Position Statements
Resolutions and Consensus Statements
Joint Statements

Revised 07 - 2016
NASN Position Statements

<table>
<thead>
<tr>
<th>Topic</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullying Prevention in Schools</td>
<td>2014</td>
</tr>
<tr>
<td>Child Maltreatment, Care of Victims of: The School Nurse’s Role</td>
<td>2014</td>
</tr>
<tr>
<td>Child Mortality in the School Setting</td>
<td>2012</td>
</tr>
<tr>
<td>Chronic Health Conditions, Managed by School Nurses</td>
<td>2012</td>
</tr>
<tr>
<td>Concussions, The Role of the School Nurse</td>
<td>2016</td>
</tr>
<tr>
<td>Coordinated School Health Programs</td>
<td>2013</td>
</tr>
<tr>
<td>Delegation, Nursing Delegation to</td>
<td></td>
</tr>
<tr>
<td>Unlicensed Assistive Personnel in the School Setting</td>
<td>2014</td>
</tr>
<tr>
<td>Diabetes Management in the School Setting</td>
<td>2012</td>
</tr>
<tr>
<td>Do Not Attempt Resuscitation (DNAR), The Role of the School Nurse</td>
<td>2014</td>
</tr>
<tr>
<td>Drug Testing in Schools</td>
<td></td>
</tr>
<tr>
<td>Education, Licensure, and Certification of School Nurses</td>
<td>2016</td>
</tr>
<tr>
<td>Electronic School Health Records, School Nurse Role in</td>
<td>2014</td>
</tr>
<tr>
<td>Emergency Preparedness and Response in the School Setting</td>
<td></td>
</tr>
<tr>
<td>– The Role of the School Nurse</td>
<td>2014</td>
</tr>
<tr>
<td>Environmental Health in the School Setting: The Role of the School Nurse</td>
<td>2014</td>
</tr>
<tr>
<td>Head Lice Management in the School Setting</td>
<td>2016</td>
</tr>
<tr>
<td>Immunizations</td>
<td>2015</td>
</tr>
<tr>
<td>Individualized Healthcare Plans, The Role of the School Nurse</td>
<td>2015</td>
</tr>
<tr>
<td>LGBTQ Students: The Role of the School Nurse</td>
<td>2016</td>
</tr>
<tr>
<td>Marijuana and Children</td>
<td>2014</td>
</tr>
<tr>
<td>Medication Administration in the School Setting</td>
<td>2012</td>
</tr>
<tr>
<td>Mental Health of Students</td>
<td>2013</td>
</tr>
<tr>
<td>Naloxone Use in the School Setting: The Role of the School Nurse</td>
<td>2015</td>
</tr>
<tr>
<td>Overweight and Obesity in Youth in Schools, The Role of the School Nurse in</td>
<td>2013</td>
</tr>
<tr>
<td>Patient Protection and Affordable Care Act: The Role of the School Nurse</td>
<td>2015</td>
</tr>
<tr>
<td>Pregnant and Parenting Students, The Role of the School Nurse</td>
<td>2015</td>
</tr>
<tr>
<td>Reimbursement for School Nursing Healthcare Services</td>
<td>2013</td>
</tr>
<tr>
<td>Restraints, Seclusion and Corporal Punishment in the School Setting-</td>
<td>2015</td>
</tr>
<tr>
<td>The Use of Role of the Licensed Practical Nurse/Licensed Vocational Nurse in the School Setting</td>
<td>2015</td>
</tr>
<tr>
<td>Role of the 21st Century School Nurse, The</td>
<td>2016</td>
</tr>
<tr>
<td>School Based Health Centers, The Complementary Roles of the School Nurse and</td>
<td>2015</td>
</tr>
<tr>
<td>School Nurse Workload: Staffing for Safe Care</td>
<td>2015</td>
</tr>
<tr>
<td>School-located Vaccination</td>
<td>2013</td>
</tr>
<tr>
<td>School- Sponsored Trips, Role of the School Nurse</td>
<td>2013</td>
</tr>
<tr>
<td>School-Sponsored Before, After and Extended School Year Programs</td>
<td></td>
</tr>
<tr>
<td>– The Role of the School Nurse</td>
<td>2014</td>
</tr>
<tr>
<td>School Violence, Role of the School Nurse in Prevention</td>
<td>2013</td>
</tr>
<tr>
<td>Section 504 and Individuals with Disabilities Education Improvement Act</td>
<td></td>
</tr>
<tr>
<td>– The Role of the School Nurse</td>
<td>2013</td>
</tr>
</tbody>
</table>
NASN Position Statements (continued)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Animals in Schools</td>
<td>2014</td>
</tr>
<tr>
<td>Supervision and Evaluation of the School Nurse</td>
<td>2013</td>
</tr>
<tr>
<td>Telehealth in Schools, The Use of</td>
<td>2012</td>
</tr>
<tr>
<td>Transition Planning for Students with Chronic Health Conditions</td>
<td>2014</td>
</tr>
<tr>
<td>Unlicensed Assistive Personnel: Their Role on the School Health Services Team</td>
<td>2015</td>
</tr>
</tbody>
</table>

NASN Resolutions and Consensus Statements

<table>
<thead>
<tr>
<th>Statement</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consensus Statement – Electronic Cigarettes and Children</td>
<td>May 2015</td>
</tr>
<tr>
<td>Resolution – Global School Nursing</td>
<td>June 2014</td>
</tr>
<tr>
<td>Resolution – Public Health as the Foundation of School Nurse Practice</td>
<td>January 2013</td>
</tr>
<tr>
<td>Resolution – State School Nurse Consultants</td>
<td>January 2013</td>
</tr>
</tbody>
</table>

NASN Joint Statements

<table>
<thead>
<tr>
<th>Statement</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early School Start Times</td>
<td>February 2015</td>
</tr>
<tr>
<td>School Nursing Services Data: Standardized Documentation, Collection, and Utilization</td>
<td>March 2014</td>
</tr>
<tr>
<td>Endorsed Statement - Appropriate Medical Care for Secondary School-Age Athletes</td>
<td>February 24, 2013</td>
</tr>
</tbody>
</table>

(access this endorsed statement on the website of the National Athletic Trainers’ Association http://www.nata.org/sites/default/files/AppropriateMedicalCare4SecondarySchoolAgeAthletes.pdf)
Bullying Prevention in Schools

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is a crucial member of the team participating in the prevention of bullying in schools. School nurses are the experts in pediatric health in schools and, therefore, can have an impact on the health and safety of all students including students who bully; students who are bullied; or students who both bully and are bullied by others (Centers for Disease Control and Prevention [CDC], 2011a, 2011b). The school nurse role includes the prevention of bullying and the identification of students who are bullied, bully others, or both. The school nurse has a significant leadership role in the implementation of bullying prevention policies and strategies.

BACKGROUND

Bullying is identified by the Centers of Disease Control and Prevention as a form of youth violence (CDC, 2011b). The 2011 Youth Risk Behavior Surveillance System indicates that nationwide 20% of students in grades 9-12 experienced bullying (CDC, 2011b). Bullying is most often defined as an attack with an intended purpose of causing physical, verbal, or emotional harm. It includes an imbalance of power between the bully and the victim and involves repeated acts over time (CDC, 2011a, 2011b; Dressler-Hawkes & Whitehead, 2009; Liu & Graves, 2011). Liu and Graves (2011) describe bullying as aggressive behavior, not a diagnosis. Children with physical, developmental, intellectual, emotional, and sensory disabilities are more likely to be bullied than their peers (U.S. Department of Health and Human Services [USDHHS], 2013). Any number of factors including physical vulnerability, gender identification, or intolerant environments may increase a student's risk to be bullied at school. Research suggests that some children with disabilities may bully others as well (USDHHS, 2013).

Bullying is the most common type of aggression and victimization experienced by school-age children (O’Brennan, Bradshaw, & Sawyer, 2009). Bullying occurs at all age levels but starts to increase in late elementary school, peaks in middle school, and generally decreases in high school. Bullying affects both boys and girls. Boys are more often involved in physical aggression (Liu & Graves, 2011). Gendron, Williams, and Guerra (2010) found girls were more often involved with social distancing or indirect forms of bullying including false rumors, insults, and exclusion. The increase in psychological bullying using technology has involved both boys and girls (CDC, 2011b).

Cyberbullying involves the use of electronic devices including instant messaging, e-mail, chats, websites, online games, social networking, and text messages (Kowalski & Limber, 2013). Kowalski and Limber (2013) note that there are similarities and differences between traditional bullying and cyberbullying; however, the differences are significant enough to define cyberbullying as a unique form of bullying. Some students may perpetuate or be the subject of both traditional bullying and cyberbullying. For some students cyberbullying may provide a venue for bullying that they would never say or do in person.

Bullying is a persistent public health concern that has a significant impact in the school setting (USDHHS, 2013). However, until the past decade, bullying was often dismissed as normative and without long-term effects (Gendron et al., 2010). Research has led to a better understanding of the serious, often long-term, consequences of bullying. Society’s shifting perspectives on bullying have been driven by high-profile cases that have resulted in accidental death or suicide. With the growing concern in the U.S. and throughout the world regarding school violence, researchers, educators, and healthcare providers have found that bullying affects students’ social-emotional health and has implications for school safety. Therefore, schools and public health officials are looking to understand why children bully and are seeking to develop effective strategies to reduce or eliminate risk factors (CDC, 2011a, 2011b).
Bullying can have serious and often long-term consequences for both the student who bullies and the student who is bullied including increased school absenteeism, diminished educational achievement, behavior issues, low self-esteem, sleep deprivation, depression, anxiety, and self-harm (Dressler-Hawkes & Whitehead, 2009). Bullied students are also at risk for physical symptoms including stomach pain, sleep disturbances, headaches, tension, bedwetting, fatigue, and decreased appetite (Kowalski & Limber, 2013). The consequences of bullying can continue into adulthood (Copeland, Wolke, Angold, & Costello, 2013). Boys who are frequently bullied have been found to suffer more often from anxiety disorders, agoraphobia, and panic disorders in adulthood (Copeland et al., 2013).

Any student can be bullied at school, particularly students with disabilities (USDHH, 2013) and other vulnerable populations such as students with academic difficulties, and speech impairments (Redmond, 2011). Students may be bullied based on their physical appearance such as glasses, hair color, and weight (Perron, 2013). Lesbian, gay, bisexual and transgender (LGBT) students are more likely to be subjected to all types of bullying (Wang & Iannotti, 2012). School nurses can advocate for students with disabilities in school by educating students and staff, advocating for student support, promoting equal access to education in the least restrictive environment, and advocating for student support in IEP and Section 504 plans (CDC, 2011b). At present, no federal law directly addresses bullying. In some cases bullying overlaps with discriminatory harassment when it is based on race, national origin, color, sex, age, disability, or religion. When bullying and harassment overlap, federally funded schools have an obligation to resolve the harassment. When the situation is not adequately resolved, the U.S. Department of Education’s Office for Civil Rights and the U.S. Department of Justice’s Civil Rights Division may be able to help (USDHHS, 2013).

Students who bully are also at risk for both health and academic problems (Kowalski & Limber, 2013). In an analysis of Youth Risk Behavior Survey data, the CDC found that middle school students who bully were more likely to report recent use of alcohol and drugs (CDC, 2011a). Students who reported that they participated in bullying also reported higher incidents of violent family encounters.

Students who both bully and are bullied were at the highest risk for negative outcomes (CDC, 2011a, 2011b). Students in middle and high school who both bully and are bullied reported the highest frequency for considering suicide, being physically hurt by a family member, harming themselves, witnessing family violence, feeling sad or hopeless, and needing to talk to someone other than a family member about feelings or problems (CDC, 2011a).

**RATIONALE**

Bullying can have serious health, physical, and psychological effects on the student who bullies; the student who is bullied; or the student who both bullies and is bullied. Bullying is not an isolated incident but occurs repeatedly over time. Therefore, the school nurse should:

- Be knowledgeable about bullying, aggression and victimization;
- Be aware of the importance of not labeling their students as “bullies” or “victims”;
- Be knowledgeable about the long-term consequences to the student who bullies, the student who is bullied, and the student who both bullies and is bullied;
- Provide leadership to bring together students, school personnel and families to implement bullying prevention strategies in the school environment and in the community;
- Participate as a key member of the school team that identifies students who bully, students who are bullied, and students who both bully and are bullied;
- Share information and observations and alert the team to signals that may identify students at risk;
- Facilitate access to school health services for students with nonspecific or somatic complaints;
- Assess students with frequent unexplained somatic complaints explicitly for bullying and stress;
- Identify concerns and work with the school team to intervene and mitigate a bullying situation;
o Create a safe space in the school health office where students can verbalize concerns about all health issues including bullying and other incidents of violence (Selekman, Pelt, Garnier & Baker, 2013);

o Foster school connectedness and personal connections with students during health encounters (Dressler-Hawke & Whitehead, 2009);

o Promote school activities that would foster home and community connectedness to reduce bullying (Haeseler, 2010);

o Educate parents, staff, and community members about the dangers of violence and aggressive behavior in children (Liu & Graves, 2011); and

o Influence policy at the local, state, and national level to advocate for students (Dressler-Hawkes & Whitehead, 2009).

CONCLUSION

Bullying can have severe short- and long-term negative social and emotional effects on the student who bullies; the student who is bullied; and the student who both bullies and is bullied. Therefore, it is important for school nurses, as the experts in pediatric health, to be knowledgeable about the impact of bullying. The school nurse can support evidence-based interventions to prevent and mitigate bullying in the school. The school nurse is a key leader to promote and enhance student safety, wellness, engagement, and learning.

REFERENCES


Acknowledgement of Authors:
Marie C. DeSisto, MSN, BSN, RN, NCSN
Suzanne Smith, BSN, RN, NCSN

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All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.
SUMMARY

It is the position of the National Association of School Nurses (NASN) that prevention, early recognition, intervention and treatment of child maltreatment are critical to the physical well-being and academic success of students. Registered professional school nurses (hereinafter referred to as school nurses) serve a vital role in the recognition of early signs of child maltreatment, assessment, identification, intervention, reporting, referral and follow-up of children in need. School nurses are uniquely qualified to participate as members of interdisciplinary teams to collaborate with school personnel, community healthcare professionals, students and families.

BACKGROUND

The Child Abuse and Prevention and Treatment Act (CAPTA), originally passed in 1974 and amended by the CAPTA Reauthorization Act of 2010, defines child maltreatment as the following:

“Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm” (CAPTA, 2010, p. 6).

A child is defined as a person who has yet to reach the age of 18 years and who is not an emancipated minor. It is important to understand that there are many exceptions and varying definitions made by individual state laws (Child Welfare Information Gateway, n.d.). All 50 states, the District of Columbia, and the U.S. territories have mandatory child maltreatment reporting laws that require certain professionals and institutions to report suspected maltreatment to a Child Protective Services agency (United States Department of Health and Human Services [USDHHS], 2010).

School nurses, teachers, and other school staff are legally required to report suspected child maltreatment (Child Welfare Information Gateway, 2012).

In 2010, Child Protective Services received approximately 3.3 million reports of suspected child maltreatment, and it was estimated that 1560 children died as the result of child maltreatment (CDC, 2012). CAPTA identified the incidence of four types of child abuse:

- 78% of cases involved neglect;
- 18% involved physical abuse;
- 9% involved sexual abuse; and
- 8% of victims suffered emotional abuse.

The psychological and academic impact of child maltreatment can be devastating and create life-long challenges. Children who have been victims of maltreatment exhibit high levels of risk taking and have impaired decision-making skills (Weller & Fisher, 2013). Children who suffered maltreatment were found to have significantly lower cognitive abilities and academic achievement (DeBellis, Wolley, & Hopper, 2013).

The lifetime economic burden of child maltreatment based on the substantiated non-fatal child maltreatment cases and the fatal cases of child maltreatment is estimated to be 124 billion dollars that includes significant costs.
for health and medical care, productivity losses, child welfare, criminal justice, and special education services (Fang, Brown, Florence, & Mercy, 2012).

RATIONALE

School personnel are often the first to become aware that a child may be a victim of maltreatment and is struggling because of adverse events occurring in his or her life. The Adverse Childhood Experiences Study (ACE) identified 17 long-term health issues that were the result of childhood abuse or neglect. These health issues were clustered by the number of adverse experiences a person identified. There is a direct correlation between the number of adverse events experienced by a victim of child maltreatment and the number of long term health issues they experience (CDC, 2010). Child maltreatment increases the childhood risk of diabetes, obesity, grade repetition, and engagement in risk-taking behaviors (USDHHS, 2010). The effect of violence alone on a child increased the risk of appetite problems by 28%, headaches by 57%, sleep problems by 94%, and stomachaches by 174% (Shannon, Bergren, & Matthews, 2010). Childhood maltreatment has been linked to long-term risk for depression (Nanni, Uher, & Danese, 2011), chronic fatigue syndrome (Fuller-Thomson, Sulman, Grennenstuhl, & Merchant, 2011), higher rates of mental health problems (Burke, Hellman, Scott, Weems, & Carrion, 2011) increased tendencies toward youth violence and intimate partner violence (USDHHS, 2010) and increased risk of psychiatric disorders (Chen et al., 2010). These long-term effects of child maltreatment influence individual health, academic achievement and the healthcare system as a whole (DeBellis et al., 2013).

Early identification and intervention is crucial in promoting recovery and preventing further victimization. Therefore, it is vital that school personnel receive training to recognize the signs of maltreatment and report accordingly. The school nurse is a leader in educating school personnel about recognition of child maltreatment. Signs that indicate child maltreatment may include child reports of maltreatment, sudden behavior changes, lack of medical referral follow-through, learning problems that have no known etiology, child responses that are consistently guarded and/or overly compliant, and child’s avoidance of home or certain individuals. Child maltreatment may present in a variety of ways (Child Welfare Information Gateway, 2013):

- Physical Abuse – non-accidental physical injury whose presentation and explanation are inconsistent with assessment data;
- Neglect – failure to provide for child’s physical, medical, educational or emotional basic needs, abandonment;
- Sexual Abuse – children who have sexual knowledge that is not commensurate with their age, sexualized behavior not developmentally appropriate for child’s age;
- Emotional Abuse – witness to maltreatment of other individuals, actions that are persistently demeaning of a child’s self-esteem; and
- Substance Abuse – prenatal exposure to illicit substances, young children who have access to and/or speak the language of illegal drugs or alcohol, children exposed to the toxic and extremely dangerous process of methamphetamine manufacture.

School nurses are involved in prevention, early identification, reporting, and treatment related to child maltreatment because of their opportunity to interact with children on a daily basis. The role of the school nurse is to report suspicion of abuse; the role of Child Protective Services is to investigate the suspicion. School nurses are accountable and responsible to do the following:

- Know local laws, regulations, policies and procedures for the process of reporting child maltreatment;
- Provide for personal body safety education to students and advocate for school health education policies that include personal body safety;
- Educate and support staff regarding the signs and symptoms of child maltreatment;
- Identify students with frequent somatic complaints which may be indicators of maltreatment;
- Support the victims of child maltreatment;
- Link victims and families to community resources, including a medical home (Health Resources and
CONCLUSION

School nurses are uniquely positioned to advance the academic achievement of students by protecting their health and safety. Prevention, early recognition, and treatment of child maltreatment are critical to the physical/emotional well-being of students and, therefore, their academic success. Additionally, school nurses serve as a resource to faculty and staff in the recognition and reporting of child maltreatment.

REFERENCES


**Acknowledgement of Authors:**
Lynnette Ondeeck, MEd, BSN, RN, NCSN
Laurie Combe, MN, BSN, RN
Cindy Jo Feeser, BSN, RN, NCSN
Rebecca King, MSN, RN, NCSN

**Acknowledgement of 2012 Issue Brief Authors:**
Linda Gibbons, MSN, RN, NCSN
Mary Suessmann, MS, BSN, RN
Sharonlee Trefry, MSN, RN, NCSN

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*All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.*
Child Mortality in the School Setting

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that data on children’s deaths in school should be recorded, analyzed and reported at the local, state and national level. The systematic review of data on child deaths is necessary to drive interventions and policies that will decrease mortality from injuries, violence, acute illness and chronic disease in the school setting (Bergren, 2010; Christian & Sege, 2010).

HISTORY

Schools are not immune from the threat of fatal injury or death of school-age children. Schools today provide care for an increasing number of chronically and acutely ill children. Medically fragile children in school require ventilators, tube feedings, medication, and other complex nursing care procedures (Allen, Henselman, Laird, Quinones, & Reutzel, 2012; Bergren, 2011). Ten percent of school-age children have asthma (Centers for Disease Control and Prevention [CDC], 2011a). Diabetes is one of the most common chronic diseases in children and adolescents, affecting 151,000 children (CDC, 2011b). The prevalence of anaphylactic food allergy among children under age 18 increased 18% from 1997-2007 (Branum & Lukacs, 2008). Overall, 15% to 18% of children and adolescents have a chronic health condition (Perrin, Bloom & Gortmaker, 2007). School children are at risk of injuries in classrooms, gyms, playgrounds and playing fields. Drug and alcohol overdoses, suicide, violence and homicide can also occur at school (American Academy of Child and Adolescent Psychology [AACAP], 2011).

DESCRIPTION OF ISSUE

There is a dearth of data surrounding the health of the 49.4 million students who attend school every day (National Center for Education Statistics [NCES], 2011). While voluminous amounts of data are reported in various national health data bases on children in hospitals, clinics and primary care offices, data is not collected or analyzed on a national level about the intensity or quality of health care that is delivered in school every day (Lear, 2007).

The lack of data on students’ health also extends to a corresponding lack of data on student deaths. In the United States, deaths of employees that occur at work are monitored and investigated by the Occupational Health and Safety Administration (OSHA). OSHA can specify that exactly 4,547 United States workers died on the job in 2010 (Bureau of Labor Statistics, 2012). However, the number of children who die at school or who die following an adverse event at school is unknown. A few states, including North Carolina and Massachusetts, collect and publish public data on chronic and acute health conditions of students in public schools (Massachusetts Department of Public Health, 2011; North Carolina Healthy Schools, 2011). However, many states do not collect that data and no national repository exists on child deaths at school and whether they are accidental or due to disease or violence.

RATIONALE

Preventable child deaths are classified as “never events” (Agency for Health Research and Quality [AHRQ], 2012). A never event is a rare, devastating, preventable adverse event (National Quality Forum [NQF], 2007). While there are widespread initiatives to eliminate devastating “never events” in healthcare settings, there is not a similar broad effort to address dire outcomes in the school setting due to the lack of data. The systematic review of child deaths in school is needed to identify strategies to create population data driven interventions for a safer school environment for all children. The increasing number of students receiving health services for serious health conditions requires vigilance to prevent those conditions from exacerbating, potentially resulting in a preventable child fatality (Malone & Bergren, 2010). Registered professional school nurses need to advocate for the collection and analysis of student health data at the local level and for the reporting and aggregation of student health data at the state and national level in order to advise health and education policy makers (Johnson, Bergren, & Westbrook, 2011 & 2012).

REFERENCES


**Acknowledgement of Authors:**

Martha Dewey Bergren, DNS, RN, NCSN, FNASN, FASHA

**Review committee:**

Linda Compton, MS, RN
Nina Fekaris, MS, RN, NCSN
Kathy Inderbitzin, MEd, RN, NCSN
Carmen Teskey, MA, RN

Adopted: June 2012
Chronic Health Conditions Managed by School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses that students with chronic health conditions have access to a full-time registered professional school nurse (hereinafter referred to as school nurse). School districts should include school nurse positions in their full-time instructional support personnel to provide health services for all students, including students with chronic health conditions. The school nurse coordinates and conducts assessment, planning, and implementation of individualized health care plans for safe and effective management of students with health conditions during the school day. The school nurse is both the provider of care and the only person qualified to delegate care to an unlicensed care provider as prescribed in state nurse practice laws and regulations and according to Scope and Standards of School Nurse Practice (National Association of School Nurses [NASN] & American Nurses Association [ANA], 2011).

HISTORY

The percentage of children and adolescents in the United States with chronic health conditions (CHC) increased from 1.8% in the 1960s to more than 25% in 2007 (Halfon & Newacheck, 2010). There is some difficulty in measuring prevalence due to the lack of a clear definition of chronic health conditions. CHC include both long-term physical and mental disorders. It is useful to use a non-categorical approach CHC, and for identifying children and adolescents as having special health care needs. These children include those with long-term physical, emotional, behavioral, and developmental disorders that require prescription medications and medical or educational services. They also include disorders that affect a child’s functional status (Forrest, Bevans, Riley, Crespo, & Louis, 2011). The non-categorical approach focuses on needs for service and risk of school failure.

Over the past few decades the number of students with CHC in schools has increased for a variety of reasons. Many students who had been confined to therapeutic settings are now being educated in the local school district in the least restrictive environment. Their right of participation is protected by federal law, including the Rehabilitation Act, Section 504 and the Individuals with Disabilities Educational Act [IDEA] of 2004. As survival rates associated with chronic conditions in infants and children continue to increase and life expectancy increases, the health care and educational service needs of students will increase. Many children with CHC now are able to attend school and succeed due to critical support services, including those provided by school nurses. The school nurse is a key member of the educational team and is the one who is responsible for planning, implementing, and monitoring the health care plans for students with CHC.

DESCRIPTION OF ISSUE

The main issues surrounding health management of students with chronic health conditions in schools are as follows:

- Health care services must be provided for students who qualify for services under IDEA or Section 504 to meet requirements of federal laws. The school nurse has an important role in interpreting a student’s health status, in explaining the impairment, and in interpreting medical and other health information in relation to the expanded e standards for eligibility under Section 504 (Zirkel, 2009).
- Development of individualized health care plans (IHP) is a nursing responsibility and is based on standards of care that are regulated by State Nurse Practice Acts and cannot be delegated to unlicensed individuals (National Council of State Boards of Nursing [NCSBN], 2005).
- Effective and safe management of chronic health conditions is complex, requires careful planning by a school nurse, and may involve delegation of nursing tasks to both licensed and unlicensed assistive personnel (UAP).
- A full-time school nurse is essential to achieve quality student health services and to meet student health needs.
- Dependable funding is required to ensure quality student health services.

**RATIONALE**

Health care needs of students with chronic health conditions are complex and continuous. School nurses assist many children not served by the health care system and work to create access to health care for students and families. Students who may not have been identified as having a chronic condition prior to school entry are identified by school nurses who then coordinate evaluation and intervention services. School nurses assist students in learning to manage chronic illness, increasing seat time in the classroom, decreasing student absenteeism, resulting in cost savings to the school district and an increase in the overall academic success of the student.

School nurses are responsible and accountable for the assessment of and planning for safe and effective medical management of students with chronic health conditions. These responsibilities cannot be delegated (NCBSN, 2005). Therefore, it is the position of NASN that school districts should provide a full-time school nurse in every school building. NASN recommends school nurse to student ratios based on student populations:

- 1:750 for students in the general population,
- 1:225 in the student populations that may require daily professional school nursing services or interventions,
- 1:125 in student populations with complex health care needs, and
- 1:1 may be necessary for individual students who require daily and continuous professional nursing services.

Additionally, Healthy People 2020 has included an objective to increase the proportion of schools that have a full-time registered school nurse-to-student of at least 1:750 (USDHHS/CDC, 2010).

A full-time school nurse is essential for oversight of the staffing plan and for informing school administrators of current staffing needs (Peterson & Wolfe, 2006).

**REFERENCES**


Acknowledgment of Authors:
Judith Morgitan, MEd, BSN, RN
Margo Bushmaer, MNSc, RN, NCSN
Marie C. DeSisto, MSM, BSN, NCSN
Carolyn Duff, MS, RN, NCSN
C. Patrice Lambert, MSN, RN, SNC
M. Kathleen Murphy, DNP, RN, FNP-BC
Sharon Roland, BSN, RN
Kendra Selser, MHS, BSN, RN
Leah Wyckoff, MS, BSN, RN
Kelly White, RN, PhD candidate (SME)

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This Position Statement replaces the Issue Brief:
School Nursing Management of Students with Chronic Health Conditions (adopted 2006)


www.nasn.org
National Association of School Nurses
8484 Georgia Avenue Suite 420
Silver Spring, Maryland 20910
1-240-821-1130
SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is an essential member of the school health team to address student concussions. The school nurse has the knowledge and skills to provide concussion prevention education to parents/guardians, students, and school staff; identify suspected concussions; and help guide the student’s post-concussion graduated academic and activity re-entry process.

BACKGROUND

Concussions are considered a type of traumatic brain injury (TBI). The potential for the occurrence of concussions in children is greatest during activities where collisions can occur, such as during physical education class, playground time, or school-sponsored sports activities (Centers for Disease Control and Prevention [CDC], 2015a).

In 2010, TBI related injuries, either alone or in combination with other injuries, resulted in about 2.5 million emergency department (ED) visits, hospital visits, or deaths in the United States (CDC, 2015b). In 2009, an estimated 248,418 children (age 19 or younger) were treated in U.S. EDs for sports and recreation-related injuries that included a diagnosis of concussion or TBI (CDC, 2011). From 2001 to 2009, the rate of ED visits for sports-related injuries rose 57% among children (age 19 or younger) (CDC, 2015b). While falls are the most common cause of concussions in children, between 2001-2009 emergency room visits for sports-related TBI diagnosis increased by 57% in school-age children (CDC, 2011). The actual incidence of concussions may be higher than is currently reported due to underreporting (Register-Mihalik et al., 2013a). In one study, researchers indicated that over 50% of concussions in high school football players go unreported with the two most common reasons being players do not consider their injury as serious enough and they do not want to be removed from the play (Register-Mihalik et al., 2013b).

Recognition of a concussion and immediate assessment is critical in preventing further injury and for post-concussion management. Any force or blow to the head and/or symptoms of a concussion in a student or athlete should be immediately evaluated by either the school nurse or designated trained school personnel. Several concussion management guidelines are available; CDC’s Heads Up Campaign for Concussion Prevention and Management (2015c) and the Rocky Mountain Hospital for Children REAP Concussion Management Program (Rocky Mountain Hospital, n.d.) are examples of evidence-based resources available for the school nurse.

Research has demonstrated that recovery for the school-age student generally occurs within three weeks from the injury, but school adjustments during this recovery period may be necessary (Halstead et al., 2013). However, for some, symptoms may last for months or longer and can lead to short- and long-term problems affecting how a young person thinks, acts, learns, and feels (CDC, 2015d). Although a concussion can have obvious direct effects on learning, there is also increasing evidence that using a concussed brain to learn may worsen concussion symptoms and perhaps even prolong recovery (Halstead et al., 2013).

During this recovery phase, the student may have an array of physical, mental, and emotional symptoms, which can affect the student in the school setting. Children with diagnosed concussions require cognitive rest and a graduated re-entry plan to pre-concussion activities, as determined by the healthcare provider (Brown et al., 2014). In addition, students are at a risk for increased emotional symptoms following a concussion, especially if concussion was associated with assault or bullying incident (Halstead et al., 2013). Recognizing the potential for
these emotional symptoms in recovering students, the school nurse can provide encouragement and information for the students, parents, and school staff.

RATIONALE

It is imperative that appropriate preventative guidelines and post-concussion accommodations are followed at school. The school nurse advocates for the prevention of concussions by educating families and school staff about the risks for concussion, adverse outcomes when a concussion occurs, and the importance of creating a safe school environment. According to the National Council of State Legislatures (NCSL), since 2007, all 50 states have enacted legislation to address youth sports-related concussions (NCIL, 2015). School nurses are identified as key stakeholders in policy development and implementation because of their unique position to be a liaison between the health and education communities (CDC, 2015b; Braine, 2013).

It is essential that school nurses are made aware when a student sustains a concussion (Weber, Parsons, & McLeon, 2015). Educating parents, teachers, coaches, and students about concussion is key as not all concussions are reported. If a student is not acting normally, referral should be made to the school nurse. Proper management of a student with a suspected concussion includes assessment for symptoms, notification to parents/guardians, referral to a healthcare professional if symptoms are noted, and -- if no symptoms are present -- instructions to parents/guardians and school staff for continued observation (CDC, 2015b).

As a student returns to school after a concussion, the school nurse works in collaboration with the healthcare provider, athletic trainer, and other school staff to support the return-to-learn process (Weber, Parsons, & McLeon, 2015; Hossler, McAvoy, Rossen, Schoessler, & Thompson, 2014). The school nurse can provide on-going monitoring of post-concussion symptoms and act as a liaison with the student’s healthcare team. For students who have persistent symptoms, the school nurse develops an individualized healthcare plan based on healthcare provider orders. If it is determined Section 504 plan is needed, the school nurse contributes to the development of plan to provide accommodations such as allowing rest during the school day, postponing testing until symptom-free, pacing (or modifying) homework or assignments, limiting screen time including use of electronics (smart boards, chrome books, etc.) in classrooms, and/or limiting physical school activities (Halstead et al., 2013).

CONCLUSION

The school nurse is in a pivotal position to implement evidence-based concussion prevention and management protocols at school. The school nurse identifies students with possible concussion, makes appropriate referrals, and assists students and families through the school and activity re-entry process. The school nurse collaborates with the team of stakeholders including healthcare providers, school staff, athletic trainers, parents and students to ensure that the physical and psychosocial needs of the students are met. School nurses provide support for the prevention of concussions by advocating for safe environments and education of students, parents/guardians and staff on concussions.

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Acknowledgement of Authors:

Deborah Cook, ADN, RN, AE‐C
Kim Bartholomew, BSN, BS, RN
Alicen Hardy, ADN, RN
Lynnette Ondeck, MEd, BSN, RN, NCSN

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*All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.*
SUMMARY

It is the position of the National Association of School Nurses (NASN) that all children need to acquire the knowledge and skills necessary to make healthy choices and to address health barriers to learning and academic success through Coordinated School Health (CSH). The registered professional school nurse (herein after referred to as the school nurse) is an integral member of this model and acts as a leader who uses professional education and skills to assist schools and communities in the development, implementation and evaluation of CSH.

BACKGROUND

The concept of a comprehensive school health program was introduced in the late 1980s in response to the status of children’s health and education. In 2007, the Centers for Disease Control incorporated this concept into the current systemic model of CSH. CSH is an organized set of policies, procedures and activities designed to protect and promote the health and well-being of students and school staff. CSH includes eight components: school health services, health education, health promotion programs, counseling, psychological and social services, school nutrition services, physical education programs, healthy school environment and family and community involvement. CSH brings together school administrators, teachers, school nurses, other school staff, students, families and community members to assess health needs, determine priorities, and plan, implement, and evaluate school health activities.

RATIONALE:

The CDC, public health community and many other national and international health, education and school nursing organizations support CSH (Stolz, Coburn and Knicklbein, 2009). Research has shown that school health programs can reduce the prevalence of health risk behaviors among youth and have a positive effect on academic performance (CDC, 2011). Schools are increasingly looked upon as an institution that can play a critical role in improving the health status of our nation’s youth. As schools examine the needs of children to determine how they can improve academic success, evidence-based research shows an inextricable link between a child's physical, emotional, and mental health and their academic outcomes.

