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Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that student behavioral health and wellness must be prioritized for students to successfully access and engage in educational opportunities. It is imperative that school systems respond to, and address, student behavioral health and wellness to ameliorate disparities related to the social determinants of health (Combe, 2019). School nurses are often the initial access point to identify concerns, determine interventions, and link families to school and/or community resources.

BACKGROUND AND RATIONALE

Behavioral health is defined by the promotion of mental health, resilience and wellbeing; treatment of disorders; and support of individuals and families who experience these disorders. Families and community partners are crucial in the effort to address these unmet needs (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).

COVID-19 has highlighted the need for enhanced monitoring of children’s mental health during public health crises (Leeb et al., 2020). The length of loneliness and social isolation imposed by disease mitigation measures can predict later mental health problems for up to nine years post-event (Loades et al., 2020). A population health perspective examines multiple determinants of health outcomes such as access to healthcare, public health interventions, social and physical environment, genetics, and individual behavior (Kindig & Stoddart, 2003). Applying a population health perspective will be critical to determine the actual effects of the pandemic in the absence or presence of other known risk factors that impact mental health (Boden et al., 2021).

A myriad of family, community, and environmental factors that often begin in childhood affect mental health, wellness, and access to care (Kaushik et al., 2016). Age, poverty, living in a rural area, a shortage of providers, an increased distance to services, and lack of transportation are frequently identified as causes of inadequate treatment for behavioral health concerns including anxiety, depression, and behavior problems (Ghandour et al., 2019). These problems are prevalent among US children with significant disparities in treatment. In the US, 13% to 20% of children, especially ages 12-17, have a mental, emotional, or behavioral disorder. Behavioral/conduct problems affect more than twice the number of boys as girls ages 6 – 11. Overall, children who are in poor health have a higher prevalence of each of these disorders (Ghandour et al., 2019). The school nurse is in a unique position to identify and assist students in obtaining appropriate referral and access to community resources.

Adverse Childhood Experiences (ACES) include physical, emotional, and sexual abuse as well as other childhood traumatic experiences. ACES are known to have negative and prolonged effects on children’s mental health (Larson et al., 2017). Multiple studies show a risk of mental health disorders and academic failure when children are exposed to trauma. Students at poverty level and from minority racial/ethnic groups have amplified exposure to trauma, yet these same students have reduced access to mental health services (Larson et al., 2017). Twenty-two percent of children living below the federal poverty level have a mental, behavioral, and/or developmental disorder (CDC, 2020a).

According to the CDC, “mental disorders among children are described as serious changes in the way children typically learn, behave, or handle their emotions, causing distress and problems getting through the day” (2020a). The percentage of children diagnosed with mental health disorders has increased, with 49.5% of adolescents having some form of mental health disorder and 22% experiencing severe impairment (National Institute of Mental
Health [NIMH], 2020). The CDC reports that ADHD, behavior problems, anxiety, and depression are the most commonly diagnosed childhood disorders.

- 9.4% of children aged 2-17 years have received an ADHD diagnosis.
- 7.4% of children aged 3-17 years have a diagnosed behavior problem.
- 7.1% of children aged 3-17 years have diagnosed anxiety.
- 3.2% of children aged 3-17 years have diagnosed depression (CDC, 2020a).

Suicide is the second leading cause of death in youth age 10-24 (Curtain & Heron, 2019). Data obtained from United States students in grades 9-12 from the CDC 2019 Youth Risk Behavior Surveillance Survey (YRBS) reveals:

- 37% of adolescents persistently felt sad or hopeless to a point where they did not engage in normal activities,
- 18.8% of students reported having seriously considered suicide, and
- 8.9% reported having attempted suicide (CDC, 2020b).

School nurses are frequently the first to identify and address behavioral health concerns and connect students and families with systems of support. The National Academies (2019) determined programs that include children, families and the community have a greater influence on positive health outcomes, especially when dealing with those from lower socioeconomic status. Positive child experiences (PCE) can offset the effects of ACES (Bethel et al., 2019). School nurse referral options to support student needs include comprehensive school mental health systems as well as primary care providers, mental health specialists, telemedicine, and school-based health centers (National Center for School Mental Health, 2019; CDC, 2018).

*The Framework for 21st Century School Nursing Practice™* (NASN, 2016) is aligned with the Whole School, Whole Community, Whole Child model (CDC, 2014). School nurses apply these practice components to address social, mental, and physical health concerns at the individual student and population level. Given the early onset of emotional, mental health and substance use disorders and their subsequent costs, investments in prevention and early intervention programs are necessary (Starkey, 2019). Proactive school nursing practice encompasses the principles of community and public health nursing. School nurse services address access to care, cultural competency, health education, health equity, outreach, risk reduction, social determinants of health, and surveillance (NASN, 2020).

Student behavioral and mental wellness is essential for students to be healthy, safe, and ready to learn. The incidence of behavioral health concerns is on the rise and negatively impacts educational achievement (Rosvall, 2020). The school nurse is the bridge between health and education in the school setting, promoting positive behavioral health and using assessment skills to identify children at risk for behavioral health needs. School nurses, in collaboration with the interdisciplinary education team, provide critical links to prevention, early identification, intervention, and referral for behavioral/mental health concerns (Ramirez, 2018).

REFERENCES


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“To optimize student health, safety and learning, it is the position of the National Association of School Nurses that a professional registered school nurse is present in every school all day, every day.”

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Bullying and Cyberbullying – 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. The school nurse role includes efforts to prevent bullying and the identification of students who are bullied, bully others, or both. The Framework for the 21st Century School Nursing Practice™ (NASN, 2016) provides direction for the school nurse to support student health and academic success by contributing to a healthy and safe school environment poised to prevent and mitigate bullying and cyberbullying.

BACKGROUND

In 2014 the Centers for Disease Control and Prevention (CDC) and the U.S. Department of Education released the first federal uniform definition of bullying for research and surveillance; the core elements of the definition include unwanted aggressive behavior, observed or perceived power imbalance, repetition of behaviors or high likelihood of repetition, and the intention to harm (Gladden, Vivalo-Kantor, Hamburger, & Lumkin, 2014). The 2015 Youth Risk Behavior Surveillance System indicates that nationwide 20% of students in grades 9-12 experienced bullying on school grounds (Kann, McManus, & Harris, 2016). The effects of bullying involve not only the individual but also families, friends, schools, and neighborhoods.

Bullying includes both traditional (in person) bullying and cyberbullying, which is defined as using technology to share aggressive messages on social media. Social media can include but is not limited to Facebook, Twitter, or Snapchat. There are two types of students who are more likely to bully others: 1) students who are well-connected to their peers, have social power, are overly concerned about their popularity, and like to dominate or be in charge of others; and 2) students who are isolated from their peers and may be depressed or anxious, have low self-esteem, be less involved in school, be easily pressured by peers, or do not identify with the emotions or feelings of others (U.S. Department of Health and Human Services [USDHHS], 2018a). Some students may be the subject of both traditional bullying and cyberbullying. The 2015 Youth Risk Behavior Surveillance System indicates approximately 16% of high school students were bullied electronically (CDC, 2016). Cyberbullying may provide a venue for some students to bully when they might not otherwise do so in person.

