great importance to adolescents. The effects of steroids can boost confidence and strength, leading abusers to overlook the potential serious and long-term damage that these substances can cause. Long-term steroid abuse can act on some of the same brain pathways that involve dopamine and serotonin. Even though anabolic steroids do not cause the same high as other drugs, they can lead to addiction. NIDA outlines the short and long-term effects of [anabolic steroids](#). Individuals who inject anabolic steroids place themselves at risk for hepatitis or other blood borne diseases (NIDA, 2016b).

Applicable Laws and Regulations

N.J.S.A. 18A:40A-1 – Curriculum

This law requires that anabolic steroids be included in the school district's substance abuse curriculum.

N.J.S.A. 18A:40A-12b – Suspicion of Anabolic Steroid Use

The law requires any teaching staff member, school nurse, or other educational personnel of any public school who has reason to believe that a pupil has used or may be using anabolic steroids, to report the matter as soon as possible to the school nurse or medical inspector or to a student assistance coordinator, and to the principal or, in his absence, to his designee. The principal or his designee must immediately notify the parent or guardian and the superintendent of schools and arrange for an examination of the pupil by a doctor selected by the parent or guardian or by the medical inspector. The pupil shall be examined as soon as possible for the purpose of diagnosing whether or



not the pupil has been using anabolic steroids. A written report of that examination must be furnished by the examining physician to the parent or guardian of the pupil and to the superintendent of schools or administrative principal.

If it is determined that the pupil has been using anabolic steroids, the pupil shall be interviewed by a student assistance coordinator or another appropriately trained teaching staff member for the purpose of determining the extent of the pupil's involvement with these substances and possible need for treatment. If it is determined that the pupil's involvement with and use of these substances represents a danger to the pupil's health and well-being, the coordinator or other teaching staff member shall refer the pupil to an appropriate treatment program which has been approved by the Commissioner of Health.

An Executive Order issued in 2005 by Governor Codey established the [New Jersey State Interscholastic Athletic Association \(2016\) Steroid Testing Policy](#). The NJSIAA also developed an [FAQ](#), [NJSIAA Steroid Testing Protocols 2017-18](#) and [NJSIAA Consent for Random Testing](#).



Key Point

Before participating in interscholastic sports, the student-athlete and the student-athlete's parent or guardian must consent, in writing, to random testing for steroids in accordance with NJSIAA policy.

Key Point

Tested athletes are selected randomly from all athletes participating in championship competition. Steroid testing may occur at any state championship site or at the school whose athletes have qualified for championship competition.

Additional Points for Nursing Practice

School nurses, athletic directors, coaches, athletic trainers and others involved with athletics must know the signs of steroid and performing enhancing drug use (PED). The National Strength and Conditioning Association (NSCA) developed [performance enhancing drugs education](#) materials for health professionals, athletes, parents, and coaches.

The National Federation of State High School Associations created an [infographic on steroid abuse in high school and college athletes](#) and offers Make the Right Choice, a multimedia educational initiative. For athletes planning to participate in college sport programs, the [NCAA drug testing FAQ](#) may be helpful.

Androstenedione (andro) is a hormone produced by the adrenal glands, ovaries, and testes. Normally, it is converted to testosterone and estradiol in both men and women. Andro is available legally only in prescription form and is a controlled substance. Human growth hormone, also known as gonadotropin, is a hormone that has an anabolic effect. Athletes take it to improve muscle mass and performance. It is available only by prescrip-

tion and is administered by injection. Erythropoietin is a type of hormone used to treat anemia in people with severe kidney disease. It increases production of red blood cells and hemoglobin, resulting in improved movement of oxygen to the muscles. Epoetin, a synthetic form of erythropoietin, is commonly used by endurance athletes.

Changes in school performance, such as dropping grades, can result from a preoccupation with body image and athletic performance. Personality changes with extreme mood swings outside the expected adolescent behaviors along with aggression, anger, and frequent loss of temper, may occur. School nurses may observe relationship instability with friends and family members as obsessive thoughts occur.

The student may spend an excessive amount of time in isolation at the gym, working out, and being preoccupied with his/her body image (Franckowiak, 2015).

NIDA for Teens provides information for adolescents on various drugs including anabolic steroids.

Anabolic Steroids

Performance Enhancing Drugs

Promoting Social, Emotional, and Mental Health

Topic: Mental Health Issues

Background and Rationale

According to the Child Mind Institute, one in five children suffers from a mental health or learning disorder and 80% of chronic mental disorders begin in childhood. Children with mental health issues are at risk for poor outcomes in school and in life. Approximately, 17.1 million young people have or have had a diagnosable psychiatric disorder. That means that one out of every five children in the US meets the criteria for a major mental disorder. Anxiety disorders such as social phobia can make students twice as likely to drop out or fail a grade. Combinations of mental health disorders (including substance abuse) are predictors for low levels of lifetime educational attainment. Fifty percent of mental health disorders begin before age 14 and 75% before age 24. For example:

- 75% of social phobia manifests by age 15;
- 75% of separation anxiety disorder manifests by age 10;
- 75% of oppositional defiant disorder manifests by age 14; and,
- 75% of ADHD manifests by age 8 (Child Mind Institute, 2016).

Experts agree that there is a growing and unmet need for mental health services for children and youth. Today's students experience stress, anxiety, bullying, family problems, depression, learning disabilities, and alcohol and substance abuse. Serious mental health problems, such as self-injurious behaviors and suicide, are on the rise. Unfortunately, most students do not receive the treatment they need due to stigma and lack of



access to services and of those who do get help, nearly two-thirds do so only in school (NASP, 2016).

The school health team plays an important role in supporting mental health and addressing mental health issues that arise. A continuum of school mental health services is critical to effectively addressing students' needs. Schools can promote mental wellness for all students, identify and address problems before they escalate or become chronic, and provide increasingly intensive, data-driven services for individual students as needed. When these services are not feasible within an individual school, school-community collaboration becomes critical. Community mental health providers can provide supplementary or intensive services that go beyond school capacities. Creating a collaborative process helps reduce gaps, redundancy, and conflict (NASP, 2016).

The National Institute of Mental Health (NIMH) provides an overview of a wide range of [mental health topics](#). It also provides [prevalence data](#) on specific mental health conditions. School nurses may find this information helpful since they are often the first school employee to identify that a student is exhibiting signs and symptoms of a possible mental health condition. Once a student is diagnosed by a qualified mental health professional, the school nurse should develop an IHP/IEHP which includes strategies to support the student. The school nurse should collaborate with other members of the school health team, the family, and the student's healthcare provider to monitor the student's health and safety.

Children ages 8-15 most often are diagnosed with mood disorders, depression, or conduct disorders with panic and anxiety disorders occurring to a lesser extent. **Anxiety** can become excessive and the individual may have difficulty controlling it. There are a wide variety of anxiety disorders, including [post traumatic stress disorder](#) (PTSD), obsessive-compulsive disorder, and specific phobias. **PTSD** is an anxiety disorder that can develop after exposure to a terrifying event or ordeal. Traumatic events that may trigger PTSD include violent personal assaults, natural or human-caused disasters, and accidents. Individuals with PTSD have persistent frightening thoughts and memories of their ordeal, may experience sleep problems, feel detached or numb, or be easily startled. **Generalized anxiety disorder (GAD)** is characterized by excessive worry about a variety of everyday problems for at least 6 months. **Panic disorder** is an [anxiety disorder](#) characterized by unexpected and repeated episodes of intense fear accompanied by physical symptoms that may include chest pain, heart palpitations, shortness of breath, dizziness, or abdominal distress. Agoraphobia is when an individual feels intense fear and anxiety of any place or situation where escape might be difficult, such as being alone outside of the home; traveling in a car, bus, or airplane; or, being in a crowded area (NIMH, 2017).

Social phobia is characterized by a persistent, intense, and chronic fear of being watched and judged by others. Students may feel embarrassed or humiliated and it may be so severe that it interferes with school and interpersonal relationships. Specific phobia involves intense and persistent fear and avoidance of a specific object or situation such as a fear of heights, spiders, or flying. Children and adolescents may also experience [eating disorders](#) such as anorexia, bulimia, and/or binge eating disorder. **Mood disorders**

include **depression**, dysthymic disorder, and bipolar disorder. **Bipolar disorder** causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. There are four basic types of bipolar disorder that involve clear changes in mood, energy, and activity levels (NIMH, 2017).

One of the most challenging and common mental health issues is depression. In 2015, an estimated 3 million adolescents aged 12 to 17 in the U.S. had at least one major depressive episode in the past year. This number represented 12.5% of the U.S. population aged 12 to 17 (NIMH, 2015). Depression may be caused by a combination of genetic, biological, environmental, and psychological factors and can happen at any age. School nurses need to know the **symptoms of depression** and associated risk factors. Depression is usually treated with medication (e.g., antidepressants), therapy, and as a last resort, electroconvulsive therapy. School nurses need to understand the types of **medications** used for a variety of disorders (NIMH, 2016).



Key Point

Many medications used to treat children and adolescents with mental illness are safe and effective. However, school nurses are advised that some medications have not been studied or approved for use with children or adolescents. A physician may prescribe a medication even though the medicine is not approved for the specific mental disorder that is being treated or for use by patients under a certain age. School nurses must carefully watch children and adolescents who take these medications on an “off-label” basis as they may have different reactions and side effects than adults (NIMH, 2016).

Suicide

In the June 2016 edition of the MMWR, the CDC released the results of the **Youth Risk Behavior Surveillance — United States, 2015**. In the 12 months prior to the survey:

- 29.9% of students nationwide said they felt so sad or hopeless almost every day for 2 or more weeks in a row that they stopped doing some usual activities;
- 17.7% of students had seriously considered attempting suicide during the 12 months before the survey;
- 14.6% of students had made a plan about how they would attempt suicide;
- 8.6% of students had attempted suicide one or more times during the 12 months before the survey; and,
- 2.8% of students nationwide had made a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (Kann, et al., 2016).

Suicide is not a normal response to stress. Suicidal thoughts or actions are a sign of extreme distress not a harmless bid for attention, and should not be ignored. Factors associated with suicide risk include:

- Depression, other mental disorders, or substance abuse disorder;
- Certain medical conditions;
- Chronic pain;
- A prior suicide attempt;
- Family history of a mental disorder or substance abuse;
- Family history of suicide;
- Family violence, including physical or sexual abuse;
- Having guns or other firearms in the home;
- Having recently been released from prison or jail; and,
- Being exposed to others' suicidal behavior, such as that of family members, peers, or celebrities (NIMH, 2017).



When an individual is considering suicide, there may be specific observable behaviors such as:

- Talking about wanting to die or wanting to kill themselves;
- Talking about feeling empty, hopeless, or having no reason to live;
- Making a plan or looking for a way to kill themselves, such as searching online, stockpiling pills, or buying a gun;
- Talking about great guilt or shame;
- Talking about feeling trapped or feeling that there are no solutions;
- Feeling unbearable pain (emotional pain or physical pain);
- Talking about being a burden to others;
- Using alcohol or drugs more often;
- Acting anxious or agitated;
- Withdrawing from family and friends;
- Changing eating and/or sleeping habits;
- Showing rage or talking about seeking revenge;
- Taking great risks that could lead to death, such as driving extremely fast;
- Talking or thinking about death often;
- Displaying extreme mood swings, suddenly changing from very sad to very calm or happy;
- Giving away important possessions;
- Saying goodbye to friends and family; and,
- Putting affairs in order, making a will (NIMH, 2017).

School staff have both a legal and ethical responsibility to recognize and appropriately respond to suicidal thinking and behavior. The entire school community must be committed to making suicide prevention a priority. Further, students and adults must be educated and empowered to take the correct actions. Schools must address the broad range of mental health issues before an incident occurs. It is important that schools understand **risk and protective factors**. These factors include:

- Family support and cohesion, including good communication;
- Peer support and close social networks;
- School and community connectedness;
- Cultural or religious beliefs that discourage suicide and promote healthy living;
- Adaptive coping and problem-solving skills, including conflict-resolution;



- General life satisfaction, good self-esteem, sense of purpose; and,
- Easy access to effective medical and mental health resources (NASP, 2015).

Although school personnel, including the school nurse, are not responsible for the diagnosis and treatment of mental health issues in students, they must be trained to detect symptoms of those at risk for suicide. All suicide threats must be taken seriously and referred to the appropriate healthcare provider for evaluation. Schools can play an active role in suicide awareness and prevention by educating students, staff, and families about mental health issues, substance abuse, and suicide risk and behaviors. Creating a safe and supportive school environment with a strong anti-bullying program is critical. Finally, students need access to mental health professionals through school-community partnerships.

School crisis, safety, and security plans should include how to deal with a suicidal act. Students must be allowed to grieve but in a way that does not glorify, romanticize, or sensationalize suicide. It is important that school administrators confirm the facts related to a death with the family and/or police. School officials should contact the family to offer condolences and ask what the school can do to help. School personnel need to pay close attention to other students (and staff) who may also be at risk of suicidal behavior. School district or community-based crisis intervention teams should be called upon to provide postvention support. Schools need to keep in mind the widespread impact of social media and how that type of communication may impact the events that follow a suicide. Similarly, suicide contagion occurs when suicidal behavior is imitated and this effect is strongest among adolescents. Studies indicate that 1%-5% of all suicides within this age group are due to contagion (100-200 teenage cluster suicides per year). School officials also need to have policies in place to address memorials and contacts with the media (NASP, 2015).

Applicable Laws and Regulations

N.J.S.A. 18A:6-111 – Instruction in Suicide Prevention

This requires instruction in suicide prevention as part of any continuing education which public school teaching staff members must complete to maintain their certification and requires that suicide prevention awareness be included in the Core Curriculum Content Standards in Comprehensive Health and Physical Education.

N.J.S.A. 18A:6-112 – Teaching Staff Education in Suicide Prevention

This requires that all teaching staff receive education in suicide prevention, amounting to 2 hours every five years, as part of their professional development requirements. The instruction in suicide prevention must include information on the relationship between the risk of suicide and incidents of harassment, intimidation, and bullying and information on reducing the risk of suicide in students who are members of communities identified as having members at high risk of suicide. Training must be provided by a licensed health care professional with special training in mental health issues.

N.J.S.A. 18A:6-113 – Curriculum

This requires the State Board of Education to revise the Core Curriculum Content Standards in Comprehensive Health and Physical Education to provide for instruction in suicide prevention in an appropriate place in the curriculum of elementary school, middle school, and high school pupils.

New Jersey Youth Suicide Prevention Advisory Council

Established in the Department of Children and Families, the New Jersey Youth Suicide Prevention Advisory Council (Council) includes appointed New Jersey citizens and representatives from a number of state departments. The purpose of the Council is to examine existing needs and services and make recommendations for youth suicide reporting, prevention, and intervention; advise on the content of informational materials to be made available to persons who report attempted or completed suicides; and, advise in the development of regulations required pursuant to N.J.S.A. § 30:9A-25 et seq.

N.J.S.A. 30:9A-13 – Youth Suicide Prevention Program

These regulations require the Commissioner of the Department of Human Services to establish a program of youth suicide prevention projects, administered by community mental health services providers in consultation with local boards of education and includes classroom instruction/materials; training programs for classroom teachers and other teaching staff members in suicide prevention; community based programs such as a 24-hour hotline; and, parent education programs and programs for the families of suicide victims.

N.J.S.A. 30:9A-24 – Reporting Requirements

This law addresses the reporting requirements of attempted or completed suicide by student. A [Suicide Reporting Form](#) is available on the NJDOE website.

N.J.S.A. 30:9A-26

This law requires a public awareness campaign on youth suicide prevention and intervention.

Additional Points for Schools Nursing Practice

Harvard University's, Center on the Developing Child provides information and a video on [resilience](#) which school nurses may find helpful, especially when training teachers or educating parents.

The Harvard University Graduate School of Education article [When the Nurse's Office is a Refuge](#) examines how school nurses can address anxiety in students.

School nurses should act as student advocate and health promoter in advancing both public awareness and education regarding suicide risk factors and treatment options.

School nurses should become involved in public awareness campaigns aimed at reducing suicide risk and promoting overall health.



Students experiencing undiagnosed depression, anxiety, or other mental health issues often present to the school health office with multiple “physical” complaints such as headache, stomach distress, or “feeling sick.” The school nurse’s assessment of these complaints, and subsequent documentation of health office visits, may warrant referral to school counseling personnel or community-based mental health services and the student’s parent/guardian.

NJDOE Suicide Prevention webpage

NASN provides **mental health resources** for school nurses.

The USDHHS sponsors a website with **mental health information** for educators.

2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention

CDC Suicide Facts

National Suicide Prevention Lifeline

NJ Prevention Hotline

NJ Suicide Report 2013 Update

How to Help Someone Thinking about Suicide is a pamphlet that has been translated into multiple languages.

After a Suicide Toolkit for Schools is made available through the American Foundation for Suicide Prevention.

Preventing Suicide Guidelines for Administrators was developed by the National Association of School Psychologists and provides background information on crisis teams, intervention, and prevention.

Model Suicide Prevention Policy

The American Association of Suicidology is a national non-profit that provides training, resources and **Infographics**.

Social, Emotional, and Mental Health

Topic: Harassment, Intimidation, and Bullying

Background and Rationale

School nurses have a critical role to play in the prevention of bullying behaviors. Bullying is defined as any unwanted aggressive behavior(s) by another youth or group of youths, who are not siblings or current dating partners, involving an observed or perceived power imbalance. The behaviors are repeated multiple times or are highly likely to be repeated.

Bullying may inflict physical, psychological, social, or educational harm. A young person can be a perpetrator, a victim, or both (CDC, 2017a).

Bullying can occur in person or as “cyber” bullying—that is, bullying takes place via email, chat rooms, instant messaging, or other forms of social media. The [CDC’s Bullying Fact Sheet](#) shows that in a 2015 nationwide survey, 20% of high school students reported being bullied on school property in the 12 months preceding the survey, and an estimated 16% of high school students reported they were bullied electronically in the 12 months before the survey (CDC, 2016a).

In addition, the incidence of suicide connected to bullying has risen. Dealing with bullying and suicide as significant public health problems, the CDC published [The Relationship Between Bullying and Suicide](#). Students who are involved with bullying (as either victim or perpetrator) may experience depression, anxiety, involvement in interpersonal violence or sexual violence, substance abuse, poor social functioning, and poor school performance, including lower grade point averages, standardized test scores, and poor attendance. These youth are at increased risk for suicide-related behavior. Youth who report both bullying others and being bullied (bully-victims) have the highest risk for suicide-related behavior of any groups that report involvement in bullying (CDC, 2014).

The US Department of Health and Human Services sponsors the [Stopbullying](#) website which provides information and resources as well as a bullying hotline and access to state policies and programs. NASN made bullying prevention a hallmark of its public health and school nursing agenda and published [Bullying Prevention in Schools](#) to provide school nurses with information and resources. The National Education Association (NEA) published [Perspectives on Bullying](#) that addresses how students who are bullied frequently confide in school nurses.

School nurses are increasingly aware of the adverse effects of bullying in school settings. Bullying affects the whole person and has enormous physical effects, including exhaustion due to lack of sleep, weight loss, fatigue, and physical pain. Students who are bullied may exhibit neck and shoulder pain, headaches, low back pain, stomach aches, feeling tense or nervous, fatigue, difficulty sleeping, dizziness, and increased frequency of illness related to chronic stress (Gini, et al., 2014). Children may also experience psychological symptoms, including but not limited to, social difficulties, internalizing symptoms, anxiety, depression, suicidal ideation, and eating disorders (Gini & Pozzoli, 2013).

Children who are victims of bullying need adult guidance, counseling, and a place to seek refuge. School nurses are well equipped to provide the physical care and emotional support these children need. School nurses and other members of the school health team need to understand the actions that constitute bullying, understand appropriate interventions, and work collaboratively to ensure that students are referred to the appropriate adult within the school system.



Applicable Laws and Regulations

On January 5, 2011, Governor Christie signed into law P.L. 2010, Chapter 122, an act concerning HIB in school settings that amended various parts of the statutory law. In particular for school policies and procedures, the act amended N.J.S.A. 18A:37-13 et seq., which include the requirements for the prevention and intervention of HIB on and off school grounds, at school-sponsored functions and on school buses. New Jersey has been at the forefront of anti-bullying legislation, programs and services. The NJDOE provides a [model policy](#) and [FAQ](#) to address incidents of harassment, intimidation and bullying (HIB).

Anti-Bullying Law

March 2012 Amendment (P.L. 2012, c.1)

N.J.A.C. 6A:16-7.7 – Harassment, Intimidation, and Bullying

This is a summary of key points contained in the HIB [regulations](#). The regulations require each district board of education to develop, adopt, and implement a policy prohibiting harassment, intimidation, or bullying on school grounds. The policy must be developed in consultation with, at a minimum, parents and other community members, school employees, school volunteers, students, and school administrators. The policy must contain, at minimum:

- A statement prohibiting harassment, intimidation or bullying of a student;
- A definition of harassment, intimidation or bullying no less inclusive than that set forth in the definition at N.J.S.A. 18A:37-14 and N.J.A.C. 6A:16-1.3;
- A description of the type of behavior expected from each student; and,
- Appropriate remedial action for a student who commits an act of harassment, intimidation or bullying that takes into account the nature of the behavior, the developmental age of the student and the student's history of problem behaviors and performance.

The policy must address any behavioral evaluation and referral as well as consequences for students who commit an act of harassment, intimidation, or bullying.

A district board of education member, school employee, contracted service provider, student, or volunteer who has witnessed, or has reliable information that a student has been subject to harassment, intimidation, or bullying must report the incident to the appropriate school official designated by the district board of education's policy, or to any school administrator or safe schools resource officer, who must immediately initiate the school district's procedures concerning harassment, intimidation, and bullying. A district board of education member or school employee who promptly reports an incident of harassment, intimidation, or bullying to the appropriate school official designated by the district board of education's policy, or to any school administrator or safe schools resource officer, and who makes the report in compliance with the district board of edu-

cation's policy, is immune from a cause of action for damages arising from a failure to remedy the reported incident, as set forth in N.J.S.A. 18A:37-16.c.

A school administrator who receives from a school district employee a report of harassment, intimidation, or bullying, and fails to initiate or conduct an investigation, or who should have known of an incident of harassment, intimidation, or bullying and fails to take sufficient action to minimize or eliminate the harassment, intimidation, or bullying, may be subject to disciplinary action.

Training must be provided annually to all school personnel and the policy must also be discussed annually with all students. An anti-bullying coordinator must be appointed to oversee the requirements set forth in the law and rules.



Key Point

The parents of students involved in a bullying incident may request a hearing with the local board of education. The Board of Education can reject, concur, or modify the superintendent's decision (N.J.S.A.18A:37-13 et seq). If the parents are still not satisfied they can appeal to Commissioner of Education (N.J.S.A.18A:37-13 et seq).

Additional Points for Nursing Practice

Students often come to the health office with an array of “physical” complaints that may actually be the result of teasing or bullying. The school nurse, along with other members of the school health team, should carefully document and investigate when these visits occur to determine if there is a pattern. The school nurse should address the issue according to school district policy.

Bullying may occur anywhere but it frequently occurs in areas of the school that have less adult supervision such as bathrooms, locker rooms, the playground, bus stop, or on the school bus. Schools need to provide adequate supervision in all areas of the school campus and at all activities associated with the school.



Key Point

The school nurse should monitor daily visits to the health office to see if the type and frequency of visits may be connected to bullying behaviors occurring before or after school or during specific school activities or classes such as recess, physical education, or lunch.

Students need to develop problem-solving techniques, coping strategies, anger management skills, and a positive self-image. High-quality health education classes, aligned with New Jersey's curriculum requirements, provide students with time to learn and practice these skills. School nurses should educate students about depression prevention strategies such as stress management, regular exercise, and finding social support. The school nurse should also advocate for a quality skill-based health curriculum that



addresses the full range of social, emotional, and mental health issues along with the skills to deal with them.

Administrators, families, and community leaders can work with the school health team to implement anti-bullying programs that ultimately foster healthy and safe school environments.

Bullying can occur at any age: [Bullying in Early Childhood](#). It is important that even young children understand bullying behaviors. Teasing that is hurtful, unkind, and constant crosses the line. Also, children need to understand when their own behavior has crossed the line.

[NJDOE Harassment, Intimidation and Bullying Page](#)

[NJEA on Bullying](#)

[National Association of School Psychologists Bullying Prevention](#)

[Kids Health Cyber Bullying](#)

[Cyber Bullying](#), a page created by Pacer Center's Teens Against Bullying.

[Preventing Bullying: The Role of Public Health and Safety Professionals](#)

Supporting Social, Emotional, and Mental Health

Topic: Sexual Violence

Background and Rationale



Because school nurses work closely with students, they may become aware of sexual behaviors that place students at risk or that may be in violation of state law. Incidents of sexual assault and dating violence have become all too common and school nurses need to understand how to respond to suspicions or confirmed incidents. Students may experience physical or sexual abuse within their

romantic relationships. Dating violence can also include harassing, stalking, or controlling a romantic partner via technology and social media. Dating abuse can be physical, sexual, or psychological. Sexual assault may not involve a "relationship" at all; incidents of sexual assault have occurred in school locker rooms and other campus locations. Sexual violence may also include sexting (CDC, 2017b). While New Jersey law and regulations specifically address harassment, intimidation, and bullying, there are numerous laws and rules that address dating violence, sexual assault, and related issues. It is im-

portant to understand that sexual violence, in all its forms, is a critical issue for students, schools, school health personnel, and communities.

The age of consent in New Jersey is 16 years old. In fact, individuals may marry with parental consent at age 16 and without consent at age 18. New Jersey also has a “Romeo and Juliet” provision which establishes a close in age exemption, allowing minors between ages 13 and 15 to engage in a sexual relationship with a partner up to 4 years older (Age of Consent, 2017). These laws vary from state to state and thus create uncertainty or misinformation about the “legality” of certain actions. In addition, students who arrive in New Jersey from other countries may have different perspectives on consent, sexual relationships, and marriage. Culture and religion may play a role as well.

Sexual assault and dating abuse are forms of sexual violence. The CDC defines **sexual violence** as a sexual act committed against someone without that person’s freely given consent. It outlines the following types:

- Completed or attempted forced penetration of a victim;
- Completed or attempted alcohol/drug-facilitated penetration of a victim;
- Completed or attempted forced acts in which a victim is made to penetrate a perpetrator or someone else;
- Completed or attempted alcohol/drug-facilitated acts in which a victim is made to penetrate a perpetrator or someone else;
- Non-physically forced penetration which occurs after a person is pressured verbally or through intimidation or misuse of authority to consent or acquiesce;
- Unwanted sexual contact; and,
- Non-contact unwanted sexual experiences (CDC, 2017c).