Students face developmental and social challenges, chronic health conditions, such as asthma and diabetes, and other serious health risks and concerns such as obesity, pregnancy, sexually transmitted diseases, motor vehicle accidents and suicide. Poverty, lack of parental involvement, and a lack of access to high-quality health care exacerbate these problems. Educating and supporting students, particularly those at high risk, to develop health promoting behaviors and effective coping strategies, can improve health and contribute to patterns of healthy behavior that will extend into adulthood.

The school nurse plays a pivotal role in CSH. Coordination of care, communication and collaboration are standards of nursing practice. The school nurse serves in a leadership position by providing school health services to students, communicating with families, health care providers and the community (American Nurses Association (ANA) and National Association of School Nurses (NASN), 2011). In a coordinated school health program, the school nurse may provide leadership or serve a supporting role in any of the following eight components:

- **School health services**: The school nurse provides emergency care assessments and interventions, management of acute and chronic health conditions, referral and support to access primary care, preventive services, communicable disease control measures, counseling for health promotion and identification and management of barriers to student learning.
• **Health education:** The school nurse provides education to classrooms, small groups and individually on numerous topics that promote healthy life choices. The school nurse reviews and recommends health education curricula addressing physical, mental, emotional, and social dimensions of health to help students develop health knowledge, positive attitudes, and skills to make health-promoting decisions, achieve health literacy, adopt health-enhancing behaviors and promote health of others. The school nurse employs data from the Youth Risk Behavior Assessment, local and state data to determine the current risks and protective factors for students.

• **Staff health promotion:** The school nurse works collaboratively with the CSH team to provide health information and health promotion activities, monitor and manage chronic conditions, provide resources, referrals and maintain staff records.

• **Counseling, psychological, and social services:** The school nurse collaborates with counseling, school psychology and social work staff to identify student psychosocial problems and provide input and intervention. Services focus on cognitive, emotional, behavioral, and social needs of students and families aimed at improving students’ mental emotional and social health through assessment, intervention and referral.

• **School nutrition services:** The school nurse promotes the integration of nutritious, affordable, and appealing meals, nutritional education, and an environment that promotes healthy eating behaviors for all students. The school nurse provides education about nutritious foods, monitors menus and food preparation, and encourages the inclusion of healthy foods on menus, in vending machines and classroom snacks. The school nurse provides information to food service regarding students with anaphylaxis and food allergies to promote student safety.

• **Physical education programs:** The school nurse collaborates with physical educators to meet physical education goals, providing information to students about physical activity, and helping to design appropriate programs for students with special health concerns and promote planned, sequential K through 12 curriculums that promote lifelong physical activity.

• **Healthy school environment:** The school nurse promotes a safe physical and psychological environment that is supportive of learning by monitoring, reporting, and intervening to correct hazards, collaborating to develop a crisis intervention plan, and providing adaptations for students with special needs.

• **Family and community involvement:** The school nurse takes a leadership role in collaborating with community agencies to identify and provide programs to meet the physical and mental health needs of children and families. The school nurse can help strengthen the collaboration among agencies and stakeholders to reviewing and analyze community data to help make informed decisions (CDC, 2013).

**CONCLUSION:**

The CSH model serves as a strategy for shaping the future health, education and social well-being of students and ultimately the communities in which they live (Stolz, Coburn & Knickelbein, 2009). A coordinated program promotes students’ optimal learning ability. The program can also maximize learning opportunities by supporting, maintaining and improving students’ physical, emotional and mental health. Its success depends on the effective integration of these components and the subsequent academic success of children. School nurses, as leaders in school health, are an integral member of the CSH team collaborating with key stakeholders, lending expertise to the development, implementation and evaluation of CSH.

**REFERENCES:**


**Acknowledgement of Authors:**
Barbara Yow, M.Ed., BSN, RN, NCSN
Laura Rochkes, MS, BSN, RN, NCSN
Rita Baszler, BSN, RN
Rose Dolatowski, MSN, RN
Rebecca King, MSN, RN, NCSN

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www.nasn.org
National Association of School Nurses
1100 Wayne Ave. Suite 925
Silver Spring, MD 20910
1-240-821-1130
Nursing Delegation to
Unlicensed Assistive Personnel in the School Setting

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the delegation of nursing tasks in the school setting can be a valuable tool for the registered professional school nurse (hereinafter referred to as school nurse), when based on the nursing definition of delegation (American Nurses Association [ANA], 2012) and in compliance with state nursing laws and/or regulations and guidance. Delegation may occur when the school nurse determines it is appropriate, but such delegation may not be appropriate for all students or all school nurse practice settings. The legal parameters for nursing delegation are defined by state laws that regulate nursing, State Board of Nursing guidelines, and Nursing Administrative Rules/Regulations (ANA, 2012; American Academy of Pediatrics [AAP], 2009).

BACKGROUND

Advances in healthcare and technology enable children with increasingly complex medical needs to be a part of the general school population. The incidence of chronic conditions such as asthma, diabetes, severe allergies, and seizure disorders in school-age children is increasing; and complex medical conditions that were previously handled in acute care settings are now being managed in the school setting, requiring school nurses to make care decisions that may include delegation where appropriate (Van Cleave, Gortmaker, & Perrin, 2010; Federal Interagency Forum on Child and Family Statistics, 2013).

Federal laws set requirements for the provision of healthcare to children in schools. For example, the Individuals with Disabilities Education Act (IDEA), Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990, include requirements to ensure that children with special healthcare needs have the right to be educated with their peers in the least restrictive environment (U.S. Department of Health and Human Services [USDHHS], 2006) and to receive support and accommodations for conditions that adversely affect their capacities for learning (Gelfman, 2005). School nurses use their expert assessment skills to appropriately delegate health-related tasks and address the specific healthcare needs of students, enabling access to a free appropriate public education (Resha, 2010).

The ANA defines nursing delegation as transferring the responsibility of performing a nursing activity to another person while retaining accountability for the outcome (ANA & the National Council of State Boards of Nursing [NCSBN], 2006). Nurses are accountable to: (1) state laws, rules, and regulations; (2) employer policies and procedures/agency regulations, and (3) standards of professional school nursing practice, including those pertaining to delegation. The decision to delegate is a serious responsibility that the school nurse determines on a case-by-case basis based on the needs and condition of the student, stability and acuity of the student’s condition, potential for harm, complexity of the task, and predictability of the outcome (ANA, 2012). Prior to delegation, the school nurse is required to perform an assessment of the student to guide the school nurse in determining the level of training and supervision required for safe delegation for this specific student. The safety and well-being of the individual student and the broader school community must be the central focus of all decisions regarding the
Delegation of nursing tasks (ANA & NCSBN, 2006). Delegation is used effectively in some areas, however unsafe and inappropriate delegation in school settings can occur. It is important for school districts, school nurses, healthcare professionals, parents/guardians and the public to understand what activities can be delegated and when delegation is appropriate. Due to the complexity of delegation in the school setting, school nurses should be provided educational opportunities to review current delegation practices, case studies, situational reviews, or simulations (Weydt, 2010).

Delegation in school nursing is a complex process in which the authority to perform a selected nursing task is transferred from the school nurse to a competent unlicensed individual, also known as unlicensed assistive personnel (UAP), in a specific situation. The decision to delegate and the supervision of those delegated to perform nursing tasks in the school setting rests solely with the school nurse. The school nurse makes the determination to delegate based on the nursing assessment and in compliance with applicable laws and/or regulations and guidance provided by professional nursing associations (ANA & NCSBN, 2006; Mitts vs. Hillsboro Union High School, 1987). In some states, delegation in the school setting is the responsibility of the building administrator, however the actual delegation of nursing tasks can only be designated by the school nurse. In other states, delegation of nursing tasks is not permitted. This underscores the importance of school nurses being knowledgeable of the delegation laws in the states where they practice, as nurse practice acts vary from state to state (Gordon & Barry, 2009).

Nursing tasks commonly performed in the home setting by a parent/guardian or caregiver take on a more complex dimension in the school setting. Often parents/guardians and school administrators are confused about why what appears to be a simple task is held to a much different and higher standard at school (Resha, 2010). One of the challenges to delegation in the school setting is that parents/guardians and school administrators may not recognize that there is a requirement for medical orders for any health-related procedures in the school setting and that nurses are held to a higher protocol standard than a parent/guardian would be when delivering the same procedure at home (Resha, 2010). The school nurse practices in the educational setting where nurses support the primary purpose of providing education and must comply with state and federal mandates, nursing licensure standards and meet the expectations of parents/guardians, while working to ensure the health and safety of all students.

Supervision of delegated nursing tasks means the delegating registered nurse must supervise or periodically monitor and assess the capabilities and competencies of the UAP to safely perform delegated tasks. Unless otherwise guided by state law, the registered nurse determines how closely to supervise and how often to reassess an unlicensed individual. If an individual, who has been assigned by a school administrator, is not competent to complete the task, whether due to lack of education, attentiveness, availability or proximity, the registered nurse must work with administration to identify a more qualified individual. Until that person can assume the responsibility of delegation, the school nurse may need to directly provide the care needed by the student. The registered nurse adheres to state laws regulating nursing and standards of nursing practice, even if it is conflicts with an administrator’s directives.

School districts must have a clear, concise, all-inclusive policy in place to address the use of delegation within the school setting, and it should be reviewed periodically. This policy should be consistent with federal and state laws, nursing practice standards, and established safe practices in accordance with evidence-based information and include the development of a developmentally appropriate Individualized Healthcare Plan (IHP) and Emergency Care Plan (ECP).
RATIONALE

The term delegation is used in other fields, but holds a unique place and meaning in the practice of nursing.

To provide for safe care, school nurses should utilize the Five Rights of Delegation (ANA & NCSBN, 2006) to guide their assessment of whether delegation is appropriate for the student and the situation.

1. The Right task
2. The Right circumstances
3. The Right person
4. The Right directions and communication
5. The Right supervision and evaluation

When a review of the Five Rights of Delegation indicates that delegation is appropriate, the school nurse must develop an individualized healthcare plan (IHP), based on the medical orders, outlining the level of care and healthcare needs of the student and indicating which nursing tasks can and cannot be delegated. Further, the continuous process of evaluation should be based on outcomes of care, ensuring that the delegated task is completed properly and produces the desired outcome.

Delegation is not appropriate for all students, all nursing tasks, or in all school nurse practice settings. Neither the American Nurses Association nor the National Council of State Boards of Nursing support delegating steps in the nursing process, including nursing assessment or the use of nursing judgment (ANA & NCBSN, 2006). Key factors guiding determination for delegation include the following: state laws, rules, and regulations; the five rights of delegation; safety issues; healthcare needs of students; school practice characteristics; and UAP competence.

CONCLUSION

NASN supports, in states where laws and regulations allow, delegation in the school setting. By law, the appropriate professional to delegate nursing tasks in the school setting is the school nurse. Delegation is a complex skill requiring professional clinical judgment, critical thinking, and final accountability for care of the client (ANA, 2012). Delegation is a strategy the school nurse can use when planning for care. It requires both knowledge and practice to become comfortable and competent in delegation. Effective delegation in school nursing practice requires a school nurse who has the requisite skill, expertise and authority to practice in the state in which the delegation occurs. Delegation is a valuable tool for meeting the healthcare needs of students in a challenging healthcare environment and in assuring that resources are managed both safely and effectively.

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**Acknowledgement of Authors:**
Joan Cagginello, MS, BSN, RN
Mary Blackborow, MSN, BSN, RN
Jessica Porter, BSN, RN, NCSN
Jody Disney, PhD, RN, NCSN
Kathleen Andresen, DNP, RN
Christine Tuck, MS, BSN, RN, NCSN

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Diabetes Management in the School Setting

Position Statement

SUMMARY

It is the position of the National Association of School Nurses that the registered professional school nurse (hereinafter referred to as school nurse) is the only school staff member who has the skills, knowledge base, and statutory authority to fully meet the healthcare needs of students with diabetes in the school setting. Diabetes management in children and adolescents requires complex daily management skills (American Association of Diabetes Educators [AADE], 2008) and health services must be provided to students with diabetes to ensure their safety in the school setting and to meet requirements of federal laws.

HISTORY

For children and youth younger than 20 years, diabetes is on the rise with an estimated 215,000 children and adolescents with type 1 or type 2, or approximately 0.26% of this age group. Annually, from 2002 to 2005 -- 15,600 youth were newly diagnosed with type 1 diabetes and 3,600 youth were newly diagnosed with type 2 diabetes (Centers for Disease Control and Prevention [CDC], 2011).

Advancing diabetes technology and management have changed the way students manage their diabetes at school. Children are monitoring their blood glucose levels several times a day, calculating carbohydrate content of meals, and dosing insulin via syringe, pen and pump to achieve a blood glucose within a target range (Bobo, Kaup, McCarty & Carlson, 2011). These intensive resources and consistent evidenced-based efforts will achieve the long-term health benefits of optimal diabetes control according to the landmark study from the Diabetes Control and Complications Trial Research Group (DCCT, 1996).

DESCRIPTION OF THE ISSUE

Each student with diabetes is unique in his or her disease process, developmental and intellectual abilities and levels of assistance required for disease management. The goals of the Diabetes Medical Management Plan (DMMP) and Individual Health Plan (IHP) are to promote normal or near normal blood glucose with minimal episodes of hypoglycemia or hyperglycemia, normal growth and development, positive mental health, and academic success (Kaufman, 2009).

The school nurse develops the IHP from the DMMP (medical orders) by collaborating with the child’s family, obtaining additional assessment findings, and outlining the diabetes management strategies and personnel needed to meet the student’s health goals in school (NDEP, 2010). The IHP identifies the student’s daily needs and management strategies for that student while in the school setting. The school nurse also coordinates the development and staff education of the Emergency Care Plan (ECP) which directs the actions to be taken by school personnel for symptoms of hypoglycemia and hyperglycemia.

Throughout childhood and adolescence, the student with diabetes is continuously moving through transitions toward more independence and self-management (Silverstein et al., 2005). They will require various levels of supervision or assistance to perform diabetes care tasks in school. Students who lack diabetes management experience or cognitive and developmental skills must have assistance with their diabetes management during the school day as determined by the nursing assessment and as outlined in the IHP.

Hypoglycemia (low blood glucose) is the greatest immediate danger to the student with diabetes. During hypoglycemic incidents, the student may not be able to self-manage due to impaired cognitive and motor function. A student experiencing hypoglycemia should never be left alone or sent anywhere alone. Communication systems and trained school staff should be in place to assist the student. Treatment for hypoglycemia should be readily available in the classroom and administered immediately (American Diabetes Association [ADA], 2011).
Hyperglycemia (high blood glucose) can develop over several hours or days, and untreated can lead to the life-threatening condition, diabetic ketoacidosis (DKA). For students using insulin infusion pumps, lack of insulin may rapidly lead to DKA (ADA, 2011). The school nurse may utilize one or more of the model National Diabetes Education Program’s (NDEP) three levels of staff training, to facilitate prompt, safe and appropriate care for students with diabetes (NDEP, 2010).

Students with disabilities, which include students with diabetes, must be given an equal opportunity to participate in academic, nonacademic, and extracurricular activities. Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 prohibit recipients of federal financial assistance from discriminating against people on the basis of disability (NDEP, 2010). These laws are enforced for schools, by the Office for Civil Rights (OCR) in the U.S. Department of Education. Schools are required to identify all students with disabilities and to provide them with a free appropriate public education (FAPE) (NDEP, 2010).

Changes in science and technology related to diabetes management require the school nurse to maintain current knowledge and skills to fully implement a student’s DMMP in the school setting (NDEP, 2010; ADA, 2011).

RATIONALE

Managing diabetes at school is most effective when there is a partnership among students, parents, school nurse, health care providers, teachers, counselors, coaches, transportation, food service employees, and administrators. The school nurse provides the health expertise and coordination needed to ensure cooperation from all partners in assisting the student toward self-management of diabetes.

A school nurse is required to develop an IHP for each student with diabetes and to provide continued oversight for the implementation and evaluation of the effectiveness of the plan in the school setting (American Nurses Association /National Association of School Nurses [ANA/NASN], 2011). Individualized healthcare planning is a function of the nursing process and cannot be delegated to unlicensed individuals (American Nurses Association /National Council of State Boards of Nursing Association of School Nurses [ANA/NCSBN ], 2006). State laws and nurse practice acts determine the extent to which school nurses can delegate nursing tasks to other school personnel in the absence of the nurse (ANA/ NASN, 2011).

Research suggests that school nurse supervision of students’ blood glucose monitoring and insulin dose adjustment significantly improves blood glucose control in children with poorly controlled type 1 diabetes (Nguyen et al., 2008). Poorly controlled diabetes and fluctuating blood glucose levels not only affect academic performance but can lead to long-term complications such as retinopathy, cardiovascular disease, and nephropathy. Maintaining blood glucose levels within a target range can prevent, reduce, and reverse long-term complications of diabetes (DDCT, 1996).

The school nurse’s role is critical in the case management and coordination of care for recognition and treatment of the student experiencing hypoglycemia in school (Butler, 2007). The school nurse fosters independent decision making, promotes healthy life-style choices and diabetes self-care ensuring a smooth transition between high school and adult diabetes medical care (Bobo & Butler, 2010). Every student with diabetes is entitled to a school nurse with the knowledge and capacity to effectively provide care and communicate with school staff, healthcare providers and families (Bobo et al., 2011).

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**Acknowledgement of Authors:**

Sarah Butler, MSN, RN, CDE, NCSN  
Nina Fekaris, MS, BSN, RN, NCSN  
Deborah Pontius, MSN, RN, NCSN  
Susan Zacharski, MEd, BSN, RN

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Blood Sugar Monitoring in the School Setting (Adopted: June 2001)  
School Nurse Role in Care and Management of the Child with Diabetes (Adopted: November 2001; Revised: June 2006)
Position Statement

**SUMMARY**

It is the position of the National Association of School Nurses (NASN) that each student with a Do Not Attempt Resuscitation (DNAR) order have an Individualized Healthcare Plan (IHP) and an Emergency Care Plan (ECP) developed by the registered professional school nurse (hereinafter referred to as school nurse) with input from parents or guardians, the student’s healthcare provider, the palliative care team, administrators, teachers, local emergency medical services, local funeral director and, when appropriate, the student in order to support the student’s access to education and palliative health care. Furthermore, a DNAR order for a student should be evaluated individually at the district level with input from the school district’s legal counsel for consideration of state and local laws.

**BACKGROUND**

Families today face many issues but none more sensitive and emotionally challenging than an order for DNAR. A DNAR order is not abandonment of medical treatment and does not rescind any obligation to provide quality care; rather it is part of the management plan. This plan is reviewed by the healthcare provider with the family to communicate the difficult decision to refrain from life sustaining treatment that is determined by the healthcare provider and family to be ineffective or that the risks would outweigh the benefits. A DNAR medical order for the school should be implemented in the context of palliative care, including comfort measures as well as addressing emotional and spiritual needs (AAP, 2010).

In a 1974 statement, the American Heart Association declared that cardiopulmonary resuscitation (CPR) was not indicated for all patients. Individuals with terminal, irreversible illnesses where death is the expected outcome do not necessarily merit CPR. In 1994 the American Academy of Pediatrics (AAP) and the National Education Association (NEA) issued guidelines on foregoing life-sustaining CPR for children and adolescents (AAP, 2010). Originally, the medical order was referred to as a Do Not Resuscitate order (DNR), which evolved to Do Not Attempt Resuscitation (DNAR), and sometimes Allow Natural Death (AND) (Selekman, Bochenek & Lukens, 2013). Currently, the order to provide comfort care is part of a much broader palliative care plan, which may include Medical Orders for Life Sustaining Treatment (MOLST) (APA, 2010). In the case of ABC School v. Mr. and Mrs. M, in Massachusetts, the court ordered the school to honor the DNAR order for a medically fragile child. In addition, the court refused to allow the school to shield staff from liability should they choose not to honor the DNAR order (Adelman, 2010).

Chronic health conditions that involve special healthcare needs affect an estimated 19.2% (14.2 million) school-age children (Bethell et al., 2011). The AAP (2010) estimates that, on any given day, there are 2,500 adolescents and 1,400 preadolescents who are within 6 months of dying from their chronic condition, such as end-stage heart, liver, kidney disease and cancer (Adleman, 2010). According to a Centers for Disease Control and Prevention survey, the percentage of schools where health services staff reported the need to follow a DNAR order increased from 29.7% in 2000 to 46.2% in 2006 (AAP, 2010).

Growing populations of students with chronic health conditions -- including terminal and irreversible illnesses, congenital defects, injuries, and malignancies, where death may be the expected outcome -- are now routinely attending school (Klick & Hauer, 2010; Adelman, 2010). Children with special healthcare needs are entitled to a free and appropriate education in the least restrictive environment (U.S. Dept. of Justice, 2005). Whenever possible, students with chronic or terminal conditions belong in school in order to access their education. Students
benefit from the psychosocial and emotional benefits of interacting with peers and maintaining their daily routine (Klick & Hauer, 2010). Because state and local laws and regulations vary regarding DNAR orders for students, each palliative care request must be reviewed by the school team with leadership from the school nurse in order to provide the best care possible in the school setting for the student (AAP, 2010). The school nurse and staff should focus on what can be provided for comfort rather than on what is not being provided. In addition, it was found in a recent NASN discussion list inquiry that deaths of students with DNAR orders often did not occur at school (Zacharski et al., 2013).

RATIONALE

Development and implementation of the IHP are the responsibility of the school nurse and are supported by the AAP (AAP, 2008). The development of the IHP requires the school nurse to do the following:

- Be knowledgeable about state and local laws and regulations regarding DNAR orders.
- Work collaboratively with the school team (the family, school psychologist, the school guidance counselor, administrators, teacher, and members of school crisis teams).
- Coordinate plan with local EMS, funeral director, hospice providers and other local agencies where applicable.
- Communicate and coordinate the development of the school plan with all members of the student’s healthcare team that may include the family, pediatrician, social worker, child life specialist and palliative care team members (Klick & Hauer, 2010).
- Participate as an essential member of team in the development of the Section 504 plan or the IEP plan, communicating the plan and the IHP to school staff while maintaining student confidentiality to the extent requested by the student/family. This plan should minimally be reviewed annually or sooner if required.
- Coordinate emotional support for staff utilizing school district and community resources, including bereavement services for the school community in collaboration with the palliative care team, school team and community mental health resources (Klick & Hauer, 2010).
- Provide support for school staff to address attitudes and cultural beliefs concerning death and dying in order for the student to have the optimum experience while at school.
- Provide clear, evidence-based information to school staff regarding the student’s condition in terms school staff can comprehend.
- Recognize the importance of self-care during this process (Morgan, 2009).
- Support nursing research to develop evidence-based care for students in need of palliative care and a DNAR in school (Morgan, 2009).

Components of the IHP include but are not limited to:

- A written DNAR request from the parent(s) as well as the healthcare provider’s written DNAR order that is acceptable per state regulations. A court order may be required (Selekman, Bochenek, & Lukens, 2013);
- DNAR information;
  - Acceptance of DNAR orders vary according to state regulations.
  - The DNAR request should have a clearly delineated date (some orders are rescinded while in hospital or otherwise. Many DNARs need to be reordered as deemed by the medical facility or state regulations). Some DNAR orders are issued for short periods of time and need to be renewed within a few weeks.
  - An original DNAR order or a copy of the order on the appropriate state EMS Palliative Care/DNAR order form may be required.
  - A state authorized Out of Hospital Do Not Resuscitate bracelet or necklace may also be accepted by Emergency Medical Services.
  - The DNAR order may be revoked at any time verbally or in writing by the parent/guardian (Zacharski et al., 2013).
• Notification of EMS and medical examiner of DNAR orders for student in school;
• Specific actions that may and may not be performed by staff clarifying end-of-life issues versus acute episodes that may require treatment/management vs. comfort care measures;
• Comfort measures which may include holding, positioning, oxygen administration, pain and bleeding control (Selekman, Bochenek, & Lukens, 2013);
• Determination of which staff members should be informed of and educated about the IHP and the DNAR order;
• Contacts in case of emergency (the parent, primary physician, and prearranged notification with the EMS provider);
• Development of a code to which all staff will know how to respond;
• Where to move the student to provide student/family privacy;
• Who will do the pronouncement of death (physician, nurse practitioner or physician assistant)? In some states, pronouncement of death becomes a concern in the school setting; i.e. the local EMS may not be able to remove the body if death has already occurred. If this happens, arrangements must be made as to who will arrive promptly to pronounce death so that the body can be removed from the school as soon as possible;
• Transportation and mortuary arrangements; and
• Plans for training and supporting staff and student’s peers.

CONCLUSION

School nurses play a pivotal role with respect to DNAR orders as well as the delivery of health care (AAP, 2010; Klick & Hauer, 2010). In addition, the school nurse is the school health professional with the knowledge, experience and skills to coordinate the care for a student with a DNAR order, linking the school with the medical and community services needed by the student, while advocating for the student and family to ensure access to a free and appropriate education (Selekman, Bochenek, & Lukens, 2013).

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Acknowledgement of Authors:
Christine M. Tuck, MS, BSN, RN, NCSN
Alicia Jordan, BSN, RN, NCSN
Patrice Lambert, MSN, RN, SNC
Jessica Porter, BSN, RN, NCSN

Acknowledgement of 2012 Issue Brief Authors:
Marie DeSisto, MSN, RN
Susan Zacharski, MEd, RN
Kay Kurbjun, MSN, RN
Janice Seleman, DNSc, RN, NCSN

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Drug Testing in Schools

**Position Statement**

**SUMMARY**

Illicit drug use is a serious problem affecting the health of the youth in America. The implementation of school-based drug testing programs is a complex issue, and more research is needed to judge their effectiveness. The National Association of School Nurses (NASN) supports community needs assessments of substance abuse problems, including substance abuse in schools. Even though federal drug abuse prevention and treatment agencies do not recommend drug testing in schools, some communities may employ a random drug testing program in their schools. In addition, a registered professional school nurse (hereinafter referred to as school nurse) may be asked to be an active participant in program planning discussions and, where applicable, subsequent program implementation.

**BACKGROUND**

The Supreme Court has ruled that random student drug testing (RSDT) – often referred to as “suspicionless testing” – is allowed in the public school system for all middle and high school-age students involved in extracurricular activities (Pottawatomie Cty. v. Earls, 2002). Initially, courts allowed public schools to conduct random testing only on student athletes (Vernonia School District v. Acton 1995). In June 2002, the U.S. Supreme Court broadened the authority of public schools to test all students enrolled in extracurricular activities for illegal drugs (Pottawatomie Cty. v. Earls, 2002). The school district involved in this 2002 Supreme Court case applied the practice to only competitive extracurricular activities that were sanctioned by the state Secondary Schools Activities Association including Future Farmers of America, Future Homemakers of America, band, choir, and cheerleading (Pottawatomie Cty. v. Earls, 2002).

Some professional organizations disagree with the presence of random drug testing in schools. In 2007, the American Academy of Pediatrics (AAP) released an addendum to its original 1996 position statement on the issue. The AAP (2007) acknowledges the need for additional research on the safety and efficacy of school and home-based drug testing. The AAP provides adolescent-specific substance abuse treatment resources to ensure appropriate referrals to rehabilitation and proposes that the primary care physician should be the first contact by parents suspecting adolescent substance use. The 2010 position statement from the Association for Addiction Professionals (NAADAC) also disputes the efficacy of school-based drug testing and questions whether a health care setting would be a more appropriate venue.

**RATIONALE**

Schools that have adopted random student drug testing intend to decrease illicit drug use among students via two routes. First, schools that conduct random testing hope it will serve as a deterrent and give students a reason to resist peer pressure to take drugs. Second, drug testing can identify adolescents who have started using drugs, which would allow for early interventions, or identify adolescents who already have problems with substance abuse, so they can be referred for treatment. In schools that have adopted random drug testing, the school nurse has the expertise and educational background to initially liaise with health care professionals in the implementation of these programs, and the knowledge of community-bases resources to facilitate follow-up care if and when necessary.

Illicit drug use among adolescents, including the use of marijuana and prescription medications, has been on the rise. In 2011, more than 8.7% of youth aged 12–17 were current drug users, (Substance Abuse and Mental Health Services Administration [SAMSHA], 2011). Abuse of prescription drugs is on the rise and
accounts for 8% of illegal drug use among adolescents (National Institute of Drug Abuse [NIDA], 2010). The findings from the 2010 National Survey on Drug Use and Health indicated that a quarter of first-time drug users began with nonmedical use of prescription drugs (Office of National Drug Control Policy, 2010).

Adolescents have access to drugs in a variety of locations, which include, but are not limited to, school grounds. According to the Youth Risk Behavior Survey (Centers for Disease Control and Prevention [CDC], 2011), more than 25% of students nationwide had been offered, sold, or given an illegal drug on school property during the preceding 12 months. The same survey indicated that 23.1% of students nationwide had used marijuana at least once, and 5.9% had used marijuana on school property more than once during the 30 days preceding the survey (CDC, 2011). These statistics are evidence of the continued problem with illicit drug use among adolescents in the United States.

CONCLUSION

School nurses understand the complex issue of drug abuse among youth, which extends beyond performing random drug testing in schools. As the primary health care professional in the school building, the school nurse is in a position to provide community-based resources in a confidential manner and to assist with referring families for prevention services in substance abuse. School nurses can serve an appropriate role in preventing drug abuse by relaying information to students, families, and school staff about the effects different drugs have on the brain and body. If a district is considering a random drug-testing program, the school nurse—along with community members, school board members, teachers, parents, physicians, and addiction professionals—should be an active participant in the discussion and should recommend considering the science before implementing a costly program. In addition, if a drug testing program is employed, school nurses should recommend it be implemented in conjunction with appropriate resources to assist students when positive test results occur, including primary care health providers and addiction professionals.

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Acknowledgement of Authors
Maureen Merritt Buchan, BSN, RN
Patricia Endsley, MSN, RN
Elizabeth Clark, MSN, RN, NCSN
Judith Morgitan, MEd, BSN, RN, CSN
Elizabeth A. Chau, RN, SRN

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www.nasn.org
National Association of School Nurses
8484 Georgia Avenue, Suite 420
Silver Spring, Maryland 20910
1-240-821-1130
SUMMARY

It is the position of the National Association of School Nurses (NASN) that every school-age child should have access to a registered professional school nurse (hereinafter referred to as the school nurse), who has a minimum of a baccalaureate degree in nursing from an accredited college or university and is licensed as a registered nurse through a board of nursing. These requirements constitute minimal preparation needed to practice at the entry level of school nursing (American Nurses Association [ANA] & NASN, 2011). Additionally, NASN supports state school nurse certification and endorses national certification of school nurses through the National Board for Certification of School Nurses (NBCSN) (NASN, 2016a).

BACKGROUND

School nursing is a subspecialty of public health nursing, which is incorporated in the curriculum for baccalaureate nursing programs. Baccalaureate nursing education develops competencies in leadership, critical thinking, quality improvement, and systems thinking. It provides graduates with nursing theory and clinical experience and cultivates their ability to translate research into evidence-based nursing practice. Baccalaureate prepared nurses also address and analyze current and emerging healthcare issues, including the need for health policy and healthcare financing (National Advisory Council on Nurse Education and Practice, 2014; Institute of Medicine [IOM], 2010).

To practice as a professional registered nurse, graduates must pass the National Council Licensure Examination for the Registered Nurse (NCLEX-RN) in their state, territory, or country in which the exam is offered. In addition to nursing licensure by a board of nursing, post-baccalaureate education and or certification approved by departments of education may be required to practice school nursing. Licensure protects the public by indicating that a nurse successfully completed an examination that demonstrated a minimal level of competency to practice professional nursing. Certification documents a higher level of competence and expertise in a focused area of practice. Requirements for state certification and the certifying bodies vary by individual state, territory, or county in which a school nurse practices.

In the 1980s, NASN developed a national certification examination and then established the National Board for Certification of School Nurses (NBCSN), which became an independent incorporation in 1991. The purpose was twofold: to promote and recognize quality practice in school nursing and to assure that certification criteria and examinations in school nursing are determined by experts in the specialty practice (NBCSN, 2015).

RATIONALE

"School nursing, a specialized practice of public health nursing, protects and promotes student health, facilitates normal development, and advances academic success. School nurses, grounded in ethical and evidence-based practice, are the leaders that 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 potentials" (NASN, 2016b). The ANA (2013) takes the position that the minimum preparation for beginning professional nursing practice in public health be a baccalaureate degree. The IOM (2010) recommends that nurses attain advanced education to be able to react to the increasing demands of nursing practice. School nursing requires advanced skills included in a baccalaureate program, which consists of the ability to practice
autonomously, supervise others, and delegate care in a community, rather than a hospital or clinic setting if allowed by state laws (ANA & NASN, 2011).

NASN’s Framework for 21st Century School Nursing Practice™ provides structure and focus for current, evidence-based school nursing practice. School nurses use these skills outlined in the practice components of each principle (NASN, 2016c). School nurses work with a vulnerable pediatric community population to achieve improved health outcomes (Kulbok, Thatcher, Park, & Meszaros, 2012). Williams and Counts (2013) found that the public benefits from the certification of nurses by way of improved client safety, increased nurse knowledge and skills, and focused nurse professional development throughout their career. “Certification for school nurses benefits the public by recognizing those nurses that have competence beyond the novice level” (Selekman & Wolfe, 2010, Preface).

CONCLUSION

Licensed registered nurses who work in the specialty practice of school nursing require advanced skills to address the complex health needs of students within a school community setting (ANA/NASN, 2011). These skills are attained through a minimum of a baccalaureate degree in nursing and validated by specialized certification in school nursing (IOM, 2011).

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**Acknowledgement of Authors:**

Valerie Beshears, MSN, RN, NCSN  
Elizabeth Clark, MSN, RN, NCSN  
Patrice Lambert, MSN, RN, SNC  

2012 Authors:  
Jodi Sheets, BSN, RN  
Carmen Teskey, MA, BSN, RN  
Barbara Yow, MEd, BSN, RN, NCSN

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*All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.*
Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that Electronic Health Records (EHRs) are essential for the registered professional school nurse (hereinafter referred to as school nurse) to provide efficient and effective care in the school and monitor the health of the entire student population. It is also the position of NASN that it is the school nurse’s role to collaborate with school administrators to ensure that EHRs use meets the highest quality standards for the safety and protection of student, family and staff information. The meaningful use of EHRs in the school setting has the potential to maximize quality, decrease cost, and prevent errors, as well as promote the interoperability of school health records with providers in other care settings (Johnson & Bergren, 2011). Additionally, EHRs in the school setting provide a means of integrating health and educational data in a way that addresses the needs of children at risk for poor health or academic outcomes. EHRs also facilitate the sharing of data into a national database of student health data.