Despite a dramatic increase in public awareness, the prevalence of bullying is still one of the most pressing issues facing our nation’s youth (Luxenberg, Limber, & Olweus, 2015). Bullying is a persistent public health concern that has a significant impact in the school setting (USDHHS, 2017a). However, until the past decade, bullying was often dismissed as normative and without long-term effects (Bradshaw, 2016). 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 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 ways to develop effective strategies to reduce or eliminate risk factors for bullying (Bradshaw, 2016).

While any student can be bullied at school, students with disabilities (USDHHS, 2017a) and other vulnerable populations such as students with academic difficulties and speech impairments (Bradshaw, 2016) are particularly at risk. Students may be bullied based on their physical appearance such as glasses, hair color, and weight (Perron, 2013). Lesbian, gay, bisexual, and transgender students are more likely to be subjected to all types of bullying (USDHHS, 2018b). Research shows a higher number of female students are bullied at school when compared to
male students, but a higher number of male students report being physically bullied and threatened with harm (Robers, Zhang, Morgan, & Musu-Gillette, 2015).

For both the student who bullies and the student who is bullied, bullying can have serious and often long-term consequences including increased school absenteeism, diminished educational achievement, behavior issues, low self-esteem, sleep deprivation, depression, anxiety, and self-harm (Luxenberg et al., 2015). Bullied students are also at risk for physical symptoms including stomach pain, sleep disturbances, headaches, tension, bedwetting, fatigue, and decreased appetite (Kowalski & Limber, 2013). In the *Bullying in U.S. Schools* report, data found that students who bully were more likely to report recent use of alcohol and drugs (Luxenberg et al., 2015). The consequences of bullying can continue into adulthood (Copeland, Wolke, Angold, & Costello, 2013).

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. Federally funded schools have an obligation to resolve bullying and harassment. If the situation is not 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, 2017b).

**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, according to Selekman, Pelt, Garnier, and Baker (2013), the school nurse should

- Be knowledgeable about bullying, aggression, victimization, and long-term consequences;
- Be aware of the importance of not labeling students as “bullies,” “targets” or “victims”;
- Participate as a key member of the school team that identifies students who are bullied, bully others or both;
- Share information and observations and alert the school team to signals that may identify students at risk;
- Assess students with frequent unexplained somatic complaints explicitly to screen for bullying and stress;
- Create a safe space at school where students can verbalize concerns about all health issues including bullying and other incidents of violence; and
- Strengthen working relationships with other school staff to be able to share concerns about school bullying (Pigozi & Jones Bartoli, 2016).

School nurses can educate students and staff and advocate for student support. According to Bradshaw (2015), school-based programs could include

- **Multi-tiered systems of support**, which includes three tiers of interventions, a) universal programs or activities for all youth within the community or school, b) selective interventions for groups of youth at risk for being involved in bullying; and c) preventive interventions tailored for students already involved in bullying.
- **Multicomponent programs** that address multiple aspects of bullying behavior and the environments that support it. Examples include examining school rules and using behavior management techniques and social emotional learning in the classroom and throughout the school to detect and provide consequences for bullying.
- **School-wide prevention activities** that include improving the school climate, strengthening supervision of students, and having a school-wide anti-bullying policy.
- **Involving families and communities** by helping caregivers learn how to talk about bullying and get involved with school-based prevention efforts.
- **Developing consistent, long-term, school-wide approaches** that strengthen youth’s social-emotional, communication, and problem-solving skills.
CONCLUSION

Bullying can have severe short- and long-term negative social and emotional effects on the student who is bullied, bullies others, or both. Creating a safe and supportive school environment is critical to preventing bullying and supporting learning and academic achievement. The school nurse 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, 2016). School nurses are, therefore, ideally situated to work with other school-based professionals to facilitate bullying interventions (Pigozi & Jones Bartoli, 2016). The school nurse can support evidence-based interventions to prevent and mitigate bullying in the school. The school nurse provides key leadership to promote and enhance student safety, wellness, engagement, and learning.

REFERENCES


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Prevention and Treatment of Child Maltreatment –
The Role of the School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that prevention, early identification, intervention and care of child maltreatment are critical to the physical/emotional well-being and academic success of students. Registered professional school nurses (hereinafter referred to as school nurses) practice within the NASN Framework for 21st Century School Nurse Practice™ and 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. Serving as members of interdisciplinary teams, school nurses also collaborate with school personnel, community stakeholders, healthcare professionals, students, and families to promote the safety and protection of children. The presence of a school nurse in every school all day, every day allows the school nurse to build trusting and supportive relationships with children/youth who may be victims of child maltreatment. Research has shown that these relationships can optimize student health, safety, and learning (CDC, 2014; Maughan et al., 2017).

BACKGROUND

Child maltreatment was initially recognized as a significant social problem in the 1960s when Henry Kempe published his article on battered child syndrome (Child Welfare Information Gateway, 2017). His work led to the adoption of a formal reporting system at the state and federal level and ultimately the passage in 1974 of the Child Abuse and Prevention and Treatment Act (CAPTA), the primary federal legislation addressing child abuse and neglect. CAPTA was most recently reauthorized in 2015 by the Justice for Victims of Trafficking Act and in 2016 by the Comprehensive Addiction and Recovery Act of 2016 (Child Welfare Information Gateway, 2017). CAPTA 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, (including sexual abuse as determined under section 111) or an act or failure to act which presents an imminent risk of serious harm" (U.S. Department of Health and Human Services [USDHHS], Administration for Children and Families [ACF], Administration on Children, Youth and Families [ACYF], Children’s Bureau, 2017, p. 7).

While this is the federal definition, it is important to understand that each state defines child maltreatment in its own state statutes and policies (Child Welfare Information Gateway, 2016). A child is defined as a person who has yet to reach the age of 18 years and who is not an emancipated minor. However, in the case of sexual abuse, the age of the child is specified by the child protection law of the state in which the child resides (Child Welfare Information Gateway, 2017).

Child maltreatment may present in a variety of forms (Child Welfare Information Gateway, 2017):

- Physical Abuse - intentional use of physical force against a child that results in or has the potential to result in physical injury

- Sexual Abuse – any completed or attempted (non-completed) sexual act, sexual contact with or exploitation of a child by adult
- **Psychological Abuse** - intentional caregiver behavior that conveys to a child that he/she is worthless, flawed, unloved, unwanted, endangered or valued only in meeting another’s needs.

- **Neglect** - the failure to provide for a child’s basic physical, emotional, or educational needs or to protect child from harm or potential harm.
  - Failure to provide - failure by a caregiver to meet the child’s basic physical, emotional, medical/dental or educational needs, or combination thereof.
  - Failure to supervise - failure by the caregiver to ensure a child’s safety within and outside the home given the child’s emotional and developmental needs.