The CDC also provides [sexual violence data](#) including information from the latest national surveys.

Recognizing that dating violence is a significant problem, the [NJ Dating Violence Model Policy](#) was created to assist schools. Provisions regarding sexting were added to the [model agreement](#) with law enforcement. School nurses need to review their district policy and know their role in the process. They also need to understand age of consent laws, particularly as they pertain to obtaining medical treatment after an assault.

Applicable Laws and Regulations

The New Jersey Code of Criminal Justice defines terms applicable to sexual misconduct in [N.J.S.A. 2C:14-1](#). Sexual penetration is defined as vaginal intercourse, cunnilingus, fellatio or anal intercourse between persons or insertion of the hand, finger or object into the anus or vagina either by the actor or upon the actor’s instruction. The depth of insertion shall not be relevant as to the question of commission of the crime. Sexual contact means an intentional touching by the victim or actor, either directly or through clothing,



of the victim's or actor's intimate parts for the purpose of degrading or humiliating the victim or sexually arousing or sexually gratifying the actor. Sexual contact of the actor with himself must be in view of the victim whom the actor knows to be present. The intimate parts include the sexual organs, genital area, anal area, inner thigh, groin, buttock or breast of a person.

The law defines mentally incapacitated as that condition in which a person is rendered temporarily incapable of understanding or controlling his conduct due to the influence of a narcotic, anesthetic, intoxicant, or other substance administered to that person without his prior knowledge or consent, or due to any other act committed upon that person which rendered that person incapable of appraising or controlling his conduct.

N.J.S.A. 2C:14-2 differentiates between **aggravated sexual assault** and **sexual assault**. The law addresses the age of the victim, the status of the perpetrator (e.g., blood relative, custodial, supervisory), the involvement of a weapon or use of force, and the ability of the victim to understand and provide consent.



Key Point

An actor is guilty of sexual assault if he commits an act of sexual contact with a victim who is less than 13 years old and the actor is at least four years older than the victim.

N.J.S.A. 9:17A-4 – Consent by Minor to Treatment

This law details when a minor may give consent for medical treatment. A minor may consent to the provision of medical or surgical care or services or a forensic sexual assault examination by a hospital or public clinic, or consent to the performance of medical or surgical care or services or a forensic sexual assault examination by a health care professional, when the minor is or believes that he or she may be afflicted with a venereal disease, or who is at least 13 years of age and is or believes that he or she may be infected with the human immunodeficiency virus or have acquired immune deficiency syndrome, or by a minor who, in the judgment of the treating health care professional, appears to have been sexually assaulted. When a minor appears to have been sexually assaulted, the minor's parents or guardian shall be notified immediately, unless the treating healthcare professional believes that it is in the best interests of the patient not to do so. Inability of the treating health care professional, hospital, or clinic to locate or notify the parents or guardian shall not preclude the provision of any emergency or medical or surgical care to the minor or the performance of a forensic sexual assault examination on the minor.

Sexting

A **Uniform State Memorandum of Agreement Between Education and Law Enforcement Officials** defines sexting as the sending of sexually explicit photos by electronic means such as text message. This may constitute a criminal act pursuant to New Jersey's child

pornography laws. For instance, it is a crime to give to someone else, offer to give to someone else, transfer, disseminate, distribute, circulate, or possess pornography depicting a child, defined as a person younger than 18 (N.J.S.A. 2C:24-4). New Jersey created an alternative to criminal prosecution for teens charged with child pornography as a result of sexting (N.J.S.A. 2A:4A-71.1). If the court deems it appropriate, these teens may be ordered to participate in an educational program or counseling in lieu of prosecution. Both the creator and subject of the sexting image must be younger than 18 to be eligible for this program.

School officials must agree to report to law enforcement officials any sexting incident that may constitute a criminal offense under the New Jersey Code of Criminal Justice. Sexting may also constitute harassment, intimidation, and bullying. Law enforcement officials agree to notify the principal of the school at which a student is enrolled when a student or a student's parent or guardian reports to the law enforcement agency that a student may be the victim of HIB, as defined in the Anti-Bullying Bill of Rights Act.

N.J.S.A. 8A:35-4.3 – Sexual Assault Prevention Education Program

This law required the NJDOE, in consultation with an advisory committee, to develop and establish guidelines for the teaching of sexual assault prevention techniques for utilization by local school districts in the establishment of a sexual assault prevention education program. The program shall be adapted to the age and understanding of the pupils and shall be emphasized in appropriate places of the curriculum sufficiently for a full and adequate treatment of the subject.

N.J.S.A. 18A:37-33 to 35 – Dating Violence Policy and Education

The Legislature established that a student who is a victim of dating violence suffers academically, and the student's safety at school is jeopardized; and since all students have a right to learn and study in a safe, supportive environment that is free from violence, each school district should have a policy to prevent, and for responding to, incidents of dating violence, and should provide dating violence education to students in order to prevent dating violence and address incidents involving dating violence. The rules provide the following definitions:

- School means in a classroom or anywhere on school property, on a school bus or other school-related vehicle, at an official school bus stop, or at any school-sponsored activity or event whether or not it is on school grounds.
- Dating partner means any person involved in an intimate association with another individual that is primarily characterized by the expectation of affectionate involvement, whether casual, serious, or long-term.
- Dating violence means a pattern of behavior where one person threatens to use, or actually uses physical, sexual, verbal, or emotional abuse to control a dating partner.



School districts are required to develop a policy that contains, at minimum, the following components:

- A statement that dating violence will not be tolerated;
- Dating violence reporting procedures;
- Guidelines for responding to at-school incidents of dating violence;
- Discipline procedures specific to at-school incidents of dating violence;
- Warning signs of dating violence; and,
- Information on safe, appropriate school, family, peer, and community resources available to address dating violence.

The policy must be made readily available to the entire school community via the school website, handbook, or other easily accessible means.

Additional Points for School Nursing Practice

School nurses must be knowledgeable of district policies and legal issues regarding sexual assault and dating violence. Such incidents can occur at any grade level.

Be sensitive to student “signals” that a relationship might be unhealthy. Educate students about healthy relationships versus an unhealthy and potentially dangerous relationships. Avoid stereotyping, as both males and females can be victims of dating violence and abuse.

Teen Dating Abuse: Recognition and Interventions: NASN School Nurse, December 2012

Digital Forms of Dating Violence: What School Nurses Need to Know: NASN School Nurse, November 2016

The CDC supports a number of prevention programs including [Safe Dates](#) and [Shifting Boundaries](#).

NASN also published the [Role of the School Nurse in Violence Prevention](#).

[Break the Cycle](#) is a national organization that supports everyone’s rights to a safe and healthy relationship, regardless of gender, ethnicity or sexual identity. It provides information, training, and advocacy.

For perspective on this issue, read [The Need for Response to Sexual Assault in Middle and High School](#).

[The Younger Victims of Sexual Violence in School](#) appeared in the August 12, 2017 edition of *The Atlantic*. It discusses how K-12 schools have addressed sexual assault issues and the role of the Office of Civil Rights.

CDC’s Dating Violence Fact Sheet

The National Coalition of STD Directors (NCSD) and Cicatelli Associates Inc. (CAI) along with the CDC collaboratively developed two **sexual health resources**: *Developing a Referral System for Sexual Health Services: An Implementation Tool Kit* and *Establishing Organizational Partnerships to Increase Student Access to Sexual Health Services: A Resource Guide for Education Agencies*. These toolkits provide information and resources how to work with community-based sexual health services for adolescents.

Supporting Social, Emotional, and Mental Health

Topic: LGBTQ Issues

Background and Rationale

Data from the 2015 Youth Risk Behavior Surveillance System (YRBSS) showed that nationwide 88.8% of students identified as heterosexual, 2.0% identified as gay or lesbian, 6.0% identified as bisexual, and 3.2% were not sure of their sexual identity (Kann, et al., 2016). Significant health disparities exist between sexual minority and nonsexual minority youth. Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) youth have a higher incidence of anxiety and depression and are more likely to be homeless than their heterosexual peers, which creates significant barriers to health, safety, and school success. Additionally, they are more likely to be the victim of harassment, bullying, and intimidation (HIB). According to the YRBSS report, 26% of transgender students were physically assaulted in school in the past year because of their gender expression (Kann, et al., 2016).

Studies show that when compared with the general population, gay and bisexual men, lesbian, and transgender individuals are more likely to:

- Use alcohol and drugs;
- Have higher rates of substance abuse;
- Not withhold from alcohol and drug use; and,
- Continue heavy drinking into later life (CDC, 2016b).

Most LGBTQ youth are happy and thrive during their adolescent years; however, those who experience anti-LGBTQ messages in school may become depressed and lonely and experience self-hate and a diminished sense of self-worth. These attitudes may result in chronic absenteeism, psychosomatic disorders, substance abuse, and acute anxiety disorders. Learning in a safe and supportive environment and having caring and accepting parents and families are especially important.

The school nurse plays an important role creating a safe and supportive school for students, their families, and school staff. As a member of the school health team, school nurses are a valuable resource for LGBTQ youth on issues such as bullying, healthcare (including mental health issues), sexual health, substance abuse prevention, and peer and family relationships. The school health office should be a “safe space” where all stu-



Key Point

The school nurse also plays an important role educating all school staff and helping to shape attitudes, ameliorate prejudices, and create positive spaces for all students.

dents feel comfortable, cared for, and valued. Addressing the needs of a sexual minority students requires a culturally sensitive, multidisciplinary approach. The school nurse serves as an advocate for school-wide change and anti-bullying policies. Supporting and sponsoring a gay-straight alliance can be an important part of creating a safe haven for every student.

Because of the risk of depression in LGBTQ students, coping strategies and stress management are critical. The school nurse educates students and staff about depression. In addition, the school nurse should maintain a list of resources for LGBTQ-friendly health-care and assist students who need referrals. As part of the school health team, nurses and counselors must work together to ensure that gender and sexual minority youth feel connected to the school community (Perron, et al., March 2017a).

Applicable Laws and Regulations

N.J.A.C. 6A:16-7.1(c)5iii – Student Codes of Conduct

These rules provide for the equitable application of the code of student conduct without regard to race; color; religion; ancestry; national origin; nationality; sex; gender; sexual orientation; gender identity or expression; marital, domestic-partnership, or civil union; mental, physical, or sensory disability; or any other distinguishing characteristic, pursuant to N.J.S.A.10:5-1 et seq.

N.J.A.C. 6A:7-1.3 – Managing for Equality and Equity in Education

Affectional or sexual orientation is defined as male or female heterosexuality, homosexuality, or bisexuality by inclination, practice, identity, or expression, having a history thereof, or being perceived, presumed, or identified by others as having such an orientation.

A discriminatory practice is a policy, action, or failure to act that limits or denies equal access to or benefits from the educational activities or programs of a school, or that generates or permits injustice or unfair or otherwise inequitable treatment of students or staff on the basis of race, creed, color, national origin, ancestry, age, marital status, affectional or sexual orientation, gender, religion, disability, or socioeconomic status.

Gender identity or expression means having or being perceived as having a gender-related identity or expression whether or not stereotypically associated with a person's assigned sex at birth.

N.J.A.C. 6A:7-1.4 – Equity Policies

Each district board of education shall adopt and implement written educational equity policies that:

1. Recognize and value the diversity of persons and groups within society and promote the acceptance of persons of diverse backgrounds regardless of race, creed, color, national origin, ancestry, age, marital status, affectional or sexual orientation, gender, religion, disability, or socioeconomic status;
2. Promote equal educational opportunity and foster through the policies, programs, and practices of the district board of education a learning environment that is free from all forms of prejudice, discrimination, and harassment based upon race, creed, color, national origin, ancestry, age, marital status, affectional or sexual orientation, gender, religion, disability, or socioeconomic status.

Additionally, school districts must provide professional development to all staff and must ensure that educational program and services are made available to all as delineated above. Every three years, districts are required to develop and submit a comprehensive equity plan that addresses these issues for students and staff.

P.L. 2010 Chapter 122 – New Jersey Anti-Bullying Bill of Rights Act

The intent of this law is to establish clear standards on what constitutes harassment, intimidation, and bullying. It provides standards on how to prevent, report, investigate, and respond to incidents of harassment, intimidation, and bullying. Note: The regulatory framework for HIB is addressed in more detail earlier in this chapter.

N.J.A.C. 6A: 16-7.7 – Bullying (HIB)

District boards of education shall develop, adopt, and implement a policy prohibiting HIB on and off school grounds, at school-sponsored functions, and on school buses. All staff members must be provided with training on the school's HIB policy and they must complete at least two hours of instruction on HIB prevention in each professional development period.



Key Point

*P.L. 2017, Chapter 137 **Schools and Transgender Students** was approved July 21, 2017 and requires the NJDOE to develop and distribute guidelines for school districts.*

Additional Points for School Nursing Practice

In order to deliver culturally sensitive care, school nurses must have an understanding of the terminology used by sexual minority students. Be advised that some terms may be defined slightly differently in various sources. However, informed school nurses will be better prepared to create an environment where LGBTQ students feel safe without fear of judgment or retribution (Selekman, 2016).



Some key definitions and terms include:

- Gender is the attitudes, feelings, and behaviors that a given culture associates with a person's biological sex (male or female).
- Sex is assigned at birth, and is based on an assessment of external genitalia, chromosomes, or gonads.
- Cisgender individuals have a gender identity that is aligned with the sex they were assigned at birth.
- Gender identity refers to a person's internal sense of being male, female, both, neither, or something else.
- Gender expression is how a person communicates or displays gender (e.g. hairstyle, clothing, speech, mannerisms).
- Homosexual describes someone who is emotionally, romantically, and physically attracted to members of the same gender.
- Gay means a male who forms his primary loving sexual, and/or intimate relationships with other men; may also be used to describe both men and women who are emotionally, romantically, and physically attracted to members of the same gender.
- Lesbian means a woman who forms her primary loving sexual, and/or intimate relationships with other women.
- Bisexual means emotionally, sexually, and/or intimately attracted to members of either sex, not necessarily at the same time.
- Transgender is an umbrella term that describes people whose gender expression differs from the sex that was assigned at birth.
- Queer is an umbrella term used to describe sexual orientation, gender identity, and gender expression; it can be used as a derogatory term depending on the context in which it is used.
- Questioning: is a term used to describe people who are in the process of exploring their sexual orientation or gender identity

Adapted from: (Perron, et.al. March 2017b).

When dealing with sensitive issues that involve a young person's sexual identity or experiences, the school nurse must maintain confidentiality (except for mandatory HIB reporting).

School nurses must not assume that all children have a "mommy" and a "daddy" and that all family members live together. The changing landscape of families requires school personnel to be sensitive and gender-neutral when referring to a child's "parents." The [Pew Research Center](#) provides insight into the number of children living in non-traditional families. Similarly, [Life Long Adoptions](#) provides some insight into same-sex households and children.

[AAP Statement in Support of Transgender Children, Adolescents and Young Adults](#)

Timely information can be found in an article in the April 2017 edition of the *Journal of School Nursing: Supporting the Health and Well-Being of Transgender Students*.

The Human Rights Campaign, the American College of Osteopathic Pediatricians, and the AAP produced *Supporting and Caring for Transgender Children*.

Human Rights Campaign Resources for Parents

The mission of **GLSEN** is to create safe and affirming schools for all, regardless of sexual orientation, gender identity, or gender expression. GLSEN developed a **Safe Space Kit** that school nurses can use to demonstrate support for LGBTQ students, educate about anti-LGBTQ bias, and advocate for changes in the school. The GLSEN Safe Space rainbow sticker is a visible symbol indicating to students that the school health office is a safe space for LGBTQ youth and that the school nurse is comfortable discussing LGBTQ issues with students in a respectful and confidential way.

Sexual minority youth may not always understand their feelings. The school health office must be a place where students can ask questions and, in private, discuss their thoughts and feelings.

Listen to what children say about their gender. Even young children can express concerns or ask questions about being a boy or a girl. **Ready, Set, Respect!** was developed by GLSEN in partnership with the **National Association of Elementary School Principals** (NAESP), an organization that serves elementary and middle school principals in the United States, Canada, and overseas and the **National Association for the Education of Young Children** (NAEYC), the world's largest organization working on behalf of young children. The program focuses on bullying and bias, family diversity, and gender roles.

The school nurse, as part of the school health team, is uniquely situated to support sexual minority youth and their families. Assess and provide referrals for families that need information and support. Community connections are important.

Welcoming Schools is a project of the Human Rights Campaign and focuses on creating a safe environment in elementary schools.

Stop Bullying

The **GSA Network** is a next-generation LGBTQ racial and gender justice organization that empowers and trains queer, trans and allied youth leaders to advocate, organize, and mobilize an intersectional movement for safer schools and healthier communities.

Gay-Straight Alliances are student clubs that work to improve school climate for all students, regardless of sexual orientation or gender identity/expression.

The ACLU publishes **Know Your Rights for High School Students**.

NJSIAA Transgender Policy for New Jersey High School Sports

An article from Educational Leadership: **Welcoming Children from Gay Families into Our Schools**.



Supporting Social, Emotional, and Mental Health

Topic: Adverse Childhood Experiences (ACEs)

Background and Rationale

New national data show that at least 38% of children in every state have had at least one adverse childhood experience (ACE) such as the death or incarceration of a parent, witnessing or being a victim of violence, or living with someone who has been suicidal or had a drug or alcohol problem. These findings come from data in the 2016 National Survey of Children's Health, conducted by the Johns Hopkins Bloomberg School of Public Health and supported by the Robert Wood Johnson Foundation (RWJF). ACEs can have serious, long-term impacts on a child's physical, social, emotional, and cognitive development. Research shows that ACEs increase the long-term risk for smoking, alcoholism, depression, heart and liver diseases, and dozens of other illnesses and unhealthy behaviors. The new data show that 33% of children with two or more ACEs have a chronic health condition involving a special health care need, compared to 13.6% of children without ACEs. Nationally, more than 46% of U.S. youth—34 million children under age 18—have had at least one ACE, and more than 20% have had at least two (RWJF, October 2017).

The study found that ACEs impact children and families across racial, ethnic, and socioeconomic groups. Roughly 40% of white children have one or more ACEs, compared to 51% of Hispanic children and nearly 64% of black children. ACEs are more prevalent among children in low-income families—62% of children with family incomes under 200% of the federal poverty level have had at least one ACE; however, 26% of children in families with incomes higher than 400% of the federal poverty level have also had one or more ACEs (RWJF, October 2017).

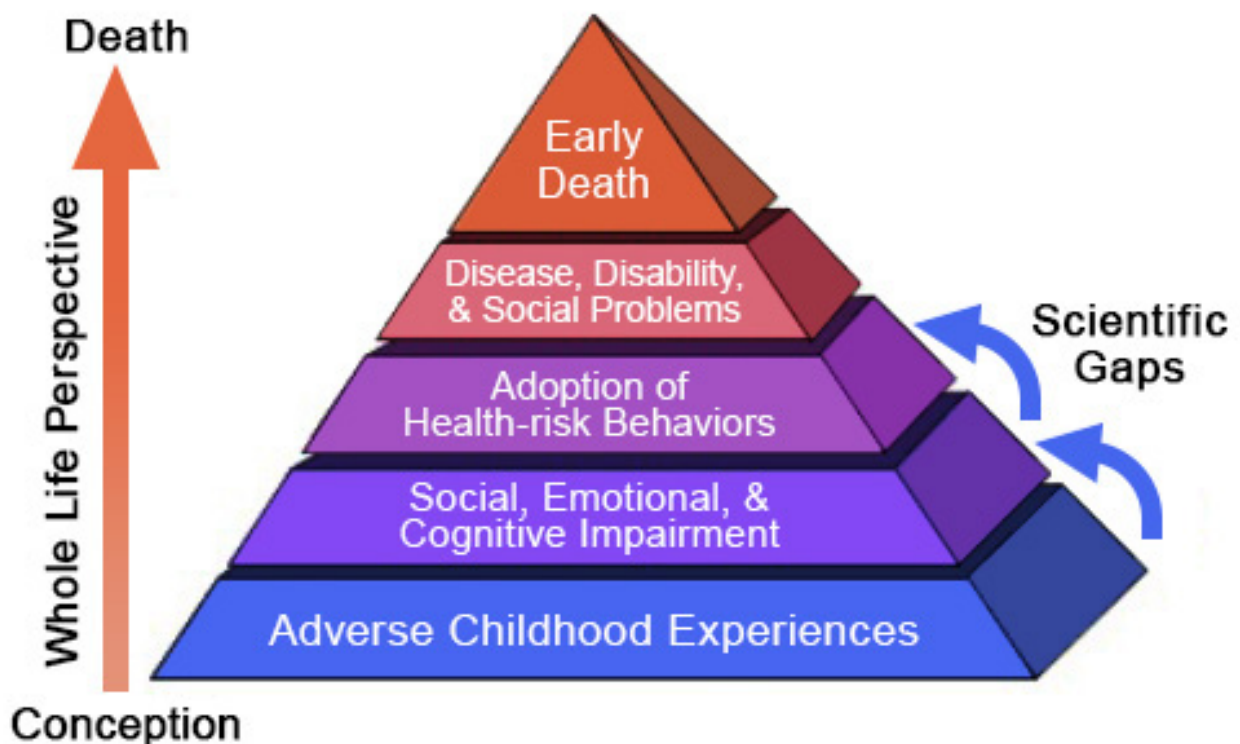
ACEs impact a child's social emotional development and chances of school success. Children ages 6 to 17 who have had two or more ACEs are twice as likely to be disengaged from school than are peers who have had no ACEs. However, these children can be taught to stay calm and in control when faced with challenges. Family routines, such as eating family meals together, reading to children, limiting screen time, and not using tobacco at home can help. According to Christina Bethell, PHD, director of the Child and Adolescent Health Measurement Initiative (CAHMI) at Johns Hopkins:

ACEs and other traumatic events don't just affect an individual child—families, neighborhoods and communities all bear the brunt of these difficult circumstances, which add up over time. If a child's stress and unhealed trauma leads to acting out in class, that disruption is felt by the other children in the room as well as the teacher. These impacts require the healing of trauma at a family, community, and societal level. Practitioners and policymakers should respond to these new data by advancing strategies that can both prevent ACEs in the first place and support families and communities as they learn and heal (RWJF, October 2017).

ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse. Examples of ACEs include:

- Physical, sexual or emotional abuse;
- Physical or emotional neglect;
- Intimate partner violence;
- Mother treated violently;
- Substance misuse within household;
- Household mental illness;
- Parental separation or divorce; and,
- Incarcerated household member (SAMHSA, 2017)

The Adverse Childhood Experiences Pyramid (SAMHSA, 2017) puts the concept of ACEs into a whole-life perspective.





Trauma sensitive schools create an environment where all students feel safe, welcomed, and supported and where addressing trauma's impact on learning is at the center of its educational mission. All school personnel are well-versed in ways to create a safe environment for every child. ACEs can even impact a child's ability to learn—to read, write, and solve mathematical problems. In order for students to engage, they must self-regulate attention, emotions, and behavior. Trauma has the power to undermine the development of language and communication skills and impact a student's sense of self. The student may have difficulty with organization and memory as well as comprehension strategies such as cause and effect. Children affected by ACEs may find creative play difficult and may present behavioral issues that frustrate educators. These children need to be taught coping skills and how to regulate their behavior. They must be taught how to deal with social cues and how to express their feelings in an appropriate way. Some children will act out while others may withdraw. The day-to-day struggles in school and at home, where situations may be insecure or stressful, can impact their relationships with adults and peers. Some children are so preoccupied with their physical and psychological safety, that they do not trust adults or even the school in general, to keep them safe. Keep in mind that schools may not know if students have been affected by traumatic events (TLPI, ND).

Programs and services are most effective when they are coordinated to help students feel safe and supported throughout the school day. Trauma sensitive schools take a "whole child" approach as well as a "whole school" approach. School policies and practices support a safe, consistent approach in every facet of school life. It cannot be effective if the strategies and expectations are limited to a few classrooms where teachers "buy-in" to the concept.

SAMHSA describes the three "Es" of trauma as Events, Experience of Events, and Effects. Events may include the actual or extreme threat of physical or psychological harm or severe, life-threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. One individual may experience an event as traumatic while it may not have the same impact on another. An individual may be disrupted physically and psychologically by an event based on how they perceive that event. How the event is experienced may be linked to cultural beliefs, the availability of social supports, or to the developmental stage of the individual. The adverse effects may be immediate or delayed and can be short or long term. Traumatic effects may range from hyper-vigilance or a constant state of arousal to numbing or avoidance, wearing the individual down physically, mentally, and emotionally. (SAMHSA, 2014).

School nurses are advantageously positioned as members of the school health team to educate and collaborate with school personnel, community health care professionals, students, and families to create a trauma-informed approach. Programs and services should focus on assets and strengths rather than risks. School nurses must remember that trauma does not occur in a vacuum; rather, trauma may impact the entire school. Similarly, trauma can also effect the entire community and the responses to significant events parallel those of individuals.

A **trauma informed approach** to care involves changing the school ethos from “what is wrong with you” to “what happened to you?” A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures:

- **Safety:** Students and staff feel physically and psychologically safe. Creating a safe and healthy school environment is a priority.
- **Trustworthiness and Transparency:** Policies and decisions are conducted in a transparent manner, building and maintaining trust with students, staff, and family members.
- **Peer Support:** Mutual self-help is important to establish safety and hope, build trust, and enhance collaboration to promote recovery and healing.
- **Collaboration and Mutuality:** Healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. As one expert stated: “one does not have to be a therapist to be therapeutic.”
- **Empowerment, Voice, and Choice:** Individuals’ strengths and experiences are recognized and built upon. The organization believes that individuals, organizations, and communities can heal and recognizes that trauma may be a unifying aspect.
- **Cultural, Historical, and Gender Issues:** The organization incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served. It moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography) and offers access to gender responsive services. It also recognizes the healing value of traditional cultural connections (SAMHSA, 2014).





The **National Childhood Traumatic Stress Network** created **Creating, Supporting, and Sustaining Trauma-Informed Schools: A System Framework** to help schools develop trauma-informed policies, training, and practices. The Network summarizes five key responsibilities of school nurses that support a trauma-informed school.