BACKGROUND

Documentation of health information is an expectation of professional school nursing practice according to the Scope and Standard of School Nursing Practice (American Nurses Association & National Association of School Nurses, 2011) and may be required by state health statutes. School nurses work with a variety of health information including immunization records, screening records, progress notes, physician orders, physical examination records, medication and treatment logs, reports of serious injury (Centers for Disease Control and Prevention, 2013), individualized healthcare plans, emergency healthcare plans, third party medical records, consent forms, the management of students’ chronic health conditions (NASN, 2012), Medicaid, and other insurance billing forms, and flow charts. 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.

Society and the United States healthcare system is transitioning from paper to electronic technology. The Centers for Medicare and Medicaid Services (CMS) actively promotes EHRs with a goal of improving health care; school nurses share this same goal. EHRs improve the efficiency and the use of school health data such as absenteeism (CDC, 2013) to determine appropriate interventions (Johnson & Guthrie, 2012). EHRs support the ability to make the right information available to the right provider at the right time to benefit student care (Johnson & Guthrie, 2012). A central component of healthcare reform is the use of electronic health records with a focus on the “meaningful use” (MU) of the data in those records to achieve the triple aim – reduced cost, improved satisfaction and improved quality (Blumenthal, 2009; Policy Researchers and Implementers, n.d.).

In 2011, 74% of school nurses reported using EHRs (NASN, 2011). Therefore, it is important for school districts to have policies and procedures in place regarding the types, maintenance, protection, access, retention, destruction, and confidentiality of student health records. Information technology professionals with school districts may require expert assistance in addressing the requirements for health documentation standards; thus school nurses should participate in the selection of documentation systems as well as the development of appropriate policies and procedures.
RATIONALE

School health records provide the mechanism for a school nurse to communicate information to students, families, the school multidisciplinary team, emergency personnel, other healthcare providers, and school nurse substitutes. Data from school health records can show evidence of student health problems that should be addressed. Data are also used for evaluation of school health programs, quality assurance, disease surveillance (Calman, Hauser, Lurio, Wu, & Pichardo, 2012) and evaluation of program outcomes.

The large caseloads and volumes of longitudinal student information collected by school nurses result in a quantity of data that is not readily managed by paper processes. Electronic documentation systems allow for efficient data management processes including the documentation, reporting, and analysis of student health data. Electronic data management systems also allow for the aggregation of data from multiple sources if the data elements are standardized across systems. The ability to build a database requires the EHRs to be able to speak the same language. Data in systems that use standardized languages and are interoperable across a variety of settings will allow the expansion of evidence to determine nursing interventions that support student academic success.

Using aggregate data from standardized school nurse documentation would support the development of a national school health database that could be used to describe the student healthcare needs, best outcome based interventions, and academic success (Johnson, Bergren, & Westbrook, 2012). The Office of the National Coordinator for Health Information Technology (ONC) predicted that the MU of EHRs will strengthen the communication of information, improve care coordination, and enhance the quality of care (Blumenthal, 2009). Aggregate data and EHRs also will assist school nurses to function within their broader role as public health nurses by providing the opportunity to improve links between other healthcare providers and public health departments (CDC, 2012).

Reports from EHR systems will allow school nurses to (Johnson & Guthrie, 2012, p. 28):

- Efficiently describe health service activity,
- Develop evidence for practice,
- Describe nursing sensitive student outcomes,
- Analyze population health,
- Evaluate the effectiveness of care delivery, and
- Manage appropriate resource allocation.

Documentation of the nursing interventions provided to students with chronic disease who need more complex care and management at schools is crucial for efficient disease management and collaboration with all of the student’s team members. The Robert Wood Johnson report (2010), Unlocking the Potential of School Nursing: Keeping Children Healthy, In School and Ready to Learn describes school nursing’s role, the “hidden system” of care, in management of chronic disease, costs and the impact on learning depend on school nurses who can expertly collaborate with the student’s family and medical home. EHRs are a crucial piece of communication and management of students with chronic disease.

School nurses can best advocate for quality EHRs by considering the following:

- The five rights of electronic documentation systems include right data, right presentation, right decisions, right work processes, and right outcomes (Amatayakul, 2009).
- Confidentiality assurance by following laws governing school health records include the Federal Family Education Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) as well as individual state laws (United States Department of Health and Human Services & United States Department of Education [USDHH & USDE], 2008).
- School nurses should address security by being involved on the school district technology team to provide input on the need for privacy and meet health documentation requirements. Special provisions must be established to protect EHRs and student privacy in the school district. The use of secure passwords,
programs to thwart hackers, and screen savers -- as well as several areas of access for the student health database and a policy of never leaving the computer unattended when student health data are accessible or viewable -- is necessary for security. Computer software should have over-write protection and an appropriate level of role-dependent secure access if multiple health office employees will be entering data.

- Federal and state laws and regulations need to be considered when determining EHR policies and procedures.
- Complete lists of EHR system requirements can be accessed in several resources (Bergren, 2005; Johnson & Guthrie, 2012).

Having a standardized electronic data system in the school setting is a reality for many schools in the U.S. In Delaware, all public school nurses use an EHR that is within the educational pupil accounting electronic records and uses standardized languages and coding of all health information and school nurse interventions (L. C. Wolfe, personal communication, September 2013). This facilitates a means for health data to be linked to student demographics and educational needs. Further, it provides an avenue for research into the relationships between school nursing activities and student outcomes.

CONCLUSION

EHRs are required for school nurses to use the aggregate data to build a standardized school health database that identifies student health trends, determines evidenced-based interventions, supports effective student healthcare models, and documents improved student academic success. Aggregated school health data allows for population-based disease surveillance (Baer, Rodriguez, & Duchin, 2011) and holds the potential for analysis by community and demographic groups, of the most effective strategies for school-based health promotion and illness prevention activities. In addressing EHR use, school nurses should, receive training on the use of the system, evaluate school district policies and procedures, initiate changes if indicated, and educate staff, students, and parents on the value of EHRs. Additionally, school nurses should be able to describe the security measures taken by the school district to protect student confidentiality. Without EHRs, the contributions of school nursing services to a child’s health and academic success cannot be fully examined or appreciated.

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**Acknowledgement of Authors:**
Cynthia Hiltz, MS, RN, LSN, NCSN
Katie Johnson, DNP, MN, RN-BC, NCSN
Julia Rae Lechtenberg, MSN, RN, NCSN
Erin Maughan, PhD, MS, RN, APHN-BC
Sharonlee Trefry, MSN, RN, NCSN

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Emergency Preparedness and Response in the School Setting

– The Role of the School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) provides leadership in all phases of emergency preparedness and response. School nurses are a vital part of the school team responsible for developing emergency response procedures for the school setting using an all-hazards approach.

The school nurse is often the first health professional who responds to an emergency. The school nurse has the education and knowledge to identify emergent situations, manage the emergency until relieved by emergency medical services (EMS) personnel, communicate the assessment and interventions to EMS personnel, and follow up with the health care provider.

BACKGROUND

Each school day, families entrust our nation’s schools to provide safe and healthy learning environments for approximately 55 million elementary and secondary school students in public and nonpublic schools (U. S. Department of Education [USDE], 2012). Families and communities expect that schools will keep children safe from threats (e.g., human-caused emergencies such as crime and violence) and hazards (e.g., natural disasters, disease outbreaks, and accidents) (USDE, 2013). There is a fundamental link between day-to-day emergency readiness and disaster preparedness. Schools that are well prepared for an individual emergency involving a student or staff member are more likely to be prepared for complex events such as community disasters (AAP, 2008).

School nurses respond to emergencies and disasters that can range from one student or adult injured to the mass illness situations observed with the H1N1 influenza pandemic (Pappas, 2011). An emergency is a dangerous event normally managed at the local level (Doyle, 2011). Disasters are distinguished from emergencies by the greater level of response required. A disaster is a dangerous event that causes a significant human and economic loss, and demands a crisis response beyond the scope of local and state resources (Federal Emergency Management Agency [FEMA], 2011; Doyle, 2013). Whether for an emergency or disaster, preparedness is essential to ensure an effective response (Doyle, 2011). Planning for health-related emergencies involves developing emergency plans for students with known health-related conditions, and utilizing first aid skills to assess and respond to other unanticipated medical emergencies.

The types of emergency events for which the school nurse must be prepared to respond include:

- Student, staff and visitor health-related emergencies, due to injury or illness.
- Large numbers of individuals in casualty incidents, such as the collapse of bleachers, exposure to toxic gas, or a school shooting (Doyle, 2013).
- Weather-related emergencies (e.g. hurricanes, tornadoes, tsunamis and flooding, snow and ice storms).
- Hazards such as explosions and fires, physical plant, technological hazards, or nuclear meltdowns that may cause damage in the school and result in physical injuries, or loss of life.

For larger scale emergencies and disasters, the National Response Framework (NRF) offers guiding principles that enable all response partners to prepare for and provide a unified national response to disasters and emergencies –
from the smallest incident to the largest catastrophe (FEMA, 2013). The term “response” as defined by NRF includes taking immediate action to save lives, protect property and the environment, and meet basic human needs. Response also includes the execution of emergency plans and actions to support short-term recovery. The NRF also describes how agencies, such as schools, can work together with communities, tribes, states, the federal government, and private partners (Doyle, 2011).

Two national response models serve as the framework for local policy and response plans. The National Incident Management System (NIMS) is a comprehensive national design for approaching incident management. NIMS provides the template for management of the incident, while the NRF provides the structure and mechanisms for national-level policy for incident management (FEMA, 2011). One component of the NIMS is the Incident Command system (ICS), which provides a standardized approach for incident management, regardless of cause, size, location, or complexity. By using ICS during an incident, schools will be able to more effectively work with the responders in their communities (USDE, 2013).

To maximize success, effective management of school emergencies requires training, preparation and planning for best practices (RWJ, 2012).

**RATIONALE**

Schools should be responsible for anticipating and preparing to respond to a variety of emergencies (Doyle, 2013). School nurses, by virtue of their education, are experts in the nursing process, which includes assessment, planning, implementation and evaluation (Doyle, 2011). During emergencies, these steps closely parallel the phases of emergency management, which include prevention/mitigation, preparedness, response, and recovery. The school nurse, as a leader, is in the unique position to provide continuous integration, coordination, and training of all school and community members within the framework of the school’s emergency management plan. The role of the school nurse within the four identified phases of emergency management planning includes the following:

**Prevention/ Mitigation:** School nurses should participate in an ongoing assessment to identify hazards from all possible sources and to reduce the potential for an emergency to occur. Examples include educating students and staff about recognizing and reporting suspicious behaviors and persons, implementing and maintaining an effective immunization program for students and staff, improving security measures to control access to school facilities and using metal detectors at entry points if appropriate (Doyle, 2011).

**Preparedness:** School nurse participation on community-wide planning groups is helpful in the facilitation of a rapid, coordinated, effective emergency response within the framework of the ICS. This includes establishing standard emergency response plans and practicing skills, drills and other exercises to evaluate the response capabilities of a school, as well as the effectiveness of the plan (e.g., medical emergency, evacuation, shelter-in-place, lock down, and intruder). Specifically, the school nurse can be instrumental in identifying unique emergency preparedness needs for children with special health care needs, as well as specific equipment and supplies needed to respond, and to assess for and provide first aid.

**Response:** The school nurse is knowledgeable about her or his role in responding to an emergency, which may include triage, training of first aid response teams, and direct physical and mental health care for all victims of an emergency, including linking them to medical and public health resources. The school nurse also serves a vital role in reuniting families during and after a crisis (RWJ, 2012). NASN’s School Emergency Triage Training (SETT) program, (NASN, 2012) provides school nurses with the knowledge, skills and resources to perform as leaders of First-Aid teams in response to mass casualty events occurring in the school setting.

**Recovery:** After a disaster, the school nurse assists students, parents, and school personnel, providing direct support and serving as the liaison between community resources and those in need. This includes
both short and long-term recovery, and may include maintenance of student and staff health status, as well as mental health issues and psychological response.

Children with Special Health Needs

Schools are responsible for the emergency management planning and response efforts to assist students with special health care needs. This includes conducting an evaluation, providing housing, and caring for these students during an emergency event (Robert Wood Johnson [RWJ], 2012). If students are required to be sheltered in school for extended periods, the school nurse plans and prepares to support and care for children with chronic health conditions, including diabetes, asthma, and allergies/anaphylaxis. These plans may include:

- Healthcare provider orders for 72-hour lockdown or disaster.
- A system for retrieving and transporting medications to areas of lockdown or evacuation.
- Provision of necessary supplies and food in the classroom or carried with the child or teacher in an evacuation or a 3-day supply in case of a lock down.
- Education of all staff members/substitutes responsible for the child with a special health needs during an emergency.
- An alarm system for students with auditory and/or visual needs.
- Back-up power source for specialized equipment.
- Emergency evacuation plan for students with physical, mental or communication limitations (e.g. visually and/or hearing impaired, students with autism, and “English as a second language” students).

Emergency Equipment

A primary role of the school nurse is to ensure a system is in place to provide triage and immediate first aid care to ill and injured students, staff and community volunteers. This is accomplished by the school nurse, or through his/her direction of others (Doyle, 2011). The availability of essential emergency supplies is an integral component of being able to render appropriate on-site care and manage the emergency condition (Doyle, 2013). The type of equipment is primarily contingent on portability for use as a first-aid kit or for use by the school nurse in the health office (Illinois Emergency Medical Services for Children, 2010). NASN’s Emergency Resources, Equipment and Supplies – With/Without A School Nurse (NASN, 2014) provides emergency equipment recommendations as a resource to schools and school nurses.

CONCLUSION

The school nurse is a leader and integral partner in developing plans for first aid, facilitating an evacuation, caring for special needs students, performing triage responsibilities, educating and training staff, providing surveillance, and reporting. The school nurse is an effective communicator and educator, responsible for sharing information about health risks and connecting students and families to providers who can offer immediate crisis care and support, and refer to appropriate mental health services for long-term support. He/she provides a unique and critical perspective in the evaluation and revision of school emergency plans. The school nurse is the primary connection to the medical/public health community (Doyle, 2013). In order to optimize positive outcomes in all phases of emergency management, it is of the utmost importance that the school team include a school nurse for emergency preparedness and response planning.

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Acknowledgement of Authors:
Christine M. Tuck, MS, BSN, RN, NCSN
Kathey Haynie, MSN, RN
Catherine Davis, BSN, RN, NCSN

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Acknowledgement of 2011 Authors:
Joan B. Cagginello, MS, BSN, RN
Sandra Clark, ADN, RN
Linda Compton, MS, RN
Catherine Davis, BSN, RN, NCSN
Marilyn Healy, BSN, PNP, RN, NCSN
Susan Hoffmann, MSN, BSN, RN, NCSN
Christine M. Tuck, MS, BSN, RN, NCSN

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Environmental Health in the School Setting:  
The Role of the School Nurse

Position Statement

SUMMARY

Environmental health is a branch of public health that is concerned with all aspects of the natural and built environment. The World Health Organization (WHO) defines environmental health as those aspects of human health and diseases that are determined by factors in the environment. It also refers to the theory and practice of assessing and controlling factors in the environment that can potentially affect health (WHO, 2011).

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is the health expert in the school setting. With a public health focus, the school nurse has the educational and clinical background required to understand the issues of environmental health in the school setting and is in a prime position to advocate for a sustainable healthy school environment.

BACKGROUND

In the school setting, environmental health is affected by the complex interaction of factors inherent in the school’s location, its occupants and school activities. Some include, but are not limited to, building materials (insulation and carpets), materials used in art, music and science classrooms, computer labs, health rooms, playground equipment, food preparation areas, waste management supplies and equipment, cleaning products, pest management equipment, fragrances, heating, cooling, and ventilation equipment, gymnasium areas, sports fields, outside parking including recreation areas and custodial and maintenance supplies and equipment.

The WHO recognizes that clean air in schools, homes, offices and other public buildings where people spend a large part of their time is a basic requirement of life and an essential determinant of health and well-being (WHO, 2011, Foreword, p. xv). The Institute of Medicine (IOM) states that asthma, cancer, cardiovascular failure, and developmental defects and delays are known ill-health effects from substandard environmental conditions (IOM, 2011). More than 50 million children attend public school every day for 6-8 hours, making schools the places for prevention – but also mitigation – of chronic health conditions (Department of Education, National Center for Education Statistics – cited in Environmental Protection Agency [EPA], 2012a, p. 2; Duff, 2013). During these hours, children may be exposed to the various contaminants in their building (Paulson & Barnett, 2010, NASN, 2011).

Children have developing organ systems that are highly susceptible to environmental stressors and are at a higher risk of exposure to toxic environmental substances; they breathe more air and drink more water than adults, are physically closer to – and spend more time on - the ground, and engage in more hand-to-mouth contact than adults. As a result, they are more vulnerable to the effects of air and water pollution, pesticides, and other toxins (EPA, 2012b; Paulsen & Barnett, 2010). Children also experience higher exposure rates to environmental pollutants than adults, increasing their vulnerability to potentially harmful chemicals. All these issues contribute to children receiving less than optimal learning experiences and higher absenteeism rates (IOM, 2011).

RATIONALE

A child’s environment plays a role in many chronic conditions faced by children today: premature birth, lead poisoning, asthma, some childhood cancers, and some birth defects [Children’s Environmental Health Network [CEHN], 2012]. For children asthma specifically has many potential causes and triggers that are found in schools: dust mites, cockroaches, rodents, mold, tobacco smoke and outdoor pollution, all with potential for triggering asthma episodes in children (CEHN, 2012). With a training and clinical background that incorporates public health,
the school nurse is ideally placed to assess the learning environment for risk factors, educate the community on the impact of environmental exposure, and advocate for the need to address environmental pollution issues. As the first responder, the school nurse is able to identify trends and abnormal illnesses that may be the result of environmental toxin exposure. The school nurse has the credibility to provide scientifically sound information about environmental issues and toxin exposures to school and community leaders and is well placed to serve on committees that affect safe environmental practice (Agency for Toxic Substances and Disease Registry [ATSDR], 2012).

CONCLUSION

“Environmental preferability, sustainability, ‘green’, reducing your environmental footprint...these terms have become part of our everyday lexicon as schools, businesses, households, and the public sector have increasingly focused on strategies and tactics designed to reduce their negative impacts on the environment and human health” (Balek, 2012, p. 16). Poor environmental quality results in children suffering ill health and lost academic instruction during their school years. The long-range burden of this will often continue into their adult lives, resulting in adults with chronic health conditions, and may affect their opportunity to excel in a chosen career.

The school nurse is witness to the daily consequences to school children when they arrive at the health room or are absent from school, but the associated costs resulting from doctor visits, hospitalization, and loss of working days for parents affect the greater community. These repercussions may result in financial hardship on the family and subsequently an economic strain on the nation’s economy. By advocating for a healthy school environment, the school nurse will provide children with a greater chance for a healthy future, with reduction of chronic disease. The school nurse promotes a healthy future for children by providing them education about their illness and teaching them to also advocate for themselves regarding environmental factors contributing to their illness.

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Acknowledgement of Authors:
Bernadette Moran McDowell, MEd, BSN, RN
Janet Bryner, BSN, RN, NCSN
Elizabeth A. Chau, RN, SRN

2012 Issue Brief Authors:
Nina Fekaris, MS, BSN, RN, NCSN
Samantha Miller-Hall, BSN, RN, NCSN
Janice Selekman, DNSc, RN, NCSN

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www.nasn.org
National Association of School Nurses
1100 Wayne Avenue, Suite 925
Silver Spring, MD 20910
1-240-821-1130
Head Lice Management in the School Setting

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the management of head lice (Pediculus humanus capitis) in the school setting should not disrupt the educational process. Leadership provided by the registered professional school nurse (hereinafter referred to as the school nurse) can impact reduction of the stigma associated with head lice by providing accurate health education including anticipatory guidance to the school community and implementing evidence-based strategies for the management of head lice in schools. Evidence-based strategies include abandoning “no-nit” school policies, allowing children to remain in class and participate in school-sponsored activities when live lice or nits (the eggs of head lice) are found on their heads, notifying parents/caregivers at the end of the school day when findings indicate the presence of a head lice infestation, and educating parents/caregivers about evidence-based treatment options.

BACKGROUND

In the United States, head lice infestations are most common among preschool and elementary school-age children and their household members regardless of socioeconomic status and hygienic living conditions (Centers for Disease Control and Prevention [CDC], 2013a). According to research head lice infestations predominantly affect the age group of 3-11 years (Frankowski & Bocchini, 2010), with an estimated 6 million to 12 million cases annually (CDC, 2013a). A 2004 study estimated annual direct and indirect costs associated with head lice infestations and recent treatment costs at $1 billion (Hansen & O’Hayre, 2004). “No-nit” policies that require a child to be free of nits before he or she can return to school lack evidence of being effective, result in unnecessary absenteeism, and may violate affected children’s civil liberties (Pontius, 2014; CDC, 2013a). Unnecessary absenteeism leads to missed learning opportunities for the student and potentially lost family wages due to loss of parent/guardian workdays (Pontius, 2014).

Head lice are not known to cause disease; however, secondary bacterial infection of the skin resulting from contaminated scratching and related lesions can occur. Research has shown that the survival of head lice when not on the head is usually less than one day, and the eggs can only hatch when incubated by body heat found near the scalp (Devore et al., 2015; CDC, 2013c). Transmission occurs primarily through head-to-head contact and infrequently through indirect contact with shared personal belongings.

Even with this knowledge, the presence of head lice can negatively affect families and schools. For the student and family there can be significant social stigma and caregiver strain (Gordon, 2007). For the school, when evidence-based policies and intervention strategies are not in place, head lice can significantly disrupt the education process (CDC, 2013c; Pontius, 2014).

In the past, many schools with “no-nit” policies expended innumerable hours and resources in attempts to eradicate head lice infestations. Studies have shown that control measures such as, mass screenings for nits, have not been shown to have a significant effect on the incidence of head lice in a school community, nor have they been shown to be cost-effective (Devore et al., 2015; Meinking & Taplin, 2011; CDC, 2013a). Communication between school personnel and parents/caregivers highlighting cases of head lice (e.g., “head lice outbreak letters”) has been shown to increase community anxiety, increase social stigma causing embarrassment of affected infested students, and puts students’ rights to confidentiality at risk (Gordon, 2007; Pontius, 2014).

Head lice treatment success is variable, adding to confusion and frustration among students, families, and members of the school community. Some children develop persistent head lice, which requires-concentrated efforts to address treatment as well as the stress experienced by the child and family (Gordon, 2007). Head lice in some communities have developed resistance to common over-the-counter treatments, resulting in the need for a more individualized approach to management by a healthcare provider (Yoon et al., 2014; Meinking et al., 2002;
Devore et al., 2015). Treatment failures can also result from initial misdiagnosis, non-adherence to a treatment protocol, a new infestation acquired after treatment, or the lack of use of an ovicidal product (Devore et al., 2015; Pontius; 2014; Pollack, Kiszewski, & Spielman, 2000; CDC, 2013b).

RATIONALE

Evidence-based strategies for the management of head lice in the school setting can reduce the incidence of infestations, the social stigma and caregiver strain experienced by students and families, and the negative impact on students’ education. The school nurse can provide leadership within the school community to effectively manage head lice by:

- Attaining knowledge and competency that reflect current evidence-based school nursing practice related to the management of head lice (American Nurses Association & National Association of School Nurses [ANA & NASN], 2011).
- Providing accurate health education to the school community focused on dispelling common myths about head lice (e.g., incidence, life cycle of the head louse, mode of transmission, importance of regular surveillance at home, recommended evidence-based treatment options, care of the environment) (ANA & NASN, 2011 Pontius, 2014).
- Advocating and providing rationale for the elimination of mass school screenings for head lice (Devore et al., 2015; CDC, 2013a).
- Educating families about how to assess their children for suspected head lice (Devore et al., 2015).
- Providing privacy when conducting student health assessment for suspected or reported cases of head lice (ANA & NASN, 2011).
- Returning affected students to class or other school sponsored activities with instruction to avoid head-to-head contact (Pontius, 2014). If live lice or nits are found,
  - Eliminating classroom-wide or school-wide family head lice notification.
  - Notifying parents/caregivers at the end of the school day to teach about evidence-based treatment options and steps to follow.
- Advocating for and providing rationale for the abandonment of “no-nit” school policies that require a child to be free of nits before he or she can return to school (Devore et al., 2015; Pontius, 2014).
- Educating parents/caregivers about the chosen evidence-based treatment option, the importance of adherence with the treatment protocol, and the importance of reassessment for recurrence (Devore et al., 2015; Pontius, 2014).

CONCLUSION

The school nurse is the health professional who provides leadership for the school community to implement evidence-based strategies for the management of head lice in the school setting. The role of the school nurse includes the following (Pontius, 2014; Devore et al., 2015; CDC, 2013a):

- Provide accurate health education to the school community about the etiology, transmission, assessment, and treatment of head lice;
- Advocate for school policy that is more caring and less exclusionary (i.e., elimination of the “no-nit” school policies);
- Implement intervention strategies that are student-centered;
- Support the current treatment recommendation of the American Academy of Pediatrics and CDC; and
- Participate in research that evaluates the effectiveness of head lice policies and educational programs.

It is unlikely that all head lice infestations can be prevented. Parents/caregivers will benefit from receiving support from the school nurse about the importance of regular surveillance at home, choosing and adhering to the protocols of evidence-based treatment recommendations, and educating to dispel head lice myths. The education mission of schools will be supported by implementing evidence-based policies and strategies under the guidance of the school nurse. The burden of unnecessary absenteeism to the students, families, and communities far outweighs the perceived risks associated with head lice.
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Acknowledgment of Authors:
Suzanne Smith, BSN, RN, NCSN
Nichole Bobo, MSN, RN
Kathy M. Strasser, MS, RN, NCSN
Kathey M. Haynie, MSN, RN
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Immunizations

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that immunizations are essential to primary prevention of disease from infancy through adulthood. Promotion of immunizations by the registered professional school nurse (hereinafter referred to as school nurse) is central to the public health focus of school nursing practice (American Nurses Association [ANA] & NASN, 2011). NASN supports the Advisory Committee on Immunization Practices (ACIP) vaccine recommendations that are adopted by the Centers for Disease Control and Prevention (CDC) (CDC, 2014a, 2014b). The school nurse is well-poised to create awareness and influence action to increase the uptake of mandated and recommended immunizations. The school nurse should use evidence-based immunization strategies, such as school-located vaccination clinics, reminders about vaccine schedules, state immunization information systems (IIS), strong vaccination recommendations, and vaccine education for students, staff, and families. Using these strategies will help reduce health-related barriers to learning (Guide to Community Preventive Services, 2008, 2009, 2010; Ylitalo, Lee, & Mehta, 2013; Bobo, Carlson, & Swaroop, 2013).

BACKGROUND

The impact of vaccines in reducing and eliminating vaccine-preventable diseases has been one of the 10 great public health achievements in the United States (CDC, 2011). The CDC estimates that vaccination of children born between 1994 and 2013 will prevent 322 million illnesses, help avoid 732,000 deaths, and save nearly $1.4 trillion in total societal costs (CDC, 2014c).

While immunization rates remain high for vaccines mandated for school entry, recommended childhood vaccines remain below the Healthy People 2020 recommended targets (US Department of Health and Human Services [USDHHS], 2010). In addition, pockets of unvaccinated children exist across the country, resulting in increasing outbreaks of diseases previously nearly eradicated and have resulted in recent outbreaks of measles and pertussis (CDC, 2014d, 2014e). The success of vaccines in disease prevention and eradication has resulted in a shift in public focus from the risk of diseases to the risk of vaccines (Freed, Clark, Butchart, Singer, & Davis, 2010).

Access to accurate, recordable, and retrievable vaccine information is an issue of growing importance. Families today frequently relocate and need access to their children’s immunization information; natural disasters have been known to destroy immunization records; and immunization records are often incomplete. Access and participation in state IIS, previously known as immunization registries, is an evidence-based strategy known to increase accurate and timely vaccine uptake (Guide to Community Preventive Services, 2010). While a national IIS is the ideal, technical and administrative requirements of current state IIS vary greatly. National consensus is that efforts should focus on robust use and interoperability of state systems (Bobo, Etkind, Martin, Chi, & Coyle, 2013).

Expansion of recommended immunizations (e.g., universal seasonal influenza vaccination and adolescent vaccines) presents additional challenges for reaching the Healthy People 2020 national health goals for vaccination coverage. The current vaccine delivery infrastructure might be the most limiting factor in achieving vaccine coverage targets. School-located vaccination has been shown to be an important venue for vaccine delivery, from polio vaccination in 1955 to the most recent H1N1 pandemic. Returning to the school as a point of vaccine delivery capitalizes on the trusted position of schools and school nurses and has the potential of not only increasing immunization rates but also increasing the standardization and retrievability of documentation of vaccinations provided. Vaccine delivery in schools is supported by the Guide to Community Preventive Services (2009), NASN (Bobo, Etkind, & Talkington, 2011) and other reports in the literature (Williams et al., 2012; Wilson, Sanchez, Blackwell, Weinstein, & Amin, 2013).

The historic role of school nurses in maintaining immunization compliance in students is evolving. The role now includes record review, referral, assisting families and students with their decision to vaccinate, immunization...
champion and advocate, and immunization provider. As a trusted source of health information, school nurses can influence vaccine uptake through education about the role of children in vaccine-preventable disease transmission and dispelling myths about the various vaccines. The presence of a school nurse, according to Salmon et al. (2004), also reduces the number of exemptions families take.

RATIONALE

NASN supports the ACIP vaccine recommendations that are adopted by the CDC and state and local vaccine mandates. NASN also supports full access of state IIS by school nurses. State IIS can provide consolidated vaccination data that can be used to design effective school-located immunization programming, leading to increased and sustained high immunization rates. State IIS are important tools for school nurses to use to facilitate immunization compliance, identify the immunization status of students in the event of disease outbreaks, and prevent duplication of vaccinations when records have been lost, destroyed or misplaced (CDC, 2013; American Academy of Pediatrics [AAP], 2006; Guide to Community Preventive Services, 2010).

School nurses are ideally positioned within their communities to educate students, families, and school staff about the critical role vaccines play in preventing disease, allowing students and staff to remain healthy and in school. The school nurse can play an important role in enhancing vaccine uptake by providing a strong vaccine recommendation; educating about vaccine-preventable diseases, vaccine myths, vaccine safety, and recommended vaccine schedules; and addressing vaccine hesitancy. It is imperative that school nurses are vigilant in assuring that they are up-to-date on the most current scientific and scholarly evidence in the area of immunizations and are not influenced by unsupported and non-scientific media reports. It is vital that they rely on the expert agencies (e.g., CDC, National Institute of Health, Department of Health and Human Services) for the correct information to educate themselves, families, administrators, teachers, and the community.

CONCLUSION

The proven benefits of immunizations and vaccine uptake do not always coincide. Collective memory of the impact of vaccine-preventable diseases such as diphtheria and polio has faded, largely due to the effectiveness of vaccines over the past several decades (Immunization Action Coalition, 2014), and recent unfounded fears about vaccine side effects have affected vaccine uptake (Freed et al., 2010; Kennedy, LaVail, Basket, & Landry, 2011; Kennedy, Basket, & Sheedy, 2011). Schools and school nurses can improve vaccine uptake among students and staff by providing evidence-based information about vaccine and providing a strong vaccine recommendation, thus averting nonmedical exemptions. School nurses should also role-model immunization compliance themselves. They can also remind students, families, and staff of immunization schedules and report and retrieve immunization information from state IIS. Schools and school nurses can partner with other stakeholders to deliver and/or access vaccines. By implementing these strategies, schools and school nurses have a key role to play in reaching the Healthy People 2020 vaccine targets.

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Acknowledgement of Authors:
Nichole Bobo, MSN, RN
Jennifer Garrett, BSN, RN, CPN, CSN
Carmen Teskey, MAS, BSN, RN, LSN
Kay Duncan, RN, CPN, MAA
Kathy Strasser, MS, BSN, RN, NCSN, LSN
Alicia L. Burrows-Mezu, MSN/Ed, BSN, BSc, RN

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Individualized Healthcare Plans:  
The Role of the School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse), in collaboration with the student, family and healthcare providers, shall meet nursing regulatory requirements and professional standards by developing an Individualized Healthcare Plan (IHP) for students whose healthcare needs affect or have the potential to affect safe and optimal school attendance and academic performance. Because health conditions can be complex and unfamiliar to school staff and the student’s requirement for nursing care can be frequent and sometimes emergent, accurate and adequate documentation of chronic medical conditions and individual needs is critical (Lyon, 2012). Development of IHPs is a nursing responsibility, based on standards of care regulated by state nurse practice acts and cannot be delegated to unlicensed individuals (National Council of State Boards of Nursing [NCSBN], 2005). It is the responsibility of the school nurse to implement and evaluate the IHP at least yearly and as changes in health status occur to determine the need for revision and evidence of desired student outcomes.

BACKGROUND

The IHP is a document based on the nursing process. Since emerging in the 1970s, the nursing process is the cornerstone of nursing practice, using a scientific approach in the identification and solution of health problems in nursing practice (Hermann, 2005). The American Nurses Association (ANA) and NASN define the nursing process as a “circular, continuous and dynamic critical-thinking process comprised of six steps and that is client-centered, interpersonal, collaborative, and universally applicable” (American Nurses Association [ANA] & NASN, 2011, p. 76). Documentation of these steps for individual students who have healthcare issues results in the development of an IHP, a variation of the nursing care plan. The term IHP refers to all care plans developed by the school nurse, especially those for students who require complex health services on a daily basis or have an illness that could result in a health crisis. These students may also have an Individualized Education Plan (IEP), a 504 Student Accommodation Plan to ensure school nursing services and access to the learning environment, or an Emergency Care Plan (ECP) for staff caring for these students (Hermann, 2005).

RATIONALE

Development of the IHP by the school nurse provides a framework for meeting clinical and administrative needs:

Demonstrates Standard of School Nursing Practice

Development and implementation of the IHP is documentation of professional performance in accordance with standards of school nursing practice, the professional expectations that guide the practice of school nursing (ANA & NASN, 2011). The Standards of School Nursing Practice are “authoritative statements of the duties that school nurses, regardless of role, population, or specialty within school nursing are expected to competently perform” (ANA & NASN 2011, p. 4). These standards “describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process” (ANA & NASN, 2011, p. 12).

Documents the Nursing Process

Creation of the IHP incorporates and documents the nursing process in student care in accordance with state nurse practice acts. The nursing process provides a framework for the nurse’s responsibility and accountability. “The RN may delegate components of care but does not delegate the nursing process itself. The practice pervasive
functions of assessment, planning, evaluation and nursing judgment cannot be delegated” (ANA & NCSBN, 2005, p.2).

School Nursing: Scope and Standards of Practice (ANA & NASN, 2011) outlines how implementation of each step of the nursing process strengthens and facilitates educational outcomes for students. These steps parallel components of a well-developed IHP.

Standard 1. Assessment: The school nurse collects comprehensive data pertinent to the healthcare consumer’s health and/or situation.