- **Trafficking** - The term sex trafficking, another form of child maltreatment, means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act. The term “severe forms of trafficking in persons” means sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age (Child Welfare Information Gateway, 2018).

All 50 states, the District of Columbia, and the U.S. territories have mandatory child maltreatment reporting laws that require certain professionals who have frequent contact with children to report suspected maltreatment to a Child Protective Services agency. These professionals are legally designated as mandatory reporters and include school nurses and other school staff. In 2016, the highest percentage (18.4%) of suspected child maltreatment reports came from education personnel (USDHHS, ACF, ACYF, Children’s Bureau, 2018).

*Child Maltreatment 2016* reports the number and rate of victims of maltreatment has fluctuated during the past five years with a 3% overall increase in the number of victims from 2012 to 2016. During 2016 an estimated 1,750 children died as a result of child maltreatment (USDHHS, ACF, ACYF, Children’s Bureau, 2018).

The National Child Abuse and Neglect Data System identified the incidence of four types of child abuse during 2016 (USDHHS, ACF, ACYF, Children’s Bureau, 2018). Neglect constituted the highest number of cases (74.8%), followed by physical abuse (18.2%), sexual abuse (8.5%) and other types of maltreatment such as psychological abuse, lack of supervision, and substance abuse exposure (6.9%) (USDHHS, ACF, ACYF, Children’s Bureau, 2018).

While recent trends show a slight increase in the number of child maltreatment reports, long term trends in rates have decreased markedly since 1992. In the years 1992-2016, sexual abuse declined 65%, physical abuse decreased 53%, and neglect dropped 12%. These long-term trends may reflect the success of various public policy and public awareness initiatives (Finkelhor, Saito, & Jones, 2018). School nurses should advocate for continued analysis, research, and development of evidence-based policy initiatives to prevent and address the overwhelming negative effects of child abuse and neglect.

**RATIONALE**

The negative impact of child maltreatment on the child, the family, and society as a whole cannot be underestimated. Maltreated children suffer both immediate and long-term impairments to their mental, emotional, physical, educational, and social well-being (Jordan, MacKay, & Woods, 2016). The seminal Adverse Childhood Experiences (ACES) study demonstrated that childhood trauma, in the form of child maltreatment and family dysfunction, are linked to leading causes of adult morbidity and mortality (Gilbert et al., 2015). The ACEs study shifted the focus of the child maltreatment field from the effect of individual types of childhood victimization to the cumulative effect of ACEs on child and adult well-being and called for strategies to prevent the occurrence of ACEs and their adverse impacts at every level (Oral, Ramirez, & Coohey, 2016). Trauma Informed Care (TIC), a crisis response strategy to help students return to school and resume learning, is an approach that schools and school nurses can promote. TIC realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, and responds appropriately (Substance Abuse and Mental Health Services Administration, 2015).
Child maltreatment prevention efforts have traditionally focused on a secondary prevention model that emphasizes reducing the risk of recurrence of child abuse and neglect (Center for Social Policy, 2014). Current efforts center on preventing maltreatment from occurring in the first place, thereby placing the focus on primary prevention and community awareness. This approach is represented by the *Strengthening Families Approach and Protective Factors Framework* developed by the Center for Social Policy (2014). There are five *Strengthening Families* protective factors:

- parental resilience
- social connections
- knowledge of parenting and child development
- social and emotional competence of children
- concrete support in times of need

School nurses have the education and skills to implement TIC and to strengthen the five protective factors. For example, school nurses may educate parents about positive behavior interventions, appropriate health care, and early literacy interventions for their children. Continued educational offerings with school nurses to increase their knowledge, confidence, attitude, and self-efficacy regarding child maltreatment are needed. There is clear evidence that clinical practice changes can contribute to the goal of overcoming child maltreatment (Jordan et al., 2016).

School nurses can be involved in prevention, early identification, reporting, and treatment related to child maltreatment because of their opportunity to interact with children daily. School nurses are professionally and ethically accountable to do the following:

- know local laws, regulations, policies, and procedures for reporting child maltreatment.
- know the signs and potential indicators of child maltreatment including sexual exploitation.
- provide clear nursing documentation that includes questions asked and answers given and use a body diagram when appropriate for suspected child maltreatment and sexual exploitation.
- provide students with personal body safety education 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.
- provide support to victims of child maltreatment.
- facilitate the linkage of victims and families to community resources, including a medical home (American Academy of Pediatrics, 2016).
- collaborate with community organizations to raise awareness and reduce the incidence of child abuse and neglect.

**CONCLUSION**

Students are central to NASN’s *Framework for 21st Century School Nursing Practice™*. School nurses implement the Framework principle of care coordination through direct care of the maltreated child, serving on interdisciplinary teams, and educating faculty and staff in the recognition and reporting of child maltreatment; the Framework principle of community/public health is illustrated by the school nurse’s implementation of evidence-based prevention models such as the *Strengthening Families Approach and TIC* (NASN, 2016). School nurses develop long-term, trusting relationships with students, which allow for detection of signs of abuse and disclosure. School nurses are uniquely positioned to positively affect the academic achievement of students by keeping them healthy, safe, and ready to learn.

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This document replaces the position statement Care of Victims of Child Maltreatment: The School Nurse’s Role (adopted January 2014).


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 data on children’s deaths in school should be recorded, analyzed and reported at the local, state and national levels. The systematic review of data on child mortality 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).

BACKGROUND

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 schools require ventilators, tube feedings, medication, and other complex nursing care procedures (Allen, Henselman, Laird, Quinones, & Reutzel, 2012; Bergren, 2011; Centers for Disease Control and Prevention [CDC], 2015; National Association of State Chronic Disease Directors [NACDD], 2016; Perrin, Anderson, & VanCleave, 2014). Chronic conditions may put students at higher risk for unexpected death. In 2015, 8.4% of children were identified as having had asthma (CDC, 2016a). Diabetes is one of the most common chronic diseases in children and adolescents, affecting 167,000 children in 2009 (CDC, 2016b). Ten percent of children over 6 years of age are allergic to peanuts, potentially at risk for life threatening anaphylaxis (Liu et al., 2010). Epilepsy primarily affects children who also bear the burden of its most catastrophic forms (Institute of Medicine [IOM], 2012). 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], 2013).

There is a dearth of data surrounding the health of the 50.4 million students who attend school every day (Kena et al., 2016). While voluminous amounts of data on children are reported in various national health data bases 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 (Patrick et al., 2014).