School nurses:

1. Oversee the health and well-being of students;
2. Assist in identifying children and staff who may need additional mental health services and support, especially students and personnel who present with somatic complaints;
3. Provide training, when appropriate, to students and personnel about the interplay of health and mental health factors;
4. Monitor the health of high-risk students; and,
5. Coordinate health and mental health referrals from staff (NCTSN, 2017).

Applicable Laws and Regulations

Because of the broad nature of childhood trauma, there are no New Jersey laws and regulations that address it specifically; rather, there are numerous laws and rules that address related issues such as mental health, substance abuse, bullying, sexual violence, and school safety and security. Please see those sections of this chapter for legal and regulatory references.

Additional Points for School Nursing Practice

The [ACES Issue Brief](#) provides important data and information on this critical issue to schools and communities.

The school health team should work collaboratively with the district's crisis team to discuss responses and interventions to an array of possible scenarios.

Since the school nurse knows many of the school's families, it is important that regular lines of communication be kept open and trust be developed and maintained, even as students get older and become less dependent on the school nurse.

So many of these issues are related. The school nurse must have a clear understanding of issues surrounding substance abuse, child abuse and neglect, mental health issues, sexual violence, and violence and bullying behaviors and how they are connected to and impact childhood trauma.

NJ Division of Children and Families Taming Trauma

A description of [trauma types](#) along with related information and resources can be found here: [National Childhood Traumatic Stress Network](#).

The NASN document, [Child Maltreatment](#), addresses the nurse's role caring for victims.

NASN adopted a position paper, [Behavioral Health of Students](#), which describes the role of the school nurse as part of the school mental health team.

The [National Resilience Institute](#) supports research and advocacy and provides training.

The [RWJF article on school attendance and health](#) addresses why some children do not attend school.

Sample ACE Survey

The [CDC ACEs](#) web page includes resources and data on ACEs.

[CHOP Childhood Adversity](#): Research focusing on adding children's voice and communication to assess adversity. The City of Philadelphia and researchers at Penn and CHOP received funding from several foundations to assess children's exposure to trauma.

A clinical article published in *Academic Pediatrics* in October 2017: [Methods to Assess Adverse Childhood Experiences of Children and Families: Toward Approaches to Promote Child Well-being in Policy and Practice](#)

The [National Institute for Trauma and Loss in Children](#) provides tools and training.

[Helping Traumatized Children Learn Vol 1 and Vol 2](#) can be downloaded free of charge.

[Child Trauma Toolkit](#) includes resources for schools and parents.

[The Heart of Learning: Compassion, Resiliency, and Academic Success](#) was published in 2009 by Western Washington University and the Washington State Office of Public Instruction.

[Child Trauma Academy](#) is a Houston-based nonprofit that provides direct services, training, and research.

Elementary level school nurses may want to read Susan E. Craig's book, *Trauma-Sensitive Schools: Learning Communities Transforming Children's Lives K-5*.

[Childhood Trauma: Expert Answers to Tough Questions From Real Teachers](#) is sponsored by the National Institute for Trauma and Loss in Children (TLC).

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CHAPTER TEN: Supporting Children, Adolescents, and Families

Topic: Reducing Chronic Absenteeism

Background and Rationale



Chronic absenteeism is defined as missing at least 10% of school days in a school year for any reason, excused or unexcused. It is a primary cause of low academic achievement and a predictor of those students who may eventually drop out of school. An estimated five to seven and a half million students miss 18 or more days of school each year, which puts them at significant risk of falling behind aca-

demically and failing to graduate from high school. Chronic absenteeism is also an equity issue because it is most prevalent among students from low-income families, students of color, students with disabilities, students who are highly mobile, and/or juvenile justice-involved youth (ED, 2016).

The National Collaborative on Education and Health, a group of over 70 stakeholders representing federal, state, and local government agencies, health and education professionals, advocates, and foundations, examined the leading health conditions and issues impacting school attendance. Clearly, students with one or more health issues are at higher risk for absenteeism and thus, interrupted learning. The Collaborative focused on those health conditions and issues that significantly impact absenteeism and whether significant disparities exist.

- Asthma prevalence is higher in Puerto Rican, African American, and Native American/Alaskan Native children. Children with asthma are 3.2 times as likely to have 10 or more days absent per year than their peers.
- Because they felt unsafe on the way or at school, 7.1% of students reported not going to school at least one day during the last 30 days.
- Children between ages 5 to 17 years miss nearly two million school days in a single year nationwide due to dental health-related problems. Children with poor oral health status are nearly 3 times more likely than their counterparts to miss school as a result of dental pain.



- Food insecurity is more than twice as prevalent among children in households headed by African Americans (36%) or Hispanics (30%), than in those headed by Caucasians (15%). Children who come from food-insecure families are more likely to be suspended from school, have higher absenteeism rates, and have poor health compared to children who come from food-secure homes.
- More African American children (32.5%) and Hispanic children (38.9%) are overweight or obese compared to 28.5% of Caucasian children. Children who are obese are 1.7 times more likely to have 10 or more absences in a given year than their non-obese peers.
- ADHD disproportionately affects urban minority youth from poor families who may not only be more likely to be affected but also less likely to receive accurate diagnosis and treatment. Children affected by ADHD are more likely to exhibit tardiness and absenteeism due to sleep problems caused by the disorder.
- African American and Latino youth are more likely to drink alcohol for the first time before age 13 (21.0% and 21.8% vs. 16.7%) and are more likely to try marijuana for the first time before age 13 (11.5% and 11.7% vs. 6.6%). Reduction of alcohol and drug use is associated with better attendance rates. There is a 10% increase in attendance for every year that the student delays beginning marijuana or alcohol use.
- Three in 10 adolescent girls in America will get pregnant at least once before age 20. Teens who become pregnant are more likely to be chronically absent, less likely to stay in school, and less likely to complete high school or college.
- Twenty-five percent of school-aged children have some form of vision impairment. Low-income and minority youth are at greater risk of under diagnosis and under treatment of vision problems and unmet need for vision care services. Students with vision impairments are at increased risk of disengagement from school and more likely to develop social and emotional problems (National Collaborative, 2015).

How does a school nurse impact student attendance? The Lucile Packard Foundation for Children's Health and Lucile Packard Children's Hospital at Stanford approached the San Jose Unified School District in California to conduct a demonstration project to evaluate what really happens to children's health and academic outcomes when there is a full-time school nurse at the school. The **key outcomes** can be found on Stanford University's website. The project found that:

- Students with access to a full-time school nurse were less likely to visit the emergency room;
- Students were more likely to visit an appropriate health care provider if they had a medical referral from the school nurse;
- Students were less likely to miss school due to illness when they had a full-time school nurse in their school; and,

- A full-time school nurse can help reduce the achievement gap that students with chronic health conditions face (Stanford, 2013; Rodriguez, et al., 2013; Healthy Schools Campaign, 2013).

In November 2017, Advocates for Children of New Jersey (ACNJ) released [Showing Up Matters: The State of Chronic Absenteeism in New Jersey, 3rd Annual Report](#). The report indicated that in the 2015-16 school year nearly 129,000, or 9.7% of New Jersey's 1.3 million students, were identified as being chronically absent while children with special needs were chronically absent 17% of the time. Contributing factors included health, safety, and transportation issues as well as a higher suspension rate for this population. The report also features a special section on the effort of a district's school nurses to serve as "navigators" for families to access supports and care for their child. Another district uses data to identify the root causes of absenteeism and how issues such as domestic violence impact student attendance (Chen & Rice, 2017).

[Attendance Works](#) is a national nonprofit organization focused on improving attendance. It provides toolkits, such as [Teaching Attendance](#), and offers technical assistance to school districts to meet their ESSA goals. It believes in a three tiered approach where a school implements universal strategies for all students, early intervention strategies to encourage and support students identified as having an attendance issue, and intensive support for students facing challenges getting to school (Attendance Works, 2017). When school nurses function as care coordinators they are better able to support all students, identify those who need some assistance, and help students with significant health and social issues that interfere with school attendance.

Applicable Laws and Regulations

In May 2017, the NJDOE published [Guidance for Reporting Student Absences and Calculating Student Chronic Absenteeism](#) to assist districts to accurately represent student attendance as an indicator of school quality. As defined in New Jersey's ESSA State Plan, *chronic absenteeism means the percentage of a school's students who are not present for 10 percent or more of the days that they were "in membership" at a school. Cumulative Days in Membership is an element in the NJDOE's Standards Measurement and Resource for Teaching (NJ SMART), a comprehensive statewide longitudinal data system, and is defined as the number of school days in session in which a student is enrolled/registered during the annual reporting period from July 1 through June 30. The count commences the first day the student is expected to start, even if they do not actually attend that day.*

The guidance explains in detail how attendance and chronic absenteeism is calculated.

N.J.A.C. 6A:32-8.3(a) and (b) – School Day in Session

A day in session is defined as a day on which the school is open and students are under the guidance and direction of a teacher(s); and the day must be 4 hours or more to be considered a full day (or at least 2 and one-half hours for kindergarten).



N.J.A.C. 6A:32-8.3(e) – School Day in Session

A half-day class shall be considered the equivalent of a full day's attendance only if in session for four hours or more, exclusive of recess periods or lunch periods.

A school may have a day in session that would not be counted as a day in membership for a particular student for the following reasons (New Jersey School Register, Ch.3):

- Religious observance (N.J.A.C. 6A:32-8.3(h));
- A college visit (up to 3 days per school year only for students in grades 11 and 12);
- "Take Our Children to Work Day" (pursuant to the memo issued by the Commissioner to all districts on April 25, 2017) or other rule issued by the Commissioner;
- Participation in observance of Veterans Day (N.J.S.A. 18A: 36-13.2) or district board of election membership activities (N.J.S.A. 18A: 36-33); or,
- The closure of a busing district that prevents a student from having transportation to the receiving school.

Schools must be in session a minimum of 180 days. This does not include summer school. Laws addressing attendance include:

N.J.S.A. 18A:38-25 – Attendance Required of Children Between Six and 16;

N.J.S.A. 18A:38-26 – Days when Attendance Required

N.J.S.A. 18A:38-27 – Truancy and Juvenile Delinquency Defined

N.J.S.A. 18A:38-28 – Truants; Return to Parents or School

N.J.S.A. 18A:38-29 – Warning and Arrest of Vagrants or Habitual Truants

N.J.A.C. 6A:16-7.6 – Attendance

Each district board of education must develop, adopt, and implement policies and procedures regarding the attendance of students at the public schools of the school district or at day schools in which students are provided with equivalent instruction. The policies and procedures must include, at a minimum, the expectations and consequences regarding the timely arrival to school and classes and attendance at school and classes.

District boards of education must define unexcused absence that counts toward truancy.

For up to four cumulative unexcused absences, the school district must make a reasonable attempt to notify the student's parents of each unexcused absence prior to the start of the following school day; make a reasonable attempt to determine the cause of the unexcused absence, including through contact with the student's parents; and, identify in consultation with the student's parents needed action designed to address patterns of unexcused absences, if any, and to have the child return to school and maintain regular attendance.

If a potential missing or abused child situation is detected, school personnel must comply with appropriate reporting laws and regulations. School personnel must cooperate with law enforcement or other authorities, as appropriate.

For between five and nine cumulative unexcused absences, in addition to the procedures above, the school district must evaluate the appropriateness of any actions taken thus far and develop an action plan to establish outcomes based upon the student's patterns of unexcused absences and to specify the interventions for supporting the student's return to school and regular attendance. This may include:

- Referral or consultation with the building's intervention and referral services team;
- Conducting tests, assessments, or evaluations of the student's academic, behavioral, and health needs;
- Considering an alternate educational placement;
- Making a referral to or coordinating with a community-based social and health provider agency or other community resource;
- Referring to a court or court program;
- Proceeding in accordance with required procedures to address a potential missing or abused child; and,
- Engaging the student's parents and family.

For cumulative unexcused absences of 10 or more, a student between the ages of six and 16 is truant and the school district must make a determination regarding the need for a court referral for the truancy; continue to consult with the parent and the involved agencies to support the student's return to school and regular attendance; and, cooperate with law enforcement and other authorities and agencies, as appropriate.

A court referral may be made when unexcused absences are determined by school officials to be violations of the compulsory education law and the district board of education's policies.

N.J.S.A. 18A:36-25.2 – Investigation and Reporting

This law addresses unexcused absences from school for five consecutive school days and requires the attendance officer of the district to investigate the absence and notify the district superintendent of the absence. In the event the investigation leads the district superintendent to have reasonable cause to believe the child has been abused or neglected, the district superintendent shall then notify the Division of Child Protection and Permanency in the Department of Children and Families for its determination of whether the division is or has been involved with the child and whether action, as appropriate, is warranted.

When a child's parent, guardian, or other person having charge and control of the child notifies a school district that the child will be withdrawing from the district and transfer-



ring to another school district, the principal of the school from which the child is withdrawing must request that the parent, guardian, or other person having charge and control of the child provide the principal with the name and location of the school district in which the child will subsequently be enrolled and the expected date of enrollment. The principal must provide the information supplied by the parent, guardian, or other person having charge and control of the child to the district superintendent. Five school days following the expected date of enrollment, the superintendent of the district of last attendance shall contact the school district in which the child is to be subsequently enrolled to determine if the child has enrolled in the district. If the child has not been so enrolled, the attendance officer of the transfer district must investigate the failure to enroll and notify the superintendent of the transfer district of the failure to enroll. In the event the investigation leads the superintendent of the transfer district to have reasonable cause to believe the child has been abused or neglected, the superintendent of the transfer district shall then notify the Division of Child Protection and Permanency in the Department of Children and Families for its determination of whether the division is or has been involved with the child and whether action, as appropriate, is warranted. If the child has been so enrolled, the district of last attendance and the transfer district shall arrange for the transfer of the child's records.



Key Point

For each student attending a receiving school with five or more cumulative unexcused absences, the absences must be reported to the sending school district and the sending school district must proceed in accordance with the district board of education policies and procedures.

Key Point

For a student with a disability, the attendance plan and its punitive and remedial procedures must be applied, where applicable, in accordance with the student's IEP and IDEA; the procedural protections set forth in N.J.A.C. 6A:14; accommodation plan under 29 U.S.C. §§ 794 and 705(20); and IHP and IEHP pursuant to N.J.A.C. 6A:16- 2.3(b)3xii.

Additional Points for School Nursing Practice

While the school nurse may be required to develop an IHP/IEHP for certain health conditions (e.g., asthma, diabetes), an IHP/IEHP should be developed for every student with a chronic health condition. The plan should address ways to support the student's attendance.

School nurses should be proactive and identify students with acute health issues that may lead to poor attendance or chronic absenteeism.

School nurses have contact with every student and often know the families of their students as well. Attending school may not be the highest priority for some students who are experiencing family issues. Students may be absent to care for younger siblings or

other family members living in the home. They may have jobs that interfere with school hours. They may also have sleep issues due to late night employment. There may be transportation issues. Not every student who is frequently absent has a health problem but he/she may require assistance from the school's social worker and a referral to community agencies to identify the root cause of attendance issues.



Key Point

School districts must attempt to identify the root cause(s) of chronic absenteeism instead of enacting punitive measures that do not actually improve attendance. The school nurse and the school health team should be actively involved in the analysis of attendance data and policy changes to support attendance.

ACNJ Chronic Absenteeism

RWJF Relationship between School Attendance and Health

Health Issues and Absenteeism

When Girls Don't Graduate, We All Fail was published by the National Women's Law Center and focuses on specific school attendance issues impacting female students.

America's Promise is a national collaborative focused on giving every students a chance to graduate. Retired General Colin Powell served as founding chair and Alma Powell serves as the current chair. National partners include the United Way, Boys and Girls Clubs of America, the National Mentoring Partnership, Points of Light, the Corporation for National and Community Services, and Communities in Schools.

Best Practices in Improving Student Attendance is a review of four school districts that have improved student attendance rates.

EVERYONE Graduates at Johns Hopkins University



Key Point

In some schools, the school nurse may also serve as the attendance officer. The job description and responsibilities for that position should be specifically separate from that of the school nurse. Nurses who serve as attendance officers must ensure that they follow school district policies and have an understanding of the laws and regulations governing attendance and truancy.



Supporting Children, Adolescents, and Families

Topic: Child Abuse and Neglect

Background and Rationale

The New Jersey Taskforce on Child Abuse and Neglect developed *Supporting Strong Families and Communities in New Jersey* to drive community partnerships, planning, dialogue, and problem solving. Child maltreatment is a public health problem that must be addressed using a population-based approach. Child abuse and neglect are the result of individual, family, and community factors. The document provides detailed New Jersey statistics and information, as well as outlining those factors that increase the likelihood that child maltreatment might occur. These factors include but are not limited to:

- Children with special needs;
- Parents who lack an understanding of children's needs, child development, and parenting skills;
- Substance abuse and/or mental health issues including depression in the family;
- Parental characteristics such as young age, low education, single parenthood, large number of dependent children, and low income;
- Family disorganization, dissolution, and violence including intimate partner violence;
- Community violence; and,
- High poverty and residential instability, high unemployment rates, and high density of alcohol outlets (NJ Taskforce, 2017).

Child maltreatment includes all types of abuse and neglect of a child under the age of 18 by a parent, caregiver, or another person in a custodial role that results in harm, potential for harm, or the threat of harm to the child.

There are four common types of child maltreatment:

- **Physical Abuse** is the use of physical force, such as hitting, kicking, shaking, burning, or other shows of force against a child;
- **Sexual Abuse** is inducing or coercing a child to engage in sexual acts and includes behaviors such as fondling, penetration, and exposing a child to other sexual activities;
- **Emotional Abuse** refers to behaviors that harm a child's self-worth or emotional well-being and may include name calling, shaming, rejection, withholding love, and threatening; and,
- **Neglect** is the failure to meet a child's basic physical and emotional needs including housing, food, clothing, education, and access to medical care (CDC, 2016).

School nurses need to understand the different kinds of child maltreatment as well as the immediate and long-term impacts of abuse and neglect. Children who are abused and neglected may suffer immediate physical injuries (e.g., cuts, bruises, burns, broken bones) and may also exhibit emotional and psychological symptoms. Child abuse and neglect may also impact a child's mental health, social development, and risk-taking behavior throughout life. Strong evidence confirms that childhood violence increases the risks of injury, sexually transmitted infections, including HIV, mental health problems, delayed cognitive development, reproductive health problems, and involvement in sex trafficking. It may also impact the child's general health, causing damage to the nervous, endocrine, circulatory, musculo-skeletal, reproductive, respiratory, and immune systems (CDC, 2016).

In response to this serious public health problem, the CDC developed [Preventing Child Abuse and Neglect](#), a technical package to help communities and states prioritize prevention activities based on the best available evidence. It also developed [Essential for Childhood: Steps to Create Safe, Stable, Nurturing Relationships and Environments](#) to assist communities to promote relationships and environments that help children grow up to be healthy and productive citizens. Schools and community-based organizations can use these materials to educate parents and school staff about healthy family development. School nurses, along with other members of the school health team, need to take an active role in the prevention of child abuse and neglect.

Early recognition, intervention and treatment of child maltreatment are critical to the physical well-being and academic success of students. School nurses serve a vital role in the recognition of early signs of child maltreatment as well as the assessment, identification, intervention, reporting, referral, and follow-up. Because of their unique relationship with students and families, school nurses and other members of the school health team can help parents address factors that put them at increased risk of abuse. School nurses can refer families to community resources that focus on child welfare and family support (NASN, 2014).

Applicable Laws and Regulations

For the entire text, go to [Statutes: Child Abuse](#). A summary of the [laws and requirements](#) follows.

N.J.S.A. 9:6-1 – Abuse, Abandonment, Cruelty, and Neglect

Abuse of a child consists of any of the following acts: (a) disposing of the custody of a child contrary to law; (b) employing or permitting a child to be employed in any vocation or employment injurious to its health or dangerous to its life or limb, or contrary to the laws of this State; (c) employing or permitting a child to be employed in any occupation, employment or vocation dangerous to the morals of such child; (d) the habitual use by the parent or by a person having the custody and control of a child, in the hearing of such child, of profane, indecent or obscene language; (e) the performing of any indecent, immoral or unlawful act or deed, in the presence of a child, that may tend to debauch or endanger or degrade the morals of the child; (f) permitting or allowing any other person



to perform any indecent, immoral or unlawful act in the presence of the child that may tend to debauch or endanger the morals of such child; (g) using excessive physical restraint on the child under circumstances which do not indicate that the child's behavior is harmful to himself, others or property; or (h) in an institution as defined in section 1 of P.L.1974, c.119 (C. 9:6-8.21), willfully isolating the child from ordinary social contact under circumstances which indicate emotional or social deprivation.

Abandonment of a child consists of any of the following acts by anyone having the custody or control of the child: (a) willfully forsaking a child; (b) failing to care for and keep the control and custody of a child so that the child shall be exposed to physical or moral risk without proper and sufficient protection; (c) failing to care for and keep the control and custody of a child so that the child shall be liable to be supported and maintained at the expense of the public, or by child caring societies or private persons not legally chargeable with its or their care, custody and control.

Cruelty to a child shall consist in any of the following acts: (a) inflicting unnecessarily severe corporal punishment upon a child; (b) inflicting upon a child unnecessary suffering or pain, either mental or physical; (c) habitually tormenting, vexing or afflicting a child; (d) any willful act of omission or commission whereby unnecessary pain and suffering, whether mental or physical, is caused or permitted to be inflicted on a child; (e) or exposing a child to unnecessary hardship, fatigue or mental or physical strains that may tend to injure the health or physical or moral well-being of such child.

Neglect of a child shall consist in any of the following acts, by anyone having the custody or control of the child: (a) willfully failing to provide proper and sufficient food, clothing, maintenance, regular school education as required by law, medical attendance or surgical treatment, and a clean and proper home, or (b) failure to do or permit to be done any act necessary for the child's physical or moral well-being. Neglect also means the continued inappropriate placement of a child in an institution, as defined in section 1 of P.L.1974, c.119 (C. 9:6-8.21), with the knowledge that the placement has resulted and may continue to result in harm to the child's mental or physical well-being.

N.J.S.A. 9:6-8.9 – Child Abuse Defined

The law defines an abused child as a child under the age of 18 years whose parent, guardian, or other person having his custody and control:

- a. Inflicts or allows to be inflicted upon such child physical injury by other than accidental means which causes or creates a substantial risk of death, or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ;
- b. Creates or allows to be created a substantial or ongoing risk of physical injury to such child by other than accidental means which would be likely to cause death or serious or protracted disfigurement, or protracted loss or impairment of the function of any bodily organ; or,

- c. Commits or allows to be committed an act of sexual abuse against the child;
- d. Or a child whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as the result of the failure of his parent or guardian, or such other person having his custody and control, to exercise a minimum degree of care (1) in supplying the child with adequate food, clothing, shelter, education, medical or surgical care though financially able to do so or though offered financial or other reasonable means to do so, or (2) in providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or substantial risk thereof, including the infliction of excessive corporal punishment or using excessive physical restraint under circumstances which do not indicate that the child's behavior is harmful to himself, others or property; or by any act of a similarly serious nature requiring the aid of the court;
- e. Or a child who has been willfully abandoned by his parent or guardian, or such other person having his custody and control;
- f. Or a child who is in an institution as defined in section 1 of P.L.1974, c.119 (C. 9:6-8.21) and (1) has been so placed inappropriately for a continued period of time with the knowledge that the placement has resulted and may continue to result in harm to the child's mental or physical well being or (2) has been willfully isolated from ordinary social contact under circumstances which indicate emotional or social deprivation.

A child shall not be considered abused pursuant to subsection f. of this section if the acts or omissions described therein occur in a day school as defined in section 1 of P.L.1974, c.119 (C. 9:6-8.21).

N.J.S.A. 9:6-8.10 – Reports of Child Abuse

Any person having reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse shall report the same immediately to DCF's Child Protection and Permanency (CP&P) by telephone or otherwise. Such reports, where possible, shall contain the names and addresses of the child and his parent, guardian, or other person having custody and control of the child and, if known, the child's age, the nature and possible extent of the child's injuries, abuse or maltreatment, including any evidence of previous injuries, abuse or maltreatment, and any other information that the person believes may be helpful with respect to the child abuse and the identity of the perpetrator.



Key Point

The school district's child abuse and neglect reporting policies and procedures must align with the requirements outlined above. School personnel do not diagnose abuse or maltreatment. They may be asked to provide CP&P additional data on past injuries or incidents that may be related to child abuse and neglect.



N.J.S.A. 9:6-8.13 – Immunity from Liability for Person Making Report

Anyone acting pursuant to this act in the making of a report under this act shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed. Any such person shall have the same immunity with respect to testimony given in any judicial proceeding resulting from such report. A person who reports or causes to report in good faith an allegation of child abuse or neglect pursuant to section 3 of P.L.1971, c. 437 (C. 9:6-8.10) and as a result thereof is discharged from employment or in any manner discriminated against with respect to compensation, hire, tenure or terms, conditions or privileges of employment, may file a cause of action for appropriate relief in the family part of the Chancery Division of the Superior Court in the county in which the discharge or alleged discrimination occurred or in the county of the person's primary residence. If the court finds that the person was discharged or discriminated against as a result of the person's reporting an allegation of child abuse or neglect, the court may grant reinstatement of employment with back pay or other legal or equitable relief.

N.J.S.A. 9:6-8.14 – Failure to Make Report

Any person knowingly violating the provisions of this act including the failure to report an act of child abuse having reasonable cause to believe that an act of child abuse has been committed, is a disorderly person.

N.J.S.A. 18A:36-24 – Missing Children

The Legislature finds that there is a growing recognition of the prevalence and consequences of child abuse and that the removal of children from school constitutes a deprivation in itself and may be an indicator of even more grievous abuses. Public schools can and should provide an early warning to the appropriate authorities when a child appears to be missing from the educational system.

N.J.S.A. 18A:36-25 – Early Detection of Missing and Abused Children

All school districts are required to establish policies designed to provide for the early detection of missing and abused children. These policies must include provisions for the notification of the appropriate law enforcement and child welfare authorities when a potential missing or abused child situation is detected.