Standard 2. Nursing Diagnosis: The school nurse analyzes the assessment data to determine the diagnoses or issues.

Standard 3. Outcome Identification: The school nurse identifies expected outcomes for a plan individualized to the healthcare consumer or the situation.

Standard 4. Planning: The school nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.

Standard 5. Implementation: The school nurse implements the identified plan.


Provides Legal Documentation
A school nurse plans safe care for students and demonstrates an appropriate standard of professional care when the IHP is used as the foundation for student health interventions. “Judicious use of the IHP as a vehicle to ensure safe nursing services and continuity of care for students with special (health) needs is a standard of care against which a school nurse’s conduct can be judged in a legal proceeding” (Hootman, Schwab, Gelfman, Gregory, & Pohlman, 2005, p. 190). Along with applicable laws including state nurse practice acts, expert testimony, organizational policies and procedures, the standard of care is a significant factor used by courts in professional liability cases (Pohlman, 2005).

Clarifies Clinical Practice
The IHP’s clinical purposes include clarifying and consolidating meaningful health information, establishing the priority set of nursing diagnoses for a student, providing communication to direct the nursing care of a student, documenting nursing practice, ensuring consistency and continuity of care as students move within and outside school districts, directing specific interventions, identifying (safe and appropriate) delegation of care, and providing methods to review and evaluate nursing goals and student outcomes (Hermann, 2005). It is important to note that student-centered outcomes are developed early in the IHP process to guide interventions and provide a basis for evaluation to take place. The IHP is the document that combines all of the student’s healthcare needs into one document for management in the school setting (Zimmerman, 2013).

Provides Administrative Information
The IHP serves administrative purposes, which include defining the focus of nursing; validating the nurse’s role in the school; facilitating management of health conditions to optimize learning; differentiating accountability of the nurse from others in the school; providing criteria for reviewing and evaluating care (quality assurance); providing data for statistical reports, research, third-party reimbursement and legal evidence; and creating a safer process for delegation of care in the school setting (Hermann, 2005).

Serves as the Foundation for Health Portion of Other Educational Plans and Emergency Plans
The IHP provides the health information and activities that can be incorporated into the health portion of other school-educational plans to foster student academic success and to meet state and federal laws and regulations. These include the Individualized Education Plan (IEP) in accordance with the Individuals with Disabilities Education
Improvement Act (P.L. 108-446, 2004) and a 504/ADA plan in accordance with Section 504 of the Rehabilitation Act (P.L. 102-569, 1992) and the Americans with Disabilities Act (P.L. 110-325, 2008).

The student Emergency Care Plan (ECP) is an emergency plan developed by the registered professional school nurse and is based on the IHP or is sometimes used instead of an IHP. The ECP is written in clear action steps using succinct terminology that can be understood by school faculty and staff who are charged with recognizing a health crisis and intervening appropriately (Zimmerman, 2013). The ECP is distributed to these individuals with the expectation that the information will be treated with confidentiality. The names of the individuals who have a copy of the ECP should be listed at the bottom (Zimmerman, 2013).

CONCLUSION

It is the responsibility of the registered professional school nurse to develop an IHP and ECP for students with healthcare needs that affect or have the potential to affect safe and optimal school attendance and academic performance. The IHP is developed by the school nurse using the nursing process in collaboration with the student, family and healthcare providers. The school nurse utilizes the IHP to provide care coordination, to facilitate the management of the student’s health condition in the school setting, to inform school-educational plans, and to promote academic success. The ECP, written by the school nurse, is for support staff with an individual plan for emergency care for the student. These plans are kept confidential yet accessible to appropriate staff.

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Acknowledgment of Authors:
Bernadette Moran McDowell, MEd, BSN, RN
Sue A. Buswell, MSN, RN, NCSN
Cheryl Mattern, MEd, BSN, RN
Georgene Westendorf, MPH, BSN, RN, NCSN, CHES
Sandra Clark, ADN, RN

Acknowledgment of 2013 Authors:
Janet Bryner, BSN, RN, NCSN
Sue A. Buswell, MSN, RN, NCSN
Sandra Clark, ADN, RN
Cheryl Mattern, MEd, BSN
Bernadette Moran McDowell, MEd, BSN, RN
Georgene Westendorf, MPH, BSN, RN, NCSN, CHES
Susan Will, MPH, BS, RN, NCSN, FNASN

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LGBTQ Students: The Role of the School Nurse

Position Statement

SUMMARY

All students -- regardless of their sexual orientation, gender identity, or gender expression -- are entitled to a safe, supportive and inclusive school environment with equal opportunities for achievement and participation. It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is a vital member of the team to support students’ health and well-being and to advocate for policies and practices in the schools that provide for the physical, psychological, and social safety of all students.

BACKGROUND

For the purposes of this position statement, the terms sexual and gender minority or LGBTQ are used to describe students who may identify as lesbian, gay, bisexual, transgender, or questioning. Sexual minority persons are those who identify themselves as gay, lesbian, or bisexual or are unsure of their sexual orientation, or those who have had sexual contact with a person of the same sex or with both sexes (American Academy of Pediatrics [AAP], 2013; Centers for Disease Control and Prevention [CDC], 2014; Kann et al., 2011). Many adolescents do not identify with any sexual minority group and may have had sexual relations with the same sex or with both sexes and those who struggle with their sexual identity and or expression and may be referred to as questioning (AAP, 2013). Gender non-conforming is a term used for people whose gender expression differs from stereotypical expression, those described as androgynous, and includes people who identify outside traditional gender categories or identify as both genders (Gay, Lesbian, Straight Education Network [GLSEN], 2014). Transgender is used to describe a person whose gender identity is different from that traditionally associated with his or her biological sex, external genitalia or assigned sex at birth (CDC, 2014); and it is also used to encompass a broad range of gender identities associated with gender non-conformity (GLSEN, 2013). Queer is an umbrella term that is embraced by some youth to describe a sexual identity, gender identity or gender expression; and some LGBT people may consider it offensive (GLSEN, 2013. It is good practice to use terms that a student uses to self-identify their sexual or gender identity or gender expression.

Gender dysphoria is defined by the American Psychiatric Association (2013) as extreme discomfort of individuals with primary and secondary sex characteristics of their assigned birth sex. In 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA) supported ending conversion therapy for youth which is an attempt to change an individual’s sexual orientation, gender identity, or gender expression through medical or behavioral interventions as it is not supported by credible evidence and may cause serious harm to young people. It perpetuates outdated views of gender roles and identities and the negative stereotype that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development (SAMHSA, 2015).

Currently 31 states have no legislation that protects LGBTQ youth from discrimination, and in eight states there are “no promo homo” laws that forbid educators from discussing LGBTQ issues (Orr, Baum & Sherouse, 2015; Teaching Tolerance, 2013). Title IX of the Education Amendments of 1972 protects against discrimination and harassment based on sex in any educational program or activity that receives federal funding and includes those who do not conform to stereotypical sexual or gender identities (GLSEN, 2014; Orr et al., 2015; U.S. Department of Education, Office for Civil Rights, 2015).

The LGBTQ population is multi-faceted with many subgroups, which makes defining the population needs difficult (Institute of Medicine [IOM], 2011). LGBTQ youth are identifying earlier and in larger numbers due to internet online support and an increase in the number of role models (Russell, Kosciw, Horn, & Saewyc, 2010). GLSEN re-
ported that transgender students received much higher levels of harassment and violence than LGB students, which resulted in transgender students missing more school, receiving lower grades, feeling isolated and not part of the school community (Greytak, Kosciw, & Díaz, 2009). In 2013, 9.5% of students in the school climate report identified as transgender (Kosciw, Greytak, Palmer, & Boesen, 2014).

In 2012, the Human Rights Campaign survey of LGBTQ youth identified family rejection (26%), school/bullying problems (21%), and fear of being out or open (18%) as the top three problems they faced. LGBTQ youth experience physical, mental, and social health risks that are higher than their heterosexual peers (CDC, 2014; SAMHSA, 2015). Those increased risks may include but are not limited to loneliness, lack of acceptance, violence, bullying, sexually transmitted infections, unintended pregnancies, substance abuse, anxiety, depression and suicide (AAP, 2013; CDC, 2014; Kann et al., 2011; Kosciw et al., 2014).

Sexual and gender minorities experience chronic stress as a result of their stigmatization. This is known as minority stress and is due to the stresses of prejudice, discrimination, parental rejection, and violence -- not their identity (AAP, 2013; IOM, 2011; SAMSHA, 2015). According to the 2013 GLSEN school climate report, 74.1% of LGBT youth were verbally harassed; 36.2% were physically harassed; 55.5% felt unsafe because of their sexual identity and 37.8% for their gender expression; 30.3% were truant for safety concerns. 55.5% of LGBT students faced discriminatory policies and practices at school while transgender students were significantly more impacted by these practices. (Kosciw et al., 2014; SAMHSA, 2015).

Studies also indicate that characteristics of social environments, including school and families can either increase or reduce vulnerability, and resilience can shape physical and mental health outcomes (Hatzenbuehler, Birkett, Van Wagenen, & Meyer, 2014; Kosciw et al., 2014; Russell et al., 2010; SAMHSA, 2015). School-based organizations have been shown to improve school climate as they can help to assure LGBT youth that they are not alone, improve school connectedness, and promote communication and understanding within the school community (AAP, 2013; CDC, 2014; Hatzenbuehler et al., 2014; Kosciw et al., 2014; Teaching Tolerance, 2013).

Rationale

School nurses have an ethical responsibility to provide care to all students, families, school staff and community equally regardless of sexual orientation, gender identity or gender expression; to maintain confidentiality and to respect the individual’s right to be treated with dignity (American Nurses Association & National Association of School Nurses, 2011; NASN, 2015). Utilizing the Framework for the 21st Century School Nursing Practice (NASN, 2015), school nurses are responsible for care coordination and should be actively involved in improving the health and safety of the school environment for all students, including LGBTQ students.

School nurses are uniquely qualified to:

- Collaborate with school personnel, community healthcare providers, families and LGBTQ students to promote improved physical and mental health outcomes and improve academic achievement (AAP, 2013; Orr, Baum, & Sherouse, 2015).

- Recognize that the health risks are disproportionately higher for LGBTQ students and provide culturally competent care in a safe, private and confidential setting (AAP, 2013).

- Make referrals for evidence-based care to healthcare professionals knowledgeable about the healthcare needs of LGBTQ youth.

- Provide support and resources for families about local and national organizations that are available to help them to support their children.

- Advocate for the creation and enforcement of inclusive zero tolerance bullying policies, attend and promote the professional development of school leadership and personnel to understand and meet the needs of LGBTQ students, promote inclusive health education and curriculum for all students, and encourage a welcoming inclusive
environment with safe spaces in the school, i.e., health office, counselor’s office, and classrooms (AAP, 2013; CDC, 2014; GLSEN, 2013; GLSEN, 2014; Teaching Tolerance, 2013).

- Promote student-led Gay Straight Alliance and other clubs supported by faculty and administrators to improve the school climate for all students, regardless of their sexual orientation or gender identity or gender expression (AAP, 2013; CDC, 2014; Hatzenbuehler, et al., 2014; Kosciw et al., 2014; Teaching Tolerance, 2013).

- Provide support for students by advocating for practices and policies that promote the physical, psychological and social safety of all students regardless of their sexual orientation, gender identity or gender expression.

- Encourage the use of gender neutral school forms, dress codes, changing space and bathrooms; use the students’ preferred names and pronouns and to protect confidentiality when contacting others if the student is not “out/open” to family or to others at school (Orr et al., 2015; Teaching Tolerance, 2013).

CONCLUSION

School nurses are uniquely positioned to model and promote respect for diversity, reduce stigma and provide confidential health services for LGBTQ students in a safe environment. Supportive families, communities and schools are factors that can help to improve health outcomes for students to live full lives regardless of sexual orientation, gender identity or gender expression. School nurses are leaders who can foster the supportive school environment and make a positive impact in the lives of everyone in the school community (NASN, 2015).

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Acknowledgement of Authors:
Mary Blackborow, MSN, RN, CSN-NJ
Jessica Porter, BSN, RN, NCSN
Darla Rebowe, BSN, RN

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Marijuana and Children

**Position Statement**

**SUMMARY**

Registered professional school nurses (hereinafter referred to as school nurses) promote wellness and disease prevention to improve health outcomes for our nation’s children. It is the position of the National Association of School Nurses (NASN) that the marijuana plant remain under the United States Drug Enforcement Agency’s (DEA) Schedule I category of the Controlled Substances Act (CSA), 21 U.S.C. § 801, et seq. (DEA, 2011, p.2). To date there is not sufficient scientific evidence for U.S. Food and Drug Administration (FDA) to approve the smoked marijuana plant for medical use. NASN believes any marijuana made available for the purpose of adult recreational use facilitates youth access and is not in the best interest of the health and well-being of students.

**BACKGROUND**

In 1970, Congress enacted laws against marijuana based in part on the conclusion that marijuana has no scientifically proven medical value. The Food and Drug Administration (FDA), responsible for approving drugs as safe and effective medicine, has thus far declined to approve smoked marijuana for any condition or disease. The FDA has noted “there is currently sound evidence that smoked marijuana is harmful” and “that no sound scientific studies support medical use of marijuana for treatment in the United States, and no animal or human data support the safety or efficacy of marijuana for general medical use” (DEA, 2011, p.3). Although the Federal law remains, beginning in 1996, with the State of California passing Proposition 215, twenty states have legalized marijuana for medical use. Two of these states, Washington and Colorado, have enacted recent laws that legalize recreational use. For more information regarding federal and state laws, resources from The National Conference of State Legislators can be accessed at [http://www.ncsl.org/issues‐research/health/state‐medical‐marijuana‐laws.aspx](http://www.ncsl.org/issues-research/health/state-medical-marijuana-laws.aspx) (National Conference of State Legislators, 2013).

**RATIONALE**

The National Institute on Drug Abuse (NIDA) (2012) summary below outlines the safety risks of smoked marijuana use and the physical and mental health consequences. These repercussions affect the health, safety and education of adolescents.

**Acute (present during intoxication)**
- Impairs short-term memory
- Impairs attention, judgment, and other cognitive functions
- Impairs coordination and balance
- Increases heart rate
- Creates psychotic episodes

**Persistent (lasting longer than intoxication but may not be permanent)**
- Memory and learning skills impairment
- Sleep impairment

**Long-term (cumulative effects of chronic abuse)**
- Can lead to addiction
- Increases risk of chronic cough, bronchitis
- Increases risk of psychosis, schizophrenia in vulnerable individuals
- May increase risk of anxiety, depression
“Because it seriously impairs judgment and motor coordination, smoked marijuana also contributes to accidents while driving. A recent analysis of data from several studies found that marijuana use more than doubles a driver’s risk of being in an accident. Further, the combination of marijuana and alcohol is worse than either substance alone with respect to driving impairment” (NIDA, 2012, para. 12).

The statistics below from the Office of National Drug Control Policy (ONDCP) (2010a, p.1) illustrate trends in the perception of harm from smoking marijuana also have been declining over the same period of time. Prior research indicates that declines in these perceptions are predictive of increases in use.

- **Past-month use of marijuana among 10th graders** increased from 13.8% in 2008 to 17.6% in 2011.
- **Past-month use of marijuana among 12th graders** increased from 18.3% in 2006 to 22.6% in 2011.
- **Drug use has increased among certain youth minority populations.** Illicit drug use has increased by 43 percent among Hispanic boys and 42 percent among African American teen girls since 2008.

Marijuana is a frequent precursor to the use of more dangerous drugs and signals a significantly enhanced likelihood of drug problems in adult life. One study found that among adults (age 26 and older) who had used cocaine, 62 percent had initiated marijuana use before age 15. The same study showed less than one percent of adults who never tried marijuana went on to use cocaine (Gfroerer et al., 2002). Furthermore, long-term studies on patterns of drug usage among young people show that very few of them use other drugs without first starting with marijuana (ONDCP, 2010b, p.11). The American Academy of Pediatrics’ (AAP) position statement on the issue of marijuana legalization based on their technical report (AAP, 2004b) states that “any change in the legal status of marijuana, even if limited to adults, could affect the prevalence of use among adolescents” (AAP, 2004a, p. 1825).

A study from the University of Pittsburgh illustrates how the adolescent brain may be more vulnerable to addictions. The study found “a strong reward-related activation in the adolescent but not in the adult dorsal striatum, a structure associated with the formation of habits and the adaptive control of behavioral patterns” (Moghaddam & Sturman, 2012, p.4). Another recent study demonstrated the neurotoxic effects of cannabis on the adolescent brain. Adolescents with cannabis dependence (before age 18) became more persistent users compared to adult persistent users and demonstrated a marked decrease in IQ score (Meier & Caspi, 2012). Furthermore, “cessation of cannabis did not fully restore neuropsychological functioning among adolescent onset former persistent cannabis users” (Meier & Caspi, 2012, p. 5).

School nurses are in a strategic position to educate students about the life-long effects and legal consequences of smoking marijuana. According to NIDA (2010), risk of drug abuse increases greatly during times of transition such as changing schools, moving, or divorce. If we can prevent drug abuse, we can prevent drug addiction. In early adolescence, when children advance from elementary through middle school, they face new and challenging social and academic situations. “Often during this period, children are exposed to abusable substances such as cigarettes and alcohol for the first time. When they enter high school, teens may encounter greater availability of drugs, drug abuse by older teens, and social activities where drugs are used.” (NIDA, 2010, p. 11).

As advocates for students, school nurses may choose to engage in public policy conversations surrounding legal reform. Bipartisan organizations such as Smart Approaches to Marijuana (SAM) provide a suggested framework that includes appropriate referral for driving under the influence of marijuana and increased intervention and prevention (SAM, 2013).

**CONCLUSION**

NASN recognizes this overwhelming evidence about the significant negative effects of marijuana use among young people. Therefore, NASN supports that the health and wellness of children in the United States is best served by
adhering to medical evidence that smoked marijuana for medicinal use is not recommended for this age group. Additionally, NASN recognizes that marijuana made available for adult recreational use poses the potential for increased prevalence and abuse potential among youth. The well-documented, serious cognitive effects; health implications; and safety concerns of recreational marijuana use lead NASN to conclude that the legal availability of marijuana presents more accessibility to the student population and, therefore, puts students at higher risk of use and health consequences.

REFERENCES


Acknowledgement of Authors:
Patricia Endsley, MSN, RN, NCSN
Mary Louise Embrey, BS

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www.nasn.org
National Association of School Nurses
1100 Wayne Avenue, Suite 925
Silver Spring, MD 20910
1-240-821-1130
**Medication Administration in the School Setting**

**Position Statement**

**SUMMARY**

It is the position of the National Association of School Nurses (NASN) that school districts develop written medication administration policies and procedures that focus on safe and efficient medication administration at school by a registered professional school nurse (hereinafter referred to as school nurse). Policies should include prescription and non-prescription medications, and address alternative, emergency, research medication, controlled substances, and medication doses that exceed manufacturer’s guidelines. These policies shall be consistent with federal and state laws, nursing practice standards and established safe practices in accordance with evidence based information. The *Individuals with Disabilities Education Act, and Section 504*, mandate schools receiving federal funding to provide “required related service”, including medication administration (O’Dell, O’Hara, Kiel, & McCullough, 2007).

**HISTORY**

Medication administration to students is one of the most common health-related activities performed in school. Historically, administering medication within the school setting has been a school nurse responsibility. As more chronically ill, medically stable children enter the school system each year, awareness of the factors that can promote and support their academic success increases, including the need for medications that enhance the student’s overall health or stabilize their chronic condition.

**DESCRIPTION OF ISSUE**

There has been a dramatic increase in the range of medications used in schools, making the medication administration process in school more complex, not less (McCarthy, Kelly, Johnson, Roman, & Zimmerman, 2006). Medication non-adherence at school has been linked to a variety of poor educational, social/emotional and physical outcomes. In addition, non-adherence to medication treatment regimes can lead to an array of educational, behavioral, and academic consequences for a child with chronic health conditions (Clay, Farris, McCarthy, Kelly, & Howard, 2008).

Policies regarding administration or carrying of any medication or product should be applied consistently with all students. The school nurse should assess each request for administration or student self-administration of any medication based on school district medication policies.

The school nurse can administer medication safely and effectively while adhering to the following set of guidelines that include:

- Adherence to school district specific medication handling and administration procedures/policies, national school nurse standards of practice, state nurse practice acts and state laws governing these practices.
- The administration of a specific medication is in accordance with existing State Board of Nursing rules and regulations, school district policies, school nursing protocols or standing orders.
- District policies must address how over-the-counter (OTC) medications are received, stored, and labeled.
- Procedures must be established and periodically reviewed for receiving, storing, administering, clarifying prescriptive orders, determining the prescribed dosage is within the safe dose range for the child’s age and weight and accounting for all medications held or administered in the school setting.
- District policies must require parental consent for exchange of information between the school nurse and prescriber for clarification of administration and report of response to medication and adverse effects.

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**www.nasn.org**

National Association of School Nurses
8484 Georgia Avenue Suite 420
Silver Spring, Maryland 20910
1-240-821-1130
Student confidentiality is maintained in all written and verbal communications, in accordance with FERPA regulations.

Specific issues and procedures are addressed on a district-by-district basis including medication errors, missed doses, transportation concerns and monitoring unlicensed assistive personnel (UAP) administration.

Medication administration policies and procedures should also address the following:

**Delegation**
In some states, medication administration can be delegated to licensed practical nurses and UAP. Delegation by nurses is defined by the American Nurses Association (ANA) as “transferring the responsibility of performing a nursing activity to another person while retaining accountability for the outcome” (ANA/NCSBN, 2006; National Association of State School Nurse Consultants [NASSNC], 2010). Nurses remain accountable to:
- State laws, rules, and regulations;
- Employer/agency regulations, and
- Standards of professional school nursing practice, including those pertaining to delegation.

The decision to delegate is a serious responsibility that the school nurse determines on a case-by-case basis based on the needs and condition of the student, stability and acuity of the student’s condition, potential for harm, complexity of the task, and predictability of the outcome (ANA, 2005). Prior to medication administration, a student assessment is completed by the school nurse. This assessment will guide the school nurse in determining if the task can be delegated and what level of training and supervision is required for safe delegation for this specific student and assignment (Gursky & Ryser, 2007). In most circumstances, a UAP is an ancillary health office staff member (health assistant/aide) who is trained in basic first aid, selected medical procedures as indicated by the needs of the school and the students served, in addition to the district health office clerical and confidentiality procedures (AAP, 2009). An audit completed by Canham, et al. (2007), highlights the importance of training in medication administration by stating that training is not a once-a-year event, but a process that is needed to ensure and sustain the safe and accurate administration of medication.

**Alternative Medication**
The National Center for Complementary and Alternative Medicine (NCCAM) defines Complimentary and Alternative Medicine (CAM) as “group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine.” (NCCAM, 2011). Medication administration policies should reflect local and state policies related to the administration of alternative medications and treatments.

**Controlled Substances**
Pharmaceutical controlled substances are drugs that have a legitimate medical purpose, coupled with a potential for abuse and psychological and physical dependence. They include opiates, stimulants, depressants, hallucinogens, and anabolic steroids. The safe and effective use of controlled substances by students at school has increased dramatically because of their accepted use in treatment of illness and disability enabling many sick and disabled children to attend school.

**Emergency Medication**
Immediate access to emergency medication is a high priority and is crucial to the effectiveness of these life-saving interventions (AAP, 2009). The administration of emergency medications, like all medications, is regulated by state laws and guidelines as well as local school district policies and protocols. Students with medical orders for life-saving medications should have a nursing assessment, and an Emergency Care Plan, developed by the school nurse.
**Research Medication**
Medication prescriptions for children that do not fall within the established United States Food and Drug Administration (FDA) guidelines for pediatric use and/or dosing may fall into two categories: off-label medication and experimental medications. Off label medications are those FDA approved medications prescribed for non-approved indications in children. Pediatric experimental or investigational drugs are those medications currently involved in clinical trials. These medications are undergoing formal study to determine the efficacy and safety of pediatric dosing, but they do not have FDA approval.

Medication administration policies should address the specific requirements for administering research medication in school, including providing the school nurse with information regarding the protocol or a study summary from the research organization, signed parental permission, reporting requirements, and any follow-up nursing actions to be taken.

**RATIONALE**
School nurses are in a position to influence the development and use of school medication policies. They are a valuable resource and should be utilized in the development of school district policies/procedures and consult on the creation of legislative policies relating to medication administration in the school setting (Canham et al., 2007). The school nurse is often the sole healthcare provider in the school setting, providing an expertise in health related care for students. A school nurse is the professional that has the knowledge and skills required for delivery of medication, the clinical knowledge and understanding of the student’s health and the responsibility to protect the health and safety of students (AAP, 2009).

**REFERENCES**


**Acknowledgment of Authors:**
Susan Zacharski, MEd, BSN, RN
Carole A. Kain, PhD, ARNP, PNP-BC
Robin Fleming, PhD, RN, CNS
Deborah Pontius, MSN, RN, NCSN

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This document combines and replaces the following Position Statements:

Alternative Medication in the School Setting (Adopted: June 2001; Revised: June 2006)
Controlled Substances in the School Setting (Adopted: November 2001)
Research Medications in the School Setting (Adopted; June 2001)

**Resources for supporting information:**
NASN’s Position Statement on Delegation, 2010 and AAP Clinical Guidelines for Medication Administration, 2009
Non Patient Specific Epinephrine, 2011
Mental Health of Students

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that mental health is as critical to academic success as physical well-being. Registered professional school nurses (hereinafter referred to as school nurses) serve a vital role in the school community by promoting positive mental health outcomes in students through school/community evidence-based programs and curricula. As members of interdisciplinary teams, school nurses collaborate with school personnel, community health care professionals, students and families, in the assessment, identification, intervention, referral, and follow-up of children in need of mental health services. School nurses are uniquely qualified to identify students with potential mental health problems. In addition, school nurses serve as advocates, facilitators, and counselors of mental health services both within the school environment and in the community.

BACKGROUND

Mental health is “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (World Health Organization, 2010, 3rd para.). Mental health encompasses behavioral, emotional, neuro-developmental, psychiatric, psychological and substance abuse issues, as well as family and community issues that can contribute to this condition and the somatic manifestations of mental health issues (American Academy of Pediatrics [AAP], 2009). An imbalance between one or more of these factors can interfere with the child’s ability to successfully develop into a healthy, productive adult.

Mental health disorders that students experience include, but are not limited to, attention deficit hyperactive disorders, autism spectrum disorders, anxiety disorders, conduct disorders, depression, bipolar disorder, disordered eating, and substance abuse. Approximately one in five children has a mental health problem, and one half of all lifetime cases of mental health disorders begin by the age of 14 (Stagman & Cooper, 2010). According to the Substance Abuse and Mental Health Administration (SAMSHA) (2012), 5 to 9% of children aged 9 to 17 experience a serious emotional disturbance in any given year that affects their ability to function at home, in school or in the community.

Stress and psychological trauma encountered by children can increase the probability of developing mental health disorders (SAMHSA, 2012). These may include victimization, grief and loss, divorce or separation, violence, child abuse or neglect, substance abuse, natural disasters, school crises, military deployments, familial mental illness and poverty (AAP, 2009; National Association of Chronic Disease Directors [NACDD], n.d.; SAMHSA, 2012). Chronic health conditions in youth continue to rise, with increasing numbers of students with diabetes, 10% diagnosed with asthma and 30% with obesity; many of these students have increased risk for mental health disorders and risk-taking behaviors (NACDD, n.d.). According to the NACDD (n.d.), the 1998 Adverse Childhood Experiences (ACE) study by Felitti and Anda identified the relationship between adverse childhood experiences and the development of emotional and physical illness in adults with increased mortality rates. The ACE study highlights the need to manage disease with a holistic approach that includes physical and behavioral health strategies (NACDD, n.d.).

The use of psychotropic drugs has increased sharply in children, with two-thirds of the prescriptions written for stimulants and antidepressants (Center for Health and Health Care in Schools, 2012). SAMHSA (2012) indicates that 40% of children receive treatment for their mental health issues, and of those that received help, nearly two-thirds -received treatment only at school (National Association of School Psychologists, n.d.). Children with mental
health problems have lower educational achievement, greater involvement with the criminal justice system, and fewer stable and long-term placements in the child welfare system than their peers (Stagman & Cooper, 2010).

Suicide is the third leading cause of death for 10-24 year olds (Cooper, Clements & Holt, 2012). The Center for Disease Control (CDC) Youth Risk Behavior Surveillance Service (YRBSS) (2011) reported that 15.8% of respondents contemplated suicide, and 7.8% attempted suicide in the previous 12 months. Bossarte, Swahn and Breiding (2009) reported that interpersonal violence and suicide were significant public health problems among adolescents and that exposure to violence has been associated with a broad range of negative physical and mental health outcomes.

CDC’s YRBSS (2011) states 20.1% of children reported being bullied on school property and 16.2% reported being victims of cyber-bullying, through email, chat rooms, instant messaging, web sites, or texting. Cooper et al., (2012) identified a strong correlation in the literature between bullying and suicidal behavior and noted that according to the CDC, bullying is associated with substance abuse, mental health and behavior problems, and psychosomatic complaints. Both cross-sectional and longitudinal studies appear to suggest females are at greater risk for suicidal behavior than males resulting from bullying, even with less exposure (Kim, Leventhal, Koh, & Boyce, 2009; Klomke et al., 2009).

According to the 2011 National School Climate Survey, 81.9% of lesbian, gay, bisexual, transgender (LGBT) students reported being verbally harassed, while 38.3% were physically harassed, and 18.3% were assaulted in school. Another 31.8% of the respondents missed at least one day of school in the past month because of safety concerns (Gay, Lesbian and Straight Education Network [GLSEN], 2012). GLSEN (2012) links school victimization with compromised academic outcomes, attendance problems, and poorer psychological well-being. GLSEN also notes that middle school students reported higher levels of victimization on sexual orientation than high school students.

The AAP Council on School Health (2013) recommends screening and early intervention of at-risk students and families. The AAP (2013) noted that meeting the child’s need for care and nurturing early is critical for normal development and can significantly influence the child’s ability to become socially adept and academically successful. According to Stagman and Cooper (2010, p.4) “preschool children face expulsion rates three times higher than children in kindergarten through grade12 due in part to lack of attention to social-emotional needs”, and children with mental health disorders may miss 18-22 days of school per year. School absences are associated with increased dropout rates that lead to economic and social repercussions for individuals, families and communities (NASN, 2012).

Barriers to mental health care include inadequate funding at the state and federal level, uninsured or limited coverage for mental health care services, health insurance barriers, lack of transportation, financial constraints, shortage of trained child mental health professionals, and the social stigma related to mental health issues. In addition, physicians in primary care practices and the emergency room setting are not sufficiently prepared in their training to recognize and address mental health problems (AAP, 2011). Many clinics have lost their funding, and schools function as a mental health system for 70 to 80% of children with mental health needs (AAP, 2011). Although the legislative reauthorization of the 2009 Children’s Health Insurance Program requires that mental health and substance abuse treatment be included with other medical benefits, and the Affordable Care Act of 2010 improves access to health insurance, there remains a lack of pediatric providers and programs providing services to children (Stagman & Cooper, 2010).

RATIONALE

NASN (2012) notes in The Case for School Nursing that the top five health conditions of children in the United States are mental health problems and that school nurses spend 32% of their time providing mental health services. School nurses work on the front lines and are familiar with the prevalence of depression, self-harm, and suicidality among children and youth (Zupp, 2013). School nurses are often the health care professionals who first assess and identify the subtle signs exhibited as externalizing behaviors such as fighting, verbal aggressiveness, substance abuse, abuse, and risky sexual behaviors or internalizing behaviors, which include self-harm, withdrawal,
somatic complaints, suicidal ideation and school behaviors associated with achievement, attendance and tardiness (NASN Editorial, 2011).

- School nurses promote student success and nurture positive youth development by using a systematic approach to healthy social and emotional development that strengthens students, families, schools, and communities.
- School nurses enhance a positive school climate by participating in their school district's interdisciplinary team whose responsibility it is to create safe school environments. This team promotes school-based curricula and initiatives that teach and role model to children and adolescents positive self-esteem, tolerance, diversity, resiliency behaviors and protective buffers, help-seeking behaviors, anti-bullying programs, antiviolence programs, and suicide prevention programs.

- Early identification and treatment of problems place school nurses on the forefront of identifying students struggling with mental, psychosocial or emotional issues, which, when not recognized, may affect educational achievement and development of full academic potential (Stevenson, 2010). For students with a mental health diagnosis, school nurses are able to promote their success through developing and implementing 504 plans, the health portion of the Special Education Individual Education Plan (IEP), and the Individualized Healthcare Plan (IHP). Using these same tools, the school nurse can assist in the re-entry of students into the school environment following homebound instruction or hospitalization and serve as a liaison between community mental health providers, the family, and school personnel.

- Advocacy skills help school nurses promote family-centered care by connecting parents and children with school and community resources for mental health services and monitoring continued treatment and follow-up. By joining forces with other health professionals in the school and the community, school nurses can act as strong advocates for child mental health programs in the political and public arena.

- Using a holistic approach, school nurses provide ongoing assessment, intervention, and follow-up of the mental and physical health of the school community. School nurses also provide education for the staff to enable them to recognize signs and symptoms of potential mental health issues and help build their capacity to address barriers to learning. They educate staff about the negative effects of bullying and victimization on students. School nurses also offer themselves as a resource to learn and strategize with the staff to prevent bullying and promote a safe learning environment for the student body.

- School nurses recognize that positive mental health is essential for academic success, and services providing prevention, assessment, early identification, intervention/treatment of mental illness, support student achievement and improve outcomes. These services must be easy to access and be designed as comprehensive coordinated programs to reduce the impact of mental health problems on the learning process. Increasing health literacy will help to eliminate or reduce the stigma of a mental health diagnosis, fragmentation of care, and barriers to mental health services.

- School nurses are uniquely positioned between policymakers and the student body as caregiver, advocate, and expert (Cooper et al., 2012). This vantage point affords the school nurse the ability to identify and intervene with at risk adolescents as well as lead in developing prevention policy (Cooper et al., 2012).

- Non-compliance with treatment is a major challenge for managing behavioral health issues in children and adolescents (Davis, Banks, Fisher, Gershenson, & Grudzinskas, 2007). 40 to 60% of families that access mental health services end therapy prematurely (AAP, 2004). Treatment and services for children and adolescents drop off rapidly after three months. School nurses provide critical case management of students to ensure that compliance with treatment continues as long as necessary (Davis et al., 2007).

CONCLUSION

Emotional and psychiatric health is necessary for optimal academic success (Stevenson, 2010). Mental health is a key component in children’s healthy development; children need to be healthy in order to learn, grow, and lead
productive lives. When appropriately treated, children and youth with mental health problems fare better at home, in schools, and in their communities (Stagman & Cooper, 2010). Understanding the relationship between frequent health office visits or somatic complaints as a sign of underlying problems, which may be organic or psycho emotional in origin, requires the unique skill set of the school nurse.