The lack of data on students’ health also extends to a corresponding lack of data on students’ 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 4,836 United States workers died on the job in 2015 (Bureau of Labor Statistics, 2016). However, the number of children who die at school or who die following an adverse event at school is often known only from anecdotal or newspaper accounts limiting the ability to understand causes or identify preventative measures (Malone & Bergren, 2010). Only half of all states review child death from all causes (Christian & Sege, 2010). Forty-three states participate in the National Center for Fatality Data Review and Prevention (NCFRP, 2016); but, despite asking if school was the location of the death, not all data elements are submitted by all states. 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, 2013; North Carolina Healthy Schools, 2016; Selekan, Wolfe, & Cole,
they feel safe and are healthy (NASN, 2015). Through these efforts, school nurses provide case management, which improves chronic health conditions and reduces absenteeism (Jacobsen et al., 2016; Moricca et al., 2013). School nurses also address chronic absenteeism by identifying and building on protective factors and connecting students and families with resources to mitigate barriers such as community resources for food, transportation, and housing (Jacobsen et al., 2016; Schroeder, Malone, McCabe, & Lipman, 2018).

School nurses develop trusting relationships with students with chronic health conditions and their families. As integral team members, school nurses help schools build a culture of attendance by creating a welcoming and engaging school environment that emphasizes building relationships with families and stresses the importance of attending school every day (Attendance Works, 2017). For example, one school assigned different team members to mentor and befriend key students at risk. The school nurse’s daily interaction with the students helped improved attendance and supported the team’s approach to absenteeism (NASN, 2015).

School nurses collect, interpret, monitor, and use data to develop population-based programs and identify students at risk for absenteeism due to health or social concerns including students with disabilities. They use their expertise in population-based care to develop programs that provide education and follow up on screenings, which also increases return-to-class rates (AAP, 2016; NASN, 2015; NASN 2016). These skills can be used in developing school-wide programs. When school nurses have access to attendance data, they can track health related attendance rates and address these concerns. School nurses can also address chronic tardiness and early dismissals related to health or social concerns that may lead to absenteeism. Yet, many schools look at daily attendance (students at school) and truancy but fail to look at health related absences (Kemp, 2016).

CONCLUSION

Chronic absenteeism is a critical problem influencing student academic achievement with potential long-term effects on health, education, and financial stability. Finding solutions to the problem of chronic absenteeism is critical for enhancing educational outcomes for students. School nurses are vital team members who identify and mitigate the health, safety, and social risk factors that are barriers to school attendance (McClanahan & Weismuller, 2015).

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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.

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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 integral member of the school team, promoting school attendance and combating student absenteeism by addressing the physical, mental, and social needs of the student. Chronic absenteeism puts students at risk for academic failure with effects that can last a lifetime and negatively impact education, health, financial stability, and employment (Robert Wood Johnson Foundation [RWJF], 2016).

BACKGROUND

Chronic absenteeism, commonly defined as missing 10% or more of school days for any reason (excused or unexcused), detracts from learning and is a proven early warning sign of academic risk and school dropout (Jacob & Lovett, 2017). A fifth of the nation’s schools report that 20% or more of their students are chronically absent; no state is untouched by the problem (Jordan & Miller, 2018). Children who are chronically absent in kindergarten and first grade are far less likely to achieve grade level reading by third grade and are four times more likely to drop out of high school (Healthy Schools Campaign, n.d.). Students who live in poverty are two to three times more likely to miss school and face significant health disparities including access to resources. Students who have disabilities or come from communities of color (African American, Native American, Pacific Islander and Latino) may also be affected disproportionately (Attendance Works, 2017).

While there are many contributing factors, addressing health-related chronic absenteeism for students is key to closing the achievement gap (National Forum on Education Statistics, 2018). One study found that 92.4% of students indicated health concerns were the reason they were ‘sometimes’ or ‘usually’ absent (Brundage, Castillo, & Batsche, 2017). Physical and mental health problems such as asthma, allergies, diabetes, obesity, seizure disorders, anxiety, and attention deficit disorder rank high among the factors contributing to chronic absenteeism (American Academy of Pediatrics [AAP] Council on School Health, 2016; Jacobsen, Meeder, & Voskuil, 2016). An estimated 27% of U.S. children have chronic health conditions (CHC) and 1 in 15 have multiple CHCs that impact school attendance (Rezaee & Pollock, 2015). Researchers have also found chronic absenteeism to be a symptom of other issues that hinder student learning, such as socioeconomic distress, health barriers, cultural and social exclusion, housing instability, food insecurity, unsafe or violent living conditions, avoidance of bullying harassment, school phobia, and family responsibilities such as caring for younger siblings (Black, Seder, & Kekahio, 2014; RWJF, 2016).

RATIONALE

Experts in chronic absenteeism recommend a 5-part strategy to improve school attendance: engage students and parents, recognize good and improved attendance, monitor school attendance data and practice, provide personalized early outreach, and develop programmatic response to barriers (Attendance Works, 2018). School nurses have the expertise and already perform these five strategies as part of their role and should thus be an integral member of the school attendance team so that efforts are coordinated and efficient.

School nurses engage students and parents and provide personalized outreach as they address the physical and social needs of students. School nurses empower students as they teach them to better understand and address the root causes of health concerns (Engelke, Swanson, & Guttu, 2014; NASN, 2016). School nurses assist families obtain students’ medications, help provide access to care, and work individually with students at school so that
they feel safe and are healthy (NASN, 2015). Through these efforts, school nurses provide case management, which improves chronic health conditions and reduces absenteeism (Jacobsen et al., 2016; Moricca et al., 2013). School nurses also address chronic absenteeism by identifying and building on protective factors and connecting students and families with resources to mitigate barriers such as community resources for food, transportation, and housing (Jacobsen et al., 2016; Schroeder, Malone, McCabe, & Lipman, 2018).

School nurses develop trusting relationships with students with chronic health conditions and their families. As integral team members, school nurses help schools build a culture of attendance by creating a welcoming and engaging school environment that emphasizes building relationships with families and stresses the importance of attending school every day (Attendance Works, 2017). For example, one school assigned different team members to mentor and befriend key students at risk. The school nurse’s daily interaction with the students helped improve attendance and supported the team’s approach to absenteeism (NASN, 2015).

School nurses collect, interpret, monitor, and use data to develop population-based programs and identify students at risk for absenteeism due to health or social concerns including students with disabilities. They use their expertise in population-based care to develop programs that provide education and follow up on screenings, which also increases return-to-class rates (AAP, 2016; NASN, 2015; NASN 2016). These skills can be used in developing school-wide programs. When school nurses have access to attendance data, they can track health related attendance rates and address these concerns. School nurses can also address chronic tardiness and early dismissals related to health or social concerns that may lead to absenteeism. Yet, many schools look at daily attendance (students at school) and truancy but fail to look at health related absences (Kemp, 2016).

CONCLUSION

Chronic absenteeism is a critical problem influencing student academic achievement with potential long-term effects on health, education, and financial stability. Finding solutions to the problem of chronic absenteeism is critical for enhancing educational outcomes for students. School nurses are vital team members who identify and mitigate the health, safety, and social risk factors that are barriers to school attendance (McClanahan & Weismuller, 2015).