N.J.A.C. 6A:16-11.1 – Adoption of Policies and Procedures

These rules require the district board of education to develop and adopt policies and procedures for school district employees, volunteers, or interns to provide for the early detection of missing, abused, or neglected children through notification of, reporting to, and cooperation with appropriate law enforcement and child welfare authorities. The policies and procedures must include a statement indicating the importance of early detection of missing, abused, or neglected children and provisions requiring school district employees, volunteers, or interns to immediately notify designated child welfare authorities of incidents of alleged missing, abused, and neglected children.

In addition, the rules state that the person having reason to believe that a child may be missing or may have been abused or neglected may inform the principal or other designated school official(s) prior to notifying designated child welfare authorities if the action will not delay immediate notification. The person notifying designated child welfare authorities shall inform the principal or other designated school official(s) of the notification, if such had not occurred prior to the notification; however, notice to the principal or other designated school official(s) need not be given when the person believes the notice would likely endanger the reporter or student involved or when the person believes the disclosure would likely result in retaliation against the student or in discrimination against the reporter with respect to his or her employment.



Key Point

The person having reason to believe that a child may be missing or may have been abused or neglected may inform the principal or other designated school official(s) prior to notifying designated child welfare authorities if the action will not delay immediate notification. School administrators cannot stop a school employee filing a report who is following the statutes outlined herein.

The rules also address reporting incidents of potentially missing, abused, or neglected children to designated law enforcement authorities as outlined in the memorandum of agreement between education and law enforcement authorities. Law enforcement authorities shall be notified about all reports by employees, volunteers, or interns working in the school district. The notification to designated law enforcement authorities on behalf of a student attending a receiving school must be made to the law enforcement authorities identified in the receiving school's memorandum of agreement.



Key Point

Under no condition shall the school district's policy require confirmation by another person to report the suspected missing, abused, or neglected child situation.

School district policies and procedures must include provisions for school district cooperation with designated child welfare and law enforcement authorities in all investigations of potential missing, abused, or neglected children. Accommodations permitting the child welfare and law enforcement investigators to interview the student in the presence of the school principal or other designated school official must be included; however, if the student is intimidated by the presence of the school representative, the student must be asked to name an employee, volunteer, or intern working in the school district whom he or she feels will be supportive and who will be allowed to accompany the student during the interview.

The policies must address scheduling interviews with an employee, volunteer, or intern working in the school district who may have information relevant to the investigation



and the release of all records of the student who is the subject of the investigation that are deemed relevant and allowable under the Family Education Rights and Privacy Act (FERPA), 34 CFR Part 99. The policy must also address the maintenance, security, and release of all confidential information about potential missing, abused, or neglected child situations.



Key Point

All information regarding allegations of potentially missing, abused, or neglected children reported to authorities about an employee, volunteer, or intern working in the school district are confidential and may be disclosed only as required to cooperate in investigations or by virtue of a court order. Records pertaining to such information must be maintained in a secure location separate from other employee personnel records and accessible only to the school district chief school administrator or his or her designee.

The release of the student to child welfare authorities while school is in session when it is necessary to protect the student or take the student to a service provider must be addressed. Removal will take place only after the principal or his or her designee has been provided, either in advance or at the time removal is sought, with appropriate documentation that the child welfare authority has already removed, or has appropriate authority to remove, the student from his or her home and address any change in school as a result of this action.



Key Point

District policy must establish a school district liaison to designated child welfare authorities to act as the primary contact person between schools in the school district and child welfare authorities with regard to general information sharing, the development of mutual training and other cooperative efforts as well as a school district liaison to law enforcement authorities to act as the primary contact person between schools in the school district and law enforcement authorities.

School districts must provide training for employees, volunteers, and interns working in the school district on the school district's policies and procedures for reporting allegations of missing, abused, or neglected child situations. All new employees, volunteers, and interns working in the school district must receive the required information and training as part of their orientation.

The policy must address the due process rights of an employee, volunteer, or intern working in the school district who has been named as a suspect in a notification to child welfare and law enforcement authorities regarding a missing, abused, or neglected child situation.

The policy must prohibit reprisal or retaliation against any person who, in good faith, reports or causes a report to be made of a potential missing, abused, or neglected child situation.

Additional Points for School Nursing Practice

The suspicion of child abuse and/or neglect may be based on the complaints of the student or the direct observation of an employee over time, or both. Although abuse is more easily recognized, neglect can take more subtle forms. Neglect includes failure of a caregiver to provide food, shelter, adequate supervision, or medical/dental care. Failure to send a child to school and keep a child reasonably clean may also constitute neglect. The school nurse may be the first school employee to observe such evidence.

School districts are mandated to cooperate with the **Division of Child Protection and Permanency**. DCP&P caseworkers and law enforcement officials, if indicated, are permitted to interview the student in the presence of the principal or designated school official.



Key Point

The purpose of the school representative is to provide support and comfort to the child, not to participate in any investigation.

DCP&P is permitted to schedule interviews with any district employee, volunteer, or intern who may have relevant information to the investigation.

School districts must annually provide information and in-service for district employees, volunteers, and interns on the district's policies and procedures for the recognition and reporting of allegations of missing, abused, or neglected child situations.



Key Point

All new school district employees, both paid and voluntary, must receive information and training as part of their orientation.

Key Point

It is not the responsibility of the school nurse or the person suspecting the abuse to investigate the allegations. Indeed, the school nurse should not examine the child unless the student presents to the nurse with a specific complaint of injury which needs immediate treatment. The designated school official may request documentation of the reported injury. If abuse is suspected, DCP&P will conduct any examination or investigation. The school nurse may be asked to share additional information with child protection officials about student injuries and visits to the health office.

School personnel cannot be discharged from employment or in any manner be discriminated against with respect to compensation, tenure, or terms, conditions, or privileges of employment as a result of making in good faith a report or causing an allegation of child abuse to be reported.



Key Point

The school district's policy cannot require confirmation by another person to report a suspected missing, abused, or neglected child situation.

The school nurse is often entrusted with confidential information about students and their families. School nurses often know a family's history and other information about the child that is unknown to other school officials. If the student is intimidated by the presence of the designated school representative, the student must be asked to name an employee, volunteer, or intern working in the school district whom he or she feels will be supportive and who will be allowed to accompany the student during the interview. It is not unusual or inappropriate for the school nurse to be asked to take on this role.



Key Point

School nurses must document on the Health History and Appraisal Form A-45 any care provided as a result of the child's injury but must be careful how the injury is described and not make any judgements about the cause.

Key Point

The school nurse should document all referrals to DCP&P on the individual student health record or electronic health record stating only that a referral was made; the date and time of the referral; and, the name of the DCP&P staff member to whom the report was made.

School nurses need to be sensitive to parenting styles and childrearing practices based on culture. What is defined as child abuse and neglect in the U.S. may be legal or acceptable in other areas of the world. While this does not justify specific actions, it does support parent education about the legal definitions and ramifications of suspected abuse that apply in New Jersey. The school nurse must educate parents while being respectful of their beliefs and traditions.

The American Academy of Child and Adolescent Psychiatry supports a [Child Abuse Resource Center](#).

The USDHHS Child Welfare Information Gateway provides information on [Child Abuse Prevention Programs](#).

[Child Help](#) provides information and sponsors a [hotline](#) dedicated to the prevention of child abuse. Serving the U.S. and Canada, the hotline is staffed 24 hours a day, 7 days a week with professional crisis counselors who—through interpreters—provide assistance in over 170 languages. The hotline offers crisis intervention, information, and referrals to thousands of emergency, social service, and support resources. All calls are confidential.

The **Child Welfare League** provides direct support to agencies that serve children and families through its programs, publications, research, conferences, professional development, and consultation.

The Role of Educators in Preventing and Responding to Child Abuse and Neglect

Stop It Now! aims to prevent the sexual abuse of children by mobilizing adults, families and communities to take actions that protect children before they are harmed.

Children, Adolescents, and Families

Topic: Adolescent Pregnancy and Parenting

Background and Rationale

Pregnancy is consistently the most common family-related reason given by female students for discontinuing high school. Young men cite becoming a parent as a major factor in their decision to leave school (ED, 2013). Schools must support pregnant and parenting students to ensure academic success and school completion.

In 2015, 229,715 babies were born to women aged 15–19 years, for a birth rate of 22.3 per 1,000 women in this age group. This is another record low for U.S. teens and a drop of 8% from 2014. Birth rates fell 9% for women aged 15–17 years and 7% for women aged 18–19 years. Unfortunately, the teen pregnancy rate remains substantially higher than other western industrialized nations and racial, ethnic, and geographic disparities persist (CDC, 2017).

There are significant social and economic costs. For example, in 2010, teen pregnancy and childbirth accounted for at least \$9.4 billion in costs to U.S. taxpayers for increased health care and foster care, increased incarceration rates among children of teen parents, and lost tax revenue because of lower educational attainment and income among teen mothers. Pregnancy and birth are significant contributors to high school dropout rates among girls. The children of teenage mothers are more likely to have lower school achievement and to drop out of high school, have more health problems, be incarcerated at some time during adolescence, give birth as a teenager, and face unemployment as a young adult (CDC, 2017). Achieving health equity, eliminating disparities, and improving the health of all groups is an overarching goal of Healthy People 2020. The CDC supports evidence-based programs and clinical services to prevent teen pregnancy and the related social determinants that contribute to it.

The National Campaign to Prevent Teen and Unplanned Pregnancy and America's Promise (a partnership dedicated to ending the dropout crisis) joined forces to identify programs that work in preventing adolescent pregnancy and reducing high school drop out rates.

Having a high school diploma alone is no longer enough to provide young people with the skills they need for a 21st century economy. Consequently, high school completion and being college- and career-ready is critical to the success of indi-



viduals, families, and our nation's competitiveness in a global economy. Too-early pregnancy and parenthood can interfere with educational attainment. As educators strive to improve graduation rates and help students succeed academically, it is important that school leaders, local health departments, and other agencies work together and leverage their expertise and resources in a way that can address both teen pregnancy and school completion. In other words, anyone interested in improving graduation rates should also be interested in reducing teen pregnancy. This is particularly important in low performing school districts (Shuger, 2012).

The National Campaign has undergone a transformation to become the **Power to Decide**. This new campaign to prevent unplanned pregnancy works to ensure that all young people—no matter who they are, where they live, or what their economic status might be—have the power to decide if, when, and under what circumstances to get pregnant. Teen pregnancy prevention requires addressing a multitude of factors such as poverty, cultural norms, religious beliefs, comprehensive sexuality education, access to contraception and medical care, and issues such as confidentiality, parental notification, and pregnancy options including adoption and abortion.

Teen pregnancy may be actively or passively “planned”—that is students often believe that it won’t happen this time. Adolescent health experts state that accidental pregnancies can be prevented through effective educational programs that delay sexual initiation, reduce or eliminate unprotected sexual activity, and address myths that pregnancy will not occur under certain conditions. Additionally, access to birth control and barrier protection is critical to reduce teen pregnancies as well as the incidence of sexually transmitted infections (Rogers & Ginsburg, 2014).

The school nurse should assist students in pregnancy identification and assist them to access quality prenatal care through a referral to a qualified healthcare provider. School nurses can assist parenting teens with childcare referrals, parenting education, and education regarding the prevention of a future pregnancy. If both parents are students, the school nurse can refer them for clinical services and healthcare to address sexually transmitted infections and pregnancy prevention. An IHP should be developed for the pregnant student, detailing any accommodations needed to help the student attend school and participate within the limits set forth by her attending healthcare provider. School nurses should also collaborate with colleagues to advocate for comprehensive sexuality education and services to prevent the incidence of pregnancy in adolescence (NASN, 2015).

Applicable Laws and Regulations

Title IX of the Education Amendments of 1972, prohibits discrimination against a student based on pregnancy, childbirth, false pregnancy, termination of pregnancy, or recovery from any of these conditions. The Title IX regulation also prohibits a school from applying any rule related to a student’s parental, family, or marital status that treats students differently based on their sex. District boards of education must ensure that policies and practices of individual employees do not discriminate against pregnant students.

Pursuant to Title IX, pregnant students are permitted to participate in any part of an educational program including, but not limited to, specific classes such as advanced placement or honors classes; extracurricular programs; interscholastic sports; honor societies; and opportunities for student leadership. A pregnant student may not be excluded from an activity that is part of the school's educational program even if the activity is not operated directly by the school.



Key Point

A minor is a person under the age of 18 in New Jersey. However, a minor may give informed consent and receive confidential care for all family planning services including: contraceptives, emergency contraception, pregnancy testing and options counseling, prenatal care, HIV testing and treatment (age 13 and older), and sexually transmitted disease care.

Key Point

A minor parent may consent to all medical care for his/her child.

N.J.S.A. 9:17A-1 – Consent by Minor to Medical, Surgical Care

The consent to the performance of medical or surgical care and procedure by a hospital or by a physician licensed to practice medicine and surgery executed by a married person who is a minor, or by a pregnant woman who is a minor, on his or her behalf or on behalf of any of his or her children, shall be valid and binding, and, for such purposes, a married person who is a minor or a pregnant woman who is a minor shall be deemed to have the same legal capacity to act and shall have the same powers and obligations as has a person of legal age. Notwithstanding any other provision of the law, an unmarried, pregnant minor may give consent to the furnishing of hospital, medical and surgical care related to her pregnancy or her child, although prior notification of a parent may be required pursuant to P.L.1999, c.145 (C.9:17A-1.1 et al.) and such consent shall not be nullified because of minority. The consent of the parent or parents of an unmarried, pregnant minor shall not be necessary in order to authorize hospital, medical and surgical care related to her pregnancy or her child.

New Jersey Safe Haven Infant Protection Act, P.L. 2000, c.58, Amending N.J.S.A. 30:4C-15.1 et seq.

N.J.A.C. 10:133K

New Jersey's **Safe Haven** Protection Act allows an individual to give up an unwanted infant safely, legally, and anonymously. The parents, or someone acting on their behalf, can bring a baby less than 30 days old to any hospital emergency room or police station. NJDCF will take the infant into custody and place the infant with a foster or pre-adoptive home.



Additional Points for School Nursing Practice

The school nurse plays a crucial leadership role in supporting the health, well-being, and educational success of pregnant and/or parenting students. In some cases, parents and families serve as the primary source of information and support for pregnant and parenting students. When that is not possible, the school nurse should assist the student to find community-service providers who provide health and supportive care to pregnant and parenting teens.

The school nurse contributes to the health and academic success of pregnant and parenting students by providing evidence-based nursing interventions that are student centered and culturally sensitive. It is not unusual for the student to deny the pregnancy. The nurse can assist the student to confirm the pregnancy and work with the school social worker to locate appropriate prenatal care and secure healthcare coverage, if needed. In addition, the school nurse and social worker offer education and support to improve family communication about the pregnancy and its impact on the student's health and education. Depending on the student's circumstances, economic assistance may be needed.

Ongoing sexual health education is critical to preventing a second pregnancy in addition to preventing STIs and HIV. The school nurse should be familiar with community resources that provide sexual health education and counseling to adolescents.

Pregnant and parenting teens may need assistance securing child care in order to return to school. The school health team plays an important role to build a support network for these students, helping them stay connected to the school while taking on the responsibilities of parenting. Care coordination with the student's healthcare provider is critical.

School nurses should educate school administrators, staff, and parents about adolescent sexual behavior, especially risk-taking behaviors. Even students in elementary or middle schools may be engaging in sexual "activities" that place them at risk for pregnancy or other sexual health issues.

The school nurse should not forget about the adolescent father. Social, developmental, and health outcomes for adolescent fathers are less understood. The school nurse should encourage adolescent males to take responsibility for their child(ren) through education and referral to community services that support children and families.

Do Something: Teen Dads

The Characteristics and Circumstances of Teen Fathers: At the Birth of Their First Child and Beyond and article in Child Trends Research Brief, June 2012

The school nurse should work with the pregnant student and her health care provider to develop an IHP/IEHP that details care during the school day along with reasonable accommodations to the regular educational program. The pregnant student may want to involve her parents/guardians; however, the law states that the consent of the parent or

parents of an unmarried, pregnant minor is not necessary in order to authorize hospital, medical and surgical care related to her pregnancy or her child.

Documentation related to pregnancy is maintained in the student's health record. This might include any observations, assessments, or care delivered by the school nurse along with any medical notes or records (e.g., activity limitations) from the healthcare provider related to her pregnancy. In the event that a parent/guardian requests to review or obtain the student's education record, all documentation related to sexual health services/reproductive services are redacted prior to disclosure to the parent/guardian unless the student provides written consent for the disclosure.

The district's Affirmative Action Coordinator is responsible for overseeing any complaint alleging discrimination against a pregnant and/or parenting student.

NASN Pregnant and Parenting Teens

Children, Adolescents, and Families

Working with Homeless, Immigrant, Refugee, and Migrant Families

Background and Rationale

School nurses are often asked to provide care for students from homeless, refugee, or immigrant families. In some parts of the state, school nurses regularly care for students from migrant families. While these family situations are different in origin, the principles of providing safe healthcare for children are paramount. Care coordination is critical. This section will examine issues related to meeting the needs of these students and their families.

Homeless children and youth are difficult to count. *Child Trends* estimates that approximately 1.4 million students were homeless during the 2013-14 school year. Homeless children are more likely to have moderate to severe acute and chronic health problems and less access to medical and dental care. They are more than twice as likely as others to repeat a school grade, be expelled or suspended, or drop out of high school. A quarter or more of homeless children have witnessed violence, and more than half have problems with anxiety and depression. Children may be separated from their parents and placed in foster care or left with friends or relatives. Societal issues such as poverty and hunger, domestic violence, and substance abuse also play a role in homelessness.

Unaccompanied youth may live on their own, including runaway youth, youth whose parents encouraged them to leave or locked them out of their home, and independent youth from families where irreconcilable conflicts or loss of contact have made it impossible for them to return home. Due to the challenges in identifying them, unaccompanied youth are often excluded from estimates of the homeless population (*Child Trends*, 2015). According to the *National Center on Family Homelessness*, the numbers are even higher with an estimated 2.5 million children homeless each year in America. The Center pub-



lished [America's Youngest Outcasts](#), a report card of state and national efforts to reduce homelessness (AIR, 2017).

As an agricultural state, New Jersey has a unique perspective on caring for migrant children and their families. Migrant and seasonal farmworkers constitute a major portion of the labor force in the agricultural industry. A migrant has principal employment in agriculture on a seasonal basis and moves to seek such employment. [Farmworker health centers](#) provide care for this special population. Low income, a lack of insurance, and a mobile lifestyle may make it difficult for migrant farm workers to access regular healthcare. Migrant health centers provide comprehensive primary and preventative health care to migrant and seasonal farmworkers and their families. They offer services on a sliding fee scale to patients regardless of their immigration status. The centers are administered by the Office of Special Population Health within the Bureau of Primary Health Care at the [Health Resources and Services Administration](#) (HRSA). There are 165 migrant health centers nationwide, supported by federal grants under Section 330 (g) of the Public Health Services Act. In some areas where the population of migrant workers is smaller, "voucher" programs have been established which enable farmworkers and their families to receive services from a participating network of health care providers (Farmworker Justice, 2017).

Considering the uncertain policy environment regarding refugees, the Pew Research Center provides [Facts about Refugees](#) which examines the numbers and places of origin and related issues. Refugee status or asylum may be granted to people who have been persecuted or fear they will be persecuted on account of race, religion, nationality, and/or membership in a particular social group or political opinion. Refugee status is a form of protection that may be granted to people who meet the definition of refugee and who are of special humanitarian concern to the United States. Refugees are generally people outside of their country who are unable or unwilling to return home because they fear serious harm (USCIS, 2017). The [National Conference of State Legislatures](#) provides current information on state immigration laws, refugee resettlement, and related issues. [Migration Policy](#) provides data on immigration trends in New Jersey.

Immigrant or refugee children pose unique issues for school personnel and school nurses, in particular. Language, cultural barriers, secrecy, mistrust, and religious issues often make it difficult to establish relationships with these children and their families. Many children arrive in schools with significant social and emotional issues due to terrorism, violence, starvation, and family loss. To address these issues, the National Association of School Psychologists (NASP) published [Supporting Refugee Children and Youth: Tips for Educators](#). The [National Child Traumatic Stress Network](#) also provides tips for school health team members, teachers, and families.

The AAP policy statement, [Providing Care For Immigrant, Homeless, and Migrant Children](#), provides insight into the needs of these children and their families. Homeless children may not have a regular source of healthcare so it may be difficult for them to follow prescribed treatments. Living in shelters may expose the children to respiratory diseases

and other infections. Children of homeless families may not have a regular source of nutritious food; thus, obesity and unhealthy eating patterns are common.

Applicable Laws and Regulations

Subtitle VII-B of The McKinney-Vento Homeless Assistance Act authorizes the federal Education for Homeless Children and Youth (EHCY) Program and is the primary piece of federal legislation related to the education of children and youth experiencing homelessness. It was reauthorized in December 2015 by Title IX, Part A, of the Every Student Succeeds Act: **McKinney-Vento Homeless Assistance Act (Title IX, Part A of ESSA)**. The regulations define homeless children and youth as individuals who lack a fixed, regular, and adequate nighttime residence. This includes:

- Children and youth who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals;
- Children and youth who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;
- Children and youth who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and,
- Migratory children who qualify as homeless because the children are living in circumstances described above.

The NJDOE Bureau of Bilingual/ESL Education provides an overview of **federal and state policy**. The NJDOE website states that undocumented children living in the United States cannot be excluded from public elementary and secondary schools based upon their immigration status. Accordingly, school districts are prohibited from requiring students to disclose or document their immigration status, making inquiries of students or parents that may expose their undocumented status or engaging in any practices that “chill” or hinder the right of access to public schools.

N.J.A.C. 6A:22-3.3 also prohibits the barring of any student from public elementary and secondary schools on the basis of immigration/visa status, except for students on F-1 visas. Districts should continue to enroll all students who are between the ages of 5 and 20 who are domiciled in the district or who are otherwise entitled to attend pursuant to **N.J.S.A. 18A:38.1**, and the implementing regulations, **N.J.A.C. 6A:22-3.2, et. seq.**

N.J.A.C. 6A:17-2.2 – Defining Homelessness

The regulations (**N.J.A.C. 6A:17**) specific to homelessness are summarized below. A district board of education must determine that a child is homeless when he or she resides in any of the following:



- A publicly or privately operated shelter designed to provide temporary living accommodations including hotels or motels; congregate shelters, including domestic violence and runaway shelters; transitional housing; and homes for adolescent mothers.
- A public or private place not designated for or ordinarily used as a regular sleeping accommodation, including cars or other vehicles including mobile homes; tents or other temporary shelters; parks; abandoned buildings; bus or train stations; or temporary shelters provided to migrant workers and their children on farm sites.
- The residence of relatives or friends where the homeless child resides out of necessity because his or her family lacks a regular or permanent residence of its own, substandard housing, or any temporary location wherein children and youth are awaiting foster care placement.

N.J. A.C. 6A:17-2.3-2.4 – Responsibilities of the School District of Residence

The school district of residence for a homeless child is responsible for the education of the child and must determine the school district in which the child shall be enrolled after consulting with the parent. The district must pay the cost of tuition pursuant to N.J.S.A. 18A:38-19, when the child attends school in another school district and it must provide for transportation for the child.

The chief school administrator of each school district must identify a school district liaison for the education of homeless children. The school district liaison facilitates communication and cooperation between the school district of residence and the school district where the homeless child resides. The liaison ensures that homeless families, children, and youth receive educational services for which they are eligible, including Head Start and Even Start programs, preschool programs administered by the local education agency, and referrals to health care, dental, mental health, and other appropriate services. The district liaison ensures that public notice of the educational rights of homeless children and youth is disseminated where such children receive services, such as schools, family shelters, and soup kitchens. The liaison also informs parents and families of all transportation services, including transportation to the school district of residence and assists them to access transportation services to school, and assists the parent or guardian to obtain the homeless child or youth's medical records or required immunizations.

Additional Points for School Nursing Practice

New Jersey has a long history as a home for immigrants. It is home to an extremely diverse population and communities across the state have experienced an increase of immigrant families. In 2015, 2 million immigrants (foreign-born individuals) comprised 22.1% of the New Jersey's population. The top countries of origin for immigrants were India (12.5% of immigrants), the Dominican Republic (8.4%), Mexico (6 %), the Philippines (4.5 %), and Korea (4 %). From 2010-2014, one in 11 children in New Jersey was a U.S.

citizen living with at least one undocumented family member (180,580 children in total) (American Immigration Council, 2017).

The [NJ Department of Human Services](#) provides specific services for homeless families and the NJDOE provides [resources for refugees](#).

Additional information is provided by the USED at [Education for Homeless Children and Youth](#).

The [NJDOE Homeless Education](#) website provides resources for schools and families.

The school nurse should work closely with the district's homeless liaison to ensure that homeless families, children, and youth receive services for which they are eligible, including Head Start and Even Start programs, preschool programs administered by the local education agency, and referrals to health care, dental, mental health, and other appropriate services.

School nurses should work with the families to obtain the student's medical records or required immunizations. The school district should work with the parents to obtain translated immunization records, if they are available.

Children in transition rarely have a medical home. The school nurse can play a key role assisting the family to identify and use healthcare services appropriately. However, many times these families have accessed numerous healthcare service providers (e.g., private physicians, urgent care centers, clinics), creating gaps in care and hindering effective communication. School nurses, as a member of the school health team, can help coordinate care and work with the district liaison to identify services to maximize benefits for the children and their families.

These gaps in care make it imperative that the school nurse keep accurate and current records and that those records are shared pursuant to the law. Even when the law requires that original records be sent to the school of transfer, most school nurses keep a copy of important health information, such as immunization records, in case the student returns to the school district at a later time.

School nurses need to understand and be sensitive to the financial, educational, geographic, linguistic, and cultural barriers that impact these children and their families. Community healthcare providers, faith-based organizations, and cultural organizations may be able to help families adjust, access care and support, and act as liaisons and interpreters when families do not speak English.

The school health team should work together to help students adjust to the new environment. Remember, some of these children have experienced atrocities too difficult to discuss. While they are trying to fit in, they are also concerned about other family members. A coordinated plan of care is critical that involves counseling, social services, and health care.



It is not unusual for undocumented children and families to have trust issues with school and government officials. Some families move frequently, fearful they or a family member will be deported.

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CHAPTER ELEVEN: Promoting Employee Wellness

Topic: Employee Health Requirements

Background and Rationale



The WSCC Model discussed in Chapter One includes Employee Wellness as one of its ten components. While much of the focus is on student health and safety, the physical and mental health of school staff contributes to the school's overall success. Healthy school employees serve as role models for students and are less likely to be absent from school. School-wide efforts can support healthy eating and

active lifestyles. Schools can also help employees manage stress and avoid injury and exposure to hazards (e.g., mold, asbestos).