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**Acknowledgement of Authors:**
Mary Blackborow, MSN, RN
Christine Tuck, MS, BSN, RN, NCSN
Patrice Lambert, MSN, RN, SNC
Jody Disney, PhD, RN
Jessica Porter, BSN, RN, NCSN
Alicia Jordan, BSN, RN, NCSN

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www.nasn.org
National Association of School Nurses
1100 Wayne Ave. Suite 925
Silver Spring, MD 20910
1-240-821-1130
SUMMARY

It is the position of the National Association of School Nurses (NASN) that the safe and effective management of opioid pain reliever (OPR)-related overdose in schools be incorporated into the school emergency preparedness and response plan. The registered professional school nurse (hereinafter referred to as school nurse) provides leadership in all phases of emergency preparedness and response. When emergencies happen, including drug-related emergencies, managing incidents at school is vital to positive outcomes. The school nurse is an essential part of the school team responsible for developing emergency response procedures. School nurses in this role should facilitate access to naloxone for the management of OPR-related overdose in the school setting.

BACKGROUND

Deaths from prescription painkillers (opioid or narcotic pain relievers) have reached epidemic levels in the past decade according to the Centers for Disease Control and Prevention (CDC) (2014a). A crucial mitigating factor involves the nonmedical use of prescription painkillers—using drugs without a prescription or using drugs to obtain the "high" they produce. In 2010, the CDC stated about 12 million Americans (age 12 or older) reported nonmedical use of prescription painkillers in the past year (CDC, 2014a). The 2013 Partnership Attitude Tracking Study (PATS) stated almost one in four teens (23 percent) reported abusing or misusing a prescription drug at least once in his or her lifetime, and one in six (16 percent) reported doing so within the past year (Feliz, 2014). According to the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Survey on Drug Use and Health in 2013, there were 2.2 million adolescents ages 12 to 17 who were current illicit drug users (SAMHSA, 2014). Given the magnitude of the problem, in 2014 the CDC added OPR overdose prevention to its list of top five public health challenges (CDC, 2014b).

RATIONALE

Schools should be responsible for anticipating and preparing to respond to a variety of emergencies (Doyle, 2013). The school nurse is often the first health professional who responds to an emergency in the school setting. The school nurse possesses the education and knowledge to identify emergent situations, manage the emergency until relieved by emergency medical services (EMS) personnel, communicate the assessment and interventions to EMS personnel, and follow up with the healthcare provider. Harm reduction approaches to OPR overdose include expanding access to naloxone, an opioid overdose antidote, which can prevent overdose deaths by reversing life-threatening respiratory depression. When administered quickly and effectively, naloxone has the potential to immediately restore breathing to a victim experiencing an opioid overdose (Hardesty, 2014).

Naloxone saves lives and can be the first step towards OPR abuse recovery. It provides an opportunity for families to have a second chance with their loved ones by getting them into an appropriate treatment regimen (Lagoy, 2014). Ensuring ready access to naloxone is one of the SAMSHA’s five strategic approaches to prevent overdose deaths (SAMHSA, 2013).

CONCLUSION

OPR overdose kills thousands of Americans every year. Many of these deaths are preventable through the timely provision of an inexpensive, safe, and effective drug and the summoning of emergency responders (Davis, Webb & Burris, 2013). School nurses must be familiar and sensitized to the legal issues, which vary from state to state in
terms of the prescription and availability of naloxone. They should review local and state policy on how to access naloxone and implement its use as part of their school emergency response protocol.

It is also important to prevent students from ever misusing opiates. School nurses are crucial primary prevention agents in school communities. Through utilization of prevention materials, school nurses can provide valuable awareness and education on the dangers of prescription drug misuse to K-12 students and their families. In addition, school nurses can help families recognize signs and symptoms of substance abuse, guide them to locate resources, and assist them in making referrals for treatment of OPR addiction.

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Acknowledgment of Authors:
Rebecca King, MSN, RN, NCSN
Mary Louise Embrey, BS

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*All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.*
Overweight and Obesity in Youth in Schools –
The Role of the School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses that the registered professional school nurse (herein after referred to as the school nurse) has the knowledge and expertise to promote the prevention of overweight and obesity and address the needs of overweight and obese youth in schools. The school nurse collaborates with students, families, school personnel, and health care providers to promote healthy weight and identify overweight and obese youth who may be at risk for health problems. The school nurse can refer and follow up with students who may need to see a health care provider. The school nurse also educates and advocates for changes in school and district policies that promote a healthy lifestyle for all students.

BACKGROUND

Overweight and obesity are an increasing problem in the United States that often begins in childhood. Overweight for children is defined as a BMI at or above the 85th and less than the 95th percentile, and obesity is defined as a BMI greater than the 95th percentile for age and gender (NIH, 2012). Obesity in children can lead to serious health concerns, once only seen in adults. The rates for overweight and obesity have doubled in children and tripled in adolescents in the past 30 years, and currently almost 32% of youth between 2 and 19 are overweight or obese, at or above the 85th percentile (CDC, 2013).

RATIONALE

The etiology of overweight and obesity is not completely understood but thought to be complex and have multi-factorial contributing factors (Crawford et al., 2010; CDC, 2012). Contributing factors may include:

- Diet and insufficient physical activity
- Heredity/Genetics
- Family/Social factors
- Behavioral/Cultural
- Environmental/Socioeconomic status
- Media marketing

Children and adolescents who are overweight and obese are at higher risk for health concerns such as (CDC, 2013; Copstead-Kirkhorn & Banasik, 2009):

- Coronary heart disease
- Hyperlipidemia (high cholesterol)
- Hypertension (high blood pressure)
- Bone and joint problems
- Sleep apnea
- Asthma
- Social and psychological problems
- Stigmatization and poor self-esteem
- Type 2 diabetes

Good quality nutrition and physical activity are essential for growth, development, and well-being. Schools and families should promote behaviors that encourage healthy nutrition, portion control, and physical activity early in childhood and continue throughout the life span. To maintain a healthy weight, children and families should incorporate nutritionally balanced eating patterns and daily physical activity of a moderate to vigorous level for 60 minutes or more each day. The Dietary Guidelines for Americans states that eating patterns established in youth
often last into adulthood making early development of healthy nutrition and physical activity behaviors a priority (U.S. Department of Agriculture [USDA] & United States Department of Health and Human Services [USDHHS], 2010).

The Physical Activity Guidelines for Americans states that regular physical activity in youth promotes health and fitness and makes it less likely they will develop risk factors for chronic illnesses. Regular physical activity also makes it more likely that youth will continue as healthy adults (USDHHS, 2008).

Healthy People 2020 (USDHHS, 2011) identifies specific goals to achieve and promote maintenance of healthy body weights. Since most children spend a large portion of their day at school, the school is a key setting to implement strategies to address this issue. The school can provide a healthy environment that supports balanced nutrition and activity.

As school nurses are in a position to reach a large number of youth, they are able to address the potential serious health problems that result from overweight and obesity. School nurses can provide essential leadership in helping students maintain a healthy weight to prevent overweight and obesity, decrease the burden of illness, and increase the quality of life.

Preventing and treating overweight and obesity requires multiple strategies. A school nurse can influence a child and his/her family to make healthy lifestyle changes by:

- Identifying students who may need further evaluation by conducting screenings (height, weight and body mass index [BMI]) and assessing students for possible risk factors associated with overweight and obesity (hypertension, acanthosis nigricans, risk for type 2 diabetes, and family history);
- Making necessary referrals to health care providers for further assessment and treatment;
- Developing individualized health plans that address elevated BMIs and the appropriate interventions for the school day and recommendations for modifications for lifestyle;
- Identifying community resources for referral for overweight and obese students;
- Providing education and information to parents and families about nutrition, physical activity and community resources;
- Encouraging follow up for counseling and psychological support for students;
- Promoting healthy messages that encourage the consumption of healthy foods and encourage physical activity in and after school;
- Serve as a role model and encourage role modeling of healthy lifestyle choices by parents and teachers;
- Promoting nutrition and activity assessment by the school to help the child and adolescent identify healthy behaviors and set goals; and
- Educating the school community about evidence-based healthy lifestyle changes, daily physical activity requirements, and preventable health risks associated with overweight/obesity.

School nurses initiate and lead the school community to influence policy and protocols related to wellness and can be the primary force in:

- Development of youth-related wellness policies,
- Promoting walk-to-school and bike-to-school programs, and
- Advocating for:
  - Community and school facilities to be available for physical activity for all people including after school and weekend times,
  - Research on the behavioral and biological causes of overweight and obesity,
  - Proper education to community youth organizations about the importance of making healthy food choices and obtaining the daily recommended amount of physical activity,
  - The importance of proper nutrition in enhancing learning and increasing brain function,
  - Nutritional school lunches,
  - Easy access to drinking water, and
Daily physical education at all schools.

CONCLUSION

The overweight and obesity problem in the United States has reached near epic proportions. School nurses are in a position to make a difference. School nurses recognize the impact of healthy eating and physical activity on academic success, promote healthy lifestyles for all students, and assist students who are overweight and obese work towards a healthy lifestyle. School nurses are in the prime position to influence the behavior of children and adolescents in developing good decision-making skills related to nutrition and physical activity to develop and achieve healthy lifestyles.

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Acknowledgement of Authors:
Bobbi Shanks, MS, BSN, RN, NCSN
Julia Lechtenberg, MSN, RN, NCSN
Suzey Delger, MSN, FNP-c
2011 Position Statement Authors:
Melissa Mehrley, MSN/Ed, RN
Nancyruth Leibold, EdD, MSN, RN, PHN, LSN

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All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.
The Patient Protection and Affordable Care Act: 
The Role of the School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) serves a vital role in the delivery of health care to our nation’s students within the healthcare system reshaped by the Patient Protection and Affordable Care Act of 2010, commonly known as the Affordable Care Act (ACA). This law presents an opportunity to transform the healthcare system through three primary goals: expanding access, improving quality and reducing cost (U. S. Government Printing Office, 2010). School nurses stand at the forefront of this system change and continue to provide evidence-based, quality interventions and preventive care that, according to recent studies, actually save healthcare dollars (Wang et al., 2014). NASN supports the concept that school nursing services receive the same financial parity as other healthcare providers to improve overall health outcomes, including insurance reimbursement for services provided to students.

BACKGROUND

Throughout the early twentieth century, American industrialists and organized labor recognized that worker illness led to lost productivity (Owen, 2009). Presidents Roosevelt, Truman, Eisenhower and Kennedy supported a national medical insurance plan financed via social security payroll taxes (Owen, 2009). In 1965, President Lyndon B. Johnson signed legislation authorizing Medicare and Medicaid, the first national medical insurance plan (Owen, 2009). Created in 1997, the Children’s Health Insurance Program (CHIP) provides affordable healthcare coverage to low-income children not eligible for Medicaid (U.S. Government Accounting Office, 2013). In 2010, President Barack Obama signed comprehensive health reform into law. The ACA aims to expand coverage, improve the healthcare delivery system and control healthcare costs (U. S. Government Printing Office, 2010).

This law also requires health insurance providers to provide “minimum essential benefits” to all Americans, regardless of their health status, age, gender or other pre-existing conditions for any plan offered through an employer or on the health insurance exchange. These benefits include the following:

- Ambulatory services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorders services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care (Bagley & Levy, 2014).

Additionally, the ACA reauthorized CHIP through 2015 (Foxhall, 2014). Beginning in 2016, states that cannot afford to sustain CHIP coverage are required to ensure that CHIP-eligible children be covered either by Medicaid or a health plan available from the health insurance exchange. Under the ACA, states have the option to receive a federal match to expand Medicaid to children and families with household incomes at or below 138 percent of the federal poverty level (Hahn & Sheingold, 2013). In states that do not accept Medicaid expansion, families with incomes below 100 percent of the federal poverty level and who are not currently eligible for Medicaid will not
have access to health insurance (Hahn & Sheingold, 2013). Americans whose household incomes range from 100 to 400 percent of the federal poverty level will have the option to purchase a health plan on the health insurance exchange and may qualify for federal tax subsidies to help offset the cost of premiums. Research demonstrates that mortality rates decrease when Medicaid coverage is expanded; thus a state’s failure to expand Medicaid eligibility has the potential to significantly impact overall community and individual health (Hahn & Sheingold, 2013).

RATIONALE

NASN supports access to quality health care for all children, including the essential health benefits provided by the ACA. Research studies estimate that 25 percent of children and adolescents in the United States have chronic health conditions (Halfon & Newacheck, 2010) and that more than 7 percent, or 1 out of every 14 children, are without health insurance (Martinez & Cohen, 2013, U.S. Department of Health and Human Services, 2012). Rates of uninsured (9.3 percent) and under insured (34.3 percent) are higher for children with special healthcare needs (Child and Adolescent Health Measurement Initiative [CAHMI] 2012).

School nurses are healthcare professionals with the skills and expertise to assist students and their families in accessing health insurance, to provide vital health services to students and to coordinate care with other healthcare providers. Inclusion of the school nurse as the leader of the school health team ensures that health is prioritized in the school environment and that school health services are a part of the larger continuum of health care across all settings. School nursing interventions that promote healthy lifestyles choices as the norm have a lasting impact to influence overall student health (Frieden, 2010). Recent studies show that every dollar invested in school nursing saves $2.20 overall (Wang et al., 2014). Furthermore, by working to the fullest extent of their education and training (IOM, 2011), school nurses have the knowledge and skill to:

- Promote population health and the prevention of chronic diseases;
- Coordinate health care among students, families and healthcare providers;
  - Reduce the number of emergency room visits;
  - Provide transitional care to prevent re-hospitalization;
  - Serve as the liaison between families of children with chronic disease and their primary healthcare providers;
- Provide critical primary (e.g., health education, immunizations), secondary (e.g., health screenings) and tertiary (e.g., chronic disease management) care to students;
- Assist in efforts to enroll families for insurance coverage;
- Advocate for and enable improved overall health care for students;
- Advocate for meaningful use of the abundance of school nursing data and promote full utilization of electronic health records;
- Assess student health conditions and provide appropriate care in the educational setting; and
- Assess, plan and implement programs to impact school community health outcomes.

CONCLUSION

School nurses keep students healthy in the communities in which the students live, learn and play. NASN actively supports the position that school nursing services receive the same financial parity as other healthcare providers to improve overall health outcomes, including insurance reimbursement for services provided to students. School nurses serve a vital role in implementing the provisions of the ACA and stand ready to collaborate with students, families, and licensed healthcare providers to improve healthcare access and insurance coverage.

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Acknowledgement for Authors:
Laurie G. Combe, MN, BSN, RN
Susan Sharpe, MBA, BSN, RN
Cynthia Jo Feerer, BSN, RN, NCSN
Lynnette Onderck, ME, BSN, NCSN
Nina Fekaris, MS, BSN, RN, NCSN

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All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.
Pregnant and Parenting Students – The Role of the School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (herein after referred to as school nurse) has a crucial leadership role on the school team to support the health, well-being and educational success of pregnant and/or parenting students.

The school nurse contributes to the health and academic success of pregnant and parenting students by providing evidence-based nursing interventions. All school-based interventions and services for pregnant and/or parenting students should be age appropriate, culturally sensitive, and student centered. Adequate support is critical for achieving high school graduation and successful parenting. The interventions provided by school nurses may include assistance in pregnancy identification, referral or provision of quality prenatal care, childcare referrals, parenting education, and education regarding prevention of future pregnancy, referral to clinical services and healthcare, as well as leadership on interdisciplinary teams. The school nurse should focus on developing Individualized Healthcare Plans and work with teams to establish systems that will accommodate the student so that she/he is able to maintain school attendance ultimately leading to graduation success. School nurses should also collaborate with colleagues and advocate for comprehensive education and services to prevent the incidence of pregnancy in adolescence.

BACKGROUND

Title IX of the Education Amendment Act of 1972 intended to end sex discrimination in education and prohibits discrimination against pregnant and/or parenting students seeking an education (American Civil Liberties Union, 2015). Schools are required to provide the same level of services to services to pregnant and parenting (female and male) students who are similarly able or unable to participate in school activities (National Women’s Law Center, 2012). The overall birth rate for adolescents 15-19 years old in 2013 was 29.4 per 1,000 (U.S. Department of Health and Human Services, Office of Adolescent Health [USHHS/OAH], 2014). This is a record low for US teens, and a drop of 6% from 2011. During this same period, birth rates also fell 8% for women aged 15–17 years and 5% for women aged 18–19 years (Centers for Disease Control and Prevention [CDC], 2015). Although these trends are positive, the rate is still higher than other developed countries.

Thirty percent of adolescent girls cite pregnancy or parenthood as a primary reason for dropping out of school (Manlove, Steward-Streng, Peterson, Scott, & Wildsmith, 2013), and Hispanic and African American teen dropout rates for pregnancy are 36 and 38%, respectively (National Conference of State Legislatures, 2015). Teen mothers who have a child before age 18 are less likely to graduate (fewer than 38 percent) and only 19% earn a GED (Azar, 2012). Two of three African American teen mothers finish high school or its equivalent by age 22 (Azar, 2012). Those that are Hispanic, however, are the least likely to finish high school, with less than half finishing by age 22 (Ng & Kaye, 2012).

RATIONALE

Adolescent childbearing may significantly reduce potential educational success, especially among urban minority youth; however, poverty and its consequences may exert even more influence (Bausch, 2011). School nurses play a key role in preventing poor pregnancy outcomes (Platt, 2014) and improving educational outcomes by implementing the following nursing interventions which are evidence-based and support the health and well-being of pregnant and/or parenting students (Bausch, 2011; Azar, 2012; Johnson, 2013; USHHS/OAH, 2014):

- Provide health education;
• Recognize signs of pregnancy;
• Discuss reproductive options with the student;
• Intervene to counter pregnancy denial;
• Assist students and their families in making healthy choices;
• Offer emotional support by fostering communication between parent and [pregnant and/or parenting] student;
• Advocate for comprehensive human development and sex education;
• Develop activities that build on student assets;
• Enhance student connections to school;
• Link students to reproductive health services;
• Connect to community education regarding the consequences of adolescent pregnancy;
• Build a support network for students including the core services of:
  o Developmentally appropriate childcare,
  o Preventive health care for infants and children,
  o Case management, and
  o Economic assistance.

These interventions will also support the transition to fatherhood for adolescent males. School nurses should encourage access for adolescent male students to their children in order to support bonding which may help to prevent disengagement of young men in the parenting process and foster future involvement in their children's lives (Johnson, 2013).

CONCLUSION

Childbearing adolescents are less likely to finish high school, more likely to rely on public assistance, more likely to be poor as adults, and more likely to have children similarly affected, which consequentially affects the parents themselves, their children, and society (USHHS/OAH, 2014). This is particularly of concern for minority youth. School nurses are well positioned to identify and support at-risk students (Platt, 2014) and are leaders in health education and public health. Teen pregnancy (prevention) is a winnable public health battle (CDC, 2014). School nurses advocate for adolescent parents and play a key supportive role in their positive academic outcomes and in promoting a healthy start for their children (Johnson, 2013).

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**Acknowledgment of Authors:**

Jody A. Disney, PhD, RN, NCSN
Alicia Jordan, BSN, RN, NCSN
Joann Wheeler, BSN, RN
Jessica Porter, BSN, RN, NCSN
Patrice Lambert, MSN, RN, SNC
Mary Blackborow, MSN, RN
Sue Zacharski, MEd, BSN, RN

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*All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.*
Reimbursement for School Nursing Healthcare Services

SUMMARY

Position Statement

Children come to school with a variety of health conditions, varying from moderate health issues to multiple, severe chronic health illnesses that have a profound and direct impact on their ability to learn. The registered professional school nurse (hereinafter referred to as school nurse) provides medically necessary services in the school setting to improve health outcomes and promote academic achievement. The nursing services provided are reimbursable services in other healthcare settings, such as hospitals, clinics and home care settings. The National Association of School Nurses (NASN) believes that school nursing services that are reimbursable nursing services in other healthcare systems should also be reimbursable services in the school setting, while maintaining the same high quality care delivery standards.

Traditionally, local and state tax revenues targeted to fund education programs have paid for school nursing health services. School nurses are in a strategic position to advocate for improving clinical processes to better fit with community healthcare providers and to align reimbursements with proposed changes. Restructuring reimbursement programs will enable healthcare funding streams to assist in paying for school nursing services delivered to students in the school setting. Developing new innovative health financing opportunities will help to increase access, improve quality and reduce costs. The goal is to promote a comprehensive and cost-effective healthcare delivery model that integrates schools, families, providers and communities.

BACKGROUND

Historically, third-party payers have provided reimbursements for healthcare services, including Medicaid, the Children’s Health Insurance Program (CHIP) and private insurance companies. Medicaid, Title XIX of the Social Security Act, enacted in 1965, regulates the coverage and payment for many healthcare services. Medicaid is a federal-state funded partnership, and each state has a State Plan that defines the healthcare services covered (National Alliance for Medicaid in Education [NAME], 1997). School nurses should contact their state Medicaid agency to clarify which school nursing services may be reimbursable and to consider possibilities to amend or expand the definition. In order for Medicaid to reimburse the service, the child must be eligible based on family income or disability; the provider – or school nurse – must be qualified to provide the service; and the service must be a covered reimbursable Medicaid service. The place of service, such as the setting of a school district, should not preclude payment for a reimbursable service.

CHIP is a program designed to cover uninsured children in families who do not qualify for Medicaid. Private insurance companies often align the benefits of insurance coverage with the benefits of coverage paid for under Medicaid, and many private insurance companies have contracts with their state Medicaid agency to coordinate benefits for children enrolled in Medicaid. Medicaid sets the standard for coverage of benefits and reimbursement (Lowe, 2012).

IEP Health-related Nursing Services

Nursing services provided as a “related service” under the Individualized Education Program (IEP) are covered reimbursable services. Specifically, these are school nursing services provided to children in special education. The federal law, Individuals with Disability Education Improvement Act (IDEIA) (2004), stipulates that if a child is receiving a related service, the state Medicaid agency must assume the financial responsibility prior to the local education agency (LEA).

EPSDT

Some school districts provide nursing services under Early Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT is a mandatory set of services and benefits for individuals under the age of 21 enrolled in Medicaid (Title XIX of the Social Security Act of 1965, Revised 1984). This is the only area in the current law in which Medicaid can reimburse for preventive services. Some school districts may offer EPSDT services to reduce barriers to healthcare
disparities and ensure children have access to needed healthcare services. EPSDT provides for early identification, assessment and treatment of healthcare conditions.

Vaccines
To ensure immunization compliance, some school districts provide immunizations to Medicaid-eligible children under the federal Vaccines for Children (VFC) Program. The vaccines are offered free of charge; however, school districts receive reimbursements for the assessment and administration of the vaccinations. Some school districts provide influenza vaccinations, which are also reimbursable.

Nurse Practitioner Services
Many school districts hire advanced practice nurses as school nurses – or, in addition to school nurses – such as pediatric nurse practitioners and family nurse practitioners, to provide primary care services, including chronic disease management. EPSDT services and treatment of minor illnesses. School districts should be intentional in harnessing opportunities to include nurse practitioners in the school setting. This is a cost-effective way to expand access where children learn and play and to provide primary care in coordination with other health providers. Nurse practitioners can also manage and prescribe medication if allowed under their state nurse practice acts and coordinate with registered nurses in the school to reduce unnecessary healthcare utilization, such as emergency room visits. Providing these services in school also helps to reduce health-related barriers to learning, thereby improving overall outcomes.

School-based Health Centers
Many models exist for school-based health centers. Some school districts provide in-kind space for school-based health centers, and community agencies provide and receive reimbursements for the services. Other school districts may hire the providers for a school-based health center, and the district receives the reimbursements. There may also be a variety of hybrid models, which provide advanced practice nursing services. It is worth exploring innovative ways to complement the care provided by school nurses, by offering an additional comprehensive range of services through a sustainable mechanism.

Chronic Disease Management
School nurses provide chronic disease management to children during the school day for asthma, diabetes, attention deficit hyperactivity disorder (ADHD), hearing disorders and many other chronic health conditions. Management of chronic health conditions are healthcare services that are reimbursable in other healthcare delivery systems. The Healthy Learner Model is an evidenced-based model for chronic disease management, which promotes a healthy learner through the provision of quality evidenced-based practice nursing services; leadership to provide capacity building that includes training and mentoring for the school nurse; and collaboration between the professional school nurse, healthcare provider, and the family (Erickson, Splett, Mullett, & Heiman, 2006). Effective chronic disease management includes a key component of care coordination. Managing chronic diseases and coordinating care may lead to a reduction in emergency department visits, decreased absences from school, improved student health outcomes and overall cost savings.

Administrative Claiming
School districts may claim “administrative activities” provided by school nurses under Medicaid, which are costs to administer the state Medicaid plan. This includes Medicaid outreach and facilitating Medicaid enrollment. School nurses in many states are participating in time studies for reimbursement for Medicaid administrative claiming (NAME, 2003). Examples of some school nursing services that may be eligible for reimbursement include, but are not limited to, assisting a student and/or family in completing and processing Medicaid enrollment forms; informing potential Medicaid eligible students and their families about the services provided by Medicaid; providing information about EPSDT; referring an individual or family to apply for Medicaid benefits; providing assistance in implementing health/medical regimes; coordinating health-related services; and making referrals for a student to receive necessary health/medical evaluations or examinations. School nurses should contact their state Medicaid agency for further information about administrative claiming in schools.

Affordable Care Act (ACA)
Schools and school nurses are in a unique position to engage in health reform implementation. The law, known as the Affordable Care Act (ACA, 2010), has three major goals: expanding access, improving quality and reducing costs. The ACA includes provisions, which will help more children obtain healthcare coverage, end lifetime and
most annual limits on care, allow young adults under 26 to stay on their parents’ health insurance, provide children and adults access to recommended preventive services without additional costs, and prohibit insurance companies from denying coverage due to pre-existing health conditions. The ACA presents an opportunity to transform the way we deliver care in this country by exploring various models of integrated and coordinated care, which improve quality, expand access and save money – with a particular focus on investing in evidence-based strategies that promote wellness and disease prevention.

504 Students
Section 504 of the Rehabilitation Act of 1973(34C.F.R. 100, 104, 106, 28C.F.R. 35) is a federal civil rights statute that assures individuals will not be discriminated against based on their disability. All school districts that receive federal dollars must comply with 504. The U.S. Department of Education, Office of Civil Rights (OCR) administers 504. A student with a physical or mental impairment that causes substantial limitation of a major life activity, such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Related services must be provided without cost to these students, including medication administration, medication management and chronic disease management. Funds available from any public or private agency may be used to meet the requirement of providing related services. An insurer or similar third party, such as medical assistance, has a valid obligation to pay for services provided to a handicapped person (34C.F.R. 104.33). Many states have passed legislation related to chronic disease management of diabetes and anaphylaxis. Best practice in establishing reimbursement for these students is to follow the practice guidelines of the state Medicaid agency that is in compliance with other health care providers in the community. Reimbursement in a school setting should not be more restrictive than for community healthcare providers. The setting should not preclude a denial for reimbursement. The emphasis should be on the provision of quality healthcare services provided by qualified providers.

RATIONALE

The responsibility of a school system is to provide quality education for our children. However, in order for children and adolescents to be successful learners, they must have their healthcare needs met. According to Julia Lear, author of Health at School: A Hidden Health Care System Emerges from the Shadows (2007), the time is ripe for school-community healthcare collaboration.

Local and state tax dollars often fund school health services. Although there is no comprehensive data that demonstrates actual healthcare spending at school, conservative estimates put annual expenditures around $10.4 billion (Lear, 2007). School nurses must take a leadership role in making the case that innovative health financing proposals, including restructuring existing reimbursement programs, will support, expand and promote access to health services. Harnessing healthcare funding to assist in paying for school nursing services delivered to students in the school setting is the only sustainable way forward. School nurses are keenly aware of the health needs of students and possess the expertise, assessment skills and judgment to provide direct, comprehensive health services for students. School nurses contribute to their local communities by helping students stay healthy, in school, and ready to learn and keeping parents and families at work. Ensuring that our children have a healthy and successful future will equip them to become productive citizens in society. This is the message that school nurses need to convey to their local, state and national policymakers, elected officials, school administrators and other stakeholders.

CONCLUSION

The Robert Wood Johnson Foundation publication, Charting Nursing’s Future – Unlocking the Potential of School Nursing: Keeping Children Healthy, In School and Ready to Learn (2010), aptly illustrates school nursing as a “hidden system” of health care. The reality is that school nurses serve on the frontlines as this nation’s safety net for our most vulnerable children. School nurses can help to address some of the nation’s most pressing health concerns while delivering quality, cost-effective health care. School districts that restructure revenue streams can use these dollars to support the delivery of health services, which ultimately will help to eliminate or reduce health-related barriers to learning and improve academic achievement.

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**Acknowledgement of Authors:**
Janet Lowe, MA, RN, CNP
Joan Cagginello, MS, RN
Linda Compton, MS, RN

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*All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.*
Use of Restraints, Seclusion and Corporal Punishment in the School Setting

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is an essential advocate for the health and well-being of all students. Promoting a safe and secure environment is vital to the educational success and emotional development of children. The use of restraints, seclusion or corporal punishment can potentially cause injury or death. Restraint and seclusion should only be used as a brief intervention where there is the risk of imminent danger to the child, staff, or classmates and only where permitted by law (Mohr, LeBel, O’Halloran, & Preustch, 2010; USDE, 2012). In addition, school nurses are in a position to promote alternative non-violent forms of positive behavior support in the school setting.

BACKGROUND

In May 2009, the United States Government Accountability Office (USGAO) published a report citing the lack of consistency in state laws governing seclusion and restraint in the school setting (USGAO, 2009). The report highlighted cases that led to the physical injury and death of students (USGAO, 2009) and the lack of background checks and adequate training for those in supervisory positions (USGAO, 2009). The report described or defined restraints and seclusion as follows:

- Physical restraint -- prevention, by personnel, of the ability for a student to move freely;
- Mechanical restraint -- any device that is intended to restrict movement except equipment that has been prescribed by a healthcare professional; and
- Seclusion -- the involuntary, solitary separation of a student to an area where he or she is physically prohibited from leaving.

In March 2010, the United States House of Representatives passed H.R. 4247, “The Preventing Harmful Restraint and Seclusion in Schools Act” (later amended to “Keeping All Students Safe Act”) (Civic Impulse, 2014a) prohibiting the use of mechanical or chemical restraints or any restraint that restricted breathing. The report defined chemical restraint as follows:

- A drug or medication used on a student to control behavior or restrict freedom of movement that is not—
  (i) Prescribed by a licensed physician or other qualified health professional acting under the scope of the professional’s authority under state law for the standard treatment of a student’s medical or psychiatric condition; and
  (ii) Administered as prescribed by the licensed physician or other qualified health professional acting under the scope of the professional’s authority under state law.

The law also required that physical restraint and seclusion should not be included in a student’s individual education plan (IEP) although such measures may be written into the crisis plan of a school “provided that such school plans are not specific to any individual student” (Civic Impulse, 2010a, p. 14). The act was amended in October 2010 after complaints were issued by a number of disability organizations, citing a “double standard of accountability” (LeBel, Nunno, Mohr & O’Halloran, 2012, p. 77) specifically aimed at those students with behavioral disorders. In April 2011, the United States House of Representatives refiled the bill as H.R. 1381 and retained the
name “Keeping All Students Safe Act” (Civic Impulse, 2014b). To provide support and information for school districts, educators, and parents on how to implement a safe learning environment for all students, the United States Department of Education (USDE) published a set of guidelines entitled Restraint and Seclusion: Resource Document (USDE, May 2012).

Corporal punishment-- which is currently allowed in 19 states-- can also adversely affect students’ self-image, can lead to anxiety and depression, can result in physical harm, inhibits the development of appropriate social skills, can cause lack of involvement in school work, and is possibly linked to domestic violence (Han, 2011; Rollins, 2012). The “Ending Corporal Punishment in Schools Act of 2014” was introduced to 113TH CONGRESS 2D SESSION. It describes corporal punishment as generally involving paddling or striking students with a wooden paddle, which can lead to abrasions, bruising, muscle injury or life threatening hemorrhages (Civic Impulse, 2015).

**RATIONALE**

The role of the school nurse is to advance the well-being, academic success, and lifelong achievement of students (NASN, 2010). To that end, school nurses provide leadership in:

- Recognizing that restraining/secluding a student either directly or indirectly is contrary to the fundamental goals and ethical traditions of nursing (American Nurses Association [ANA], 2012);
- Recognizing that corporal punishment places students at risk for negative outcomes that include physical injury, increased aggression, altered social development, and mental health issues (Rollins, 2011);
- Facilitating optimal development and positive response to interventions;
- Assessing the physical and mental health needs of students;
- Identifying the meaning and/or purpose of student behavior;
- Providing therapeutic health interventions to prevent and/or de-escalate harmful behavior and/or potential health problems;
- Developing and promoting health, safety, and wellness policies and training needs of staff as they relate to behavioral interventions while facilitating a healthy environment;
- Providing care coordination linking the student, family, healthcare provider and school;
- Actively collaborating with others to build student and family capacity for adaptation, self-management, self-advocacy, and learning;
- Supporting the development of policy that includes staff training for the prevention of restraints in school settings to address violent and other unwarranted behaviors;
- Recognizing that students are more likely to achieve when they:
  - Have clear expectations and routines,
  - Are acknowledged for positive behavior, and
  - Are treated in a manner that preserves their human dignity (ANA, 2012; USDE, 2012);)
- Recognizing that school nurses should advocate for reduction of the use of restraint/seclusion and the elimination of corporal punishment in schools by:
  - Encouraging the use of policies and procedures to keep students and school personnel safe (LeBel et al., 2012),
  - Identifying the meaning/purpose of student behavior, which may lead to the use of restraint/seclusion (USDE, 2012),
  - Promoting a systematic approach to assessment, intervention and evaluation as the best means of response to behavior (ANA, 2012), and
  - Recognizing that adequate consistent staffing ratios in all classrooms are necessary, especially in at-risk classrooms (USDE, 2012),
- Recognizing that schools should provide prevention strategies, including positive behavioral support training and de-escalation methods for all school staff and administrators (USDE, 2012);
- Recognizing that schools should have clear policies related to the brief use of restraint/seclusion, where there is the risk of imminent danger to the child, staff or classmates, including the reporting process to alert parents/guardians and appropriate school staff (USDE, 2012); and
• Recognizing that, if restraint/seclusion must be utilized to protect the safety of the student, staff or fellow classmate:
  o It should be a developmentally appropriate method of restraint used in the least restrictive manner (ANA, 2012),
  o The child should be closely monitored on a one-to-one basis, and
  o It should be used only in accordance with applicable law.