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Students with Chronic Health Conditions: The Role of the School Nurse

Position Statement

SUMMARY
It is the position of the National Association of School Nurses (NASN) that to optimize student health, safety, and learning, a professional registered school nurse (hereinafter referred to as school nurse) be present all day, every day. The American Academy of Pediatrics’ Council on School Health (2016) highlights the important role school nurses play across a child’s continuum of care and recommends that every school should have at least one nurse. The Every Student Succeeds Act (2015) identifies school nurses as leaders of student chronic disease management in schools. Utilizing the nursing process, the school nurse manages chronic health conditions in the school setting by providing direct care, providing case management, and advocating for students and families to help them access needed resources and support to achieve academic success (CDC, 2017b).

BACKGROUND
Chronic health conditions include acquired, incurable diseases and other illnesses lasting more than 12 months (U.S. Department of Health and Human Services, 2011). These conditions include long-term physical, emotional, behavioral, functional and developmental disorders that occur along a continuum from mild to severely disabling (McClanahan & Weismuller, 2015). It is estimated that one in four students in United States schools may have a chronic health condition (Jackson, Vann, Kotch, Pahel, & Lee, 2011; Van Cleave, Gortmaker, & Perrin, 2010). Approximately 6% of those students have multiple chronic conditions leading to challenges with treatment adherence, disease acceptance, lifestyle modification, care coordination, increased exposure to chronic condition risk factors, and difficulties transitioning to adult healthcare settings (Anderson, 2010; Rezaee & Pollock, 2015). Children with chronic conditions are at risk for high absentee rates, low student engagement, dropping-out of school, exposure to bullying, disruptive behaviors, poor grades, and below-average performance on standardized achievement tests (Forrest, Bevans, Riley, Crespo, & Louis, 2011; Bethell et al., 2012). As life expectancy for students with chronic conditions increases, the complexity of the healthcare and educational service needs of students also increases (Martin & Osterman, 2013).

School nurses are responsible for informing educational communities about the impact of the chronic health condition(s) on students’ abilities to engage in their education. These students’ rights of participation and access to school healthcare services are protected by the Rehabilitation Act, Section 504 (1973) and the Individuals with Disabilities Education Improvement Act [IDEIA](2004). It is the responsibility of local school districts to educate students with chronic conditions in the least restrictive environment. The school nurse collaborates with education staff to promote a safe and accommodating school environment for children with chronic health conditions (American Nurses Association & National Association of School Nurses [NASN], 2017; Brook, Hiltz, Kopplin, & Lindeke, 2015).
RATIONALE
The special needs of students with chronic health conditions are complex and continuous. The school nurse has a pivotal role in:

- interpreting a student’s health status;
- explaining the health impairment to the school team;
- translating the healthcare provider orders into the school setting by developing Individualized Healthcare Plans;
- providing assessment, direct care, coordination and evaluation of care;
- providing nursing delegation that aligns with state nurse practice acts, rules and regulations; and
- advocating for appropriate accommodations in the educational setting (Leroy, Wallin, & Lee, 2017; McClanahan & Weismuller, 2015; NASN, 2015; Zirkel, Granthom, & Lovato, 2012).

The services of a school nurse support readiness to learn, classroom participation, and academic progress (ANA & NASN, 2017; Bethell et al., 2012; NASN, 2015). Bethell et al., 2012; NASN, 2015). The Whole School, Whole Community, Whole Child Model (WSCC) (ASCD and Centers for Disease Control and Prevention [CDC], 2014) reminds schools and communities that the child, at the center of educational systems, must be healthy, safe, engaged, supported and challenged. The school nurse works to support the constructs of WSCC by coordinating intervention and evaluation services, identifying previously unrecognized symptom patterns and student responses to those patterns, and referring students to the appropriate resources (CDC, 2017a). By assisting students with the management of their chronic conditions, the school nurse contributes to risk reduction, increased classroom seat time, decreased student absenteeism, improved academic success, and cost savings to families and educational and healthcare systems (Forbes, 2014; NASN, 2015; Wang et al., 2014, Michael, Merlo, Basch, Wentzel, & Wechsler, 2015). School nurses decrease chronic absenteeism by assisting families to access health care; by providing condition-related education to parents, students and staff; and by coordinating care between school, family and medical home (Jacobsen, Meeder, & Voskuil, 2016).

School nursing services result in improved health outcomes for students with chronic health conditions (Leroy et al., 2017). The school nurse, working within the constructs of the Framework for 21st Century School Nursing Practice (NASN, 2015) plays a decisive role in mitigating the long-term impact of chronic health conditions on children by coordinating the interests of families, education, healthcare systems, public health, insurance, and community agencies (McClanahan & Weismuller, 2015; Wolfe, 2013). Healthcare providers can utilize the power of school nurses to maintain the health of students who have chronic conditions at the highest level; decrease healthcare costs, unnecessary use of emergency rooms, and hospitalizations; and increase quality of care (Wang et al., 2014). The school nurse collaborates with transition planning teams to facilitate seamless movement of the student through the educational and healthcare settings (Bargeron, Contri, Gibbons, Ruch-Ross, & Sanabria, 2015; NASN, 2014). School nurse care coordination between “schools, parents and health-care providers assists students with chronic health conditions...to optimize health and learning” (Miller, Coffield, Leroy & Wallin, 2016, p. 362). Considering the positive impact school nurses have on health and academic outcomes of students with chronic conditions, school systems should develop processes to include school nurses at the outset of student enrollment and in special education individual education planning.

CONCLUSION
It is the position of NASN that to optimize student health, safety, and learning, a school nurse be present all day, every day. The school nurse is part of a comprehensive healthcare and education system. The school nurse is well positioned to support the health and academic success of students with chronic health conditions by providing
direct care and facilitating the many practice components of care coordination (Bargeron et al., 2015; Brook et al., 2015; NASN 2015). School nurse advocacy helps students and families to access needed resources in support of academic achievement (CDC, 2017). School nurses are leaders who provide care coordination, health education and promotion, quality improvement, and critical thinking skills that benefit schools, families, the healthcare system, and most importantly children with chronic health conditions.

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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.
Concussions: School Based Management

Position Statement

NASN POSITION
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/care coordination in collaboration with the school-based team to manage student concussion. The school nurse has the healthcare knowledge and skills to provide concussion prevention education to parents/guardians, students, and school staff; identify suspected concussions; and help guide students as they return to academics/learning, physical activities, and sports.