Employee wellness involves a comprehensive approach that provides a coordinated set of programs, policies, benefits, and environmental supports to address multiple risk factors (e.g., lack of physical activity, tobacco use) and health conditions (e.g., diabetes, depression). School districts and their health insurance providers can work with community partners to offer preventive health services such as flu vaccinations. Ultimately, the goal is to decrease employee health insurance premiums, reduce employee absenteeism and turnover, and cut the costs of substitutes (CDC, 2015).

The Directors of Health Promotion and Education (DHPE) created [School Employee Wellness](#), a comprehensive guide providing information, practical tools, and resources to develop a school employee wellness program. Similarly, the Kaiser Permanente program, [Thriving Schools](#), supports school employee wellness as an essential component of healthy schools. It provides resources and materials for staff wellness programs. The NEA's [Healthy Futures](#) program provides information on stress management, obesity and weight issues, and depression. Many employers believe that creating a culture of health in the workplace can attract and retain high-quality employees. To support these efforts, the NJDOH created the [Working Well Toolkit](#) to help workplaces develop health promotion policies and programs.

As a member of the school health team, the school nurse plays an important role in staff wellness. The school health team or school health advisory committee should include employee health as an important component of a school-wide approach to wellness.



Representatives from the district's human resources department and the school physician should be included in these discussions. The support of the district board of education as well as district and school administrators is critical to implementing employee wellness programs.

The school nurse's role is largely a preventive one since most employee health information is strictly confidential. However, a school employee can choose to inform the school nurse of a medical condition that may require care or intervention during the school day. In addition, the school nurse may choose to provide health promotion services such as weigh-ins and BP checks for those employee who choose to participate. The school nurse may also be called upon to render first aid or emergency care for school personnel and as follow-up, submit district mandated incident reports documenting the situation and care rendered. The school nurse should follow all district policies and procedures regarding any care provided to school and district employees.

As a member of the school health team, the school nurse can advise the district board of education on developing a comprehensive staff wellness program that focuses on a range of health-promoting activities.

District board of education polices that support such activities might include:

- Allowing staff to have access to school facilities such as gymnasiums and weight rooms before, during, and after school;
- Enacting nutrition policies and standards for all foods made available during the school day and at school-sponsored events;
- Banning all tobacco products in school buildings, on school grounds, and at school sponsored activities;
- Creating safe and supportive environments for the entire school community;
- Integrating staff wellness into the culture of the school;
- Connecting staff wellness activities with employee assistance programs, access to preventive care, and other programs such as after school child care;
- Providing worksite screening programs and community health fairs; and,
- Asking employees for input on ways to improve the program and services (Sustainable Jersey Schools, 2017).

Applicable Laws and Regulations

N.J.S.A. 18A:16-2 through 5 – School Employee Health Examinations

This law addresses employee physical examinations and drug testing. Districts must require any candidate for employment who has received a conditional offer of employment to undergo a physical examination. It also permits the board to adopt policy for the physical examination of employees.

The district board of education may require individual psychiatric or physical examinations of any employee whenever, in the judgment of the board, an employee shows evidence of deviation from normal physical or mental health. Any such examination may, if the board so requires, include laboratory tests or fluoroscopic or X-ray procedures for the obtaining of additional diagnostic data.

Nothing in the law affects screening for tuberculosis or fitness examinations for bus drivers as required pursuant to statute, rule, or regulation.



Key Point

School bus drivers and aides shall meet tuberculin testing requirements pursuant to N.J.A.C. 6A:32-6.3(b)2iv.

A board of education may include testing for usage of controlled dangerous substances as defined in N.J.S.2C:35-2 as part of any physical examination which is required of a candidate for employment who has received a conditional offer of employment. Any testing must be conducted by a physician or institution designated by the board of education and the costs paid by the board. The NJDOE, in consultation with the NJDOH, was charged with developing guidelines for school boards electing to require the testing.

N.J.S.A. 8A:16-3 – Character of Examinations

Any such examination may be made by a physician or institution designated by the board, in which case the cost thereof and of all laboratory tests and fluoroscopic or X-ray procedures is borne by the board or, at the option of the employee, they may be made by a physician or institution of his own choosing, approved by the board, in which case said examination at the employee's expense.

N.J.S.A. 18A:16-4 – Sick Leave; Dismissal

If the result of any such examination indicates mental abnormality or communicable disease, the employee is ineligible for further service until proof of recovery, satisfactory to the board, is furnished. If the employee is under contract or has tenure, he may be granted sick leave with compensation as provided by law and upon satisfactory recovery, be permitted to complete the term of his contract, if he is under contract, or be reemployed with the same tenure as he possessed at the time his services were discontinued, if he has tenure, unless his absence will exceed a period of two years.

N.J.S.A. 18A:16-5 – Records of Examinations

All records and reports relating to any such examination are the property of the board and filed with its medical inspector as confidential information but may be open for inspection by officers of the state department of health and the local board of health.



N.J.A.C. 6A:32-6.1-6.3 – School Health Employee Examinations

These regulations define health history as the record of a person's past health events obtained in writing, completed by the individual or his or her physician. A health screening means the use of one or more diagnostic tools to test a person for the presence or precursors of a particular disease. A physical examination means the assessment of an individual's health, in accordance with the requirements of N.J.A.C. 6A:16-2.2.

These rules apply to candidates for employment in a school districts. District boards of education must adopt written policies and procedures for the physical examination of candidates for employment and, where the school district so chooses, for the physical examination of employees.

The district board of education must require candidates for employment who have received a conditional offer of employment to undergo a physical examination such as testing for usage of controlled or dangerous substances or to determine whether the candidate is able to perform with reasonable accommodation job-related functions pursuant to P.L.101-336, Americans with Disabilities Act of 1990.

The district board of education may require physical or psychiatric examinations of a school district employee whenever, in the judgment of the district board of education, an employee shows evidence of deviation from normal physical or mental health. It may also require an examination to determine the individual's physical and mental fitness to perform with reasonable accommodation the position he or she currently holds, or to detect any health risks to students and other employees. When a district board of education requires an employee to undergo an individual examination, the employee must be provided with a written statement of reasons for the required examination and be provided with a hearing, if requested. The determination of such a hearing shall be appealable to the Commissioner.

An employee may, without reprisal, refuse to waive his or her right to protect the confidentiality of medical information, in accordance with P.L.104-191, Health Insurance Portability and Accountability Act of 1996.

Individual employees may provide health-status information, including medications, that may be of value to medical personnel in the event of an emergency requiring treatment. In such instances, an employee may also choose to share with the building principal and, if desired, with the certified school nurse, information regarding current health status to assure ready access in a medical emergency.

Health records of candidates for employment and of current employees, including computerized records, must be secured, stored, and maintained separately from other personnel files. Health records may be shared only with authorized individuals in accordance with N.J.S.A. 18A:16-5.

The district board of education bears the cost of examinations made by a physician or institution designated by the district board of education. However, the employee bears

the cost if the examination is performed by a physician or institution designated by the employee with approval of the district board of education.

Here are the laws for [Federal Drug Testing](#) of transportation employees.

Additional Points for School Nursing Practice

The school district's human resources department is responsible for the district's employee wellness program. However, the school nurse plays an important role educating personnel about various health issues that may impact their health, advising them about health promotion strategies such as immunizations, and offering support for those interested in improving their health. The school nurse should be aware of district policies, procedures, and required forms and reports.

Population health focuses on keeping New Jersey's citizens well, preventing those at risk from getting sick, and keeping those with chronic conditions from getting sicker. Population health promotes prevention, wellness, and equity in all environments, resulting in a healthy New Jersey. Employee wellness programs are an integral part of a public health approach to prevention and the early identification of health problems.



Key Point

Minimum assessments, including physical examination forms, are based on the policies and procedures of the district board of education.

The Department of Health and Human Services provides information on [Employers and Health Information in the Workplace](#).

Some school districts require employees to annually update emergency contact information. The employee is not required to share health and emergency information with the school nurse. The employee may choose to share the information with the school administrator or secretary as well as district officials. The school nurse and building administrator should plan how to manage staff emergencies, including providing contact information to first responders when an employee is unable to do so.

When an employee discloses a physical or mental health issue, the school nurse must maintain confidentiality; however, student safety is paramount. The school nurse may need to encourage the employee to discuss his/her concerns with the building principal or appropriate district-level administrator. However, the school nurse must be cognizant of school-based and community services available to the adults working in the school. It is important to refer the employee to an appropriate provider and document for the nurse's personal records since employee records are not accessible to the school nurse. When in doubt, discuss the concerns with the school physician.

NJEA maintains a list of [School Health and Safety Websites](#) that includes links to advocacy groups and state agencies. The National Education Association (NEA) created [Healthy](#)



Futures which provides health and safety information for school staff and includes staff wellness materials. Similarly, the American Federation of Teachers (AFT) created **Health and Safety for All** which addresses worksite issues such as workplace bullying, ergonomics, and asbestos exposure.

The Alliance for a Healthier Generation provides information and materials to help schools establish a **staff wellness program**.

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CHAPTER TWELVE: Educating Students, Staff, and Families Introduction

Introduction



The school nurse provides health education to students and their families. In some cases, the school nurse works with students and families to manage a chronic illness or to secure health care for a potential health problem and at the same time, educates them about the healthcare system. The school nurse may also be involved in K-12 health education instruction as a guest speaker or as a regular instructor

(if appropriately certified) and should play an important role in the development and implementation of the district's health education curriculum. The school nurse also plays a vital role educating families and the community about health concerns, safety issues, and preventive care. This chapter addresses how the school nurse serves the school community as a health educator.

Topic: Mandated Health Education for Families

Background and Rationale

Parents are the first and primary educators for their children. However, many parents feel ill-equipped to handle the myriad of health issues and concerns that confront families today. While access to health information is readily available via the internet or from friends and other family members, parents often need help to determine if the information is accurate and appropriate for their child. In addition, informed parents are better advocates for their children, and for school programs that support student health and safety. Educating parents about health issues is a key strategy for improving their children's overall health and academic success. New Jersey requires schools to educate parents and families about a variety of health and safety issues.

Applicable Laws and Regulations

N.J.S.A. 18A: 40-41 – Sudden Cardiac Arrest Pamphlet

The NJDOE, NJDOH, AHA, and AAP developed a pamphlet, [Sudden Cardiac Death in Young Athletes](#), that provides information about sudden cardiac arrest to student-athletes and their parents or guardians. The pamphlet is available on the NJDOE website and includes an explanation of sudden cardiac arrest; its incidence among student athletes;



a description of early warning signs, including fainting, labored breathing, chest pains, dizziness and abnormal heart rate, and the risks associated with continuing to play or practice after experiencing one or more of the symptoms; an overview of the options that are privately available to screen for cardiac conditions that may lead to sudden cardiac arrest, including a statement about the limitations of these options. The law requires that districts use a **Sign-off Sheet** as acknowledgment that the pamphlet has been received and reviewed by the student-athlete and his/her parents.

The law requires each school district and nonpublic school to distribute the pamphlet to the parents or guardians of students participating in athletic activities. A student participating in or desiring to participate in an athletic activity and the student's parent or guardian shall, each year and prior to participation by the student in an athletic activity, sign and return to the student's school the sign-off form acknowledging the receipt and review of the informational pamphlet.

For the purposes of the law, "athletic activity" means interscholastic athletics; an athletic contest or competition, other than interscholastic athletics, that is sponsored by or associated with a school district or nonpublic school, including cheerleading and club-sponsored sports activities; and any practice or inter-school practice or scrimmage for those activities.

The law also allows a school district or nonpublic school to hold an informational meeting prior to the start of each athletic season for students-athletes, their parents or guardians, coaches, athletic trainers, the school physician, school nurses, and other school officials on the nature, risk, symptoms and early warning signs, prevention, and treatment of sudden cardiac arrest.



Key Point

For the purposes of these requirements, private schools are the same as nonpublic schools. A nonpublic school means an elementary or secondary school within the state, other than a public school, offering education for grades kindergarten through 12, or any combination of them, wherein any child may legally fulfill compulsory school attendance requirements and which complies with the requirements of Title VI of the Civil Rights Act of 1964 [N.J.S.A. 18A:46A-2(b)]. An approved private school for students with disabilities or "APSSD" means an entity approved by the NJDOE according to N.J.A.C. 6A:14-7.1 through 7.3 to provide special education and related services to a student with disabilities placed in the APSSD by a parent/guardian, sending district board of education, or State agency responsible for providing the student's education through implementation of his or her individualized education program (IEP).

N.J.S.A. 18A:40-41.1-41.4 – Interscholastic Athletic Head Injury Safety Training Program

This law requires the NJDOE to develop and implement an interscholastic athletic head injury safety training program. It requires professional education for the school physician, an interscholastic sport or cheerleading coach, and an athletic trainer involved in a public or nonpublic school interscholastic sports program or cheerleading program. The safety training program focuses on the recognition of the symptoms of head and neck injuries, concussions, and injuries related to second-impact syndrome; and the appropriate amount of time to delay the return to competition or practice of a student-athlete or cheerleader who has sustained a concussion or other head injury. The NJDOE is required to update the safety training program, as necessary, to ensure that it reflects the most current information available on the nature, risk, and treatment of sports-related concussions and other head injuries. The NJDOE was also required to develop an educational fact sheet that provides information about sports-related concussions and other head injuries for distribution annually to the parents or guardians of student-athletes and cheerleaders. A signed acknowledgment of the receipt of the fact sheet by the student-athlete or cheerleader and his parent or guardian is also required. The NJDOE has developed **model policies and materials on concussions**.

N.J.S.A. 18A:40-21.2 – Meningitis Fact Sheet

This law requires school districts to distribute an **educational fact sheet on meningitis** annually to parents or guardians of students in the sixth grade. It also requires that the fact sheet be made available to private schools educating students in grades 6 through 12, or any combination thereof. Private schools are encouraged to distribute the fact sheet to parents or guardians of students at the school.

N.J.S.A. 18A:40-41.8 & 41.9 – Protective Eyewear for Children Participating in Sports

This law states that it is necessary and prudent to educate parents and children about sports-related eye injuries in order to reduce the needless loss of sight that can occur during sports activities. It requires the development of an educational fact sheet on **Sports Related Eye Injuries**. Each school district and nonpublic school must distribute the educational fact sheet annually to the parents or guardians of students.

N.J.S.A. 18A:40-42 – Educational Fact Sheet About HPV

This law required the development of an educational fact sheet about the human papillomavirus (HPV) for distribution to parents or guardians of students in grades seven through 12. The **HPV Fact Sheet** includes information about the causes, symptoms, and means of transmission of HPV and where additional information can be obtained. School districts must distribute the educational fact sheet annually to parents or guardians of students in grade seven and the educational fact sheet must also be made available to private schools educating students in grades seven through 12. Private schools are encouraged, but not required, to distribute the fact sheet to parents or guardians of students at the school.



N.J.S.A. 18A:40-44 – Child's Exposure to Violence on Electronic Devices.

This law required the NJDOE to develop a **Media Violence Pamphlet** that explains how a parent can limit a child's exposure to violence on television, cell phones, computers, and other electronic devices. The NJDOE distributes the pamphlet, at no charge, to all school districts in the State, and makes additional copies available to nonpublic schools, upon request. Each school district shall distribute the pamphlet to the parents or guardians of students attending the schools of the district.

N.J.A.C. 6A:16-2.2(i) – New Jersey FamilyCare

School districts are required to make accessible information regarding the **NJ Family-Care Program** for students who are without medical coverage.

P.L.2017, CHAPTER 167, approved July 21, 2017

This law requires school districts and nonpublic schools that participate in interscholastic sports or cheerleading programs to distribute an **opioid abuse and addiction fact sheet** annually to the parents or guardians of student-athletes and cheerleaders, and to obtain a signed acknowledgement of the receipt of the fact sheet by the student and his parent or guardian.

NJDOE Opioid Fact Sheet Memo: January 2018

Additional Points for School Nursing Practice



Key Point

Many of the educational requirements address potential athletic injuries. The school nurse should work with the athletic director, trainer, and coaches to ensure that the materials are distributed and that the acknowledgement forms are returned to the school nurse for inclusion in the student athlete's health file.

Many of these laws require the NJDOE to update information as it becomes available; however, it may be prudent for the school nurse, in collaboration with the school health team, to review the materials annually to ensure that they are current and accurate. Existing requirements can be found on the NJDOE webpage **Keeping Our Kids Safe, Healthy and In School**.

District administrators need to document that the required materials have been distributed to parents, either in paper form or via the district's website. The district may also sponsor informational parent meetings prior to the beginning of the athletic seasons. The school nurse can use this program to meet parents and demonstrate commitment to the school's sports safety program.

The CDC provides information and resources on **Sports Safety** which includes information on concussions, bike safety, and youth sports programs.

The **National Center for Sports Safety** supports youth sports safety programs.

The **Heads Up** concussion program provides resources for nurses and other school professionals as well as posters that can be used with students and parents.

Educating Students, Staff, and Families

Topic: K-12 Health Education

Background and Rationale

Health education is one of the ten components of the WSCC model presented in Chapter One of this manual. Formalized health education is defined as planned learning experiences designed to help students acquire the information and skills needed to make quality health decisions. Health education should be based on an assessment of student health needs and planned in collaboration with the community. Students might also acquire health information from the school nurse or more informally through posters, assemblies, public service announcements, or conversations with family and peers (CDC, 2015).

In the 1990s, the educational community began to focus on “standards”—statements of what students should know and be able to do. The **National Health Education Standards (NHES)** were developed to establish, promote, and support health-enhancing behaviors for PreK-12 students. The NHES laid the groundwork for the development of New Jersey’s first set of Core Curriculum Content Standards (1996, 2004, 2009) and subsequently, the **2014 New Jersey Student Learning Standards for Comprehensive Health and Physical Education (CHPE)**.

New Jersey has a long standing commitment to health education for students in grades K-12. After World War I, many states mandated health, safety, and physical education for public school students. The New Jersey mandate focused on physical conditioning and was created to better prepare young men for the rigors of military service. Since that time, family life education, HIV/AIDS prevention education, and substance abuse education have been added to the original requirement. In addition, numerous statutes require instruction in specific issues such as Lyme disease, sexual assault prevention, fire safety, or cancer awareness. Many of the topics addressed in these mandates have been incorporated into the CHPE Standards. All students must participate in a comprehensive and sequential health and physical education program that emphasizes the natural interdisciplinary connection among wellness, health, and physical education. The CHPE Standards are grounded in the belief that students need the knowledge and skills to support life-long healthy behaviors. When the standards were developed, every effort was made to address all existing mandates and new ones were added as they became law.

The NJDOE offers school nurse instructional certification which requires at least 21 semester hours including methods of teaching health and curriculum development in pre-school through grade 12. This educational endorsement authorizes the holder to perform nursing services and teach in areas related to health in all public schools. In some school districts, school nurses provide regularly scheduled health education classes in addition to their health services responsibilities. In other schools districts, school nurses provide



periodic or supplemental instruction in areas like family life education. In some districts, schools nurse do not provide any classroom instruction.

While the school nurse may not actually serve as the “health teacher,” the nurse plays an important role in the development of the district’s health curriculum and the materials used to deliver instruction. The school nurse can provide important health data and information to guide the development of a developmentally appropriate and culturally sensitive health education program that meets the needs of the district’s population. The school nurse may very well serve as a voice for students who want and need health education instruction that is evidence-based, current, and medically accurate.

Applicable Laws and Regulations



Key Point

*Many of the requirements refer to the New Jersey Comprehensive Health and Physical Education Standards or the Curriculum Framework. For more recent iteration, review the CHPE **Model Curriculum** and related materials on the NJ-DOE's **CHPE** page.*

N.J.S.A. 18A:35-5 – Maintenance of Physical Training Courses

This law requires each board of education to conduct as a part of the instruction in the public schools courses in health, safety, and physical education. The courses must be adapted to the ages and capabilities of the pupils. To ensure that students are capable of participating in physical education, the district may require medical inspection pursuant to N.J.S.A.18A:40-4. “...to determine...fitness to participate in any health, safety, and physical education course required by law.”

N.J.S.A. 18A:35-7 – Course Required

Expanding on the language above, this law requires health, safety, and physical education for all pupils except kindergarten pupils. Health, safety, and physical education must be a part of the curriculum prescribed for the several grades. The conduct and attainment of the pupils must be marked as in other courses or subjects and are part of the requirements for promotion or graduation.

N.J.S.A. 18A:35-8 – Time Devoted to Course

The time devoted to courses in health, safety, and physical education must aggregate at least two and one-half hours (150 minutes) in each school week, or proportionately less when holidays fall within the week.



Key Point

The district determines the distribution of the minutes in order to meet the requirements set forth in the Student Learning Standards and local curriculum.

N.J.S.A. 18A:40A-1 – Instructional Programs on Drugs, Alcohol, Anabolic Steroids, Tobacco, and Controlled Dangerous Substances

This law requires boards of education to implement instructional programs on the nature of drugs, alcohol, anabolic steroids, tobacco, and controlled dangerous substances and their physiological, psychological, sociological, and legal effects on the individual, the family, and society. This is required in each public school and in each grade from kindergarten through 12 in a manner adapted to the age and understanding of the pupils.

N.J.A.C. 6A:16-3.1 – Establishment of Comprehensive Alcohol, Tobacco, and Other Drug Abuse Programs

These regulations require each district board of education to establish a comprehensive program of prevention, intervention, referral for evaluation, referral for treatment, and continuity of care for student alcohol, tobacco, and other drug abuse in the school district's public elementary and secondary schools. The purpose of the prevention component of the program is to keep students from using alcohol, tobacco or other drugs; reduce or eliminate the incidence and prevalence of student alcohol, tobacco and other drug abuse; reduce factors that place students at risk for involvement with alcohol, tobacco or other drugs through school and community-based planning processes; contribute to the development of school environments and alternative activities that are alcohol, tobacco and other drug-free; increase the knowledge and skills of students, staff and community members for avoiding the harmful effects of alcohol, tobacco and other drug use; and actively involve staff, students, parents, and other community members in the development and implementation of prevention program plans.

N.J.S.A. 18A:35-5.1 – Lyme Disease Curriculum Guidelines

This law required the NJDOE and NJDOH to develop curriculum guidelines for the teaching of information on the prevention of Lyme Disease within the public school health curriculum. The guidelines shall emphasize disease prevention and sensitivity for victims of the disease. The Commissioner of Education shall periodically review and update the guidelines to insure that the curriculum reflects the most current information available.



Key Point

Lyme disease prevention was incorporated into the New Jersey Learning Standards.

Key Point

*Classroom activities to meet the original standards were included in the **1999 Comprehensive Health and Physical Education Framework** (available but archived). The Framework provides sample strategies to teach about Lyme disease and other mandated subjects.*

Key Point

Making a Difference: Lyme Disease Prevention Education Guide was developed by the NJDOE in 1995. Because it was a “paper” document, it may be difficult to obtain.



N.J.S.A. 18A:35-5.4 – Instruction on Breast Self-Examination

This law requires each board of education which operates an educational program for students in grades 7 through 12 to offer instruction in breast self-examination. The instruction must take place as part of the district's implementation of the Core Curriculum Content Standards in Comprehensive Health and Physical Education. The Framework provides school districts with sample activities that may be used to support implementation of the instructional requirement.

N.J.S.A. 18A:35-4.3 – Sexual Assault Prevention Education Program

This law required the NJDOE, in consultation with an advisory committee provided for in the law, to develop and establish guidelines for the teaching of sexual assault prevention techniques for utilization by local school districts in the establishment of a sexual assault prevention education program.

N.J.S.A. 18A:35-4.23 – Domestic Violence and Child Abuse Instruction

This law allows a school district to include instruction on the problems of domestic violence and child abuse in an appropriate place in the curriculum of elementary school, middle school, and high school pupils. The instruction must include the psychology and dynamics of family violence, dating violence, and child abuse, the relationship of alcohol and drug use to such violence and abuse, the relationship of animal cruelty to such violence and abuse, and methods of non-violent problem-solving.

N.J.S.A. 18A:35-4.23a – Dating Violence Education

This law requires each school district to incorporate dating violence education that is age appropriate into the health education curriculum as part of the district's implementation of the Core Curriculum Content Standards in Comprehensive Health and Physical Education for students in grades 7 through 12. Instruction must include, but not be limited to, information on the definition of dating violence, recognizing dating violence warning signs, and the characteristics of healthy relationships. The law defines "dating partner" as any person involved in an intimate association with another individual that is primarily characterized by the expectation of affectionate involvement, whether casual, serious, or long-term and "dating violence" as a pattern of behavior where one person threatens to use, or actually uses, physical, sexual, verbal, or emotional abuse to control a dating partner.

Upon written request to the school principal, a parent or legal guardian of a student less than 18 years of age, shall be permitted within a reasonable period of time after the request is made, to examine the dating violence education program instruction materials developed by the school district.

The NJDOE provides a [Model Dating Violence Policy](#) and [Dating Violence Resources](#).



Key Point

The NJDOE's Health and Physical Education FAQ provides information on family life education, medical excuses from PE, and other information of interest to school nurses.

N.J.S.A. 18A:35-4.7 – Parent’s Statement of Conflict with Conscience

This law permits a parent or guardian to present to the school principal a written and signed statement that any part of the instruction in health, family life education, or sex education is in conflict with his conscience or sincerely held moral or religious beliefs. The student shall be excused from that portion of the course where such instruction is being given with no penalties as to credit or graduation.

N.J.S.A. 18A:35-4.20 & 21 – Sex Education Programs to Stress Abstinence

This law requires that any sex education included as part of any planned course, curriculum, or other instructional program and that is intended to impart information or promote discussion or understanding in regard to human sexual behavior, sexual feelings and sexual values, human sexuality and reproduction, pregnancy avoidance or termination, HIV infection or sexually transmitted diseases, regardless of whether such instruction is described as, or incorporated into a description of “sex education,” “family life education,” “family health education,” “health education,” “family living,” “health,” “self esteem,” or any other course, curriculum program or goal of education, and any materials including, but not limited, to handouts, speakers, notes or audiovisuals presented on school property concerning methods for the prevention of acquired immune deficiency syndrome (HIV/AIDS), other sexually transmitted diseases and of avoiding pregnancy, shall stress that abstinence from sexual activity is the only completely reliable means of eliminating the sexual transmission of HIV/AIDS and other sexually transmitted diseases and of avoiding pregnancy.