Organizations that utilize restraints/seclusion should keep and analyze data about such use to provide constructive insight about how to decrease the need for such measures and promptly implement appropriate remediation.

CONCLUSION

NASN recognizes that restraining or secluding a student, either directly or indirectly, can potentially cause injury or death. Where there is the risk of imminent danger to the child, staff or classmates, and the law permits NASN supports schools developing specific policies related to brief use of restraints/seclusion and the use of alternative non-violent forms of positive behavior support in the school setting. School nurses are leaders within their schools and communities and are positioned to support the implementation of the USDE recommendations while advocating for policies that promote a safe and secure learning environment for students.

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**Acknowledgement of Authors**
Lynnette J. Ondeck, MEd, BSN, RN, NCSN

**Acknowledgement of 2014 Authors:**
Elizabeth Clark, MSN, RN, NCSN
Linda Compton, MS, RN
Georgene Westendorf, MPH, BSN, NCSN
Sue Buswell, MSN, BSN, RN, NCSN
Elizabeth Chau, SRN, RN

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*All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.*
Role of the Licensed Practical Nurse/Licensed Vocational Nurse in the School Setting

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the Licensed Practical Nurse or Licensed Vocational Nurse (LPN/LVN) can be a valuable member of the school health team led by the registered professional school nurse (hereinafter referred to as school nurse). The LPN/LVN performs nursing functions and shared nursing responsibilities, according to the scope of practice outlined by the nurse practice act of the state in which the LPN/LVN is licensed, and under the supervision of the school nurse (Schwab, Hootman, Gelfman, Gregory, & Pohlman, 2005).

BACKGROUND

LPNs/LVNs are nurses who complete a 12-month program offered through vocational high schools or community colleges followed by passing the state licensure exam. Their practice is guided by state nurse practice acts that outline the scope of their practice and include working under the supervision of a registered nurse (RN). Each state’s nurse practice act regulates the scope and practice of both the RN and the LPN/LVN (Laubin, Schwab, & Doyle, 2013). Registered nurses complete two to four years of pre-service preparation at a community college or university followed by passing the state licensure exam.

The demand for health services in schools has increased over the last few decades partly because of an increased number of students with special healthcare needs and disabilities. In the school setting, there are increasing numbers of students with disabilities and chronic conditions (i.e. intellectual disability, hearing impairment, speech or language impairment, visual impairment, emotional disturbance, orthopedic impairment, autism, traumatic brain injury, other health impairment, learning disability, asthma, diabetes, seizures and life-threatening food allergies) requiring nursing services. The needs of the students may include medication administration, care coordination for students with chronic disease, intermittent catheterization, tracheostomy care and suctioning, gastrostomy care and feedings, skin assessment, positioning, or equipment monitoring (Caldart-Olson & Thronson, 2013).

Federal regulations define the right of students with special health needs to receive the services they need to attend public school, including school health services. The laws guarantee access to education and support services for special education and regular education students with disabilities and with special healthcare needs (Gibbons, Lehr, & Selekman, 2013). Individuals with Disability Education Improvement Act (IDEIA) (2004), Rehabilitation Act of 1973 (§504) (2000), and the Americans With Disabilities Act of 1990 (ADA) (2000) are three federal laws that stipulate that students with special healthcare needs have the right to be educated with their peers in the least restrictive environment (Gibbons et al., 2013). These students also have the right to receive support and accommodations for conditions that adversely affect their capacity for learning (Schwab et al., 2005).

RATIONALE

Sharing some nursing tasks provides the school nurse an opportunity to fully implement the school nurse role including development of Individualized Healthcare Plans and carrying out the health education and case management tasks (Fleming, 2011). In order to safely create an effective school health team and determine the appropriate use of nursing resources, the school nurse should consider the following action steps:
1. Complete nursing assessments for students with disabilities and chronic conditions in the school, and determine the individual healthcare needs.

2. Examine the unique parameters of the state’s nurse practice act – the definitions of scope of practice. These state-specific statutes will determine what nursing tasks the LPN/LVN can carry out in that state (American Nurses Association [ANA], 2012).

3. Review if the LPN/LVN can work independently. Some nurse practice acts preclude an LPN/LVN from functioning independently because in these states an LVN/LPN can only work under the direct supervision of a registered nurse. In states such as these, LPNs/LVNs may only be assigned to positions where they have onsite supervision by a registered nurse such as one-on-one nursing services or a second nurse in large high schools.

4. Determine which nursing tasks and actions can be appropriately assigned or delegated in accordance with state nurse practice acts to the LPN/LVN. Some examples include medication administration, delegated student-specific tasks, and assisting in managing the minor injuries and illness complaints that make up a large portion of health room visits.

5. Plan for the process of RN supervision based on the number of students served and the acuity of the needs of the students served. The state’s nurse practice act will outline requirements for RN supervision. Consider whether onsite supervision is required or if one RN may supervise more than one school (National Association of State School Nurse Consultants & NASN, 2012).

CONCLUSION

LPNs/LVNs can be a valuable part of school health teams that provide nursing services to meet the increasing number and acuity of student healthcare needs. The RN leads the school health team, performs the nursing assessment and develops the Individualized Healthcare Plan (IHP). The RN is the professional accountable for assessing the individual student healthcare needs and determining who has the capability and competence to provide appropriate care for the student (Resha, 2010). The scope of practice of LPNs/LVNs may include implementing the IHP and administering medications under RN supervision according to state nurse practice acts. LPNs/LVNs must work closely with the school nurse so that the healthcare needs and safety of all students are provided for during the school day. As more children with special healthcare needs enter the school system, the roles of the school nurse and the LPN/LVN become even more critical in assuring the rights, safety, and educational experiences of all students.

REFERENCES


Individuals with Disability Education Improvement Act (2004), 20 U.S.C. 1400 et seq.


Related NASN Position Statements:

Role of the School Nurse (2011)

Education, Licensure, and Certification of School Nurses (2012)
http://www.nasn.org/portals/0/positions/2012pseducation.pdf

Acknowledgment of Authors:
Jessica Porter, BSN, RN, NCSN
Anne Coyle, BSN, RN, NCSN
Cheryl-Ann Resha, EdD, MSN, RN, FNASN
Joan Cagginello, MS, BSN, RN

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The Role of the 21st Century School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that every child has access all day, every day to a full time registered professional school nurse (hereinafter referred to as school nurse). The school nurse serves in a pivotal role that bridges health care and education. Grounded by standards of practice, services provided by the school nurse include leadership, community/public health, care coordination, and quality improvement (NASN, 2016a).

BACKGROUND

The practice of school nursing began in the United States on October 1, 1902, when Lina Rogers, the first school nurse, was hired to reduce absenteeism by intervening with students and families regarding healthcare needs related to communicable diseases. After one month of successful nursing interventions in the New York City schools, she led the implementation of evidence-based nursing care across the city (Struthers, 1917). Since that time, school nurses continue to provide communicable disease management, but their role has expanded and is increasingly diverse.

A student’s health is directly related to his or her ability to learn. Children with unmet health needs have a difficult time engaging in the educational process. The school nurse supports student success by providing health care through assessment, intervention, and follow-up for all children within the school setting. The school nurse addresses the physical, mental, emotional, and social health needs of students and supports their achievement in the learning process.

Students who are medically fragile or who deal with chronic health issues are coming to school in increasing numbers and with increasingly complex medical problems that require complicated treatments commonly provided by the school nurse (Lineberry & Ikes, 2015). Chronic conditions such as asthma, anaphylaxis, type 1 and type 2 diabetes, epilepsy, obesity, and mental health concerns may affect the student’s ability to be in school and ready to learn.

The National Survey of Children with Special Healthcare Needs has determined that 11.2 million U.S. children are at risk for chronic physical, developmental, behavioral, or emotional conditions. These students may require health related services in schools (U.S. Department of Health and Human Services, Maternal and Child Health Bureau, 2013).

School nurses address the social determinants of health, such as income, housing, transportation, employment, access to health insurance, and environmental health. Social determinants are identified to be the cause of 80% of health concerns (Booske, Athens, Kindig, Park, & Remington, 2010). In the United States, nearly one quarter of children attending school live in households below the federal poverty level (United States Census Bureau, 2014). Children from lower income families have a more difficult time accessing medical treatment for chronic diseases (Perrin, 2014).

RATIONALE

School nursing is a specialized practice of nursing that advances the well-being, academic success, and lifelong achievement and health of students. Keeping children healthy, safe, in school, and ready to learn should be a top priority for both healthcare and educational systems. With approximately 50.1 million students in public
elementary and secondary schools, educational institutions are excellent locations to promote health in children (National Center for Education Statistics, n.d.) and the school nurse is uniquely positioned to meet student health needs.

Leadership
School nurses lead in the development of policies, programs, and procedures for the provision of school health services at an individual or district level (NASN, 2016a), relying on student-centered, evidence-based practice and performance data to inform care (Robert Wood Johnson Foundation, 2009). Integrating ethical provisions into all areas of practice, the school nurse leads in delivery of care that preserves and protects student and family autonomy, dignity, privacy, and other rights sensitive to diversity in the school setting (American Nurses Association [ANA] & NASN, 2011).

As an advocate for the individual student, the school nurse provides skills and education that encourage self-empowerment, problem solving, effective communication, and collaboration with others (ANA, 2015a). Promoting the concept of self-management is an important aspect of the school nurse role and enables the student to manage his/her condition and to make life decisions (Tengland, 2012). The school nurse advocates for safety by participating in the development of school safety plans to address bullying, school violence, and the full range of emergency incidents that may occur at school (Wolfe, 2013).

At the policy development and implementation level, school nurses provide system-level leadership and act as change agents, promoting education and healthcare reform. According to the ANA (2015b), registered nurses believe that it is their obligation to help improve issues related to health care, consumer care, health, and wellness. Educational preparation for the school nurse should be at the baccalaureate level (NASN, 2016b), and school nurses should continue to pursue professional development and continuing nursing education throughout their careers (Wolfe, 2013).

Community/Public Health
School nursing is grounded in community/public health (Schaffer, Anderson, & Rising, 2015). The goal of community/public health moves beyond the individual to focus on community health promotion and disease prevention and is one of the primary roles of the school nurse (Wold & Seleman, 2013). School nurses employ cultural competency in delivering effective care in culturally diverse communities (Office of Minority Health, 2013).

The school nurse employs primary prevention by providing health education that promotes physical and mental health and informs healthcare decisions, prevents disease, and enhances school performance. Addressing such topics as healthy lifestyles, risk-reducing behaviors, developmental needs, activities of daily living, and preventive self-care, and the school nurse uses teaching methods that are appropriate to the student’s developmental level, learning needs, readiness, and ability to learn. Screenings, referrals, and follow-up are secondary prevention strategies that school nurses utilize to detect and treat health-related issues in their early stage (NASN, 2016a). School nurses provide tertiary prevention by addressing diagnosed health conditions and concerns.

Student absences due to infectious disease cause the loss of millions of school days each year (Centers for Disease Control and Prevention, 2011). Based on standards of practice and community health perspective, the school nurse provides a safe and healthy school environment through control of infectious disease, which includes promotion of vaccines, utilization of school-wide infection control measures, and disease surveillance and reporting. Immunization compliance is much greater in schools with school nurses (Baisch, Lundeen, & Murphy, 2011).

The school nurse strives to promote health equity, assisting students and families in connecting with healthcare services, financial resources, shelter, food, and health promotion. This role encompasses responsibility for all students within the school community, and the school nurse is often the only healthcare professional aware of all the services and agencies involved in a student’s care.

Care Coordination
School nurses are members of two divergent communities (educational and medical/nursing), and as such are able to communicate fluently and actively collaborate with practitioners from both fields (Wolfe, 2013). As a case manager, the school nurse coordinates student health care between the medical home, family, and school. The school nurse is an essential member of interdisciplinary teams, bringing the health expertise necessary to develop a student’s Individualized Education Plan or Section 504 plan designed to reduce health related barriers to learning (Zimmerman, 2013). Creating, updating, and implementing Individualized Healthcare Plans are fundamental to the school nurse role (McClanahan & Weismuller, 2015).

School nurses deliver quality health care and nursing intervention for actual and potential health problems. They provide for the direct care needs of the student, including medication administration and routine treatments and procedures (Lineberry & Ickes, 2015). Education of school staff by the school nurse is imperative to the successful management of a child with a chronic condition or special healthcare need and is codified as a role of the school nurse in the Every Student Succeeds Act (2015).

Current school health practice models and school nurse workloads may require school nurses to delegate healthcare tasks to unlicensed assistive personnel in order to support the health and safety needs of students (Shannon & Kubelka, 2013). However, the availability of school nurses to work directly with students to assess symptoms and provide treatment increases students’ time in the classroom and parents’ time at work (Lineberry & Ickes, 2015).

Quality Improvement

Quality improvement is a continuous and systematic process that leads to measurable improvements and outcomes (Health Resources and Services Administration, 2011) and is integral to healthcare reform and standards of practice (Agency for Healthcare Research and Quality, 2011). Continuous quality improvement is the nursing process in action: assessment, identification of the issue, development of a plan of action, implementation of the plan, and evaluation of the outcome. Data collection through this process is a necessary role of the school nurse.

Formal school nursing research is needed to ensure that delivery of care to students and school communities by the school nurse is based on current evidence. School nurses utilize research data as they advocate and illustrate the impact of their role on meaningful health and academic outcomes (NASN, 2016a).

CONCLUSION

It is the position of NASN that school nurses play an essential role in keeping children healthy, safe, and ready to learn. The school nurse is a member of a unique discipline of professional nursing and is often the sole healthcare provider in an academic setting. Twenty-first century school nursing practice is student-centered, occurring within the context of the student’s family and school community (NASN, 2016a). It is essential that all students have access to a full time school nurse all day, every day (American Academy of Pediatrics, 2016).

REFERENCES


**Acknowledgement of Authors:**
Sue A. Buswell, MSN, RN, NCSN
Julia Lechtenberg, MSN, RN, NCSN
Elizabeth Hinkson, MSN, RN, NCSN
Teresa Cowan, BSN, RN
Laurie G. Combe, MN, RN, NCSN
Nina Fekaris, MS, BSN, RN, NCSN
Elizabeth Chau, SRN, RN

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Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the unique combination of school nursing services and school-based health centers (SBHCs) facilitate positive health outcomes for students. The registered professional school nurse (hereinafter referred to as school nurse) is responsible for management of the daily health needs of the student population. SBHCs, operating as medical clinics, complement the work of school nurses by providing a readily accessible referral site for students who are without a medical home. School nurses work collaboratively with SBHCs to provide an array of health services to keep students healthy, in school, and ready to learn. School nurses and SBHCs both function as health safety nets for children in need (Robert Wood Johnson Foundation [RWJF], 2010; Bavin, 2012) and should collaborate to provide comprehensive health care to students.

BACKGROUND

School nursing began in the early 1900s with Lena Rogers addressing attendance issues created when students were excluded unnecessarily from school (Keeton, Soleimanpour, & Brindis, 2012). SBHCs were established during the 1970s to provide medical services to those students who could not afford or access primary health care. There is a distinct difference in the services provided by school nurses and the SBHC. The School Based Health Alliance (SBHA) and NASN agree that SBHCs do not duplicate or replace school nursing services (RWJF, 2010). School nurses are part of the hidden healthcare system (RWJF, 2010). School nurses have been shown to save medical care costs as well as parent and teacher productivity (Wang et al., 2014). School nurses are responsible for the day-to-day health of students and the larger school community through (Cornell & Seleman, 2013; RWJF, 2010):

- management of chronic disease and life-threatening health conditions,
- individual and population-based disease surveillance,
- health promotion,
- assistance in securing insurance and healthcare providers,
- preparation for and response to medical emergencies,
- care for students dependent on medical technology,
- mental health services,
- screenings and referrals,
- immunization compliance,
- medication management,
- healthcare planning and education,
- follow-up care, and
- care coordination.

SBHCs provide a variety of healthcare services to meet the unique needs of the community in which they reside; thereby overcoming barriers of a diverse range of clients (Keeton, Soleimanpour, & Brindis, 2012). These services may include primary care, comprehensive health assessments, treatment of acute illness and prescriptions for medications (Barnett & Allison, 2012). SBHCs improve access to care by removing barriers that may include (Guo, Wade, Pan, & Keller, 2010):

- financial (lack of insurance or low income),
- providers who will accept the student’s insurance,
- lack of transportation to appointments,
- scheduling conflicts, and
- parent/guardians work schedules.

Both school nurses and SBHCs have shown a direct impact on educational outcomes such as attendance. School nurses send home 13% fewer students than unlicensed school personnel (Pennington & Delaney, 2008). Bonaiuto (2007) demonstrated that students who have access to school nurse case management had improved attendance rates. Students enrolled in SBHC services had a significant decrease in the number of early dismissals from school when compared to students who did not have access to SBHCs (Van Cura, 2010).

**RATIONALE**

School nurses provide the critical link between the education system, students, families, the school community, the community at-large, and the medical community. School nurses are leaders in the school community, providing oversight for the health and safety of the students through school health policies and programs. SBHCs provide the school nurse with a referral site for needed medical intervention. Within that framework, the school nurse functions as part of the healthcare team by advocating for development of SBHCs and facilitating student access to the full array of services provided by the SBHC. In addition, school nurses refer and coordinate care for students enrolled in SBHCs. School nurses should have input into the development of SBHCs in their school systems and should sit on advisory boards for SBHCs (Cornell & Selekman, 2013).

The school nurse and the SBHC staff should work collaboratively to develop a shared case management structure, to coordinate nursing and treatment care plans for students who require follow-up, and to collect data to study outcomes and cost effectiveness of care. The collaboration between the school nurse and the SBHC staff includes the development of policies and systems that ensure the quality and confidentiality of care received by students and the implementation of wellness and disease prevention programs to improve health outcomes for all members of the school community (Cornell & Selekman, 2013).

**CONCLUSION**

School nurses are leaders in the school community, providing oversight for the health and safety of the students through school health policies and programs. SBHCs provide primary medical care that may include dental and mental health services. Together, school nurses and SBHCs work to provide for medical needs and promote health in school so that students are ready to learn. School nurses are the critical link between the education system, students, families, community, and medical care. School nurses and SBHC staff should work as partners to develop policies, collect data and evaluate processes to improve health outcomes for the students and communities they serve.

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Acknowledgement of Authors:
Lynnette Ondeck, MEd, BSN, RN, NCSN
Laurie Combe, MN, BSN, RN
Rita Baszler, BSN, RN
Janet Wright, BSN, RN, NCSN

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School Nurse Workload: Staffing for Safe Care

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that daily access to a registered professional school nurse (hereinafter referred to as a school nurse) can significantly improve students’ health, safety, and abilities to learn. To meet the health and safety needs of students, families, and school communities, school nurse workloads should be determined at least annually, using student and community specific health data.

BACKGROUND

School nurse-to-student ratios were first recommended in the 1970s, when laws were enacted to protect the rights for all students to attend public school, including those with significant health needs. Those laws included The Rehabilitation Act of 1973, Section 504 (2000) and Public Law 94-142, the Education for all Handicapped Children Act (1975), reauthorized in 2004 as the Individuals with Disabilities Education Improvement Act [IDEIA], (2004). Although evidence to support ratios was limited, some states and NASN recommended one school nurse to 750 students in the healthy student population; 1:225 for student populations requiring daily professional nursing services; 1:125 for student populations with complex healthcare needs; and 1:1 for individual students requiring daily, continuous professional nursing services (American Nurses Association [ANA]/NASN, 2011). While a ratio of one school nurse to 750 students has been widely recommended and was acknowledged in Healthy People 2020 (U.S. Department of Health and Human Services [USDHHS], 2014a) and by the American Academy of Pediatrics [AAP] (2008), a one-size-fits-all workload determination is inadequate to fill the increasingly complex health needs of students and school communities (AAP, 2008; ANA/NASN, 2011).

In addition to the laws that established rights for children with disabilities to attend school, medical advances have increased the number of students with special healthcare needs in schools. The Centers for Disease Control and Prevention (CDC) (2013) estimates that one in eight children are born prematurely, are more likely to have neurologic deficits and cognitive delays, and need lifetime health accommodations and/or require academic accommodations (Martin & Osterman, 2013; World Health Organization [WHO], 2012; Zirkel, Granthom, & Lovato, 2012). Students diagnosed and treated for cancer (American Cancer Society, 2012) or other life-threatening conditions such as congenital heart disease (American Heart Association 2014) return to schools sooner and often require special nursing care. Students who in the past would have been cared for in therapeutic settings now attend and must receive care in schools (Fauteux, 2010). Furthermore, the percentage of students who have chronic conditions such as asthma and diabetes, which require health care at school, has increased significantly (Van Cleave, Gortmaker, & Perrin, 2010; CDC, 2011a).

A growing body of evidence also indicates the impact social determinants have on health and the ability to address health concerns (CDC, 2014a). Where and how children live and play impacts their health. Shifting cultural, economic, political and environmental influences result in students and school communities with frequently changing health and social needs. These factors include economic instability, international strife, globalization, immigration, violence, and natural disasters (Weeks et al., 2013). The U.S. 2010 census revealed that the number of people who spoke a language at home other than English more than doubled between 1980 and 2010 (Ryan, 2013), and communication barriers challenge access to health care (Meyer, 2012). Global travel brings students in contact with infectious diseases such as H1N1 influenza, polio, Middle East Respiratory Syndrome (MERS), measles, and Ebola virus (CDC, 2010, 2012, 2014b, 2014c, 2014d). Increased mental health problems in students result from stress, disaster, and trauma (Chau, 2012; Harvard Educational Review, 2011; National Association of School Psychologists, 2012; WHO, 2012). Poverty continues to be a concern. Lower socioeconomic status is linked to poor health outcomes due to stressed environmental conditions, risky health behaviors, and limited access to
Appropriate additional care was identified as primary locations to address student health issues, and the school nurse is often the healthcare provider that a student sees on a regular basis (Albanese, 2014; The Patient Protection and Affordable Care Act, 2010; Institute of Medicine [IOM], 2011, 2012). School nursing is a key component of the coordinated school health framework and is included in the Whole School, Whole Community, Whole Child model (ASCD, 2014; CDC, 2014e).

Appropriate school nurse staffing is related to better student attendance and academic success (Cooper, 2005; Moricca et al., 2013). When there is a school nurse present, a principal gains nearly one hour per day and teachers an extra 20 minutes a day to focus on education instead of student health issues (Baisch, Lundeen, & Murphy, 2011; Hill & Hollis, 2012). Baisch, Lundeen, & Murphy (2011) found that increased school nurse staffing resulted in improvements in immunization rates, vision correction, and identification of life-threatening conditions. Wang et al. (2014) determined that for every dollar spent for school nursing, $2.20 was saved in health care procedures and parent time away from work. Full-time school nurses in the schools studied by Wang et al. (2014) were attributed to preventing excess medical costs and to improved parent and teacher productivity.

Inadequate staffing can lead to adverse consequences (Kerfoot & Douglas, 2013). For example, the lack of access to a school nurse, who could have identified declining health status and provided or obtained necessary care, may have contributed to the 2014 deaths of two students in Philadelphia schools (Boyle, 2014; Superville & Blad, 2014). Insufficient staffing also leads to inconsistent care of students and to increased nurse turnover, which results in additional costs to school districts (American Association of Colleges of Nursing, 2014; Duffield et al., 2011; Hoi, Ismail, Ong, & Kang, 2010).

RATIONALE

The determination of adequate nurse staffing is a complex decision-making process (ANA, 2014; Weston, Brewer, & Peterson, 2012). Individual state laws which regulate nursing practice to protect public health, safety and welfare must be followed. Student acuity status must be determined, as well as student care needs, including medications, health procedures, care coordination, case management, and staff training / supervision. In addition, a community health needs assessment will identify the social determinants that impact the health of students so that school nurses and administrators can plan to address those needs. Social determinants of community health and health disparities must be accounted for when determining school nurse staffing including how students and their families are affected by (CDC 2011b, 2014a; Fleming, 2011; Meyer, 2012; USDHHS, 2014b):

- Health behaviors, health condition and disease prevalence, immunization levels;
- Socioeconomic status, employment, education level;
- Housing status, food security, transportation access;
- Social and cultural supports and influences, discrimination;
- Access to healthcare, health insurance, and social services;
- Environmental stresses; and
- Language and communication barriers.

RECOMMENDATIONS
NASN and the National Association of State School Nurse Consultants (NASSNC) (2012, 2014) assert that every student needs direct access to a school nurse so that all students have the opportunity to be healthy, safe, and ready to learn. In order to achieve adequate school nurse staffing, NASN recommends:

- Using a multifactorial health assessment approach that includes not only acuity and care but also social determinants of health to determine effective school nurse workloads for safe care of students.
- Developing evidence-based tools for evaluating factors that influence student health and safety and for developing staffing and workload models that support this evidence.
- Conducting research to determine the best models for school nurse leadership in school health, such as RN only, RN-led school health teams, and RNs certified in the specialty practice of school nursing.
- Increasing involvement of school nurses at national, state, and local levels in policy decisions that affect the health of students.

CONCLUSION

NASN believes that school nursing services must be determined at levels sufficient to provide the range of health care necessary to meet the needs of school populations. Social determinants of health and student health care needs must be considered when implementing appropriate school nurse staffing and workloads. Maintaining the health and safety of students is critical to the educational success and well-being of our nation’s children.

Related NASN Position Statements

- Role of the School Nurse (2011)

- School Nurse Role in Electronic School Health Records (2014)

- Child Mortality in the School Setting (2012)

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**Acknowledgement of Authors** (listed alphabetically):
Rosemary Dolatowski, MSN, RN
Patricia Endsley, MSN, RN, NCSN
Cynthia Hiltz, MS, RN, LSN, NCSN
Annette Johansen, MEd, RN, NCSN
Erin Maughan, PhD, MS, RN, APHN-BC
Lindsey Minchella, MSN, RN, NBCN, FNASN
Sharonlee Trefry, MSN, RN, NCSN

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All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.
School-located Vaccination

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that reaching high vaccination coverage of school-age children and their families, as outlined in Healthy People 2020 (U.S. Department of Health and Human Services [USDHHS] Office of Disease Prevention and Health Promotion, 2010a) is an important public health objective. NASN further recognizes there is a shortfall in meeting these goals for many of the vaccines recommended, in particular for adolescents and adults (Centers for Disease Control and Prevention [CDC], 2012a, 2012b).

National guidance from the National Vaccine Plan (strategy 4.2.4) (USDHHS, 2010b) and the Community Preventive Services Task Force (2009) call for enhancing access to vaccination in non-healthcare settings, such as schools. School-located vaccination (SLV) can augment other emerging alternative vaccination sites.

The registered professional school nurse (hereinafter referred to as school nurse) is in a critical position to create awareness, influence action, and provide leadership in the development of SLV programs. School nurses play a pivotal role in the success of SLV through their familiarity with the school environment, community attitudes and beliefs, students’ preexisting health conditions, and their established relationships with parents/guardians. The development of the school as a vaccination site also enhances community preparedness for possible mass vaccinations in the event of an influenza pandemic or other emergency (CDC, 2007; Stinchfield, 2008).

BACKGROUND

Historically, SLV has been shown to enhance vaccine uptake. In 1875, New York City used schools to deliver the smallpox vaccine. Schools were again utilized in the 1950s to deliver the Salk polio vaccine. In 1969, schools held vaccine clinics to administer the rubella vaccine and again in the 1990s, to conduct Hepatitis B catch-up clinics (Mazyck, 2009; Duffy, 1978; Lambert & Markel, 2000; Hodge & Gostin, 2002). More recently, SLV clinics were held for varicella vaccines, and in 2009 there was widespread use of schools to administer the H1N1 vaccine (Wright, 2010).

However, broad adoption of a modern SLV has been slow. Reasons for this are varied, but a major reason is that the widespread morbidity and mortality caused by vaccine-preventable diseases have faded from memory. This is largely due to the effectiveness of vaccines over the past several decades.

On November 16 and 17, 2010, a cross-sector, interdisciplinary meeting was co-hosted by NASN, the National Association of City and County Health Officials and the Association of State and Territorial Health Officials in Washington, D.C. Participants were drawn from organizations representing public health, education, medical practice, government agencies, patient advocacy and industry. The group identified two key challenges to developing, sustaining and expanding SLV: 1) funding (ensuring adequate resources and reimbursement for immunizations) and 2) documentation (tracking and communication of immunization histories to the medical home) (Bobo, Etkind, & Talkington, 2010).

RATIONALE

School-located vaccination provides an opportunity to address the challenges associated with vaccinating a large number of children, a short window of time for vaccination, and the need for annual revaccination by bringing the
vaccines to where the children are (Effler et al., 2010; McCauley, Fishbein, & Santoli, 2008). The school is an ideal place to reach the 52 million children from all cultures, socioeconomic and age groups that attend each day; and the school is conveniently located in a familiar and trusted community environment. This directly benefits the immunized children and the resulting herd immunity provides indirect protection to families, unimmunized classmates, school staff, and the broader community (Cawley, Hull, & Rousculp, 2010).

One strategy to improve immunization rates in the United States is to capitalize on the trusted position of schools and school nurses and to establish SLV. The school nurse can play a critical role in planning SLV because of understanding both the needs of public health and education. For example:

- School nurses have experience collaborating with community partners including local and state public health departments, school officials, other nurses, teachers, emergency planning authorities, child health agencies, families, community leaders and local healthcare providers. The school and public health partnership is a familiar model for the delivery of health care in many communities. This collaboration is key to successful SLV.
- School nurses are considered a trusted source of health information by school boards and school officials. They can educate these groups on the impact of vaccination on school attendance.
- They can provide accurate information and dispel myths about vaccines because they are a trusted source of health information by families.
- They are familiar with the health status of students and thus able to mitigate potential contraindications for vaccines.
- School nurses understand the implications of FERPA and HIPAA related to recording and sharing immunization information.

In addition, schools and school nurses provide significant logistical assets for implementing SLV. For example:

- Schools have the space and capacity to host SLV (e.g., gym, library, cafeteria).
- School start and end times provide the framework for scheduling SLV, with the least disruption to the school day.
- School nurses can assist with securing volunteers, such as parents and other community partners, to assist with SLV.
- School nurses understand mandated and recommended vaccination schedules and vaccine administration.
- School nurse relationships with parents/families can be critical in obtaining consent for vaccination.
- School nurses can create SLVs as the norm to enhance community-wide emergency preparedness.

It should be noted there is a difference between a school-located and a school-based vaccination clinic. Limited resources are a reality for most schools, making it impossible to shoulder the burden of fully implementing a school-based vaccination clinic (i.e., salaries for personnel, securing the vaccine, storing the vaccine, coordinating reimbursement). A school-located (also referred to as school-placed) vaccination clinic, by definition, requires collaboration between the school and community (i.e., health department, local hospital, or other outside entity) (Mazyck, 2009; CDC, 2010).

Immunization reduces disease among children and adults and is cost-saving to society (Schmier, Li, King, Nichol, & Mahadevia, 2008). SLV clinics can increase immunization compliance, keep students in school and parents/guardians at work while increasing the immunization rates of school-age children (Williams et al., 2012). Schools and school nurses need to be recognized as playing an important role in non-emergent and emergency prevention of vaccine-preventable disease.

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**Acknowledgement of Authors:**

Nichole Bobo, MSN, RN
Kathleen C. Rose, MHA, RN, NCSN
Christine Tuck, MS, BSN, RN, NCSN
Jennifer Garrett, BSN, RN, CPN, CSN

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*All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.*
School-Sponsored Trips, Role of the School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses, that the registered professional school nurse (hereinafter referred to as school nurse) is in a unique position to support students so that their individual healthcare needs are met both at school and on school-sponsored trips. The school nurse has the nursing background to appropriately assess the proposed school-sponsored trip to determine the accommodations needed to allow all students to safely participate in activities. All students, including students with special healthcare needs, have the right to participate in school-sponsored trips (also referred to as field trips). School nurses must serve a role in the planning and coordination for all school-sponsored trips, including those off-campus, so that all students with healthcare needs remain healthy and safe. This planning process includes making accommodations for healthcare needs, determining required medications and treatments, and preparing for potential emergencies.

BACKGROUND

Schools offer school-sponsored trips to enhance the educational experience for students or to reward class accomplishments. A trip may be as simple as a local excursion for just a few hours or as complicated as a trip for several days/ nights to a different city, state or country. While schools may invite parents/guardians of the student with healthcare needs to accompany the student on the trip, school officials cannot mandate that they attend.

Three federal laws provide important protection to students with disabilities. Section 504 of the Rehabilitation Act of 1973 and Title II of the American Disabilities Act of 1990 (ADA) are civil rights laws that prohibit discrimination against individuals with disabilities. The Individuals with Disabilities Education Improvement Act (IDEIA), reauthorized in 2004, mandates a free and appropriate education in the least restrictive environment for those students who qualify for special education services (U.S. Department of Education, 2011). All schools that receive federal monies are subject to follow Section 504 and the ADA Act (Gibbons, Lehr, & Selekman, 2013). Many states have additional laws that provide supplementary protections for students.

Estimates indicate that in the United States, 26.6% of children have special healthcare needs (Van Cleave, Gortmaker, & Perrin, 2010). Of these children, 86% receive prescribed medication, 52% require specialty medical care, 33% require vision care, 25% require mental health services, 23% require specialty therapies and 11% require the use of medical equipment (U.S. Department of Health and Human Services, 2008).

“The level of nursing or healthcare services required for a student in the classroom is, at a minimum, the same level of care that the student requires during school programs outside of the classroom” (Hootman, Schwab, Gelfman, Gregory, & Pohlman, 2005, p. 223). As the number of students with specialized healthcare needs increases, it is critical that all school systems develop policies to address the provision of safe and competent health services for students while they are away from school buildings for school-sponsored trips (Kentucky Department of Education, 2012).

RATIONALE

A system should be in place to engage the school nurse in all planning phases of the school-sponsored trip to ensure that all necessary accommodations are in place. Currently, the costs associated with providing these accommodations are the responsibility of the school district and must be considered in the initial planning phases of a proposed school-sponsored trip (Foley, 2013). The school nurse should perform an individual health assessment and develop the IHP at the beginning of the school year to appropriately plan safe care for students
with medical needs throughout the school year, including the potential for off-campus school-sponsored trips. The student’s healthcare needs on field trips are determined through a collaborative process coordinated by the school nurse, reviewed annually and include a nursing assessment, the healthcare provider orders and information provided by the family (Moses, Gilchrest, & Schwab, 2005). The IHP outlines the plan for meeting the healthcare needs of the student at school and during school-sponsored trips, and is utilized to create emergency care plans (ECP). Behrmann (2010) states “although children with food allergy have a serious medical condition, their allergy should not result in their exclusion from events, such as field trips” (p. 186). This is true for all students with health needs.

The school nurse’s knowledge about the individual needs of the students place him/her in a unique position to coordinate care that enables the student to fully participate in a safe and healthy school-sponsored trip experience. Planning steps may include:

- Assessing the transportation method, determining the food that will be served, the staff whom will be present, the layout of the planned visitation site, duration of the trip, and proximity to emergency medical care.
- Addressing medication, medical treatments and procedures required during the trip, as well as the potential for health emergencies.