BACKGROUND and RATIONALE
A concussion is a type of traumatic brain injury (TBI) caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move rapidly back and forth. This sudden movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging brain cells (CDC, 2019a). The CDC has a checklist for initial assessment of possible concussion as well as danger signs for when the person should immediately be seen in an emergency department (CDC, 2019b). It should be noted that the initial assessment severity of TBI does not necessarily predict the extent of disability arising from TBI (NASEM, 2019). Approximately 2.5 million or 15.1% of United States high school students reported having at least one concussion on the 2017 Youth Risk Behavior Survey (DePadiia et al., 2017). All 50 states have enacted a sports concussion law, establishing protocols such as removal from play, return to play protocols, and concussion information for student athletes and their parents (Green, 2018). However, many states do not have return to school / return to learning laws or guidelines. The 5th International Consensus Statement on Concussion recommended that children with concussion should be managed conservatively, with the emphasis on return to learn before returning to sports. (McCrory, Meeuwisse & Dvorak et al., 2017). Concussion in children and adolescents can also occur outside of sports, such as motor vehicle accidents, a fall or collision from riding a bicycle (Haarbauer-Krupa et al., 2018). Regardless of where or how a concussion occurs, it is vital to properly recognize and respond to a suspected concussion to prevent further injury and to help with recovery (CDC, 2019a).

Schools must identify and support the educational and emotional needs of students by offering ascending levels of academic interventions (McAvoiy et al., 2018). To assist students returning to school after a concussion, the school-based concussion management team led by the school nurse should consist of the school guidance counselor, school psychologist/counselor, athletic trainer, primary care physician, teachers, and parents. The team should counsel the student and family regarding the process of gradually increasing the duration and intensity of academic activities as tolerated, with the goal of increasing participation and learning without exacerbating symptoms (Lumba-Brown et al., 2018).

Recovery from concussion is different for each student. Most students only require short-term academic adjustments as they recover. The school nurse coordinates concussion care by taking the lead between the medical and educational teams. Based on the severity and symptoms the student is experiencing, the school nurse, in consultation with the concussion management team, creates “a plan of care written by the school nurse for students with or at risk for physical or mental health needs” called an Individualized Healthcare Plan (IHP) (ANA & NASN, 2017, p 90; McNeal & Selekman, 2017). When planning the student’s return to academics/learning the school team also considers the effect of comorbid conditions, such as Attention Deficit Hyperactivity Disorder, depression, migraine headaches, sleep disorders, or other learning disabilities (McNeal & Selekman, 2017). When a concussion is prolonged or severe, a more formal 504 plan of accommodations is the next ascending support to be used. (McAvoiy, et al., 2018). If the student’s learning cannot be supported by an IHP or 504, an individualized education plan may be warranted for students with more chronic cognitive or emotional disabilities.
The school nurse, individually or as a member of a collaborative school committee, identifies students with possible concussion, makes appropriate referrals, and by way of care coordination leads students and families through the return to academics/learning and eventually a gradual return to physical activity including sports.

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Nursing Delegation in the School Setting

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that, when necessary and permitted by law, the registered professional school nurse (hereinafter referred to as school nurse) can implement safe and effective delegation of nursing tasks to unlicensed assistive personnel, (UAP) at school. Delegation is an important practice component of the Care Coordination principle within NASN’s Framework for 21st Century School Nursing Practice (NASN, 2016). Safe nursing delegation requires that the school nurse is knowledgeable about the profession’s guidance on delegation, state nurse practice acts, (NPA), other applicable federal and state laws, and district policies (Resha, 2017; Mitts vs. Hillsboro Union High School, 1987). Proper delegation requires communication and collaboration between the school nurse, healthcare providers, school administrators, parents, teachers, and UAP. It is the position of NASN that a school nurse be present in school all day, every day to optimize student health, safety, and learning. However, current educational, health, safety, and economic conditions may necessitate the delegation of nursing tasks by the school nurse to unlicensed assistive personnel to protect every student’s right to quality school health services.

BACKGROUND AND RATIONALE

Delegation, as defined by the American Nurses Association, (ANA, 2012) is “the transfer of responsibility for the performance of an activity to another, with the former retaining accountability for the outcome” (p. 6). According to the National Council of State Boards of Nursing (NCSBN, 2016), “delegation is allowing a delegatee to perform a specific nursing activity, skill, or procedure that is beyond the delegatee’s traditional role and not routinely performed” (p. 6). In the community setting of schools, delegation occurs when the school nurse assigns the performance of a specific nursing task to another person, often an UAP. Some states and school districts refer to UAP as paraprofessionals, health clerks, nursing assistants, health aides, or teacher’s aides (Bobo, 2014). The school nurse can only consider delegating nursing tasks that do not involve nursing judgment or any component of the nursing process, such as nursing assessment or developing individualized healthcare plans (ANA, 2012; Bobo, 2014; NCSBN, 2016).

School nurses face an ever-increasing workload, a concept that takes into account school nurse to student ratios, acuity, and factors that influence quality school nursing care in support of academic achievement including mental/emotional conditions and social determinants impacting health (Combe, et al., 2015). In addition, the legal responsibility of schools to ensure access to a free, appropriate public education (FAPE) for all children under Section 504 of the Rehabilitation Act of 1973 (Section 504), or the Individuals with Disabilities Education Act, (IDEA) puts school nurses at the forefront of ensuring that students with healthcare needs are identified and accommodated (Rehabilitation Act of 1973, Section 504; Individuals with Disabilities Education Act [IDEA], 2004).

The decision to delegate a nursing task in the school setting is the sole responsibility of the school nurse who must consider the needs of the individual student, as well as those of the school population, the stability and predictability of the student’s condition, school nurse workloads, documented training and competence of the delegatee, and the ability of the school nurse to supervise the delegatee, as well as the student’s health outcomes. (NCSBN, 2016; Shannon & Kubelka, 2013; Mitts vs. Hillsboro Union High School, 1987). Due to the complexity of delegation in the school setting and evidence that suggests delegation is a skill that nurses
generally do not acquire in their educational preparation, school nurses should be provided educational opportunities to develop competence in the complex skills of delegation (Maningo & Panthofer, 2018).

Parents/guardians and school administrators need guidance in understanding the safety and legal requirements surrounding delegation as dictated by state NPA's and federal regulations. Just as in other healthcare settings, safe and legal nursing delegation in the school setting must be supervised by a registered nurse who monitors delivery of care and periodically assesses the competence of the UAP (Johnson, 2017; Shannon & Kubelka, 2013). Unless otherwise guided by state law or district policy, the school nurse determines how closely to supervise and how often to reassess the UAP. If the school nurse determines that delegation is not safe and the UAP is not competent to complete the task for any reason, the school nurse must work with the school administration to identify a more qualified individual who is willing to accept the responsibilities of delegation. The school nurse may need to rescind delegation and make provisions for the needed health service until the newly assigned delegatee is competent to assume the responsibility to perform and document the delegated task (NCSBN, 2016).

State laws and regulations regarding delegation vary considerably and the school nurse must adhere not only to their own state's laws and regulations, but also those of other states for out-of-state school-sponsored events (Kappel, 2018). In addition, licensing laws must be considered to ensure that the school nurse can legally provide nursing services in the state where a school-sponsored event occurs (Kappel, 2018). New legislation often demands changes in school district policies and school districts must have a clear, current, and all-inclusive school health services delegation policy that establishes safe practice and aligns with legal stipulations (Lineberry, Whitney & Noland 2018).