The law also requires that instruction in family life and HIV/AIDS include the reasons, skills and strategies for remaining or becoming abstinent from sexual activity. Any instruction concerning the use of contraceptives or prophylactics such as condoms shall also include information on their failure rates for preventing pregnancy, HIV and other sexually transmitted diseases in actual use among adolescent populations and shall clearly explain the difference between risk reduction through the use of such devices and risk elimination through abstinence.

**Key Point**

This law does not require school districts to implement an abstinence-only approach. It requires programs and materials to emphasize abstinence when developing a comprehensive curriculum that addresses the requirements in the CHPE Standards.

N.J.S.A. 8A:37-13 – Harassment, Intimidation and Bullying

This law states that a safe and civil environment in school is necessary for students to learn and achieve high academic standards; harassment, intimidation or bullying, like other disruptive or violent behaviors, is conduct that disrupts both a student’s ability to learn and a school’s ability to educate its students in a safe environment; and since students learn by example, school administrators, faculty, staff, and volunteers should



be commended for demonstrating appropriate behavior, treating others with civility and respect, and refusing to tolerate harassment, intimidation or bullying.

N.J.S.A. 18A:37-17 – Establishment of Bullying Prevention Programs

The law requires schools and school districts to annually establish, implement, document, and assess bullying prevention programs or approaches, and other initiatives involving school staff, students, administrators, volunteers, parents, law enforcement, and community members. The programs or approaches shall be designed to create school-wide conditions to prevent and address harassment, intimidation, and bullying. A school district may implement bullying prevention programs and approaches that may be available at no cost from the NJDOE, the New Jersey State Bar Foundation, or any other entity. A school district may, at its own discretion, implement bullying prevention programs and approaches which impose a cost on the district.

N.J.S.A. 18A:35-4.26 – Instruction in Gang Violence Prevention

This law requires each board of education that operates an educational program for elementary school students to offer instruction in gang violence prevention and in ways to avoid membership in gangs. The instruction shall take place as part of the district's implementation of the Core Curriculum Content Standards in Comprehensive Health and Physical Education. The Framework provides school districts with sample materials that may be used to support implementation of the instructional requirement.

N.J.S.A. 18A:35-4.27 – Instruction on Responsible Use of Social Media

This law requires each school district to incorporate instruction on the responsible use of social media into the technology education curriculum for students in grades 6 through 8 as part of the district's implementation of the Core Curriculum Content Standards in Technology. The instruction shall provide students with information on the purpose and acceptable use of various social media platforms; social media behavior that ensures cyber safety, cyber security, and cyber ethics; and the potential negative consequences, including cyber bullying, of failing to use various social media platforms responsibly.

N.J.S.A. 18A:35-4.28 & 29 – Instruction in CPR and AEDs

This law requires the board of education of a public school district that includes grades 9 through 12, or the board of trustees of a charter school that includes grades 9 through 12, to provide instruction in cardiopulmonary resuscitation and the use of an automated external defibrillator to each student prior to graduation as part of the district's implementation of the Core Curriculum Content Standards in Comprehensive Health and Physical Education. The board of education, or board of trustees, may select a no-cost, non-certification instructional program to meet this requirement. However, the instruction provided pursuant to shall be modeled from an instructional program established by the American Heart Association, American Red Cross, or other nationally recognized association with expertise in instruction in cardiopulmonary resuscitation and the use of an automated external defibrillator; and include a hands-on learning component for each participating student.

N.J.S.A. 18A:6-111 – Suicide Prevention

This law requires instruction in suicide prevention in public schools as part of any continuing education that public school teaching staff members must complete to maintain their certification. It also requires suicide prevention awareness in the Core Curriculum Content Standards in Comprehensive Health and Physical Education.

N.J.S.A. 18A:6-2 – Instruction in Accident and Fire Prevention

Regular courses of instruction in accident prevention and fire prevention shall be given in every public and private school in this state, and instruction shall be adapted to the understanding of the several grades and classes in said schools.

N.J.S.A. 18A:7F-4.3 – Organ Donation

This law requires information about organ donation to be given to students in grades 9 through 12. The instruction must emphasize the benefits of organ and tissue donation to the health and well-being of society generally and to individuals whose lives are saved by organ and tissue donations, so that students will be motivated to make an affirmative decision to register as donors when they become adults. It must also address myths and misunderstandings regarding organ and tissue donation and explain the options available to adults, including the option of designating a decision-maker to make the donation decision on one's behalf. The program should instill an understanding of the consequences when an individual does not make a decision to become an organ donor and does not register or otherwise record a designated decision-maker.

N.J.S.A. 18A:36-5.1 – School Violence Awareness Week

This law designates the week beginning with the third Monday in October of each year as "School Violence Awareness Week." School districts shall observe this week by organizing activities to prevent school violence including, but not limited to, age-appropriate opportunities for student discussion on conflict resolution, issues of student diversity, and tolerance. Law enforcement personnel shall be invited to join members of the teaching staff in the discussions. Programs shall also be provided for school board employees that are designed to help them recognize warning signs of school violence and to instruct them on recommended conduct during an incident of school violence. The NJDOE shall provide guidelines and information to boards of education for use in planning the activities in observance of the week and such funds as are necessary to pay the costs of the required activities and programs.

N.J.S.A. 18A:40-32 & 33 – Cancer Awareness Week

This law designates the second week of January as "Cancer Awareness Week" in all the public schools in New Jersey and required the Commissioner of Education, in consultation with the State school boards, to develop a cancer awareness program appropriate for school-aged children.



Key Point

Cancer prevention is included in the CHPE Learning Standards.

N.J.S.A. 18A:33-6 – Display of Poster Illustrating Choke Prevention Techniques

This law requires each local board of education to ensure that posters illustrating choke prevention techniques such as the Heimlich Maneuver are prominently displayed in all school cafeterias, faculty dining rooms, and all other public school locations designated as places where food is consumed. It also requires the district to have pamphlets illustrating choke prevention techniques available in every school for free distribution to students.

N.J.S.A. 18A:40-43 – New Jersey Safe Haven Infant Protection Act

This law requires each board of education which operates an educational program for public school students in grades 7 through 12 to ensure that posters providing information on the provisions of the “New Jersey Safe Haven Infant Protection Act,” are prominently displayed in the school nurse’s office and health education classrooms. It also requires the school to have **Safe Haven materials** available in the guidance office of every public school with students in grades 7 through 12 for free distribution to students.

Additional Points for School Nursing Practice

The school nurse is the school’s resident healthcare professional. The school nurse should work with members of the school health team and the administration to ensure that information shared with students and parents in classrooms, in the gym or on the athletic field, and in assembly programs is medically accurate, current, and unbiased.



Key Point

If your school is planning a health-related assembly program or speaker, the school health team should investigate the presenter or vendor, check out the credentials of the speakers, review the program in advance, and seek out references from local school districts. The school health team should make sure that such programs are not biased or inflammatory and that appropriate resources are in place for potential follow-up services such as counseling.

There is a dedicated webpage that addresses New Jersey’s requirements for **Comprehensive Health and Physical Education**. A “teaching” school nurse may want to check it frequently for changes and updates.

School nurses who provide regularly scheduled health instruction should become families with **SGO Guidance** addressing health education and physical education.

NJAHPERD provides resources on teacher accountability, instruction, recess, and other health education topics.

Even if the school nurse is not “teaching” in the classroom setting, the nurse needs to be aware of the content of health instruction. Students may have questions and concerns about the information learned in health education classes. The school nurse is often viewed as the “expert.” Parents may also contact the school nurse about the depth and accuracy of information included in the school’s health program.



Key Point

Students may feel more comfortable asking questions in the privacy of the health office. Make sure you are familiar with what is being taught at each grade level so you can respond accordingly and respect the student’s right to privacy.

School nurses frequently provide health education to students with chronic health conditions. Be sure to document those encounters and use materials that are current, accurate, and designed for the age and developmental level of the student.

NASN’s position paper, the **Role of the 21st Century School Nurse**, looks at the school nurses’ role in primary, secondary, and tertiary prevention. Health education, as a form of primary prevention, promotes physical and mental health and informs healthcare decisions, prevents disease, and enhances school performance.

The school nurse has a responsibility to promote health and wellness. The nurse may provide health education to individual students or to groups of students through formal and informal means. As a member of the school health team and/or the school health advisory council, the school nurse plays a critical role in analyzing health data to develop and implement programs and policies that meet the needs of all students.



Key Point

*The CDC developed numerous tools to help schools improve health instruction. The Health Education Curriculum Analysis Tool (**HECAT**) provides a common set of tools to assist with the selection or development of health education curricula. The HECAT contains guidance, analysis tools, scoring rubrics, and resources for carrying out a clear, complete, and consistent examination of health education curricula. The CDC also developed the **Characteristics of Effective Health Education Curricula** which helps schools design and choose a science-based health program and materials.*

Key Point

*The CDC’s **School Health Index (SHI)** is an online planning guide that can be used to help schools examine their health and safety policies and programs. There is a separate SHI for elementary and middle/high schools.*



Key Point

*When designing a family life or sexuality education program, review the CDC-produced **Developing a Scope and Sequence for Sexual Health Education**. In addition to the **National Health Education Standards**, a collaborative of national organizations developed the **National Sexuality Education Standards**, which align with the NHES but focus specifically on sexuality education.*

To learn more about national efforts in school health, go to [CDC Healthy Youth Profiles](#).

[Advocates for Youth: Comprehensive Sex Education Research and Results](#)

USDHHS Office of Adolescent Health: [Evidence Based Teen Pregnancy Prevention Programs](#)

In June 2016, AAP's Committee on Adolescence and Committee on Psychosocial Aspects of Child and Family Health published a report, [Sexuality Education for Children and Adolescents](#).

[NIH Evidence-Based Programs](#)

[A Guide to Evidence-Based Programs for Adolescent Health: Programs, Tools, and More](#) provides an annotated list of resources with links to evidence-based practices.

[SHAPE America Health Education Toolbox](#)

Educating Students, Staff, and Families

Topic: School Wellness Policies and Initiatives

Background and Rationale

Childhood obesity is a national epidemic. Nearly 1 in 3 children (ages 2-19) in the United States is overweight or obese, putting them at risk for serious health problems. One way to address this problem has been the implementation of policies and practices that support healthy eating and increased physical activity (Alliance for a Healthier Generation, 2016). These activities are known as school wellness programs.

Schools play a critical role in promoting student health, preventing childhood obesity, and combating problems associated with poor nutrition and physical inactivity. In 2004, Congress passed the Child Nutrition and Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Reauthorization Act (Sec. 204 of Public Law 108-265). This act required by law that all local education agencies (LEAs) participating in the National School Lunch Program or other child nutrition programs create local school wellness policies by 2006. Wellness policies are developed at the local level so the individual needs of each LEA can be addressed. In 2010, Congress passed the Healthy, Hunger-Free Kids Act of 2010 (Sec. 204 of Public Law 111-296), and added new provi-

sions for local school wellness policies related to implementation, evaluation, and publicly reporting on progress of local school wellness policies. The final rule strengthened the requirements on public involvement, transparency, implementation, and evaluation (USDA, 2017).

To assist school districts to develop sound wellness policies, the CDC created **School Wellness in Action** which highlights key elements that contribute to the successful implementation of school and district policies. Critical to the process is a “wellness champion,” an individual who serves as the driving force for developing and implementing the wellness policy. In many school districts a single wellness champion—such as a school nurse, district superintendent, or community member—starts the process and keeps it going when challenges arise. School wellness activities provide an opportunity for school nurses to demonstrate leadership skills, collaborate with interested stakeholders, and advocate for programs and services that support school and community wellness.

Many schools and districts set up wellness councils or school health advisory councils to develop their wellness policies and to implement programs and activities. The school health team can be easily expanded to create a school wellness council. Several states developed guides to effective advisory councils (**North Carolina** and **Texas**). Wellness policies are most effective when students and their families are involved and “buy-in.” Additionally, it is crucial to involve community stakeholders in the process for help with funding, evaluation, and services.

The New Jersey Department of Agriculture’s (NJDA) Division of Food and Nutrition works closely with the U.S. Department of Agriculture (USDA) to implement school foods policies. It also works with the NJDOE and NJDOH to ensure that all children have access to safe and healthy meals at school. The NJDA feeds school children daily through the federal School Breakfast and Lunch programs. These programs provide nutritionally balanced meals to children at low or no cost. The NJDA created an **FAQ** to help schools align their policies and practices to meet state and federal requirements and adopted the model policy used in the Alliance for a Healthier Generations Healthy Schools Program. A basic district-level policy, it meets the minimum federal standards for local school wellness policy implementation under the Healthy, Hunger-Free Kids Act of 2010. The NJDAG also developed a **Wellness Policy Assessment Tool** to assist districts to implement the wellness policy mandate.

The school nurse can play a pivotal role in the development and implementation of the local wellness policy. As leader or “champion,” the nurse can serve as a member of the district or school wellness committee and actively participate in programs and services to support the health of students and staff. School nurses have knowledge and expertise in healthy eating, weight control, and exercise and are familiar with community resources to support the implementation of the policy.



Applicable Laws and Regulations

The creation of school wellness policies has its origins at the federal level but is regulated at the state level. Here is a [Summary of the Final Rule](#) from July 2016 that established a new framework and guidelines for the development of wellness policies.

Additional Points for School Nursing Practice

The NJDA provides a [Wellness Policy Assessment Tool](#).

When developing wellness policies, school districts need to take into account their unique circumstances, challenges, and opportunities. Other factors that school districts must consider are socioeconomic status of the student body, school size, rural or urban location, and presence of immigrant, dual-language, or limited-English students.

The school nurse can play a pivotal role in the development of the school wellness policy. The NASN practice paper, [School Wellness: What the Law Looks Like](#), provides an overview of the requirements and resources. NASN encourages school nurses to become involved in local wellness councils.

The U.S. Department of Agriculture Food and Nutrition Services created a [School Wellness Policy Outreach Toolkit](#) with sample letters, posters, and social media posts.

Action for Healthy Kids (AFHK) developed [School Wellness Policies 101](#) which provides parents and community stakeholders on school wellness policies. It also offers [Tools for Schools](#) which provides information on wellness policies, grants, and community-based programs to support the wellness message.

Funding for wellness-related programs may be available from a variety of sources including government agencies, healthcare providers, and community based-organizations. Even small grants can be used to promote healthy eating or increase physical activity in a school. Spark provides a [grant funding tool](#). CATCH also provides a [grant finder tool](#). Another possible funding source is [Action for Health Kids Apply for Grants](#)

The Alliance for a Healthier Generation provides resources for [Wellness Committees](#).

The [Shaping NJ School Toolkit: Creating Healthy Active Schools](#) provides user-friendly strategies, policy components, and associated actions, practices, tools, and resources for current or potential members of school wellness teams to advance policy development and implementation efforts focused on nutrition and physical activity in schools.

Educating Students, Staff, and Families

Topic: Health-Related Professional Development Requirements for School Staff

Background and Rationale

When the New Jersey Legislature passes a new school health law, it is not unusual for it to also include mandated professional development for school personnel. Some laws requiring training for school personnel have been on record for many years. This has created a long list of annual trainings, some of which are specifically “assigned” to the school nurse while others may be delivered by the school physician, SAC, counselor, or other health experts. An increasing number of trainings programs can be offered electronically or online.

In 2016, Research for Action (RFA), a nonprofit educational research organization, investigated how mandated professional development activities were addressed in New Jersey’s schools. RFA found that many of the professional development mandates were not related specifically to curriculum and instruction. In fact, most of the required professional learning activities were “health-centric;” that is, the focus of the professional development was on specific topics addressing prevention, school safety and security, general health issues, and athletic-related health issues. Over 60% of responding school districts reported that in eight of the ten topics related to health, state-mandated professional development was provided by internal staff such as the school nurse. The survey results can be found [here](#).

In today’s schools, students present with a myriad of health issues that may require emergency actions or instructional accommodations. Similarly, training may focus on ways school staff can protect themselves. Unfortunately, as the list of requirements has grown, it has become more difficult for schools to provide sufficient time to fulfill the mandates in meaningful ways.

The school nurse has specific professional development responsibilities under the law and is often called upon to deliver additional training to school personnel on a wide range of issues. School districts must consider more efficient ways to deliver health-related professional development training that is still effective and meaningful for both seasoned and novice professionals, coaches, school support staff, bus drivers, volunteers, and others that interact with students.



Key Point

Certified school nurses are teaching staff members and must address continuing education requirements as both a professional nurse and educator.



Applicable Laws and Regulations

N.J.A.C. 6A:9C – Professional Development

These regulations aim to create a system of high-quality professional development that continuously serves educators' professional learning and practice in support of positive learning outcomes for all New Jersey students and to support improved student achievement of the New Jersey Student Learning Standards. The rules define professional learning as coherent, sustained, evidence-based strategies that improve educator effectiveness and student achievement. Additional NJDOE regulations and guidance regarding standards and professional development can be found [here](#).

The NJDOE developed a chart that outlines **state required professional development**. It includes a summary of the requirement as well as the authorizing citations, educators who should receive the professional development, timelines, and additional information. The requirements are grouped under the following topics:

- Reading Disabilities
- Prevention: Suicide, Substance Abuse, Harassment, Intimidation, and Bullying
- School Safety, Security and Code of Student Conduct
- Health
- Interscholastic Activities
- Additional Professional Development Topics

Please note that older versions of the chart omitted Lyme disease training which has been required since 1993. The original chart did not include the mandated cardiac PD module but it was updated to include both in August 2016.

Additional Points for School Nursing Practice

The school nurse or school physician may be called upon to deliver professional development and training to school personnel about many health issues. Collaborate with the school physician to develop materials that can be easily adapted for use with various audiences (e.g. teachers, aides, bus drivers).



Key Point

School personnel will be more engaged if the health “lectures” are interactive, related to their work, brief, and appropriate for their experience and background knowledge.

The school health advisory council (SHAC) or wellness committee can serve as a professional learning community (PLC) for health-related school staff. The PLC can address health education needs and programs for the entire school community.

School districts should consider developing or purchasing online training programs for some generic health issues. This can increase accountability and provides flexibility to deliver the programs to new school staff throughout the school year. The school nurse and school physician should review the materials before purchase to ensure they are medically accurate, current, and appropriate for a school audience.

School nurses may be called upon to provide training in communicable diseases and their prevention; asthma and the use of a nebulizer; diabetes and the administration of glucagon; anaphylaxis and the administration of epinephrine; and universal precautions and blood-borne pathogens. School nurses may need different programs and materials for general training versus student-specific training.



Key Point

School districts need to consider the preparation time necessary to develop, review, and implement school health training programs. While the programs are required by law, it may be difficult for a school nurse to develop and present these programs during the regular school day.

Key Point

Encourage the school principal to include school health issues on staff meeting agendas. Faculty can submit questions in advance of the meeting or each month a different health topic can be presented.

The district and school administration is responsible for maintaining professional development records. The school nurse should keep records of training completed by volunteer delegates for glucagon or epinephrine since the nurse is training and “delegating” the task.

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CHAPTER THIRTEEN: Promoting a Healthy School Environment

Introduction



The WSCC model expanded the traditional coordinated school health (CSH) model from eight components to ten. In the original CSH model, the school environment component was called Healthy and Safe School Environment. This single component addressed both the school's social and emotional climate as well as the physical environment of the school building and campus. As states and school

districts began to use the original CSH model, it became evident that the component needed to be separated into two distinct components: one that addresses the school's social and emotional climate and another that addresses the upkeep of the building and grounds and how that impacts health and learning. The WSCC model refers to that component as a school's **physical environment** (CDC, 2015).

This chapter focuses on creating a healthy and safe school environment with particular attention to the school's physical condition. It focuses on environmental conditions that may impact student learning such as noise, lighting, temperature, ventilation, and maintenance practices as well as policies and procedures that protect students and staff from exposure to chemicals, toxins and blood-borne pathogens. Chapter Nine of this document addresses the WSCC component that focuses on the school's **social and emotional climate** (CDC, 2015).

According to the **National Center for Safe Supportive Learning Environments**, a school's physical environment has an effect on student achievement and behavior and impacts teacher absenteeism and morale. However, the school's physical condition and that of the surrounding fields and neighborhoods can have a significant impact on the health of students and staff. Children spend more than six hours per day for at least 180 days per year in school. The impact of the school's physical environment cannot be underestimated (NCSSLE, 2017).

While the school nurse may not be responsible for the school's upkeep, the school health team plays an important role in preventing, reducing, or eliminating environmental hazards that compromise the health and safety of students and their families, as well as school personnel, by working with the district board of education to develop environ-



mentally sensitive and health promoting policies and practices. The school nurse plays a pivotal role in identifying potential hazards, collecting data about possible exposure and symptoms, and working with public health and environmental protection officials to correct deficiencies and prevent further exposures.

The chart below, developed by the World Health Organization (2002) is an excellent summary of potential school physical environment hazards.

Components of a Healthy School Environment	
Provision of Basic Necessities	• Shelter • Warmth • Water • Food • Light • Ventilation • Sanitary facilities • Emergency medical care
Protection from Biological Threats	• Molds • Unsafe or insufficient water • Unsafe food • Vector-borne diseases • Venomous animals • Rodents and hazardous insects • Other animals (e.g.dogs)
Protection from Physical Threats	• Traffic and transport • Violence and crime • Injuries • Extreme heat and cold • Radiation
Protection from Chemical Threats	• Air pollution • Water pollution • Pesticides • Hazardous waste • Hazardous materials and finishes • Asbestos • Paint • Cleaning agents

Topic: Blood Borne Pathogens and Universal Precautions

Background and Rationale

School nurses are professionally educated and prepared to prevent the transmission of bloodborne pathogens. However, most school employees are not prepared to respond to emergencies that may expose them to blood or other body fluids. Administrators, teachers and classroom assistants, bus drivers, coaches, food service workers and custodians may all be called upon to deliver emergency care. This action may place them at risk for exposure to the pathogens that most commonly cause Hepatitis A, B, or C or HIV. Individuals may also risk exposure to bacterial infections through open or draining wounds or sores or on discarded dressings. Additionally, exposure to human waste or other body fluids may place one at risk for gastroenteritis caused by *Shigella* or *Salmonella*. All personnel, students, and families should be trained to prevent the spread of infections in general, and in particular, those spread by blood and other body fluids. The school nurse should make infection control a priority.

Two agencies are responsible for developing and enforcing standards and policies related to occupational exposure. Specifically, the U.S. Department of Labor's Occupational Safety and Health Administration (OSHA) provides information and general guidance regarding **bloodborne pathogens**. The NJDOH's Workplace Health and Safety Unit is home to **PEOSH**, the state's public employee version of OSHA.

The federal OSHA standard, **29 CFR 1910.1030** Exposure to Blood Borne Pathogens, was adopted by PEOSH. This standard protects workers in the public sector in New Jersey who may come in contact with blood or other potentially infectious materials. In general, the standard requires employers to:

- Establish an exposure control plan;
- Implement the use of universal precautions;
- Identify and use engineering controls;
- Identify and ensure the use of work practice controls;
- Provide personal protective equipment (PPE), such as gloves, gowns, eye protection, and masks;
- Make available hepatitis B vaccinations to all workers with occupational exposure;
- Make available post-exposure evaluation and follow-up to any occupationally exposed worker who experiences an exposure incident;
- Use labels and signs to communicate hazards;
- Provide information and training to workers; and,
- Maintain worker medical and training records (CDC, 2017a).



The school nurse collaborates with district administration and other members of the school health team to ensure that district policies and practices comply with PEOSH regulations. This is particularly important in the school health office and the athletic trainer's office. However, the importance of universal practices throughout the school cannot be underestimated. The district's maintenance and facilities departments play an important role in supporting a safe and healthy school environment.

The district board of education has an obligation to provide a safe environment for students and staff. The following questions should be addressed:

1. Are all school personnel educated on precautions?
 2. Have all school personnel received appropriate vaccinations?
 3. Have optimal work practice controls and appropriate labels and signs been instituted?
 4. Is personal protective equipment on hand?
 5. Have best practice protocols been implemented when an exposure occurs?
 6. Is there a working partnership with district administration to determine that staff medical and training records are maintained?
 7. Has the Exposure Control Plan been reviewed and updated annually?
 8. Is regulated medical waste handled in accordance with New Jersey regulations?
- (Adapted from: NJDOH-PEOSH, 2003).

Additional information on **bloodborne infectious diseases** is available from the CDC's National Institute for Occupational Safety and Health (NIOSH).

Applicable Laws and Regulations

N.J.A.C. 6A:16-1.3 defines universal precautions as a set of procedures designed to prevent transmission of human immunodeficiency virus (HIV), hepatitis B virus, and other bloodborne pathogens.

N.J.A.C. 6A:16-2.1(a)7 requires the utilization of sanitation and hygiene when handling blood and bodily fluids pursuant to N.J.A.C.12:100-4.2, Safety and Health Standards for Public Employees, and in compliance with 29 CFR 1910.1030, Public Employees Occupational Safety and Health Program (PEOSH) Blood Borne Pathogens Standards.

N.J.A.C. 7:26 – State of New Jersey, Department of Environmental Protection

Division of Solid and Hazardous Waste Regulations

N.J.S.A. 18A:40-3 – Lectures to Teachers

This law requires the medical inspector (school physician) or school nurse to lecture teachers about communicable diseases and the recognized measures for the promotion of health and the prevention of disease.



Key Point

This law was enacted in 1967; thus it references “teachers” rather than school personnel or all school employees. All school employees and volunteers need to be educated about communicable diseases and infection control strategies.

29 CFR Part 1910.1030 – Occupational Safety and Health Administration Bloodborne Pathogens

Universal precautions is an approach to infection control in which all human blood and certain body fluids are handled as if to be infectious for HIV, HBV, HCV and other blood-borne pathogens. The use of universal precautions is the best strategy to prevent contact with blood or other potentially infectious materials (OPIM). Universal precautions includes the use of gloves, masks, and gowns if blood or OPIM exposure is anticipated.

Additional Points for School Nursing Practice

As the school’s health professional, the school nurse should ensure that everyone understands the need to practice universal precautions with every incident involving blood and other body fluids. All school personnel must be trained to implement the district’s policies and procedures. The school nurse should collaborate with the school physician and administration to evaluate and update infection control policies, as needed.