If allowed by state law, including applicable state nurse practice acts, and district policy/procedures, the school nurse may consider delegating some tasks to a non-nurse, school staff member such as a teacher, utilizing the American Nurses Association’s Principles for Delegation by Registered Nurses to Unlicensed Assistive Personnel (UAP), which includes a nursing decision tree (ANA, 2012). If the school nurse who is familiar with the student’s health condition and treatment determines that medical care cannot legally or safely be delegated, a school nurse may need to accompany the student (Prenni, 2009), and an additional school nurse may need to cover the school health office.

If the school-sponsored trip takes place in a different state or country, plans must be in place to meet the nursing license and practice laws of that state or country. The Nurse Licensure Compact (NLC) allows nurses to have one multistate license, with the ability to practice in both their home state and other party states. A nurse who holds a license issued by a state that is not a member of the NLC has a single-state license that is only valid in that state. They must request and receive permission from the respective state’s board of nursing, to practice in another state (NCSBN, 2012). Even if a trip is in a compact state, the nurse must still know the nursing laws/regulations of that state and practice accordingly, regardless of whether she/he is delegating tasks to a non-nurse school staff member or actually attending the school-sponsored trips and performing the necessary health services (NCSBN, 2011). If the nurse is traveling to another country, the nurse must consult with the consulate of the visiting country for permission to practice nursing (K. Erwin, personal communication, 3/14/13).

**CONCLUSION**

School-sponsored trips can be some of the most memorable experiences for students. Administrators, school staff, families and students must work closely with the school nurse to so that the healthcare needs and safety of all students are provided for during school-sponsored trips. As more children with specialized healthcare needs enter the school system, the role of the school nurse becomes even more critical in assuring the rights, safety and educational experiences of all students.

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Acknowledgment of Authors:
Kathleen C. Rose, MHA, RN, NCSN
Christine M. Tuck, MS, BSN, RN, NCSN
Alicia L. Burrows-Meze, MSN/Ed, BSN, BSc, RN

2012 Issue Brief Authors:
Lauren Mazzapica, BSN, RN
Janice Seleman, DNSc, RN, NC
Carmen Teskey, MA, RN, LSN

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All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.
School-Sponsored Before, After and Extended School Year Programs:
The Role of the School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) has the educational and clinical background to coordinate the necessary school health services to provide students with the same health, nutrition, and safety needs while attending school-sponsored before, after, and extended school year programs as the students receive during the traditional school day/year. In 2010, the White House Task Force on Obesity called for an increase in access to safe supervised physical activities beyond the school day (White House Task Force on Childhood Obesity Report to the President, 2010); and, as these programs have expanded, the necessity for providing quality, effective healthcare services during these hours has developed. As the expert in school health services delivery models of health care, the school nurse is an essential facilitator for student access to these programs. The school nurse plays a vital role in preparing the school-sponsored before and after school and extended school year program personnel with the necessary resources to respond to a health emergency.

BACKGROUND

Each afternoon throughout the United States, 15 million children -- more than a quarter of our child population - are alone and unsupervised after school (Afterschool Alliance, 2009). Research continues to support the premise that students who receive adult supervision and additional learning opportunities outside of the traditional school day show improved academic achievement, are less likely to engage in unhealthy behaviors, and have a better attitude toward school (Centers for Disease Control and Prevention [CDC], 2009). Students continue to have the same health, nutrition, and safety needs when enrolled in school programs that occur beyond the traditional school day. School-sponsored extended school year programs and before and after school programs that are a part of the school system should, at a minimum, engage the school nurse to act in an advisory capacity to address these student needs (Afterschool Alliance, n.d.).

RATIONALE

On-site, school-sponsored before and after school programs, as well as extended school year programs, are on the increase in school districts across the United States primarily due to funding from federal, state, and local monies. No Child Left Behind mandated before, after, and summer school programs for students in low performing schools starting in 2002, and currently over 1.6 million students across the United States benefit from these programs (Afterschool Alliance, 2013.) Programs are offered to all students, including students receiving special education services and those with identified health conditions. School nurses will likely have such programs in their local school districts. The Scope and Standards of Practice for School Nurses (American Nurses Association [ANA]/National Association of School Nurses [NASN], 2011) promotes a safe and healthy environment; therefore, the school nurse should function as both a resource and an advocate for health-related issues in the school setting, including school-sponsored before, after, and extended school year programs. The staff planning and providing these school-sponsored programs will need consultation on various medical concerns, including response to health-related emergencies, disaster preparedness, first aid, CPR, recognition of signs and symptoms of child abuse and neglect, and procedures for protecting against blood borne pathogens. The school nurse should be engaged by program leaders to provide this consultation. Students with special healthcare needs may require nursing services beyond the regular school day; and supplies, staff, and nursing services for providing these additional services should be considered.
In on-site, school-sponsored extended school year and before and after school programs, the school nurse may explore the use of delegation to provide effective healthcare services, if allowable, according to the State Nurse Practice Act. Delegation is defined as the assignment of the performance of a nursing activity to a non-nurse. Accountability remains with the registered nurse. State laws and regulations must be followed and standards of school nursing practice must be upheld (ANA & NASN, 2011). The implications of appropriate delegation of nursing tasks for school nurses center around four major themes: development of school policies, competence in the five rights of delegation, education, and relationship building (Resha, 2010).

When engaged by school-sponsored extended school year and before and after school program leaders, the school nurse can provide expertise on a variety of issues faced by school staff, including but not limited to:

- Maintaining confidentiality,
- Management of chronic diseases, such as asthma and diabetes,
- Management of health care for children with disabilities,
- Management of allergy exposure and anaphylaxis,
- Management of seizures,
- Management of medication administration,
- Management of communicable diseases,
- Nutrition and food safety issues,
- Mental health and substance abuse issues and referrals,
- Environmental safety issues, and
- Management of medical emergencies and disaster preparedness.

The school nurse should ensure emergency response plans are in place to address health-related events that could occur either at school or during school-related activities in the school setting, including before, after, and extended school year programs. Emergency preparedness must be a priority every day. When the school nurse is not available at the school, the school nurse often remains responsible for training and developing plans for use by others serving the school (Cosby, Miller, & Youngman, 2013). Successful integration of students who are dependent on medical technology requires a coordinated effort among the school nurse, educational staff, primary care physician, family, and -- when appropriate -- the student (Raymond, 2009).

CONCLUSION

School nurses are the healthcare experts in their buildings and should be engaged with program leaders to take an active role in this process outside the school day as well as during the more traditional school day. When involved with on-site, school-sponsored before, after, and extended school year programs, the school nurse will advance the academic achievement of participating students by promoting the health and safety aspects of these programs. It is imperative, therefore, that the school nurse is an active participant in providing guidance to school-sponsored program staff so they can intervene with actual and potential health problems experienced by the students in attendance. In order to achieve this, the school nurse should recommend any necessary budgetary resources needed to ensure supplies, staff, and programs are made available for the safe delivery of health care, including delegating nursing-related tasks as directed by their state nurse practice act and – when agreed upon – providing direct nursing services.

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**Acknowledgement of Authors:**
Elizabeth Clark, MSN, RN, NCSN
Sue Ann Buswell, MSN, RN, NCSN
Judith Morgitan, MEd, BSN, RN
Linda Compton, MS, RN
Georgene Westendorf, MPH, BSN, NCSN, CHES
Elizabeth Chau, SRN, RN

**2012 Issue Brief Authors:**
Barbara Yow, MEd, BSN, RN, NCSN
Cynthia Hiltz, MS, RN, LSN, NCSN
Lynn Rochkes, MS, BSN, RN, NCSN
Connie Board, BSN, RN, NCSN

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*All position statement from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.*
School Violence, Role of the School Nurse in Prevention

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that registered professional school nurses (hereinafter referred to as school nurses) advance safe school environments by promoting the prevention and reduction of school violence. School nurses collaborate with school personnel, healthcare providers, parents, and community members to identify and implement evidence-based educational programs promoting violence prevention. The curriculum used should improve students’ communication, behavior management, and conflict resolution skills. School nurses assess and refer at-risk students in need of evaluation and treatment for symptoms of aggression and victimization.

BACKGROUND

Violence is defined as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation” (World Health Organization [WHO], 2013, para. 2). School violence is youth violence that occurs on school property, on the way to and from school or school-sponsored events, or during a school-sponsored event. A young person can be a victim of, a perpetrator of, or a witness to school violence (CDC, 2013). School violence includes fighting/assaults (with or without weapons by two or more-individuals); bullying; physical, sexual and psychological child abuse; dating violence; and violence against oneself-(intentional non-suicidal self-injury) (Selekman, Pelt, Garnier, & Baker, 2013). Violence against oneself, such as cutting and self-mutilation or cutting, can take many forms and often have a psychological basis. Rather than an expression of violence, these are expressions of deep pain and the attempts to control or express that pain (Selekman et al., 2013).

School violence may be reduced by advancing a school environment that supports zero tolerance for weapons of any kind, focusing on anger-management, and counseling for the victim, aggressor and bystanders. School violence has an impact on the social, psychological, and physical well-being of students and staff. It disrupts the teaching-learning process through fear, intimidation, absenteeism, or class disruption and affects the victim, the aggressor and the bystanders (Johnson, 2009; Selekman et al., 2013). In 2009, 4 percent of students age 12-18 reported that they were afraid of an attack or harm at school, and 4 percent of students avoided either a school activity or one or more places in the school because of fear of being attacked or harmed. According to Robers, Zhang, Truman, & Snyder (2010), preliminary data show that there were 33 school-associated violent deaths from July 1, 2009, through June 30, 2010. Of the 33 student, staff, and nonstudent school-associated violent deaths, 25 were homicides; 5 were suicides; and 3 were legal interventions. In 2009-10, about 74 percent of public schools recorded one or more violent incidents of crime; 16 percent recorded one or more serious violent incidents; and 44 percent recorded one or more thefts. In 2010, there were about 828,000 nonfatal victimizations at school, which include 470,000 victims of theft and 359,000 victims of violence (simple assault and serious violence). Staff safety is also a concern with 10 percent of teachers threatened by injury.

Male students are at a higher risk of violent incidents resulting in death and non-fatal injuries (Kaya, Bilgin, & Singer, 2011). However, violence involving females has increased significantly; girls now account for 30 percent of juvenile arrests (Zahn et al., 2010). Dating violence, a pattern of actual or threatened acts of physical, sexual, and/or emotional abuse, perpetrated by an adolescent against a current or former dating partner, frequently occurs on school grounds and may include insults, coercion, social sabotage, and sexual harassment in addition to threats and/or acts of physical or sexual abuse (A Safe Place, n.d.). School shootings, while rare, are often committed by students or former students who experienced persistent bullying, persecution, threats, or injuries by peers (Reuter-Rice, 2008). The Centers for Disease Control and Prevention (CDC) (2012) found that violence and bullying may have a negative effect on health throughout life. Indicators of School Crime and Safety: 2011 cites that during the 2009-10 school year:

- 23 percent of public schools reported that bullying occurred among students on a daily or weekly basis;
- 8 percent of public schools reported that cyber-bullying had occurred among students daily or at least once a week at school or away from school;
- 9 percent reported student acts of disrespect for teachers other than verbal abuse on a daily or weekly basis;
- 5 percent reported that student verbal abuse of teachers occurred on a daily or weekly basis; and
- 16 percent reported gang activities during the school year (Robers et al., 2012).

Teen victims are more likely to be depressed, do poorly in school, have eating disorders, and engage in other unhealthy behaviors such as drug and alcohol use. Lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth who experience high levels of school victimization in middle and high school report impaired physical and mental health in young adulthood. This includes depression, suicide attempts requiring medical care, sexually transmitted diseases (STDs) and risk of HIV (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011).

RATIONALE

The ultimate goal of the school nurse is prevention of violence and the prioritization of safety for students, staff and the school community as a whole. This involves providing education to the school community in problem solving and conflict resolution skills, recognizing early warning signs that lead to violence and factors outside of the school setting that might predispose a child to violent behavior or threaten students’ safety. School nurses have the expertise to assist students in developing problem-solving and conflict resolution techniques, coping and anger management skills, and positive self-images. School nurses are able to serve on school safety and curriculum committees, identifying, advocating and implementing prevention programs within the school community. School nurses possess the knowledge to be active members of crisis intervention teams to address violent situations in the school setting. School nurses can be involved in curriculum committees that identify and implement evidence-based intervention and prevention programs. School nurses are able to support the efforts of administration to provide and maintain security; offer programs to parents that support building skills in the areas of communication, problem-solving, and monitoring of their children; and assist in the development of district and school discipline policy or code of conduct documents. School nurses are able, individually and through their national association, to assess and address violent behavior (Jacobson, Reisch, Temkin, Kedroski, & Kluba, 2011). When violence occurs, school nurses are positioned to intervene, working collaboratively to change the dynamics of the crisis situation (Reuter-Rice, 2008).

School nurse interventions to prevent violence include the following:

- Facilitate student connectedness to the school community (Greene, 2008).
- Engage parents in school activities that promote connections with their children, and foster communication, problem-solving, limit setting, and monitoring of children.
- Support activities and strategies to help establish a climate that promotes and practices respect for others and for the property of others.
- Support policies of zero tolerance for weapons on school property, including school buses.
- Advocate for adult monitoring in the hallways between classes and at the beginning and end of the school day (Blosnich & Bossarte, 2011), and the assignment of staff to monitor the playground, cafeteria, and school entrances before and after school.
- Serve as positive role models, developing mentoring programs for at-risk youth and families.
- Educate students and their parents about gun safety (Selekman et al., 2013).

When violence occurs, school nurse interventions to address violent behaviors include their ability to:

- Coordinate emergency response until rescue teams arrive;
- Provide nursing care for injured students;
- Apply crisis intervention strategies that help de-escalate a crisis situation and help resolve the conflict;
- Identify and refer those students who require more in-depth counseling services’ and
- Participate in crisis intervention teams.

School nurses recognize the multiple factors that may increase or decrease a youth’s risk of becoming a perpetrator or victim of school violence, and school nurses are able to identify students at risk. The CDC (2011) has identified potential risk factors and protective factors that may determine whether or not a student may become a perpetrator or victim, including individual and family characteristics.
CONCLUSION

School nurses promote violence prevention by:

- assisting in the creation of a school environment of safety and trust where students are assured that caring, trained adults are present and equipped to take action on their behalf;
- engaging in classroom discussions that facilitate respectful communication among students and staff; and
- advancing education of the school community that builds skills in communication, problem-solving, anger management, coping and conflict resolution (Jacobson et al., 2011).

Advancing a peaceful school environment requires time, attention to detail, and community education. The individual, family, and society all have significant roles in successful violence prevention in the school community (Kaya, Bilgin, & Singer, 2011).

REFERENCES


Acknowledgement of Authors:
Christine Tuck, MS, BSN, RN, NCSN
Joan B. Cagginello, MS, BSN, RN
Kathleen C. Rose, MHA, RN, NCSN

2012 Issue Brief Authors:
JoAnn D. Blout, RN, NCSN
Kathleen C. Rose, MHA, RN, NCSN
Mary Suessmann, MS, BSN, RN, NJ-CSN
Kara Coleman, BSN, RN, CPN, CCRN
Janice Selekman, DNSc, RN, NC

Resource: Please also see NASN’s *Violence in Schools Resource at* http://www.nasn.org/ToolsResources/ViolenceinSchools

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*All position statements from the National Association of School Nurses will automatically expire five years after publication unless renewed and recommended for position statement development.*
SUMMARY

It is the position of the National Association of School Nurses that the registered professional school nurse (hereinafter referred to as school nurse) is an essential member of the team participating in the identification and evaluation of students who may be eligible for services through the implementation of Section 504 of the Rehabilitation Act and the Individuals with Disabilities Education Improvement Act (IDEIA, formerly IDEA). School nurses are the link between the medical and educational communities and are a primary resource to the school team (Zirkel, Granthom, & Lovato, 2012).

BACKGROUND

Section 504 of the Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794 § 504) is a federal civil rights law that prohibits discrimination against individuals on the basis of disabilities and guarantees access to federally funded programs, including public school, for disabled individuals. The Office for Civil Rights (OCR) is the federal administrative agency within the U.S. Department of Education charged with implementing the law and monitoring compliance (U.S. Department of Education [USDE], Office for Civil Rights [OCR], 2011). Section 504 along with IDEIA provides a comprehensive process in accommodating students with disabilities (Sampson & Galemore, 2012.)

In September 2008 the U.S. Congress passed the American with Disabilities Act (ADA) Amendments Act effective on January 1, 2009, in an effort to broaden the definition of a disability. “Section 504 and the ADA define disability as (1) a physical or mental impairment that substantially limits a major life activity; (2) a record of such impairment; or (3) being regarded as having such impairment ( 29 U.S.C. § 705(9) (B); 42U.S.C. § 12102(1))” (USDE, 2012, p.2). The Amendments Act does not change these basic elements but rather broadens them to be more inclusive. In addition, the Amendments Act provides a list of major life activities or major bodily functions, which are examples and are not limited to these lists (USDE, 2012).

The Section 504 regulations provide a framework for school district policy and procedure.

- Public, private, parochial and postsecondary education institutions must comply if they receive any form of federal funding (Sampson & Galemore, 2012).
- Schools must identify students who may have disabling conditions (Child Find).
- Schools must establish standards and procedures for evaluation of disabled students and eligibility determination.
- Schools must meet individual needs of disabled students to insure they have the same access to education as non-disabled students.
- Identification of students and determination of their individual eligibility for accommodations are to be a collaborative process accomplished by a school-based 504 team.
- Anyone can make a referral for evaluation of a student’s eligibility.

Services provided under a Section 504 plan are meant to provide the student with disabilities a Free and Appropriate Public Education (FAPE). “Such an education consists of regular or special education and related aids and services designed to meet the individual educational needs of students with disabilities as adequately as the needs of students without disabilities are met”(USDE, 2011. p. 1).
Individuals with Disabilities Education Improvement Act

The Education for All Handicapped Children Act (EHA), now known as the Individual with Disabilities Education Improvement Act (IDEIA), was passed as law in 1975 as IDEA and revised in 1997 and again in 2004 to IDEIA. This law established national standards for the free appropriate public education of children with disability-related learning problems in the least restrictive environment.

The focus of the 2004 amendment revision includes awareness of 1) the mislabeling and higher dropout rates among minority children with disabilities, 2) the increased number of minority children served in special education compared to the general school population, 3) the discrepancies in the number of minority children referred and placed in special education services, and 4) the schools that serve mainly white students and also have mostly white teachers. (This combination tends to place disproportionately higher numbers of minority children in special education [Dang, 2010]).

Careful consideration needs to be given when using the terms disability and developmental disability. A disability can be defined as “general limitations in a physical, mental, or sensory function caused by one or more health conditions” (Dang, 2010, p. 253) and a developmental disability is defined as “a severe, chronic disability that begins any time from birth through age 21 and is expected to last for a lifetime” (Dang, 2010, p. 253). Disabilities can be cognitive, physical, or a combination of both (Dang, 2010).

IDEIA 2004 mandates that states look at the individual student’s response to scientific, researched-based intervention when determining whether a student has a specific learning disability. Response to Intervention (RTI) is a three-tiered intervention process that assists schools in identifying students who are at risk of a learning disability. A student does not need to complete all three levels of RTI before an evaluation for special education is completed and should not be a reason for delaying a referral (NICHCY, 2012).

The definition of school nurse was expanded and re-named in amendments made in 2004. In section 300.34(c) (13), the terms school nurse services and school health services were clarified. In this version, school nurse services are defined as services provided by a qualified school nurse and school health services can be defined as services provided by either a qualified school nurse or person otherwise deemed qualified (USDE, 2012).

RATIONALE

School nurses have been identified as integral members of multiple disciplinary teams. They use their expertise to identify students who have possible health, socio-emotional or developmental issues that put them at greater risk of learning issues, and by contributing to the individual health and educational plans.

The school nurse’s role in the 504 or IDEA process may include (Gibbons, Lehr, & Selekmman, 2013, p. 269-270):

- Assisting in identifying children who may need special educational or health-related services.
- Assessing the identified child’s functional and physical health status, in collaboration with the child, parent(s)/guardian(s), and healthcare providers.
- Developing individualized healthcare plans (IHP) and emergency care plans (ECP) based on a nursing assessment.
- Recommending to the team health-related accommodations or services that may be required.
- Assisting the team in developing an Individual Educational Plan (IEP) or 504 Accommodation Plan that provides for the required health needs of the child and enables the student to participate in his or her educational program.
- Assisting the parent(s)/guardians and teachers to identify and remove health-related barriers to learning.
- Providing in-service training for teachers and staff regarding the individual health needs of the child.
- Providing and/or supervising unlicensed assistive personnel to provide specialized healthcare services in the school setting.
• Evaluating the effectiveness of the health-related components of the IEP with the child, parent(s), and other team members, and making revisions to the plan as needed.

A school nurse who is knowledgeable of federal laws related to working with students with disabilities, long term illnesses, or other disorders can make significant contributions to the health and academic success of these students. It is the school nurse’s responsibility to understand the laws, refer students who may be eligible for the services as outlined in these laws, and participate on school teams that determine eligibility for services covered by Section 504 and IDEA. Through shared responsibility with other team members, the school nurse contributes to the planning and implementation of Individual Education Plans and Section 504 Accommodations. The student’s IHP and/or ECP are an appropriate starting point for Section 504 accommodations (Sampson & Galemore, 2012).

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Acknowledgement of Authors:

Lynnette Ondock, MEd, BSN, RN, NCSN
Kendra Selser, MHS, BSN, RN
Georgene Westendorf, MPH, BSN, RN, NCSN, CHES
Leah Wyckoff, MS, BSN, RN, NCSN

Review Committee
Susan Zacharski, MEd, BSN, RN
Carolyn Duff, MS, RN, NCSN
Cynthia Galemore, MSEd, BSN, RN, NCSN

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This document replaces the following Issue Briefs:

- School Health Nursing Services Role in Health Care Section 504 of The Rehabilitation Act of 1973 (Adopted: 2005)

For more information refer to:

- 504 and IDEA Comparison Chart, National Center for Learning Disabilities;  
  [http://www2.ed.gov/about/offices/list/ocr/504faq.htm](http://www2.ed.gov/about/offices/list/ocr/504faq.htm);
- Questions and Answers on the ADA Amendments Act of 2008 for Students with Disabilities Attending Public Elementary and Secondary Schools [http://www2.ed.gov/about/offices/list/ocr/docs/dcl-504faq-201109.html](http://www2.ed.gov/about/offices/list/ocr/docs/dcl-504faq-201109.html); and
- Protecting Students with Disabilities [http://www2.ed.gov/about/offices/list/ocr/504faq.html](http://www2.ed.gov/about/offices/list/ocr/504faq.html)

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All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.
Service Animals in School

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that registered school nurses (hereinafter referred to as school nurses) are integral to the team planning process necessary to successfully integrate “service animals” into schools. A request to bring a service animal into the school setting presents questions due to the complex disability discrimination laws, emerging medical and psychological data concerning service animal benefits (Winkle, Crowe & Hendrix, 2012), various interpretations of what criteria to use to distinguish between a trained service animal and a household pet, and potential effects on other students and staff. School nurses assess, plan, and coordinate care to develop an Individualized Healthcare Plans (IHP) for students with special healthcare needs, including students who may require the use of a service animal during the school day. Just as a student may need a wheelchair or other adaptive device, service animals are essential to some students’ ability to be at school. School nurses are leaders in the development and evaluation of school health policies and programs that address the health and safety needs of students in the school environment (ANA & NASN, 2011).

BACKGROUND

Animals that provide for the physical and mental well-being of humans are perhaps the most admired of all working animals. “Service animal” is a term that distinguishes those animals that serve individuals with physical or mental disabilities, usually on a one-on-one basis, from pets or other types of skilled animals, such as police dogs (Ensminger, 2010). The term, though primarily legal, is used quite broadly in today’s society.

In the past 20 years there has been an expansion of the diversity of service animals being utilized by persons with disabilities, with different opinions as to what truly is a “service animal”. Effective March 15, 2011, the Americans with Disabilities Act (ADA) regulations define a service animal as “a dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability” (United States Department of Justice [USDJ], 2011). In addition, there is a new, separate provision which includes miniature horses in the definition of a “service animal” if the miniature horse has been individually trained to do work or perform tasks for people with disabilities (Jacobs, 2011). Examples of such work or tasks include:

- guiding people who are blind,
- alerting people who are deaf,
- pulling a wheelchair,
- alerting and protecting a person who is having a seizure,
- reminding a person with mental illness to take medications,
- sensing and alerting a person with diabetes experiencing low blood sugar,
- calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties.

Service animals are working animals. A service animal has been trained to provide work or tasks directly related to the person’s disability. Animals whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA (USDJ, 2011). Children who may require a service animal in school are supported by the ADA regulation, Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), Individuals with Disabilities in Education Act (20 U.S.C. 1400 et seq), as well as state and local laws.

RATIONALE

School districts recognize that service animals may be used to provide assistance to some students/staff with disabilities, which includes the presence of the service animal in the school, on school property; including school buses, and at school activities. Schools have a legal responsibility to provide planning and services for children with
special healthcare needs, including allowing service animals into schools. Planning promotes quality care for students with special healthcare needs in school and enhances the student’s academic success.

Communication among the family, school, and healthcare provider is critical and may uncover adaptations or alternatives to the service animal’s presence in schools. However, if a student presents with a service animal unannounced, some educational legal experts advise to allow the animal similarly to allowing a student to use a wheelchair or crutches. In some states’ laws, neither the person nor the service animal “shall be denied right of entry and use of facilities of any public place of accommodation” (Illinois Human Rights Act, 2006).

Initial questions to ask upon receiving a request for a service animal to accompany a child in school include the following:

- Is the service animal required because of a defined disability (per Section 504 definitions)?
- Will the animal impact the student’s academic and behavioral functions to support his or her education?
- Does the student need the service animal for equal access to educational services and programs?
- What work or task has the service animal been trained to perform?
- How will the service animal alert its handler/student to an impending incident, such as an oncoming seizure or low blood glucose?
- How will having a service animal in a building affect students/staff that may have an allergy to the service animal or a distinct fear of the animal?

School district policy concerning service animals should address the following:

- Compliance with current federal, state and local laws regarding service animals in schools (Wisch, 2013).
- Written documentation from a veterinarian that the service animal is in good health and properly vaccinated. Although such documentation is not legally required, it helps confirm that the animal is safe to be around other students at the school (Virginia Department of Education, 2011).
- Provision of training for staff and students in rationale for, and interaction with, the service animal.
- Education of students, staff members and the community on the role of service animals and the laws permitting them access to public places.
- Control of the service animal in school. “Service animals must be harnessed, leashed, or tethered unless these devices interfere with the service animal’s work or the individual’s disability prevents using these devices. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls” (USDJ, 2011, para. 6).
- Schools may exclude any service animal if that animal is out of control; the animal’s handler does not take effective action to control it; or the animal is not housebroken (USDJ, 2011).

Other factors that the school should consider include the following:

- Review any existing state law regarding service animals.
- According to the law, schools are not responsible for care, including elimination needs, food or a special location for service animals (USDJ, 2011). The animal’s owner/family is responsible for the “care and supervision of the service animal” (USDJ, 2011). However, many students who have service animals are not able to provide care for their animal at school. Communication and planning between school and home are essential in making adaptations to this rule (Minchella, 2011).
- When there is more than one service animal in a school building, special arrangements should be made so the animals can meet each other in a controlled setting.
- When a miniature horse is the service animal, the type, size, and weight of the miniature horse and whether the facility can accommodate these features without compromising legitimate safety requirements that are necessary for safe operation should also be considered. Other requirements which apply to service animals shall apply to miniature horses (USDJ, 2011).
- Although many service animals wear a vest identifying them as such, there is no federal requirement that the service animal wear a harness, backpack, or vest identifying it as a service animal. In some states, such a requirement is expressly prohibited (Illinois State Board of Education, 2012).
CONCLUSION

The school nurse identifies student health issues and special needs that are relevant to the student’s educational progress and, along with the multi-disciplinary team, recommends services or program modifications that the student may need or require. The school nurse is a leader in educating, advocating, supporting placement of, and evaluating the success of these services. Communication and planning are essential in supporting the student with a service animal. The school nurse plays a key role in facilitating this communication and planning process.

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Acknowledgement of Authors:
Jennifer Garret, BSN, RN, CPN, CSN
Carmen Teskey, MA, BSN, RN
Kay Duncan, RN, MAA, CPN
Kathy Strasser, MS, BSN, RN, NCSN, LSN

Acknowledgement of 2012 Issue Brief Authors:
Christine Tuck, MS, BSN, RN, NCSN
Nina Fekaris, MS, BSN, RN, NCSN
Lindsey Minchella, MSN, RN, NCSN

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This document replaces the Issue Brief Service Animals in Schools (Adopted January 2012).

All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.
Supervision and Evaluation of the School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as the school nurse) should be clinically supervised and evaluated by a registered nurse knowledgeable of the scope and standards of practice for school nursing. The school nurse job description and performance evaluation should be based on the standards of school nursing practice, the standards of professional performance, and related competencies described in the current version of “School Nursing: Scope and Standards of Practice” (American Nurses Association [ANA] & National Association of School Nurses [NASN], 2011).

BACKGROUND

The school nurse is often the only healthcare provider in a school. However, school nurses may be supervised and evaluated by school administrators who have little or no knowledge and understanding of the school nurse role. Liability exists when school administrators, who do not fully understand the scope and standards of school nursing practice, are responsible for supervising and evaluating the clinical competency of the school nurse (Hootman, 2013; McDaniel et al., 2013).

NASN, in collaboration with the ANA, has developed standards of practice that apply to the specialty practice of school nursing. These standards provide a framework for the expansive scope of practice and authoritative statements of the duties that school nurses are expected to competently perform. To be truly meaningful, the standards statements and the accompanying competencies must be further refined to reflect the context of practice, district policies, and state nurse practice acts. The standards of practice and professional performance for school nursing provide the tools to focus on the tasks that promote the health and academic achievement of all students (McDaniel, Overman, Guttu & Engelke, 2013) and guide the evaluation of competencies needed to meet these standards.

RATIONALE

In order to meet students’ health needs and to function effectively with school and community team members, school nurses need supervision and evaluation to maintain and improve competence in this independent practice. Accurate job descriptions and an evaluation process that includes both an administrative and a clinical nursing component are essential and should be based on the standards of practice and professional performance for school nursing practice. School nurses are instrumental in creating and revising job descriptions and the competencies to be included in a performance evaluation (McDaniel et al., 2013).

Clinical Supervision

As the health needs of today’s students have increased in the school setting, school nurses have expanded their base of knowledge and skills to safely care for them (Resha, 2009). School nurses need the support provided by clinical supervision, which requires “specialized, professional knowledge, skills and related credentials for the practice of school nursing. It promotes, enhances and updates the professional growth of school nurses in terms of their professional and clinical skills and knowledge” (Connecticut State Department of Education, 2009, p. 20).

The National Association of State School Nurse Consultants’ (NASSNC) 2007 position paper supports clinical supervision of school nurses by licensed, experienced registered nurses rather than a non-nurse supervisor. NASN
and the NASSNC recommend that school nurses be supervised and evaluated by a school nurse because the integrity and quality of nursing practice is enhanced when clinical supervision is provided (Somerville, 2013)

If school districts do not have an administrator who is a school nurse, it is recommended that a designated lead school nurse provide clinical supervision.

Performance Evaluations
School nurses function as independent practitioners who are accountable under the scope of their professional license, applicable district policies and procedures and their state’s nurse practice act. For this reason, professional accountability through a performance evaluation process is essential to ensure professional competency and growth (Beirne, 2009).

In the 2008 position statement “Professional Role Competence” the ANA states,

The public has a right to expect registered nurses to demonstrate professional competence throughout their careers. ANA believes the registered nurse is individually responsible and accountable for maintaining professional competence. The ANA further believes that it is the nursing profession’s responsibility to shape and guide any process for assuring nurse competence. Regulatory agencies define minimal standards for regulation of practice to protect the public. The employer is responsible and accountable to provide an environment conducive to competent practice. Assurance of competence is the shared responsibility of the profession, individual nurses, professional organizations, credentialing and certification entities, regulatory agencies, employers, and other key stakeholders (para. 1).

Best practice requires a nurse in the role of supervisor, coach, mentor or preceptor to evaluate the clinical practice of the school nurse, identify the professional competencies outlined in the job description, and determine the need for professional development (Beirne, 2009; Hootman, 2013). Performance evaluations can also be enhanced through a process of self-evaluation and the development of a professional portfolio that documents competencies that meet standards of school nursing practice. Additional performance indicators, not related to the practice of nursing, can be evaluated by educational administrators and others (ANA & NASN, 2011; McDaniel et al., 2013).

In districts without school nurse administrators, a self-evaluation process and use of a professional portfolio become increasingly important. Contracting with a school nurse supervisor in another school district for the nursing component of a performance evaluation is recommended. School nurses without nurse administrators can take a leadership role in assisting their administration in developing a performance evaluation tool that includes a self-evaluation based on scope and standards of school nursing practice and non-nursing performance indicators. Co-development of a performance evaluation tool can increase the administration’s understanding of the school nurse role in the school setting (Green & Reffel, 2009).

CONCLUSION
Student health and safety and the continuous improvement of individual school nursing practice is the goal of performance management (Somerville, 2013), supervision and evaluation. The school nurse can “provide valuable, needed services to students if he or she has core skills and knowledge, mastery of competencies, and is supported by a supervisor who offers guidance, encourages professional development and provides evaluation” (Connecticut State Department of Education, 2009, p.25).

As the only healthcare provider in the school setting, the school nurse is often supervised and evaluated by a non-nurse staff member. According to the guidelines developed by the ANA and NASN’s (2011) scope and standards of practice, the school nurse’s performance evaluation should consist of three components: a self-evaluation completed by the school nurse, a clinical evaluation performed by another registered nurse and a non-clinical evaluation, which may be completed by a non-clinical supervisor.
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Acknowledgement of Authors:
Debra Robarge, BSN, RN, NCSN
Anne Coyle, BSN, RN, NCSN
Pat Endsley, MSN, RN
Elaine Mauter, BSN, RN

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All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.
The Use of Telehealth in Schools

SUMMARY

Telehealth has been defined as “the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration” (United States Department of Health and Human Services [USDHHS], n.d.). Telehealth enables collaboration of healthcare professionals to provide healthcare services across a variety of settings. The registered professional school nurse (hereinafter referred to as a school nurse) uses clinical knowledge and judgment to provide health care to students and staff, perform health screenings and coordinate referrals to the medical home or private healthcare provider (Wolfe, 2013). The school nurse serves in a pivotal role to provide expertise and oversight for the provision of school health services, promotion of health education, and connection between the academic setting and healthcare settings. Therefore, the school nurse is a critical link to the successful implementation and use of telehealth technology.