Current school nurse workloads (Willgerodt, Brock, & Maughan 2018), school district fiscal constraints, and the need to ensure FAPE make nursing delegation a potential strategy to meet the healthcare needs of students. Delegation is not appropriate for all students, all nursing tasks, or in all school nurse practice settings. Neither the NASN nor the NCSBN support delegating steps in the nursing process, including nursing assessment or the use of nursing judgment (NASN, 2016, NCBSN, 2016). Key factors guiding determination for delegation include state laws, rules, and regulations; the five rights of delegation; safety issues; individual student healthcare needs; health services capacities, and UAP competence.

SUMMARY

NASN supports school nursing delegation of appropriate nursing tasks to UAPs as permitted by state laws and regulations to meet student health and safety needs. School nurses implement NASN’s Framework for 21st Century School Nursing Practice™ principle of care coordination through direct and delegated care of students with healthcare needs (NASN, 2016). 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). Delegation is a complex skill requiring professional clinical judgment, critical thinking, and accountability for the outcome of the delegated task. When applied appropriately, delegation of nursing tasks to UAP can be safe, effective, and cost saving and can allow the school nurse to focus on professional practice that involves implementation of the nursing process (NCSBN, 2016).
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Diabetes Management 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 the school staff member who has the knowledge, skills, 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], 2016). Health services must be provided to students with diabetes to ensure their healthcare needs are met; requirements of relevant federal and state laws are met; and they can fully participate in school and school-sponsored events (AADE, 2016).

BACKGROUND

Diabetes is the third most common chronic health disease affecting an estimated 2.22/1,000 children and adolescents according to The Search for Diabetes in Youth (SEARCH) Study (Pettitt et al., 2014). Children and adolescents are defined as youth under the age of 20 years. In 2009, approximately 191,986 or one in 433 youth with diabetes lived in the U.S. From these, 87% have type 1 diabetes and 11% have type 2 diabetes (Pettitt et al., 2014). In the year 2008 to 2009, 18,436 youth were newly diagnosed with type 1 diabetes and 5,089 youth were newly diagnosed with type 2 diabetes (Centers for Disease Control and Prevention [CDC], 2014).

Advances in diabetes technology continue to enhance the students’ ability to manage diabetes at school, thus improving their quality of life. Children and adolescents monitor blood glucose levels several times a day via blood glucose meters and continuous glucose monitors, conduct carbohydrate calculations, and inject insulin via syringe, pen and pump to attain blood glucose control (Brown, 2016). Intensive resources and consistent evidenced-based interventions 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, 1993).

Each student with diabetes is unique in his or her disease process, developmental and intellectual abilities, and levels of assistance required for disease management. An individualized Diabetes Medical Management Plan (DMMP) is completed by the healthcare provider and includes the medical orders to manage the student’s diabetes needs during the school day and at school-sponsored activities (Jackson et al., 2015). The school nurse develops an individualized healthcare plan (IHP) in partnership with the student and his or her family, based on the medical orders in the DMMP and the nurse’s assessment. (American Nurses Association/National Association of School Nurses [ANA/NASN], 2011). The IHP outlines the student’s diabetes management strategies and personnel needed to meet the student’s health goals in school (National Diabetes Education Program [NDEP], 2016). The school nurse also prepares an emergency care plan (ECP), based on the DMMP medical orders, that summarizes how to recognize and treat hypoglycemia and hyperglycemia and directs action to take in an emergency. Copies of the ECP should be distributed to all school personnel who have responsibilities for the student during the school day and during school-sponsored activities (NDEP, 2016).

Throughout childhood and adolescence, the student who has diabetes continuously moves through transitions toward increasing levels of independence and self-management (American Diabetes Association [ADA], 2016), requiring 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 nursing assessment and as outlined in the IHP (Wyckoff, Hanchon, & Gregg, 2015).
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, sent anywhere alone, or escorted by another student. Communication systems and trained school staff should be in place to assist the student. Hypoglycemia can occur suddenly and requires immediate treatment (NDEP, 2016).

Another complication of diabetes, hyperglycemia (high blood glucose), can develop over several hours or days (NDEP, 2016). If untreated, hyperglycemia can lead to the life-threatening condition, diabetic ketoacidosis (DKA) (Wyckoff et al., 2015). For students using insulin infusion pumps, lack of rapid-acting insulin increases their risks of developing DKA more rapidly (Brown, 2016). School nurses may utilize one or more of the model NDEP three levels of staff training to facilitate prompt, safe, and appropriate care for students with diabetes (NDEP, 2016).

Students with disabilities, which include students who have special healthcare needs such as 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 prohibit recipients of federal financial assistance from discriminating against people on the basis of disability (NDEP, 2016). These laws are enforced 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, 2016).

Advances in science, technology, and evidence-based practices related to diabetes management require school nurses to attain and maintain current knowledge and competence in the delivery and coordination of the care for the student with diabetes (NDEP, 2016, Pansier & Schultz, 2015).

RATIONALE

Children and adolescents with diabetes are confronted with many challenges and potential educational barriers in school. Some of the main barriers include lack of informed and trained staff, absence of a school nurse who is on site daily, and lack of diabetes management policies (Pansier & Schultz, 2015). School-based diabetes interventions led by school nurses are essential to improve health and academic outcomes and ensure a safe school environment for children and adolescents with diabetes.

The increasing prevalence of health-related disabilities, including type 1 and type 2 diabetes, has compounded the need for coordination of care between the school, the student’s healthcare team, the family, and service providing agencies (McClanahan & Weismuller, 2015). Recent studies show that care coordination in the school setting improves quality of life, diabetes glucose control, ability to self-manage, readiness to learn, classroom participation, and academic performance (Pansier & Schultz, 2015). Care coordination, a core professional school nursing principle, and its related practice components involve developing and maintaining competence in creating, updating, and implementing care plans that comprehensively create an environment where students will maintain optimal health in the school setting so that they can succeed academically (NASN, 2016).

School nurses implement the DMMP, develop IHPs and ECPs, and train school personnel (McClanahan & Weismuller, 2015). When nursing delegation of diabetes care tasks is deemed appropriate, the school nurse provides ongoing supervision and evaluation of student health outcomes (Wyckoff et al., 2015). School nurses are accountable for addressing the students’ ongoing healthcare needs, encourage independence and self-care within the student’s ability, and promote a healthy, safe school environment that is conducive to learning (NDEP, 2016).

Ineffective management of diabetes in school may lead to absenteeism, depression, stress, poor academic performance, and poor quality of life (Pansier & Schulz, 2015). Managing diabetes at school is most effective when there is a partnership among students, parents/guardians, school nurses, healthcare providers, and other school personnel (e.g., 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. Poorly controlled diabetes not only affects 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 (DCCT, 1993).