Effective hand washing is essential to minimize disease transmission. The district board of education must ensure that students and employees have access to running water and soap and the school nurse should teach everyone the proper way to wash their hands. The use of hand sanitizers, while an effective stop-gap measure, should not be the primary hand sanitation method used by students and staff.



Key Point

*The CDC provides recommendations on the use of **hand sanitizers** and how to wash one’s hands.*

Engineering controls are devices that isolate or remove the bloodborne pathogens hazard from the workplace. They include sharps disposal containers, self-sheathing needles, and safer medical devices such as sharps with engineered sharps-injury protection and needle-less systems. Work practice controls can reduce the possibility of exposure by changing the way a task is performed, such as appropriate practices for handling and disposing of contaminated sharps, handling specimens, handling laundry, and cleaning contaminated surfaces and items.



Key Point

Don gloves whenever handling blood or bodily fluids. Don mask/gown if deemed appropriate for potential exposure.



Key Point

Improvements in infection control are ongoing and require surveillance to keep abreast of advancements. As things change, the school nurse and school physician must articulate and clarify needed modifications to policy and/or practice.

The district board of education must provide personal protective equipment (PPE), such as gloves, gowns, eye protection, and masks. As employers, the district must clean, repair, and replace this equipment, as needed, at no cost to the employee.



Key Point

Employers are legally bound to provide PPE at no cost to the employee.

All employees with occupational exposure must be informed about the availability of hepatitis B vaccinations. This vaccination must be offered after the employee has received the required bloodborne pathogens training and within 10 days of initial assignment to a job with occupational exposure.

An **exposure incident** is a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials (OPIM). The evaluation and follow-up is at no cost to the employee and includes:

- Documenting the route(s) of exposure and the circumstances under which the exposure incident occurred;
- Identifying and testing the source individual for HBV and HIV infectivity, if the source individual consents or the law does not require consent;
- Collecting and testing the exposed worker's blood, if the worker consents;
- Offering post-exposure prophylaxis;
- Offering counseling; and,
- Evaluating reported illnesses (OSHA, 2011).



Key Point

Coaches, administrators, and healthcare personnel are encouraged to be vaccinated for HBV. Documentation of this immunization should be housed in the employees' personnel file.

The occupational healthcare professional will provide a limited written opinion to the employer and all diagnoses must remain confidential.



Key Point

The school nurse is typically the first responder during school hours and responds in accordance with evidence-based practice and district policies and procedures. Depending on district policies, the school nurse may or may not be involved in the post-exposure process.

Schools do not typically consider themselves as generators of **medical waste**. However, students and staff may have medical conditions that require the use of injectable devices and needles. In addition, it is possible that schools might generate laundry contaminated with blood, vomitus, urine, or feces. Warning labels must be affixed to containers of regulated waste including containers of contaminated reusable sharps; refrigerators and freezers containing blood or OPIM; other containers used to store, transport, or ship blood or OPIM; contaminated equipment that is being shipped or serviced; and bags or containers of contaminated laundry, except as provided in the standard. Facilities may use red bags or red containers instead of labels.



Key Point

The school nurse may serve as a resource for the school's environmental services and science laboratories to ensure compliance with OSHA and workplace safety

Employers must ensure that their workers receive regular training that covers all elements of the standard including, but not limited to (1) information on bloodborne pathogens and diseases; (2) methods used to control occupational exposure; (3) hepatitis B vaccine; and (4) medical evaluation and post-exposure follow-up procedures. Employers must offer this training on initial assignment, at least annually thereafter, and when new or modified tasks or procedures affect a worker's occupational exposure. Employees must have the opportunity to ask the trainer questions. Also, training must be presented at an educational level and in a language that employees understand.



Key Point

*The school nurse is encouraged to take a lead role in providing education to the school community. Educational programs should be reviewed, critiqued, and sanctioned by the school nurse and school physician to ensure that they are appropriate for the specific school setting, since many programs are designed for hospital or field-based healthcare providers. The materials used for employee learning must be provided in a language the employee understands and the nurse needs to be available to answer any questions the learners may have. One resource is the **Heartsaver® Bloodborne Pathogens Training** provided by the American Heart Association.*

The exposure control plan is a written plan to eliminate or minimize occupational exposures. The employer must prepare an exposure determination that contains a list of job classifications in which all workers have occupational exposure and a list of job classifications in which some workers have occupational exposure, along with a list of the tasks and procedures performed by those employees which result in their exposure. Employers must update the plan annually to reflect changes in tasks, procedures, and positions that affect occupational exposure, and also technological changes that eliminate or reduce occupational exposure. In addition, employers must annually document in the plan that they have considered and begun using appropriate, commercially available, effective, and safer medical devices designed to eliminate or minimize occupational exposure. Employers must also document that they have solicited input from frontline workers in identifying, evaluating, and selecting effective engineering and work practice controls.

The school nurse must be familiar with the district's Exposure Control Plan to determine if school health office operations are in compliance. A **Standard Model Exposure and Control Plan and Employer Guide** is available.



Key Point

At minimum, the plan should include a statement of employer policy; the designation of employees responsible for implementation of various plan elements; a determination of employee exposure; and the implementation of various methods of exposure control, including universal precautions, engineering controls, and work practices; personal protective equipment; training; HBV vaccination; post-exposure evaluation and follow-up; housekeeping; labeling; and employer record keeping.

Regulated Medical Waste (RMW) is governed by N.J.A.C. 7:26 and is addressed in the **Standard Model Exposure and Control Plan and Employer Guide**. RMW includes but is not limited to sharps (used and unused); items saturated with blood (wet or caked); and discarded live and attenuated vaccines. Sharps are defined as, but not limited to, hypodermic needles and all syringes to which a needle can be attached.



Key Point

In the school setting this includes, but is not limited to, needles attached to insulin pens, catheters from insulin pump insertion sets, and lancets.

The New Jersey Department of Environmental Protection (NJDEP) oversees the disposal of medical waste and schools must register as generators. Information on registering and other important topics can be found in the [Guidance Document for Regulated Medical Waste](#). In general, medical waste generators must:

- Segregate RMW into (1) sharps and (2) fluids;
- Ensure that containers are appropriately labeled (medical waste) and marked (generator or transporter company name/address) and are impervious to sharps;
- Ensure that waste is not stored for more than one year;
- Use medical waste transporters that are registered with the Division of Solid and Hazardous Waste at NJDEP and who possess a Certificate of Public Convenience and Necessity; and,
- Use the proper tracking form and retain a copy for three years.

Promoting a Healthy School Environment

Topic: Safe Drinking Water

Background and Rationale

Getting sufficient water every day is important. Healthy people meet their fluid needs by drinking when thirsty and drinking with meals. However, this is not always easy for students in the classroom. Schools often restrict the use of water bottles in the classroom and school staff may limit access to school water fountains. In some schools, only certain water fountains are operational. However, access to water is critical to health, as it helps keep the body temperature normal, helps the body eliminate waste, and keeps the joints cushioned and lubricated.

The CDC encourages schools to allow access to drinking water as a healthy alternative to sugar-sweetened beverages. Water consumption as part of the school day helps students maintain hydration. Studies show that adequate hydration also may improve cognitive function in children and adolescents. Drinking water, if fluoridated, also plays a role in preventing dental caries (cavities). To help schools improve water access, the CDC published [Increasing Access to Drinking Water in Schools](#) (CDC, 2014).

As if ready access to potable drinking water is not enough, some New Jersey schools discovered high levels of lead contamination in the water supply. In response, the State Board of Education adopted regulations requiring testing for lead in all drinking water



outlets within 365 days of the effective date of the regulations, which was July 13, 2016. All districts were directed to develop a lead sampling plan to govern the collection and analysis of drinking water samples. Samples were sent to a certified testing laboratory for analysis. The NJDEP, Division of Water Supply and Geoscience, provides additional information on [lead sampling in schools](#) as does the [EPA](#). The [New Jersey School Boards Association Lead Testing in Schools](#) provides additional information on the new requirements.

The impact of lead exposure cannot be underestimated. Funded by the CDC, New Jersey developed a [State Plan](#) to eliminate and address lead exposure by 2010; however, many of those goals have yet to be realized. According to the CDC, the major source of lead exposure among U.S. children continues to be lead-based paint and lead-contaminated dust found in deteriorating buildings. Despite banning lead-based paint in housing in 1978, approximately 24 million housing units in the United States have deteriorated leaded paint and elevated levels of lead-contaminated house dust. More than 4 million of these dwellings are home to one or more young children. Lead can also be found in water pipes inside homes or pipes that connect homes to the main water supply pipe. Lead found in tap water usually comes from the decay of old lead-based pipes, fixtures or from leaded solder that connects drinking water pipes (CDC, 2005; CDC, 2016).



Key Point

Exposure to lead impacts children from all social and economic levels but children living at or below the poverty line who live in older housing with lead paint are at greatest risk. Children may be exposed to lead by eating and drinking food or water containing lead or from dishes or glasses that contain lead, inhaling lead dust from lead-based paint or lead-contaminated soil, or from playing with toys with lead paint.

In [Learn about Lead](#), the EPA explains where lead comes from and how lead might impact children. Lead is particularly dangerous to children because they absorb more lead and their brains and nervous systems are more sensitive to the damaging effects of lead. Lead exposure may cause neurological and physical effects. Even low levels of lead exposure may lead to behavior and learning problems; lower IQ and hyperactivity; slowed growth; hearing problems; and, anemia. In rare cases, ingestion of lead can cause seizures, coma and even death (EPA, 2017a). A blood lead level (BLL) of 5 micrograms per deciliter (5mcg/dL) requires public health action. Exposure to lead may be present with or without signs or symptoms (CDC, 2017b).

New Jersey has a complex system of laws, regulations, and programs that address the management of water, wastewater, and stormwater. While everyone needs access to safe drinking water, the state's infrastructure varies based on geographic region. Access to safe and clean water has been impacted by urban development, farming, coastal issues, and preservation efforts. The NJDEP has oversight for the state's [water supply](#). The pres-

ence of lead in school water supplies in schools throughout the state has brought to light the impact of lead exposure as well as the need for safe drinking water in schools.

School nurses play an important role identifying children impacted by lead exposure and assisting students and their families to obtain care and assistance in school and at home. While lead exposure has been more common in urban areas, New Jersey's older water delivery systems have now made lead exposure a state-wide issue. In addition, school nurses who work in rural areas of the State may encounter students who have been exposed to other substances through contaminated wells. In view of these concerns, the school nurse should educate students and staff about the importance of hydration during the school day and as part of school-sponsored activities, and work with school administrators to ensure that safe drinking water is always available.

Applicable Laws and Regulations

State Board of Education Regulations, July 2016

N.J.A.C. 6A:26-1.2 and N.J.A.C. 6A:26-12.4

Testing for Lead in School Drinking Water

Testing for Lead in Drinking Water in All Educational Facilities

NJDOH Lead FAQ

USDA Water Availability During School Meals

Additional Points for School Nursing Practice

The school nurse plays an important part in ensuring access to safe, lead-free drinking water. As a health expert, the school nurse also knows how important hydration is to normal cognitive functioning and should encourage school officials to make drinking water available and accessible at all times. In addition, the school nurse should work closely with physical education teachers and coaches to ensure that water is readily available during periods of physical activity.

The issue of lead exposure poses a different issue for the school nurse. It is quite likely that a school-aged child was exposed to lead before entering school and has yet to be "diagnosed." Ultimately, the parent/guardian and the child's medical home are responsible for lead exposure testing at 12 and 24 months of age. However, a child may exhibit learning difficulties post exposure and may never have been tested. When reviewing the child's health history, the school nurse must be aware of the possibility of previous lead exposure and know the possible effects associated with an elevated BLL. Once confirmed, the results of any testing and referrals should be documented on the child's Health History and Appraisal Form (A-45) and an IHP should be developed. As part of the school health team, the school nurse should work with the social worker and other appropriate school personnel to assist the family to receive care and follow-up. In addition, the child may be referred to the school's IR&S team or CST for additional evaluation and accommodations.



Key Point

The school nurse should educate school personnel about the impact of lead exposure and provide education to all stakeholders (e.g., students, families, teachers) about the primary prevention of lead exposure. The school health team/school wellness council may advocate for community-based and culturally sensitive approaches to prevention guided by a needs assessment.



Key Point

***Educational Interventions**, published by the CDC, outlines available scientific data describing the effects of lead, summarizes in plain language IDEA parts B and C, and provides information on how these provisions relate to children affected by lead.*

The [Sustainable Jersey Schools](#) program is a nonprofit organization that provides tools, training, and financial incentives to support and reward schools as they pursue sustainability programs. Access to healthy drinking water is one program area.

The EPA published [Sensible Steps to Healthier School Environments](#) which describes cost effective ways to improve the health of students and staff.

The AAP has information for parents on [Lead in Tap Water](#).

Promoting a Healthy School Environment

Topic: Indoor Air Quality

Background and Rationale

Indoor Air Quality (IAQ) refers to the air quality within and around buildings and structures, especially as it relates to the health and comfort of building occupants. Even after a single exposure to a pollutant, an individual may exhibit symptoms such as irritation of the eyes, nose, and throat; headaches; dizziness; and fatigue. Such immediate effects are usually short-term and treatable. However, for individuals with asthma or other respiratory conditions, indoor pollutants may cause serious problems. The IAQ may be influenced by an inadequate supply of outdoor air or from conditions created by heating and cooling systems. The presence of mold, radon, or second-hand smoke also contribute to poor air quality (EPA, 2017b).

The EPA program, [Creating Healthy Indoor Air Quality in Schools](#), assists school districts to develop policies and practices that promote a healthy learning environment. Why is this so important? The EPA's quick reference guide, [Student Health and Academic Performance](#) explains why. Clearly, scientific evidence has long demonstrated an association between poor IAQ and respiratory health effects, including asthma. Maintenance issues in schools such as mold and moisture or excessive use of cleaning chemicals have been shown to trigger asthma and allergies. Dust mites, pests, and molds all contribute

to poor air quality in schools. In addition, exposure to diesel exhaust from school buses and other vehicles also impacts allergies and asthma (EPA, 2012).

The New Jersey **Indoor Air Quality Standard** was established by the New Jersey Department of Labor to protect public employees. It sets standards for indoor air quality in existing buildings occupied by public employees during their regular working hours. In addition, the NJDOH provides information on an indoor environmental health assessment (IEHA) for **educational facilities** and childcare centers undergoing renovations, remodeling, or conversions.

School nurses play an important role in evaluating the impact of indoor air quality by documenting student and staff health issues. For example, an increase in the number of health office visits for allergy or respiratory problems might indicate that the school needs to reassess its IAQ. The school nurse may also play an important role in the development of policies and practices that support a healthy school environment. The EPA provides the **Tools for Schools Action Kit** which provides sample policies and information to help school nurses promote healthy indoor air quality. In its position paper, **Environmental Health in the School Setting: The Role of the School Nurse**, NASN calls upon school nurses, as public health specialists, to advocate for a sustainable healthy school environment.

Applicable Laws and Regulations

N.J.A.C. 12:100-13 – New Jersey Indoor Air Quality Standard

N.J.A.C. 8:50 – Standards for Indoor Environment Certification

PEOSH regulations apply to public employees working inside existing public buildings during regular working hours.

The **NJDEP School Facilities Directory** and the **NJDOH Environmental and Indoor Health** web pages provide information on mold, asbestos, radon, and lead.

Additional Points for School Nursing Practice

The school nurse should carefully document health complaints that may be exacerbated or caused by poor indoor air quality and discuss the concerns with school administration. Allergens, mold, and other indoor air quality issues may impact student and staff health and attendance.



Key Point

When writing a student's IEP/IHEP, the school nurse may need to address the impact of indoor air quality on the student's health condition and develop strategies to address those issues.

The school nurse should review the **designated person** indoor air quality program Power Point offered by the NJDOH.



The **Sustainable New Jersey Schools** program provides tools and resources to address indoor air quality, HVAC systems, indoor mold issues, radon, and other air quality issues as well as outdoor air quality issues and anti-idling policies. The program works with PAC-NJ and the **Asthma Friendly Schools** program.

The EPA published **Sensible Steps to Healthier School Environments** which describes cost effective ways to improve the health of students and staff.

The CDC provides several resources that address **indoor environmental quality**, **air quality in homes**, and **air pollution and respiratory health**.

The American Federation of Teachers (AFT) provides guidance on **indoor air quality**.

Promoting a Healthy School Environment

Topic: Noise

Background and Rationale

The traditional definition of noise is “unwanted or disturbing sound.” Sound may interfere with normal activities such as sleeping or conversation. **Noise pollution** may increase stress and blood pressure and hearing loss may result. At a young age, children are exposed to a wide range of noise-producing activities including community and street noise from cars, trucks, planes, and motorcycles as well as industrial and construction noise. In addition, many children use headphones to watch television, listen to music, or play games on a computer (EPA, 2017c).

The World Health Organization (WHO) provides a thorough review and explanation of **recreational exposure** and hearing loss. Ears are designed to process moderate levels of sound in the normal environment. Exposure to much higher sound levels for extended periods are potentially harmful. The impact of loud sounds on hearing depends on three main factors: sound intensity (volume), duration of exposure, and distance from the sound source. By regulating all or one of these variables, it is possible to protect the ears (WHO, 2015).

Noise is measured by the intensity and frequency of sound waves that hit the ear. The decibel (dB) is the measurement used to measure the volume of sound; thus, the greater the number of decibels, the louder the noise. This has a higher potential of causing harm to a child's ears (WHO, 2015). The **American Academy of Audiology Classroom Acoustics** position paper advocates for appropriate acoustical learning environments.

Noise induced hearing loss (NIHL) is a permanent hearing loss associated with prolonged exposure to high levels of noise or an explosive noise event. Noise is a threat to a child's physical and physiological health, including learning and behaviors. Noise has the potential to interfere with speech and language and impair learning. Individuals may exhibit difficulty hearing, especially soft or faint sounds. Normal conversation may sound muffled or unclear and the individual may complain of ringing or buzzing in the ears (Johns Hopkins Medicine, ND.)

Because adults may experience the same kinds of hearing loss, the National Institute for Occupational Safety and Health (NIOSH) focuses primarily on occupational **Hearing Loss Prevention**. The CDC addresses non-occupational **noise induced hearing loss** while the National Institute on Deafness and Other Communication Disorders at NIH publishes national **hearing loss statistics**.

As required by law and regulations, school nurses routinely screen students for hearing loss and refer students for additional testing. Noise produced as part of the everyday school environment may also contribute to hearing loss and cause stress and anxiety. Schools in urban areas must contend with community and traffic noise. Excessive noise may be a factor in the gymnasium or in music rooms. The use of technology in schools presents issues as students use headphones to engage in learning. Noise is everywhere in schools and depending on the school building's structure, the extent of that noise can have profound impacts on student concentration and learning. Noise may also impact the adults working in the school environment.

Applicable Laws and Regulations

Currently, there are no laws or regulations that explicitly address noise reduction for students in the school setting. District boards of education are required to provide audiometric screening as outlined in Chapter Three of this document.

The EPA **Noise Control Act** was enacted in 1972. Since that time, the EPA shifted the primary responsibility for regulating noise to state and local governments; however, the Act and the Quiet Communities Act of 1978 were never rescinded by Congress and remain in effect today, although essentially unfunded.

Additional Points for School Nursing Practice

The New Jersey Education Association (NJEA) published an article **Reducing Noise in Schools** which provides an overview of noise-related issues for both students and staff.

The school nurse should carefully evaluate any complaints of hearing loss and refer any student or staff member who complains of tinnitus (especially after a loud explosive event) to an audiologist.



Key Point

Even vibration and noise from nearby traffic or the school's HVAC system may interfere with the audiometric screening process. The school nurse should ensure a quiet environment for audiometric testing.

Students should use protective ear plugs and head sets if conducting experiments or activities that may result in loud noise.

The school nurse should discuss with students and staff the use of headphones and sound moderation.



When conducting hearing screening, ask students if noise interferes with their daily activities. Some students may have sleep disorders or experience stress due to neighborhood noise while others may spend time using headphones or listening to loud music.

The **Safe Schools Manual** contains self-inspection checklists covering environmental, health and safety regulations for secondary occupational and career orientation programs in New Jersey public schools. It was developed by the Environmental and Occupational Health Sciences Institute with support by the NJDOE'S, Office of Career and Technical Education. It is available via mobile app download in both the App Store and Google Play.

Promoting a Healthy School Environment

Topic: Extreme Weather and Temperatures

Background and Rationale

While New Jersey still experiences a "four season" climate, it also experiences weather events such as hurricanes, tornados, floods, and drought. It also experiences periods of high heat and humidity as well as snowstorms and freezing conditions. School nurses need to be prepared for such weather extremes and can help students and families prepare as well.

Children are more susceptible to temperature extremes and their health effects. They are less able to regulate their body temperature compared with adults. Temperature extremes include heat waves, unseasonably cold weather, and winter storms. Children may also be exposed to inadequate heating or cooling or may spend time outside without the proper clothing. Children have a smaller body mass to surface ratio than adults, making them more vulnerable to heat and they lose fluids faster than adults which may also lead to dehydration. Children play outside more thus increasing their exposure to heat and cold (AAP, 2017). The AAP addresses these issues in **Extreme Temperatures**.

A **Child Care Weather Watch** was developed by the Iowa Department of Public Health to help child care providers determine appropriate activities and attire based on weather conditions. The National Health and Safety Performance Standards, Guidelines for Early Care and Education Programs, address **Playing Outdoors** and the importance of addressing specific weather conditions.

The EPA published **Sensible Steps to Healthier School Environments** which describes cost effective ways to improve the health of students and staff. The document provides guidance on dealing with extreme heat events as well as overexposure to ultraviolet (UV) radiation.

Internal and external temperature changes can significantly impact the learning process and impact the health of both students and staff. Healthy Schools Now, a New Jersey coalition of parents, educators, and other stakeholders, produced a **Temperature Fact**

Sheet that summarizes these issues. However, no large scale studies have produced conclusive evidence to support an optimal temperature for learning.

Because many New Jersey schools are not air conditioned, district boards of education may decide to close schools or shorten the school day during heat waves. Similarly, weather emergencies due to extreme cold, ice, and snow are not uncommon in New Jersey. Schools should prepare students, staff, and families for these circumstances. In addition, schools should develop policies to limit exposure to heat and sun, especially during school-sponsored activities. A good resource is **Sun Safety at School** published by the CDC.

Applicable Laws and Regulations

There are no current laws or regulations that explicitly address optimal temperature or temperature-related issues for schools.

Several bills to establish temperature control guidelines for school district facilities have been introduced; however, none have been approved.

N.J.A.C. 12:100-13.3(a)4 – Temperature in Public Office Buildings

These regulations, adopted in 2007, apply to public office buildings. When temperatures in office buildings are outside of the range of 68 to 79 degrees Fahrenheit, the employer must check to make sure the HVAC system is in proper operating order and take appropriate action.

N.J.A.C. 6A:26-12.1 – Facilities Maintenance Requirements

All facilities and structures and parts thereof shall be maintained in a safe, healthy, and energy-efficient condition. All service equipment, means of egress, devices, and safeguards that are required by the Uniform Construction Code (UCC) in a building or structure, when erected, altered, or repaired, shall be maintained in good working order.

Additional Points for School Nursing Practice

The school nurse should work with district administrators to develop and implement policies that address temperature-related issues and sun safety. The policies should address weather and sun safety issues during physical education, recess, athletics, after-school activities, and on field trips. District policy should address the use of sunscreen during school activities.

When it is excessively cold or hot and humid, the school nurse may need to confer with administrators and school staff to limit outdoor activities.

Encourage students and staff to drink more water during excessive heat episodes. If the school limits access to drinking water, advocate for students and staff to have access to bottled water in classrooms.



Educate students and staff to wear light weight and light colored clothing during episodes of excessive heat. The school nurse should encourage students to wear sun-protective clothing and hats during outdoor activities.

Assess students for heat exhaustion/stroke and give appropriate nursing care including notifying parents/guardian. The CDC developed a handy [Heat-Related Illness Chart](#) that helps school nurses and other personnel deal with health-related issues.

HEAT-RELATED ILLNESSES	
WHAT TO LOOK FOR	WHAT TO DO
HEAT STROKE	
• High body temperature (103°F or higher) • Hot, red, dry, or damp skin • Fast, strong pulse • Headache • Dizziness • Nausea • Confusion • Losing consciousness (passing out)	• Call 911 right away-heat stroke is a medical emergency • Move the person to a cooler place • Help lower the person's temperature with cool cloths or a cool bath • Do not give the person anything to drink
HEAT EXHAUSTION	
• Heavy sweating • Cold, pale, and clammy skin • Fast, weak pulse • Nausea or vomiting • Muscle cramps • Tiredness or weakness • Dizziness • Headache • Fainting (passing out)	• Move to a cool place • Loosen your clothes • Put cool, wet cloths on your body or take a cool bath • Sip water Get medical help right away if: • You are throwing up • Your symptoms get worse • Your symptoms last longer than 1 hour
HEAT CRAMPS	
• Heavy sweating during intense exercise • Muscle pain or spasms	• Stop physical activity and move to a cool place • Drink water or a sports drink • Wait for cramps to go away before you do any more physical activity Get medical help right away if: • Cramps last longer than 1 hour • You're on a low-sodium diet • You have heart problems
SUNBURN	
• Painful, red, and warm skin • Blisters on the skin	• Stay out of the sun until your sunburn heals • Put cool cloths on sunburned areas or take a cool bath • Put moisturizing lotion on sunburned areas • Do not break blisters
HEAT RASH	
• Red clusters of small blisters that look like pimples on the skin (usually on the neck, chest, groin, or in elbow creases)	• Stay in a cool, dry place • Keep the rash dry • Use powder (like baby powder) to soothe the rash



Promoting a Healthy School Environment

Topic: Integrated Pest Management

Background and Rationale

It is not unusual to find pests in a school building. While the cafeteria kitchen may be the obvious location to find insects and rodents, student lockers, untidy desks, and closets in classrooms may harbor vermin and insects. Gymnasiums and locker rooms may serve as a breeding ground for pests. Pests can present outside the building in landscaped areas, on athletic fields, and in or near dumpsters. Even school buses can host a myriad of pests. Common pests found in schools include ants, bees and wasps, cockroaches, mosquitos, lice, bed bugs, rats, and mice (EPA, 2016).