It is the position of the National Association of School Nurses (NASN) that telehealth technology may be used to augment school health services but not replace in-person health care provided by the school nurse.

HISTORY

The world has become increasingly reliant on a variety of technologies to manage information needs. Technology is “revolutionizing the way that health care is delivered with a steady infusion of new solutions to clinical environments” (Healthcare Information and Management Systems Society [HIMSS], 2011 p. 3). “Nurses have already taken a leadership role in embracing technology as a necessary tool to innovate the delivery of health care” (HIMSS, 2011, p. 2). School nurses need to be aware of and utilize telehealth when available to facilitate the delivery of health care in the school setting.

School-based telehealth includes using telephones, teleconferences, or web cameras in the school to connect to a distant healthcare provider. More sophisticated electronic monitoring equipment can be used in telehealth, such as an otoscope that transmits the image to a remote provider or stethoscope that transmits sounds with the goal of connecting a student with a distant health provider (The Children’s Partnership, 2009). Some school systems are experimenting and finding success with telehealth programs to extend the range of services in school health and decrease absenteeism for illness or disease-management encounters (Spooner & Gotlieb, 2007).

DESCRIPTION OF ISSUE

The use of telehealth is “increasing access to acute and specialty care for children; helping children and families manage chronic conditions; facilitating health education for children, families and school personnel; and increasing the capacity of school nurses and school-based health centers to meet the healthcare needs of students” (The Children’s Partnership, 2009, p. 2).

Telehealth includes a wide range of services delivered, managed, and coordinated by all health-related disciplines via exchange of electronic information and telecommunications technologies. The goal is that “telehealth (a term that has largely replaced telemedicine) will provide health care beyond diagnosis and treatment to include services that focus on health maintenance, disease prevention, and education” (Stokowski, 2008, p. 1). Telehealth includes both clinical and non-clinical uses. Examples of clinical telehealth are transmission of medical images for diagnoses, remote monitoring, and health advice by telephones such as teletriage. Non-clinical telehealth includes distance education, health system integration, online information, and health data management (Stokowski, 2008).
Telehealth clearly has the potential to enhance health care of all students. Families in rural or low-income areas often face barriers and challenges in obtaining healthcare services for youth because of “travel distances, lack of transportation, inability to finance care, lack of healthcare insurance, and limited access to physicians. The use of telehealth in schools mitigates some of these difficulties and allows students access to medical care” (Burke, Ott, Albright, Bynum, & Hall-Barrow, 2008, p. 927).

The challenges related to telehealth technology include quality of service, confidentiality, standards, documentation process, protocols, follow-up, parental rights, liability, jurisdiction, and cost to implement and access equipment, school policies, and coordination of services. Therefore, school nurses must partner with the regulatory and professional agencies to implement, develop and use standards for safe and effective telehealth practice. Telehealth is emerging as a valuable way to “complement and expand the capacity of schools to meet the healthcare needs of children, particularly those who are low-income and living in medically underserved areas, while keeping them in school and their parents at work” (The Children’s Partnership, 2009, p. 2).

RATIONALE

Student health and educational performance are highly interdependent. It is well documented that healthy children perform better in school; therefore, school nurses have an important role in promoting the health of children (Bonaiuto, 2007; Engelke, Guttu, Warren, & Swanson, 2008).

Technology, including telehealth, has the potential to greatly expand the services provided by the school nurse but cannot and should not replace the school nurse. School nurses need to keep current with modern technology to support and enhance their clinical practice. The school nurse serves as a liaison between students, school personnel, family, community and healthcare providers to advocate for health care and a healthy school environment (American Nurses Association (ANA) and National Association of School Nurses (NASN), 2011) and the school nurse’s involvement is critical in the application of telehealth technology in the school setting (The Children’s Partnership, 2009).

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**Acknowledgement of Authors:**

Susan Hoffmann, MSN, RN, NCSN
Rosemary Dolatowski, MSN, RN
Bernadette McDowell, MEd, BSN
Patty Mancuso, RN, BSN
Laura L. Rochkes, RN, BSN, MS, NCSN
Theresa Ernst Wavra, BSN, RN, CPN
Janice Seleman, DNSc, RN, NCSN

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Please also see NASN’s Position Statement on The Role of the School Nurse
Transition Planning for Students with Chronic Health Conditions

**Position Statement**

**SUMMARY**

It is the position of the National Association of School Nurses (NASN) that all children with chronic health conditions should receive coordinated and deliberate transition planning to maximize lifelong functioning and well-being. Transition planning refers to a coordinated set of activities to assist students with chronic health conditions to begin in school, and then move from one school to another, from hospitalization back to school, and from the secondary school system into their next stage of life (Selekman, Bocheneck, & Lukens, 2013). The registered professional school nurse (hereinafter referred to as school nurse) has the perspective and skills to provide care coordination and lead the planning team to address transitions for students with chronic health conditions.

**BACKGROUND**

Increasing numbers of children with special healthcare needs and complex medical conditions attend school on a regular basis (American Academy of Pediatrics [AAP], 2008). According to Murphy and Carbone (2011), there are 10 million U.S. children with special healthcare needs. Advances in medicine and technology allow most children with chronic conditions to reach adulthood. Changes in healthcare delivery (e.g., reduced hospital stays and increased outpatient care) have shifted the burden of care to the community (Shaw & McCabe, 2008). For example, Lotstein and colleagues (AAP, 2013) identified that youth with type 1 diabetes are at an increased risk for poor glycemic control after transition from pediatric to adult care and need additional support with moving to adult care. In 2011, the AAP reported that transition planning has been uncertain, incomplete, or late; and the transfer of care has not been clearly planned.

Federal laws support transition planning for students with chronic health conditions by requiring schools to provide students with equal opportunity to participate in academic, nonacademic, and extracurricular activities.

- The Individuals with Disabilities Education Improvement Act (IDEIA), 2010 regulations, entitles students with disabilities and those who need specialized instructions to receive the services needed to have access to a free and appropriate education (FAPE) in the least restrictive environment. IDEIA has a limited set of recognized impairments and criteria. These impairments have an adverse effect on educational performance necessitating special education, specific to learning (Zirkel, Granthom, & Lovato, 2012).

- For those students who do not qualify for services under IDEIA, Section 504 of the Rehabilitation Act (1973) requires that reasonable accommodations be provided so that the student can fully participate in the educational experience.


Eligibility under Section 504 and the ADA equates to meeting three essential elements for the definition of disability, which includes (a) physical or mental impairment that (b) substantially limits (c) one or more major life activities (Zirkel, Granthom, & Lovato, 2012).

In addition to support provided by federal law, Lineham (2010) found that planning for timely and seamless transitions should be in place to avoid interruptions of students’ access to the services needed to fully participate at school. Providing for the health needs of students with chronic health conditions and enabling them to have...
access to the same educational opportunities as their peers have positive benefits (Wideman-Johnston, 2011). These benefits include enhancing their self-identity and increasing resiliency.

RATIONALE

Transition planning includes coordinated, deliberate, and community-based strategies to ensure positive health and academic outcomes for the student with a chronic illness, disability or injury (Craig, Eby, & Whittington, 2011). The goal of transition planning is to maximize the student’s health and academic experience. Communication between the healthcare provider and school is critical to raising awareness of the transition needs of the student and determining how to best address these needs (Glang et al., 2008). For example, when transitioning a child into the school system after a prolonged hospitalization for injury or illness, both the child and the school environment must be evaluated to identify services and accommodations needed for the student to fully engage in his or her educational experience (AAP, 2008). The transition planning for adolescents with special healthcare needs transitioning to adulthood includes the development of self-management and decision-making skills to foster active participation in maintaining his/her own health (AAP, 2011).

Transition plans for students with chronic health conditions should be developed for each planned transition in collaboration with the healthcare provider, parent/guardian, student, teachers, and other appropriate school staff. According to the AAP (2008), school nurses are positioned to take the lead in making these transition plans. These plans should identify, support, or promote access to needed services and resources both within and outside the school setting. Transition plans should focus on providing the needed accommodations and services to meet academic, social, and emotional needs; stimulate academic motivation; and promote adjustment to the school setting (Shaw & McCabe, 2008). The development and implementation of a transition plan can improve the quality of life for the child and his or her family by providing the support needed to promote student health and academic success. Individualized transition planning that is started with the healthcare provider prior to school entry empowers the parents/guardian to clarify the needs of their child and identify preferred strategies to meet those needs (Glang et al., 2008). In addition, the school and school nurse are better prepared to implement the transition plan in a coordinated and seamless manner.

It is important to address the following issues when transition planning with students that have chronic health conditions:

- Privacy of student health information — “The HIPAA Privacy Rule allows covered healthcare providers to disclose PHI about students to school nurses, physicians, or other healthcare providers for treatment purposes, without the authorization of the student or student’s parent. For example, a student’s primary care physician may discuss the student’s medication and other healthcare needs with a school nurse who will administer the student’s medication and provide care to the student while the student is at school.” (U.S. Department of Health and Human Services, 2008, p. 1).

- Transition plans must be individualized. Students with similar medical conditions may respond to and adjust differently as a result of temperament, comorbidities, stage of disease, family factors and social support (Shaw & McCabe, 2008).

- The school nurse should lead the school health team. Since school nurses often cover multiple schools, the school nurse may need to delegate nursing tasks when allowed by district policy and state law in order to implement the transition plan for a student.

- In accordance with state law, when nursing tasks are delegated to other members of the school health team, the school nurse remains accountable for the decision to delegate, for training the delegate and for providing ongoing supervision of the delegate (American Nurses Association [ANA], 2012; Kruger, Toker, Radjenovic, Comeaux, & Macha, 2009).
The role of the school nurse is essential in caring for children with chronic health conditions (Kruger et al., 2009). In order to effectively support transitions for students with chronic health conditions, school nurses should do the following:

- Be knowledgeable about applicable local, state and federal law;
- Maintain clinical competence to provide direct care and/or delegate care for children with chronic health conditions, injuries or disabilities;
- Develop a relationship with the student’s healthcare provider and family to assure that the medical orders and resulting individual health plans are implemented correctly;
- Provide consultation and/or referral to the medical home and community resources (AAP, 2008);
- Identify needs across the coordination team for continuing education regarding chronic conditions (Kruger et al., 2009);
- Influence the development of policies surrounding chronic disease management and coordinated school health programs (AAP, 2008);
- Ensure that there is adequate communication and collaboration between the student and family, healthcare provider, school officials, and providers of community-based resources (AAP, 2008); and
- Ensure continuity, compliance and supervision of care for the child with a chronic condition or injury who attends school (AAP, 2008).

CONCLUSION

The education system is greatly impacted by children with chronic health conditions. School nurses must advocate for meeting the healthcare needs and services that these children require. Effective transition planning is a shared responsibility of all professionals involved in the care of children with chronic conditions (Lineham, 2010). Transitioning -- whether at the time of beginning school, from school to school, school to adult life or between the hospital and school environment -- provides an opportunity for care coordination led by the school nurse.

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**Acknowledgement of Authors:**
Rita Baszler, BSN, RN
Laura Rochkes, MS, BSN, RN, NCSN
Rosemary Dolatowski, MSN, RN
Irene Mendes, MEd, BSN, RN, PHN
Barbara Yow, MEd, BSN, RN, NCSN
Sarah Butler, MS, RN, CDE, NCSN
Nina Fekaris, MS, BSN, RN, NCSN

**Acknowledgement of 2012 Issue Brief Authors:**
Debra M. Robarge, BSN, RN, NCSN
Leigh Ann DiFusco, MSN, RN, CNOR
Janice Seleman, DNSc, RN, NCSN
Janet Bryner, BSN, RN, NCSN
Kendra Selser, MHS, BSN, RN
Leah Wyckoff, MS, BSN, RN, NCSN
Georgene Westendorf, MPH, BSN, NCSN, CHES
Robin Fleming, PhD, RN

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All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.
Unlicensed Assistive Personnel: Their Role on the School Health Services Team

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that, where laws permit, unlicensed assistive personnel (UAP) can have valuable and necessary roles as assistants to school nurses. It is the professional responsibility of the registered professional school nurse (herein after referred to as school nurse) to identify UAP in the school setting and to train, evaluate for competency, monitor and supervise the selected individuals. The school nurse is accountable for ensuring continued competency of UAP beyond the initial documented training and for maintaining competency to provide health services to individual students according to individualized healthcare plans (IHPs) and/or district policies.

BACKGROUND

In school-age children, the incidence of chronic conditions such as asthma, diabetes, and life-threatening food allergies is increasing. Also on the rise is the number of complex medical conditions in school populations. All of these conditions require healthcare planning and management and may require that school nurses make care decisions including nursing delegation to UAP where appropriate (Hootman, 2013). As school nurses create IHPs for students, student safety is of paramount importance in implementation, including the decision to enlist assistance by UAP (American Nurses Association [ANA], 2012 ANA & National Council of State Boards of Nursing [NCSBN], 2006; Caldart-Olson & Thronson, 2013; Gordon & Barry, 2009). The school nurse must clearly state to school administration and UAP that ongoing supervision is a necessary component of nursing delegation.

Because a UAP works under the direction of the school nurse, the school nurse must conduct documented training, must supervise the UAP and must be in control of the decision to delegate a healthcare task (Bobo, 2014; Caldart-Olson & Thronson, 2013; Gibbons, Lehr & Selekman, 2013). The UAP must agree to function according to the written instructions of the school nurse. Informing the UAP of the laws that cover and protect them, including state and federal laws and statutes as well as district guidelines and policies, is critical to protect all parties from harm and liability (Shannon & Kubelka, 2013). The capacity of school nurses to effectively provide required supervision of multiple UAP must be considered before using UAP (Hootman, 2013).

In order to protect the UAP, the school and the health and safety of students, the school nurse must follow the scope and standards of school nursing which include carrying out the steps of nursing delegation, thereby setting the boundaries within which UAP can safely and legally function ANA (2013). To facilitate a better understanding of the school nurse role and the impact of UAP coverage, communication is needed between school nurses, school administrators, school personnel and families (Shannon & Kubelka, 2013; Bobo, 2014). It is important for administrators to understand that school nurses must address the following questions prior to delegation (ANA, 2012; Bobo, 2014; Resha, 2010; Raible, 2012; Hootman, 2013; Caldart-Olson & Thronson, 2013).

1. Is this the right task to be delegated?
2. Are the right circumstances in place to allow delegation?
3. Is this the right person for this task?
4. Is there appropriate communication and direction between the nurse and the UAP?
5. Is the school nurse in a position to monitor, evaluate and provide ongoing supervision of the UAP?

UAP in schools may not have health services as their primary employment role and may be called upon intermittently to assist the school nurse. UAP are school personnel who do not hold a healthcare license but are trained to provide care to students under the direction and supervision of a school nurse. Therefore,
paraprofessionals, classroom assistants, administrators, teachers, bus monitors or drivers, playground attendants or office staff may perform healthcare tasks as needed and serve as UAP. In some schools, UAP may be employed specifically to work in the health office and may be identified as health clerks, nursing assistants, health aides, patient care technicians, nurses' aides, certified nursing assistants, health techs, clinic assistants or self-care aides (Bobo, 2014; Raible, 2012; Foley, 2013; Davis-Aldritt, 2013).

Whenever a UAP is responsible for the care and safety of a student, documented training by the school nurse should occur prior to delegation of the nursing task (ANA, 2012; Davis-Aldritt, 2013; Hootman, 2013). The decision to include UAP as part of a student healthcare team is made by the school nurse and guided by district policies and the students’ IHP. (Karsting, 2012). There may be times when it is inappropriate for school nurses to delegate to UAP; and standards of nursing delegation, state statutes and local policies will guide those decisions and support their rationale (Hootman, 2013). Schools must realize that, even with exemplary UAP training and supervision, adverse events can occur, (e.g., medication errors, failure to recognize early onset of health emergencies related to chronic illnesses such as asthma and diabetes) increasing the loss of school time by students (Vollinger, Bergren, & Belmonte-Mann, 2011). School nurses, therefore, make decisions regarding use of UAP based on the situation at hand, the environment, the experience and training of the UAP and the health status of the student.

RATIONALE

UAP, although not health professionals, can play important roles within school health teams when appropriate nursing delegation is in place (Hootman, 2013). Key factors guiding delegation to UAP in addition to state statutes and rules include safety issues, medical needs of the student, and UAP competence— including education, attentiveness, availability or proximity to the students they care for (Vollinger et al., 2011; Bobo, 2014; ANA & NCSBN, 2006; Resha, 2010; Gordon & Barry, 2009). Other key factors include the school nurse’s ability to train, monitor, supervise and evaluate the UAP (Hootman, 2013).

UAP may assist school nurses thereby allowing school nurses time to fully implement professional school nursing roles including care coordination for students, and development of IHPs, Emergency Care Plans (ECP), 504 plans and Individualized Educational Plans (IEPs). UAP assistance also allows school nursing time to contribute to the education of students with special healthcare needs through assessment, planning, providing proper nursing care, and evaluating outcomes. School nurse professional practice requires critical thinking and judgment integral to the nursing process, as well as health promotion, disease prevention and addressing special health issues (Hootman, 2013; Foley, 2013; Davis-Aldritt, 2013; Resha, 2010; Quelly, 2014).

When the school nurse determines the appropriateness of using a UAP and conducts the proper documented training and supervision, the UAP can contribute to the healthcare needs of students in schools (Shannon & Kubelka, 2013; Resha, 2010). Tasks that may be performed by and delegated to UAP are dependent on state nurse practice laws. If allowed by law, tasks UAP can perform with proper training and oversight by the school nurse include first aid, screenings, maintaining student health records, non-complex daily procedures and other health office tasks. In addition to following verbal and written directions, UAP may also be trained to do selected emergency procedures, perform selected student-specific nursing tasks and administer medications allowable in their states (Raible, 2012; Hootman, 2013; Foley, 2013; Davis-Aldritt, 2013; Bobo, 2014).

CONCLUSION

Where laws permit, the use of unlicensed assistive personnel who are trained, monitored, supervised and assessed by the school nurse can be a positive asset to the healthcare team. UAP perform valuable supportive roles in meeting healthcare needs of students and in assuring that available resources are managed both safely and effectively. The use of UAP in schools for specific tasks is a decision the school nurse makes on a case-by-case basis and is determined through a nursing decision-making process that includes the five components of nursing delegation (ANA, 2012; ANA/NCSBN, 2006; Bobo, 2014).
REFERENCES


Related NASN Position Statements:
Nursing Delegation to Unlicensed Assistive Personnel in the School Setting (2014)

Acknowledgement of Authors:
Kathleen C. Rose, MHA-N, BS, RN
Jody Disney, PhD, RN, NCSN
Kathleen Andresen, DNP, RN
Christine Tuck, MS, BSN, RN, NCSN
Jessica Porter, BSN, RN, NCSN
Nicole Bobo, MSN, RN

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Electronic Cigarettes and Children

Consensus Statement

SUMMARY STATEMENT

It is the opinion of the National Association of School Nurses (NASN) that the use of electronic cigarettes (e-cigarettes) contributes to youth access to nicotine that has long-term health consequences. E-cigarettes contain nicotine derived from tobacco that is highly addictive and has harmful effects on the adolescent brain. Tobacco use in the United States is the leading cause of preventable death and disease and children who begin smoking before 18 are more likely to become addicted to nicotine (U.S. Department of Health and Human Services [USDHSS], 2014).

• Electronic nicotine delivery systems (ENDS) are battery-operated devices that deliver nicotine, flavorings and other chemicals in aerosol form that may be inhaled. It is also known as vaping since water vapor is introduced into the air instead of smoke (Morbidity & Mortality Weekly Report [MMWR], 2013; Substance Abuse & Mental Health Services Administration, 2014; Trumbo & Harper, 2013).

• ENDS include but are not limited to e-cigarettes, e-pipes, and e-hookahs and appear shaped as pens, or lipstick cases (Paradise, 2014).

• Insufficient research exist to support claims that e-cigarettes aid in smoking cessation, are safer for the environment, are healthier than cigarettes, and have no second-hand effect (Popova & Ling, 2013; Deeming Tobacco Products To Be Subject to the Federal Food, Drug, and Cosmetic Act [proposed], 2014).

• There are concerns that e-cigarettes contribute to normalizing smoking as a social norm and may be a gateway to smoking tobacco (Choi, Fabian, Mottey, Corbett & Forster, 2012; Krishnan-Sarin, Morean, Camenga, Cavallo & Kong, 2014; USDHSS, 2014).

• Currently e-cigarettes that make no medical claims are not regulated and are sold in all 50 states and on the internet without age verification in many cases. The amount of nicotine and chemicals is not regulated and there are concerns about safety (Deeming Tobacco Products to Be Subject to the Federal Food, Drug, and Cosmetic Act [proposed], 2014).

• As of November 2014, forty states have introduced legislation with age restrictions for sale of e-cigarettes to minors; 27 states have bans on indoor smoking; and only three states include e-cigarettes in the ban (Marynak et al., 2014). Currently there is no national standard and many localities have introduced their own laws.

• According to Hodge, Collmer, Orenstein, Millea and Van Buren (2013) current regulations that ban tobacco advertising do not extend to e-cigarettes that depict smoking-like behaviors. They also report that profits for ENDS in 2012 were $300 million dollars and are anticipated to grow to one billion by 2016. Some research has found that increased exposure to advertising of e-cigarettes had increased intention to smoke cigarettes among never smokers (Bunnell et al., 2015; Krishnan-Sarin et al., 2014; USDHSS, 2014). The 2009 Family Smoking and Tobacco Control Act (TCA) gave the Food and Drug Administration (FDA) the authority to regulate tobacco and in 2014, the FDA did not include advertising of ENDS in the expansion of deemed tobacco products (Deeming Tobacco Products to Be Subject to the Federal Food, Drug, and Cosmetic Act [proposed], 2014).

• E-cigarette use among adolescents has increased rapidly. Ever use of e-cigarettes in grades 6-12 increased from 3.3% to 6.8% from 2011 and 2012 (MMWR, 2013). The number of never cigarette smokers that had used e-cigarettes more than tripled from 2011 to 2013 (Bunnell et al., 2015).
• FDA oversight of tobacco products can provide important information about deemed tobacco production and manufacture and help limit youth exposure to these products. The proposed rule for deemed tobacco products would also enable FDA to explore whether different products pose different levels of risk, and would help the agency develop policies to improve public health (FDA, 2015).

• Calls to poison control centers regarding adverse effect of e-cigarettes now account for 41.7% of calls about tobacco products; 51.1% of these calls were for events involving young children. Also reported was one suicide by intravenous use of the nicotine liquid (Chatham-Stephens et al., 2014).

• It is necessary to monitor patterns of use of an increasingly wide array of tobacco products across all populations in order to develop effective interventions to prevent tobacco use among youth (Arrazola, Neff, Kennedy, Holder-Hayes & Jones, 2014; Bunnell et al., 2015; USDHHS, 2014).

RATIONAL

Healthy people 2020 goals for tobacco use are to decrease initiation of tobacco use in children, adolescents and young people; to reduce tobacco use in adolescents and adults; to increase smoking cessation by adolescents and adults and to increase counseling and screening about tobacco use in ambulatory settings (USDHSS, 2010).

• School nurses are instrumental in promoting wellness of staff and students. As part of a comprehensive school health program, school nurses should initiate the discussion about e-cigarettes and ensure that e-cigarettes are included in tobacco education curriculum and no smoking policies in schools; provide individual counseling and education to students, staff and families; and identify resources for smoking cessation.

• School nurses are advocates for national, state and local policies that improve health outcomes for children and families. On the local level, school nurses can advocate for increasing the cost of e-cigarettes and involve the community to restrict minors’ access to e-cigarettes and to include e-cigarettes in state and local policies regarding tobacco use that are consistent with the Centers for Disease Control and Prevention’s (2014) Best Practices for Tobacco Control. Nationally, school nurses can advocate for federal regulations to limit marketing and advertising in all media that is consistent with guidelines for tobacco products and ensuring safety of all components of e-cigarettes.

REFERENCES


Adopted: May 2015

All consensus statements from the National Association of School Nurses will automatically expire one year after publication unless renewed and recommended for position statement development.
Global School Nursing

Resolution

Whereas, the National Association of School Nurses (NASN) recognizes the growing impact of globalization on the health and safety of all children; and

Whereas, NASN recognizes that with the increase in mobility across the world children cross borders; and diseases, health concerns, and environmental issues know no boundaries; and

Whereas, NASN recognizes that school nursing is a specialized practice of professional nursing that occurs throughout the world; and

Whereas, NASN recognizes that school nurses throughout the world share an interest in the health and well-being of children and adolescents; and

Whereas, NASN recognizes that exchanging professional knowledge and expertise with school nurse colleagues will promote professional development; therefore, be it

Resolved, that in an effort to meet the needs of students throughout the world, NASN will continue to support the profession of school nursing internationally to serve as the expert resource in advancing the well-being, academic success, and lifelong achievement of students within their international community setting.

Adopted: 2010
Revised: June 2014

All resolutions from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.
Public Health as the Foundation of School Nursing Practice

Resolution

Whereas, the founder of public health nursing, Lillian Wald, recognized from its conception in 1902 that the philosophy and principles of public health underlie school nursing practice; and

Whereas, school nursing services are provided in an educational setting where promoting and maintaining the optimal health status of students are critical to the success of the local education agency’s mission; and

Whereas, School Nursing Scope and Standards of Practice (ANA &NASN, 2011) supports the core functions of public health using knowledge from nursing, public health science, and education to provide primary, secondary and tertiary interventions to promote health and prevent disease within the school setting; and professional registered nurses enter the practice of school nursing from a variety of educational and work backgrounds and most often are supervised by an administrator without a nursing or healthcare background; and

Whereas, the American Nurses Association recognizes that the practice of school nursing is “grounded in core public health functions” in providing care for youth and adults in the educational setting (ANA, 2007, p. 1); and

Whereas, school health services provide a channel for integrating public health into communities to improve population health as outlined by the Institute of Medicine (2012); and

Whereas, school nurses are uniquely positioned to engage a large percentage of our nation’s youth, their families and school community to promote health and prevent disease; therefore, be it

Resolved, that the school nurse role is unique because it encompasses individual, community and population health; and

Resolved, that school nurses have the competencies that are individually focused and related to community and population care; and

Resolved, that the National Association of School Nurses recognizes that public health provides the foundation for the specialty practice of school nursing and is an integral focus of the organization.

References


Resolution

Whereas, school nursing is a specialized practice of professional nursing that advances the well-being, academic success and lifelong achievement of students; and

Whereas, school nursing services are provided in an educational setting where promoting and maintaining the optimal health status of students is critical to the success of the local education agency’s mission; and

Whereas, professional registered nurses enter the practice of school nursing from a variety of educational and work backgrounds and most often are supervised by an administrator without a nursing or healthcare background; and

Whereas, state-wide school health policies, nursing procedures, and quality assurance measures are needed for ensuring the delivery of safe and effective nursing services; and

Whereas, state school nurse consultants monitor, interpret and disseminate changes in health policy, nursing, legislation, and legal issues that impact school nursing practice; and

Whereas, state school nurse consultants facilitate the development of state standards of care in school nursing and school health programs and serve as the liaison between state departments of health and departments of education; and

Whereas, state school nurse consultants facilitate professional development for school nurses that focus on current school nursing practice trends; therefore, be it

Resolved, that the National Association of School Nurses supports having a state school nurse consultant in every state and the District of Columbia to develop and promote quality standards for school health services; act as a liaison between educators, parents and the general public regarding the relationship between the health of a student and his or her capacity to learn; and serve as a resource expert in school nursing practice and school health programs.

NASN supports educational requirements for state school nurse consultants, which include at least a Bachelor of Science degree in nursing and a Master’s degree in a related field. Professional certification as a school nurse is preferred. NASN recommends that state school nurse consultants be administratively housed within each state’s department of health and/or department of education in order to facilitate mutual collaboration between these agencies.

Adopted: January 2013

This Resolution replaces the following Position Statement: State School Nurse Consultants (Adopted June 1998; Revised July 2004)

All resolutions from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.

Adopted: January 2013

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Early School Start Times

Consensus Statement

SUMMARY STATEMENT

Optimal sleep during growth and development is critical for the health, safety and academic success of our nation’s youth. Over half of high school youth and near one third in middle school report 7 hours or less sleep on school nights (National Sleep Foundation, 2014). These reports are in sharp contrast to recommended adolescent (age 12-17) sleep requirements of approximately 9 to 10 hours (Carskadon, 2011). The registered professional school nurse (hereinafter referred to as school nurse) is in a pivotal position to collaborate with students, families, teachers, pediatric nurses, school administration officials, and other health care professionals to address factors contributing to insufficient sleep. A significant modifiable factor contributing to insufficient sleep during adolescence is early school start times during middle school and high school. The National Association of School Nurses (NASN) and the Society of Pediatric Nurses (SPN) support delaying school start times for middle school and high school students as proposed in the policy statement on School Start Times for Adolescents by the American Academy of Pediatrics (Adolescent Sleep Working Group, 2014). This recommendation is based upon the following key factors in adolescent sleep:

- Adolescents require approximately 9-10 hours of sleep nightly (Carskadon, 2011).
- Developmental and physiological changes in adolescent sleep contribute to shifts in nighttime sleep times and later bedtimes, but not necessarily a decrease in sleep requirement (Carskadon, 2011).
- Home electronic media use by adolescents before bedtime affects sleep quality (National Sleep Foundation, 2014).
- Parents/guardians are unaware of adolescent sleep needs and/or the sleep duration of their adolescents (American Academy of Pediatrics [AAP] Adolescent Sleep Working Group, 2014).
- Parent/guardian enforced bedtimes throughout adolescence is associated with longer sleep duration (Short et al., 2011).
- Delaying school start times for adolescents to no earlier than 8:25 am is associated with longer sleep duration on school nights (Boergers, Gable, & Owens, 2014).
- Delay of school start times is associated with improved mood and reduced daytime sleepiness (Boergers, Gable, & Owens, 2014).
- Insufficient sleep and irregular sleep/wake patterns are associated with an increased risk for daytime sleepiness, academic and emotional difficulties, safety hazards, and cardio-metabolic disease (AAP, Adolescent Sleep Working Group, 2014).
RATIONALE

The need for sleep is a biological necessity for all mammals, and studies have shown that the absence of sleep results in impairment of functional ability (Iber, 2013). During the four stages of sleep – REM, N1, N2, and N3 - task learning is refined through the enhancement and pruning of synaptic connections. Each sleep stage has a responsibility for temporarily storing, evaluating, discarding “nonsense” information and preserving new and valued knowledge (Iber, 2013).

During adolescence, the secretion of the melatonin hormone begins later in the day resulting in a corresponding delay in the desire to sleep (Carskadon, 2013). The postponement of this biological event is further delayed if the adolescent is not in a dimly lit environment – often the case if there is homework to finish. However, although staying awake longer is easier for the adolescent, the desire to sleep longer is unavoidable. This becomes problematic when the total amount of sleep is reduced, as is often the case during the school year. In addition, studies have shown that children and adolescents from low income or racial and ethnic minorities are at a greater risk for sleep disorders due to overcrowding, excessive noise, and concerns for their own or their family safety (Owens, 2014).

In Healthy People 2020 (2014), a new core indicator has been developed entitled Sleep Health which calls for a reduction in

- adolescent sleep loss;
- unhealthy sleep behaviors (irregular sleep/wake patterns, overuse of electronic media in the bedroom, and the consumption of excessive caffeine); and
- the potential consequences of inadequate sleep (depression and suicidal ideation, obesity, auto accidents attributed to drowsiness, and poor academic performance) (Owens, 2014).

NASN and SPN highlight a contributing – and modifiable – factor to promoting an increase in sleep obtained by teenagers is to delay the start of school day for middle and high school students. NASN and SPN acknowledge the challenges of alterations in after-school sports and activities, along with adjustments to parental/guardian schedules and other modifiable factors such as the need for families to

- self-regulate sleep habits;
- set bedtime limits;
- set limits on social networking; and
- discuss the use of electronic media in the bedroom.

SPN and NASN stand ready to collaborate with administrators, teachers, parents, school boards and communities to address this public health issue by

- Working with parents to understand developmental changes in sleep/wake patterns during adolescence.
- Educating parents on the importance of setting bedtime limits.
- Identifying adolescents at risk.
- Working with teachers and parents to monitor academic course loads and extracurricular activities.
- Identifying strategies to promote optimal sleep.
- Limiting the use of caffeine and other stimulants.
- Limiting the use of electronic media and social networking.

Adolescence is a time when sleep patterns change and biological clocks alter, often leading to poor quality and insufficient sleep. Their ability to concentrate, problem-solve and assimilate new information is impaired. SPN and NASN encourage all parties involved to consider implementing later school start times for teens.
REFERENCES


Adopted: February 2015


All consensus statements from the National Association of School Nurses will automatically expire one year after publication unless renewed and recommended for position statement development.
School Nursing Services Data:  
Standardized Documentation, Collection, and Utilization  
Joint Resolution  
National Association of School Nurses (NASN) & National Association of State School Nurse Consultants (NASSNC)

Whereas, school nurses positively influence the health outcomes of students (NASN, 2013) and the health of students affects their learning skills, motivation, and school engagement (Forrest, Bevans, Riley, Crespo, & Louis, 2012);

Whereas, school nurses document significant amounts of individual and population level health data – particularly for students with specific health care needs, and those outside of traditional health care settings (Johnson, Bergren, & Westbrook, 2012); and

Whereas, school health services data should be an integral part of education and health data, but is currently missing in the analysis of health and education outcomes because this information is not uniformly collected, collated, or reviewed (Healthy Schools Campaign & TFAH 2012), and

Whereas, school nurses contribute to a system of care for students, but without integrated health and education networks, this care is at risk of being fragmented, resulting in higher costs, limited quality, and reduced satisfaction (Johnson & Bergren 2011); and

Whereas, the aggregation of population level data in school health records has the potential to demonstrate the prevalence of health conditions; provide research on longitudinal outcomes; and identify community strengths and opportunities for improvement that will benefit all students and the school community (Johnson, et al., 2012); and

Whereas, the development of standardized variables as part of a common school health dataset with a process for data collection similar to processes used in health and education data management, is critical to providing consistent, quality care for all students (Johnson, et. al., 2012); and

Now, Therefore, Be It Resolved that NASN and NASSNC will lead in the development of a standardized dataset for all nurses working in school settings to use as the foundation for compiling and collecting data on the student population. This comprehensive dataset will focus on the broad aspects of the health needs of students and the outcomes of school nursing interventions, including analysis of nursing-sensitive student outcomes. The goals of this process include integrating school nursing services data into other established datasets (health and education) to provide a comprehensive analysis; addressing the current and emerging health needs of students; providing concrete insight about the correlation between student outcomes and evidence-based models of school nursing practice.
REFERENCES