Controlling pests in schools is a difficult job but one that must be addressed to support a healthy school environment. Pests can carry disease and some bite. Cockroach and rodent infestations have been identified as asthma triggers. However, exposure to chemicals and pesticides may also be a health hazard and may contribute to the incidence of childhood cancer. In 2002, New Jersey adopted legislation that lead to the development of the **New Jersey Integrated Pest Management (IPM) Program**. This program requires school districts to develop a thoughtful, holistic approach to controlling pests, using a wide variety of tools such as sanitation, structural modifications, and other management techniques rather than automatically turning to chemical control as a first option (NJDEP, 2015). Because children are more vulnerable to the effects of pesticides than adults, the school environment is an ideal place to reduce the potential for pesticide exposure through an IPM program. An effective program will reduce student and staff exposure to pesticides, reduce pests that may carry allergens or disease pathogens, and reduce environmental pollution.

The EPA recommends that schools monitor pest populations to determine where, when, and what kind of controls should be applied. Schools can reduce pest infestations by identifying and removing conditions that will attract pests. It also describes preventive measures that include:

- Restricting where food is eaten;
- Moving dumpsters and food disposal containers away from the school;
- Repairing and maintaining leaking pipes;
- Pressure cleaning food service areas;
- Sealing cracks and crevices;
- Instituting sanitation measures;
- Cleaning gutters and directing water flow away from buildings to prevent saturation; and,
- Educating students and staff about how their actions affect pest management and control (EPA, 2016).



The IPM approach encourages schools to use lower-risk methods of pest removal and prevention that minimize health risks to humans and the environment. The school nurse, as part of the school health team, plays an important role in educating students and staff to prevent pest infestations as well as educating school administrators, maintenance, and ground personnel about the possible health impacts of pesticides on students and staff. The school nurse should document and report student and staff health issues that may arise from either infestations or the use of various pest control measures.

Applicable Laws and Regulations

IPM Laws and Regulations

This page provides an overview of New Jersey's requirements and links to the laws and regulations.

At the federal level, EPA's mandate for integrated pest management (IPM) in schools comes from basic federal law: "support the adoption of IPM," which is stated in [U.S. Code at Title 5, Section 136r-1](#).

Additional Points for School Nursing Practice

How to Do... IPM at School: A How to Manual for New Jersey Schools

IPM should be regularly discussed by the school health team. The school nurse should play an active role in these discussions and related policy decisions, since pests and the pest management system may impact the health and safety of students and staff.

The school nurse can work with the building administration to identify pest sightings. Some schools use a "sighting" log to help identify pest locations.

The nurse needs to know when and where pesticides will be used on school grounds since these substances may cause severe respiratory distress in some students and staff. The application of pesticides should be limited to non-school hours, whenever possible.

The University of Florida created a [School IPM](#) resource with information for students, parents, and educators.

A school-wide outbreak of head lice or bed bugs could be addressed using the principles of IPM. The EPA offers an IPM list serv, webinars, and other materials such as [Managing Pests: Lice, Bedbugs](#), and [Bed Bugs and Schools](#).

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CHAPTER FOURTEEN: Improving School Health and School Nursing Practice

Introduction



Continuous improvement means constantly researching, reviewing, and updating policies and practices. It means examining improvements and outcomes, collecting necessary data, and connecting that information to the mission of the school: academic achievement and learning. While many school nurses may not feel comfortable conducting “research,” it is critical that school nurses look to

evidence-based practice standards. School nurses must stay current in the field of nursing but they must also have an understanding of educational language, principles, and practices. The value of certified school nurses increases because they can speak and understand two languages: health and education.

The school nurse, as part of the school health team, should ensure that school health programs are current, medically accurate, developmentally appropriate, and aligned with federal and state laws and regulations. This is a cumbersome, time-consuming task. As the resident school health specialist, the school nurse must have a clear vision for school health programs, supported by data and high-quality resources. As lifelong learners, school nurses must continuously advance their knowledge and skills. As the school health champion, school nurses serve as change agents, advocates, and leaders, always keeping in mind the needs of the whole child.

This document provides a wealth of resources for school nurses to read, review, analyze, and discuss as they assume roles as school health leaders, advocates, and change agents. The resources listed below were recommended by New Jersey school nurse leaders; however, the NJSSNA does not specifically endorse organizations, books, journals, websites, or other media. The list is representative of agencies and organizations that address health and education.



School Nursing and Health Organizations
National Association of School Nurses
New Jersey State School Nurses Association
American Nurses Association
New Jersey State Nurses Association
American School Health Association
American Public Health Association
Society for Public Health Education
SHAPE America
New Jersey Association for Health, Physical Education, Recreation and Dance
Association of State and Territorial Health Officials
National Association of Chronic Disease Directors
Association of Maternal and Child Health Programs
National Association of State and Territorial AIDS Directors
School-Based Health Alliance

State and Federal Health Agencies
U.S. Department of Health and Human Services
Administration for Children and Families
Centers for Disease Control and Prevention
Centers for Medicare and Medicaid Services
Food and Drug Administration
Health Resources and Services Administration
National Institutes of Health
National Institute on Drug Abuse
Substance Abuse and Mental Health Services Administration
New Jersey Department of Health
Communicable Disease Service
Division of Mental Health and Addiction Services
Chronic Disease Programs
Community Health and Wellness
Emergency Medical Services

Family Health Services
HIV, STDs and TB Services
NJ Immunization Information System (NJIS)
Local Public Health
Maternal and Child Health
Medicinal Marijuana
Minority and Multicultural Health
Population Health
Special Child Health and Early Intervention Services
Tobacco
New Jersey Division of Consumer Affairs
New Jersey Board of Nursing

Education Organizations
ASCD
AASA: The School Superintendent's Association
Association for Middle Level Education
National Association of Elementary School Principals
Natioanl Association of School Psychologists
National Association of Secondary School Principals
National Association of State Boards of Education
National School Boards Association
New Jersey Association of School Administrators
New Jersey Principals and Supervisors Association
New Jersey School Boards Association
New Jersey State Interscholastic Athletic Association

State and Federal Education Agencies
U.S. Department of Education
Office of Elementary and Secondary Education
Office of Special Education and Rehabilitative Services



New Jersey Department of Education
Office of Special Education
Office of Certification and Induction
Office of Evaluation-Achieve NJ
Office of Professional Development
Office of School Facilities
Office of Early Childhood and Family Engagement
Academic Standards
Office of Student Support Services/Student Health
Office of Supplemental Educational Programs: Title I
County Offices of Education

Other Federal and State Agencies
Environmental Protection Agency
U.S. Department of Agriculture
New Jersey Department of Agriculture
New Jersey Department of Children and Families
Child Protection and Permanency
Children's System of Care
Adolescent Services
New Jersey Department of Environmental Protection
New Jersey Department of Human Services
Catastrophic Illness in Children Relief Fund
Commission for the Blind
Division of Deaf and Hard of Hearing
Division of Developmental Disabilities
Division of Medical Assistance and Health Services
New Jersey Office of Emergency Management-Ready NJ

National and State Initiatives
AAP Council on School Health
AAP TEAMS: Enhancing School Health Services
Action for Healthy Kids

Advocates for Youth
Alliance for a Healthier Generation
America's Promise Alliance
CDC Virtual Healthy School
Healthy Schools Campaign
National PTA
Power to Decide
RWJF Healthy Children Healthy Weight
School-Based Health Alliance
Thriving Schools
Trust for America's Health

Emergency Contacts

Poison Control	1-800-222-1222
Reporting Child Abuse	1-877-652-2873/1-877-NJABUSE
New Jersey FamilyCare	1-800-701-0710

Suggested Books, Journals, Websites and E-News

NASN Get Connected!

CHEN: Comprehensive Health Education Network

School Health Action

Medline Plus

Red Book, 2015, published by the American Academy of Pediatrics Committee on Infectious Diseases (available from AAP)

Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, 4th Edition (available from AAP)

Managing Infectious Diseases in Child Care and Schools, 4th Edition: A Quick Reference Guide by Susan S. Aronson, MD, FAAP, and Timothy R. Shope, MD, MPH, FAAP (available as e-book from AAP)

School Nursing: Scope and Standards of Practice 3rd Edition (available from NASN)



School Nurse Resource Manual, Ninth Edition: A Guide to Practice by Vicki Taliaferro and Cheryl Resha (available on Amazon)

School Nursing: A Comprehensive Text, 2nd Edition 2013, by Janice Selekman (available from NASN and Amazon)

Fitzpatrick's Color Atlas and Synopsis of Clinical Dermatology, 8th Edition by Klaus Wolff, Richard Allen Johnson, Arturo P. Saavedra and Ellen K. Roh (Available from Amazon)

Assessment of the School-Age Child and Adolescent by Margaret R. Colyar (available from F.A. Davis Publishing)

Individualized Healthcare Plans for the School Nurse, Second Edition by Donna Zaigler, Martha Arnold, & Susan Will (Available from Sunrise River Press)

Journal of School Nursing (NASN)

Journal of School Health (ASHA)

Journal of Adolescent Health (Society for Adolescent Health and Medicine)

American Journal of Public Health (APHA)

Health Education and Behavior (SOPHE)



APPENDICES: Acknowledgements



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The NJSSNA Executive Board is dedicated to advancing school nursing practice in New Jersey.

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School nurses are required to understand the language of both education and health. Throughout this document, many acronyms and abbreviations are used.

ACRONYMS AND ABBREVIATIONS	
A-300	Working Papers Form
A-45	Health History and Appraisal Form
AAA	American Academy of Audiology
AAD	American Academy of Dentistry
AAFA	Asthma and Allergy Foundation of America
AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
AAP-COSH	American Academy of Pediatrics Committee on School Health
AAPD	American Academy of Pediatric Dentistry
AAPOS	American Association for Pediatric Ophthalmology and Strabismus
ACAAI	American College of Allergy, Asthma, and Immunology
ACC	American College of Cardiology
ACE	Adverse Childhood Experience
ACIP	Advisory Committee on Immunization Practices
ACNJ	Advocates for Children of New Jersey
ADA	American Dental Association
ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Disorder with Hyperactivity
AFHK	Action for Healthy Kids
AFT	American Federation of Teachers
AHA	American Heart Association
AIDS	Acquired Immunodeficiency Syndrome
ALA	American Lung Association
AMA	American Medical Association
AMCHP	Association of Maternal Child Health Programs
ANA	American Nurses Association
ANSI	American National Standards Institute
AOA	American Optometric Association



ACRONYMS AND ABBREVIATIONS	
APHA	American Public Health Association
APN	Advanced Practice Nurse
ARC	American Red Cross
ASAPNJ	Association of Student Assistance Professionals of New Jersey
ASCD	Association for Supervision and Curriculum Development
ASD	Autism Spectrum Disorder
ASHA	American School Health Association
ASHA	American Speech-Language-Hearing Association
ASTHO	Association of State and Territorial Health Officials
ATC	Certified Athletic Trainer
BCG	Bacille Calmette-Guerin TB Vaccine
BMI	Body Mass Index
BP	Blood Pressure
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CDS	Communicable Disease Service
CEOHS	Consumer, Environmental and Occupational Health Service
CF	Cystic Fibrosis
CHADD	Children and Adults with Attention-Deficit/Hyperactivity Disorder
CHIP	Children's Health Insurance Program
CHOP	Children's Hospital of Philadelphia
CHPE	Comprehensive Health Education and Physical Education
COSH	Committee of School Health
CP	Cerebral Palsy
CPR	Cardiopulmonary Resuscitation
CSH	Coordinated School Health
CYSHCN	Children and Youth with Special Healthcare Needs
DASH	Division of Adolescent and School Health
DCA	Department of Consumer Affairs
DEA	Drug Enforcement Agency
DHHS	Department of Health and Human Services

ACRONYMS AND ABBREVIATIONS	
DHPE	Directors of Health Promotion and Education
DMMP	Diabetes Medical Management Plan
DNR/DNAR	Do Not Resuscitate
EAP	Employee Assistance Program
ED	US Department of Education
EIB	Exercise Induced Bronchospasm
EMS	Emergency Medical Services
EMSC	Emergency Medical Services for Children
EPA	Environmental Protection Agency
ESSA	Every Student Succeeds Act
EVVRS	Electronic Violence and Vandalism Reporting System
FAME	Food Allergy Management and Education
FARE	Food Allergy Research and Education
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Administration
FERPA	Family Educational Right and Privacy Act
GLSEN	Gay, Lesbian and Straight Education Network
HECAT	Health Education Curriculum Analysis Tool
HIB	Haemophilus influenzae type b Vaccination
HIB	Harassment, Intimidation and Bullying
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HRSA	Health Resources and Services Administration
I&RS	Intervention and Referral Services
IAQ	Indoor Air Quality
IDEA	Individuals with Disabilities Education Act
IEHA	Indoor Environmental Health Assessment
IEHP	Individualized Emergency Healthcare Plan
IEP	Individualized Education Plan/Program
IGRA	Interferon-Gamma Release Assays: Blood Tests for TB Infection



ACRONYMS AND ABBREVIATIONS	
IHP	Individualized Healthcare Plan
IMM-7	Annual Immunization Status Report
IMM-8	Standard School/Child Care Center Immunization Record
IOM	Institute of Medicine
IZDP	Infectious and Zoonotic Disease Program
JOSH	Journal of School Health
JOSN	Journal of School Nursing
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Questioning
LTBI	Latent Tuberculosis Infection
MAC	Medicaid Administrative Claiming
MCH	Maternal Child Health
MMP	Medicaid-Medicare Plan
MMWR	Morbidity and Mortality Weekly Report
MRSA	Methicillin-Resistant Staphylococcus Aureus
NACDD	National Association of Chronic Disease Directors
NAEPP	National Asthma Education and Prevention Program
NAESP	National Association of Elementary School Principals
NASBE	National Association of State Boards of Education
NASN	National Association of School Nurses
NASP	National Association of School Psychologists
NASSP	National Association of Secondary School Principals
NBCSN	National Board for Certification of School Nurses
NEA	National Education Association
NEI	National Eye Institute
NHES	National Health Education Standards
NIDDK	National Institute of Diabetes & Digestive & Kidney Diseases
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NINDS	National Institute of Neurological Disorders and Stroke
NIOSH	National Institute for Occupational Safety
NJAC	New Jersey Administrative Code

ACRONYMS AND ABBREVIATIONS	
NJBON	New Jersey Board of Nursing
NJCCCS	New Jersey Core Curriculum Content Standards
NJDAG	New Jersey Department of Agriculture
NJDCF	New Jersey Department of Children and Families
NJDEP	New Jersey Department of Environmental Protection
NJDOE	New Jersey Department of Education
NJDOH	New Jersey Department of Health
NJEA	New Jersey Education Association
NJIIS	New Jersey Immunization Information System
NJLPS	New Jersey Department of Law and Public Safety
NJPSA	New Jersey Principals and Supervisors Association
NJSA	New Jersey Statutes Annotated
NJSBA	New Jersey School Boards Association
NJSHAD	New Jersey State Health Assessment Data System
NJSIAA	New Jersey State Interscholastic Athletic Association
NJSLS	New Jersey Student Learning Standards
NJSMART	New Jersey Standards Measurement and Resource for Teaching
NJSNA	New Jersey State Nurses Association
NJSSNA	New Jersey State School Nurses Association
NJTSS	New Jersey Tiered System of Supports.
NLC	Nurse Licensure Compact
NLHBI	National Lung, heart and Blood Institute
NSBA	National School Boards Association
OAG	Office of the Attorney General
OCR	Office of Civil Rights
OPIM	Other Potentially Infectious Materials
OSHA	Occupational Safety and Health Administration
OTC	Over-the-Counter
PA	Physician Assistant
PACNJ	Pediatric/Adult Asthma Coalition of New Jersey
PECAT	Physical Education Curriculum Analysis Tool



ACRONYMS AND ABBREVIATIONS	
PED	Performance-Enhancing Drug (Substances)
PEOSHA	Public Employees Occupational Safety and Health Administration
PEP	Post-Exposure Prophylaxis
PPE	Personal Protective Equipment
PrEP	Pre-Exposure Prophylaxis
RMW	Regulated Medical Waste
RTI	Response to Intervention
RWJF	Robert Wood Johnson Foundation
SAC	Substance Awareness Coordinator/Student Assistance Counselor
SAMHSA	Substance Abuse and Mental Health Services Administration
SAMPROTM	School-Based Asthma Management Program
SAP	Student Assistance Professional
SBA	Spina Bifida Association
SBHA	School-Based Health Alliance
SCD	Sickle Cell Disease
SCT	Sickle Cell Trait
SEMI	Special Education Medicaid Initiative
SNHL	Sensorineural Hearing Loss
SPAN	Statewide Parent Advocacy Network
SRS	Scoliosis Research Society
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TST	Tuberculin Skin Test
USDA	United States Department of Agriculture
USDHHS	United States Department of Health and Human Services
USED	United States Department of Education
USPSTF	U.S. Preventive Services Task Force
VPDP	Vaccine Preventable Disease Program
WHO	World Health Organization
WSCC	Whole School, Whole Community, Whole Child
YRBSS	Youth Risk Behavior Surveillance System

School Health Mandates At-a Glance

Prepared by Gina Emge, RN, MSN, CSN-NJ

Certified School Nurse Annual Presentations*

Topic	Law or Code
Anaphylaxis/Epinephrine Autoinjector Delegate	N.J.S.A.18A:40-12.5 & 12.6 N.J.A.C. 6A:16-2.3(b)
Asthma	N.J.S.A.18A:40-12.9
Blood Borne Pathogens	N.J.S.A. 34:6A-25
Diabetes/Glucagon Delegate	NJ.S.A. 18A:40-12.11-21 N.J.A.C. 6A:6-2.3(b)

Certified School Nurse Role*

Topic	Law or Code
Conduct health screenings (height, weight, blood pressure, hearing, vision, scoliosis) and notify parent/guardian of any findings not consistent with norm.	N.J.S.A. 18A: 40-4, 4.3 N.J.A.C. 6A: 16-2.2 (l) N.J.A.C. 6A: 16-2.3(b) 3.ii
Monitor vital signs and general health status for emergent issues for students suspected of being under the influence of alcohol and controlled dangerous substances.	N.J.S.A. 18A: 40-4 N.J.S.A. 18A: 40A-12 N.J.A.C. 6A: 16-2.2 (h) 5.i N.J.A.C. 6A: 16-2.3 (b) 3.ii
Administer asthma medications through the use of a nebulizer; maintain care of nebulizer	N.J.S.A. 18A:40-12.7 & 12.8 N.J.A.C. 6A:16-2.1(a)5 N.J.A.C. 6A:16-2.3(b)2
Obtain Asthma Treatment Plan from student's medical home.	N.J.S.A. 18A: 40-12.3 N.J.A.C. 6A:16-2.1(a)5.iii
Providing education to staff regarding diabetes. Providing education to delegates regarding administration of glucagon.	N.J.S.A. 18A: 40-12.11-21 N.J.A.C. 6A: 16-2.3(b) 3. vii
Assume primary responsibility for epinephrine administration.	N.J.S.A. 18A: 40-12.6. 2



Topic	Law or Code
Provide education to staff regarding anaphylaxis. Provide education to delegates regarding administration of epinephrine via epinephrine autoinjector.	N.J.S.A.18A: 40-12.6a & 12.6c N.J.S.A. 18A: 40-12.6 N.J.A.C. 6A: 16-2.3(b) 3. vii
Instructing teachers on communicable disease and other health concerns.	N.J.S.A. 18A: 40-3 N.J.A.C. 6A: 16-2.3(b) 3.xv
Administration of medication.	N.J.A.C. 6A: 16-2.1(a) 2. ii
Collect specimen for alcohol or other drug testing in a state licensed collection station or clinical laboratory (grades 9-12).	N.J.S.A. 18A: 40A-23 N.J.A.C. 6A:16-4.4 (d) 3
Review completed health history update questionnaire for students participating in athletics. Share with school athletic trainer for review if applicable.	N.J.S.A. 18A: 40-41.7 2.b N.J.A.C. 6A: 16-2.3 (b) 3. xvi
Carry out written orders of the medical home and standing orders of the school physician.	N.J.A.C. 6A: 16-2.3 (b) 3.i
Maintain student health records that include the following mandated records: findings of health histories, medical examinations and health screenings. Ascertain entry examination documentation upon enrollment in school.	N.J.S.A. 18A: 40-4, 4.3 N.J.A.C. 6A: 16-2.2, 2.4 N.J.A.C. 6A: 16-2.3 (b) 3 N.J.A.C. 6A:16-2.2(h) 2
Monitor student immunization status: Recommend to school principal students who shall not be admitted or retained in the school building based on a parent's failure to provide evidence of the student's immunization according to the schedules specified. Annually review student immunization records to confirm with the medical home that the medical condition for the exemption from immunization continues to be applicable. Documentation of immunizations against communicable diseases or exemption from these immunizations. Review and update annually immunization records. Monitor provisional immunization. Submit Annual Immunization Status report (IMM-7). Prepare immunization records and make accessible for inspection by NJDOH or local board of health given 24 notice.	N.J.A.C. 8: 57-4.2 N.J.A.C. 6A: 16-2.3 (b) 3 N.J.A.C. 8: 57-4.3 N.J.A.C. 6A: 16-2.3 (b) 3 N.J.A.C. 8: 57- 4.3, 4.4 N.J.A.C. 6A: 16-2.2 (a) N.J.A.C. 8:57-4.5 N.J.A.C. 8:57-4.8 N.J.A.C. 8:57-4.9

Topic	Law or Code
Recommend to the school principal exclusion of students who show evidence of communicable disease. Immediately report by telephone to the health officer of the jurisdiction in which the school is located any communicable diseases identified as reportable pursuant to N.J.A.C. 8:57-1, whether confirmed or presumed.	N.J.S.A. 18A: 40-7, 8, 9, 10, 11 N.J.A.C. 6A: 16-2.3 (b) 3. vi N.J.A.C. 6A: 16-2.2 (d)
Review and summarize available health and medical information regarding the student and transmitting a summary of relevant health and medical information to the child study team.	N.J.A.C. 6A: 14-3.4 (j) N.J.A.C. 6A: 16-2.3 (b) 3. xi
Writing and updating at least annually, any written healthcare plan and the individualized emergency healthcare plan for student's medical needs including IHP and IEHP for students with chronic medical conditions including diabetes, asthma, and life-threatening allergies.	N.J.S.A. 18A: 40-12.11, 12.12, 12.13, 12.15 N.J.A.C. 6A: 16-2.1 (a) 5. iii N.J.A.C. 6A: 16-2.3 (b) 3. xii
Writing and updating, at least annually, any written healthcare provisions required under Section 504 federal law.	Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a) N.J.A.C. 6A: 16-2.3 (b) 3. xiii
Assisting in the development of and implementing school district healthcare procedures for students in the event of an emergency. First Responder for Sudden Cardiac Event, use of an AED.	N.J.A.C. 6A: 16-2.3 (b) 3. xiv N.J.S.A. 18A: 40-41b N.J.A.C. 6A: 16-2.1 (a) 4. vi
Directing and supervising the health services activities of any school staff to whom the certified school nurse has delegated a nursing task.	N.J.A.C. 6A: 16-2.3 (b) 3. ix
Consultation on development of nursing services plan.	N.J.A.C. 6A: 16-2.3 (a) 4. xii
Carry out written orders of the medical home and standing orders of the school physician.	N.J.A.C. 6A: 16-2.3 (b) 3. i
Care of ill or injured students.	N.J.A.C. 6A: 16-2.1 (a) 4. iii
Notification of parents of any student determined to need immediate medical care.	N.J.A.C. 6A: 16-2.1 (a) 4. v



Topic	Law or Code
Perform tuberculosis tests on students.	N.J.S.A. 18A: 40-16 N.J.A.C. 6A: 16-2.2 (c) N.J.A.C. 6A: 16-2.3 (a) 4. x
Provide documentation to the school physician regarding incomplete medical examination using screening results from current school screening.	N.J.A.C. 6A: 16- 2.2 (h) 1. ii (3)
Classroom instruction in areas related to health. For CSN Instructional Only.	N.J.S.A. 18A: 40A-4 N.J.A.C. 6A: 9B-14.3 N.J.A.C. 6A: 16-2.3 (b) 3. x

*N.J.S.A., N.J.A.C., and Section 504 of the Rehabilitation Act of 1973, may or may not specifically identify these actions to be completed by the certified school nurse (CSN), however, the CSN is the most qualified and appropriate operative to fulfill these requirements.

N.J.A.C. 6A: 16-2.3(c) School districts may appoint a noncertified nurse under the supervision of a certified school nurse to supplement the services of a certified school nurse provided that:

1. The noncertified nurse shall be assigned to the same building or complex as the certified school nurse pursuant to N.J.S.A. 18A:40-3.3a.
2. A noncertified nurse is limited to providing services only as permitted under the noncertified nurse's license issued by the State Board of Nursing.

N.J.A.C. 6A: 16-1.3 Definitions

"Noncertified Nurse" is defined as a person who holds a current license as a professional nurse from the State Board of Nursing and is employed by a district board of education or nonpublic school, and who is not certified as a school nurse by the Department of Education.

NJ Board of Nursing Laws

45: 11-26. Professional nurses

a. Qualifications of applicants. An applicant for a license to practice professional nursing shall submit to the board evidence in such form as the board may prescribe that said applicant: (1) has attained his or her eighteenth birthday; (2) is of good moral character, is not a habitual user of drugs and has never been convicted or has not pleaded nolo contendere, non vult contendere or non vult to an indictment, information or complaint alleging a violation of any Federal or State law relating to narcotic drugs; (3) holds a diploma from an accredited 4-year high school or the equivalent thereof as determined by the New Jersey State Department of Education; (4) has completed a course of professional

nursing study in an accredited school of professional nursing as defined by the board and holds a diploma therefrom.

e. Title and abbreviations used by licensee. Any person who holds a license to practice professional nursing under this act shall during the effective period of such license be entitled to use the title “Registered Nurse” and the abbreviation “R.N.” The effective period of a license or a renewal thereof shall commence on the date of issuance and shall terminate at the end of the calendar year in which it is issued, and shall not include any period of suspension ordered by the board as hereinafter provided.

L.1947, c. 262, p. 949, s. 4. Amended by L.1952, c. 352, p. 1135, s. 1; L.1955, c. 58, p. 199, s. 2; L.1964, c. 197, s. 1; L.1966, c. 186, s. 2, eff. June 30, 1966.

N.J.A.C. 6A:9B, State Board of Examiners & Certification, sunsets 11/12/22

N.J.A.C. 6A:16, Programs to Support Student Development, sunsets 2/18/21