CONCLUSION

Diabetes is listed as the third most common chronic health condition that impacts approximately one in 433 children and adolescents in the United States (Pettitt et al., 2014). The school nurse is the most appropriate staff member in the school to fully meet the healthcare needs of students and should be the key coordinator and care provider for the student who has diabetes (ADA, 2016). The school nurse’s competence in the practice components of the principle of Care Coordination (e.g., case management, collaborative communication, providing and/or coordinating the provision of direct care, training of non-medical personnel) is essential to promoting the health, safety, and academic success of students who have diabetes within the school setting (AADE, 2016; McClanahan, 2015; NASN, 2016).

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Do Not Attempt Resuscitation – The Role of the School Nurse

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 benefits from having an Individualized Healthcare Plan (IHP) and an Emergency Care Plan (ECP) developed by the registered professional school nurse (hereinafter referred to as school nurse). While it is not a common occurrence for children with a Do Not Attempt Resuscitation (DNAR) order to die while at school, it is important to develop a plan in the event it does happen (DeMitchell & Thompson, 2017). Furthermore, a DNAR order for a student needs to be reviewed individually at the district level with input from the school district’s legal counsel for consideration of state and local laws and according to district DNAR policy. As advocates for their students, school nurses work with the school team, the parents, and students’ healthcare provider to meet the students’ underlying healthcare needs as well as establish protocols and practices that enable students to receive best practice care throughout the entire course of their condition while they are in school.

BACKGROUND

In 1974 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 would not benefit from CPR (Larcher, Craig, Bhogal, Wilkinson, & Brierly, 2015). 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 physician 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).

The number of children and young people with palliative care needs is rising (Peate, 2015). According to Singh, Click, McCracken, and Hebbar (2017), pediatric hospice and palliative medicine physicians strive to “relieve suffering, improve quality of life, facilitate informed decision-making, and assist in care coordination” with the greater goal of improving the quality of medical care delivered to patients and their families during acute and chronic illness. Students with chronic or terminal conditions, when possible, belong in school. Students benefit from participation in all school activities, including the psychosocial and emotional benefits of interacting with peers and maintaining their daily routine (Klick & Hauer, 2010; Zacharski et al., 2013). State and local laws/regulations vary regarding DNAR orders for student.

Currently, the order to provide comfort care is part of a much broader palliative care plan that may include Medical Orders for Life Sustaining Treatment (MOLST) (APA, 2010). In some states, school nurses are required to honor DNAR orders. In the case of ABC and DEF School v. Mr. and Mrs. M in the state of Massachusetts (1997), the court ordered the school to honor the DNAR order for a medically fragile child (Adelman, 2010; Deutch, Martin, & Mueller, 2015; Putman, 2017). 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).

According to the 2011/2012 National Survey of Children with Special Health Care Needs (CSHCN), approximately 14.6 million children ages 0-17 years in the United States, or 19.8 %, have special healthcare needs. The percentages of CSHCN range from 14.4%-26.4% across 50 states and the District of Columbia (Centers for Disease Control and Prevention’s National Center for Health Statistics, n.d.). The AAP (2010) estimates that, on any given day, there are 3900 school-age children who are within six months of dying from chronic health conditions (as cited in Putnam, 2017). According to a Centers for Disease Control and Prevention [CDC] 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 (Brener, Wheeler, Wolf, Vernon-Smiley, & Caldart-Olson, 2007).
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). The Office for Civil Rights of the DOE (2016) states that a free and appropriate public education must be provided to each person with a disability (a person with a significant mental or physical impairment, or history of such, that substantially limits a major life activity). Services must be provided in the least restrictive environment.

RATIONALE

The National Association of School Nurses’ *Framework for 21st Century School Nursing Practice™* directly aligns with care coordination as a key concept in the school setting (NASN, 2016). Decisions to limit treatments—or which treatments should be given—are made by clinical teams in partnership with the parents and child, if appropriate (Larcher et al., 2015). Communication within healthcare teams and with parents and children is important and needs to include those in the community who also have a duty of care to the child. All clinical staff need to have access to continuing professional training and education in communication skills, ethics and the issues raised by decisions to limit treatments (Larcher et al., 2015).

Families face many challenging issues but perhaps none more sensitive and emotionally challenging than that of an order for DNAR. A DNAR order is not abandonment of medical treatment and does not replace any obligation to provide quality care; rather it is part of the management plan. A DNAR order is in place to facilitate the individual with a terminal illness receiving the best care possible at the end of life. The healthcare provider(s) and the family review and determine this plan to communicate the difficult decision to refrain from life-sustaining treatment that would be ineffective or to guide when risks of treatment outweigh the benefits. A DNAR physician order for the school is implemented in the context of palliative care, including comfort measures as well as addressing the emotional and spiritual needs of the student (AAP, 2010).

The school nurse is a specialized practitioner who focuses on education and health and provides an important link between the school, home, and community (Perry 2014). Care plans for students with DNAR orders should be implemented in the context of palliative care and include comfort measures (Zacharski et al., 2013). School nurses must be knowledgeable about state and district regulations, community support systems, resources for advocacy, and the process of writing and implementing IHPs for students with DNAR orders (Zacharski et al., 2013). In addition, an ECP may be required to give non-medical staff information necessary to provide appropriate medical care for students who have DNAR orders (Larcher et al., 2015). Each palliative care request must be reviewed with the student’s healthcare provider, determining orders and direction for his or her client, and with the school nurse, leading the school team in order to provide the best care possible in the school setting for the student (AAP, 2010). The school nurse and staff focus on what can be provided for comfort rather than on what is not being provided (Zacharski et al., 2013).

CONCLUSION

School nurses play a pivotal role in supporting students with DNAR orders through the development of an IHP and ECP (AAP, 2010; Peate, 2015). 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 (DeMitchell & Thompson, 2017; Selekmant et al., 2013). School nurses along with the school district should create clear, written policies related to DNAR with regard to their state laws and statutes (Perry, 2014).

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Position Statement

NASN POSITION
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, 2017). Additionally, NASN (n.d.) supports state school nurse certification/licensure and endorses national certification of school nurses through the National Board for Certification of School Nurses.

BACKGROUND AND RATIONALE
To respond to the increasing demands for public health nursing, the American Academy of Nursing (Kub et al., 2017) and the National Advisory Council of Nurse Education and Practice (2016) recommends that nurses attain advanced education. The Public Health Nursing: Scope and Standards of Practice states that the minimum preparation for beginning professional nursing practice in public health is a baccalaureate degree in nursing (ANA, 2013). School nursing is founded in public health nursing and is defined as follows:

[A] specialized practice of nursing [which] protects and promotes student health, facilitates optimal development, and advances academic success. School nurses, grounded in ethical and evidence-based practice, are the leaders who bridge health care and education, provide care coordination, advocate for quality student-centered care, and collaborate to design systems that allow individuals and communities to develop their full potentials (ANA & NASN, 2017).

School nursing is further outlined in the Framework for 21st Century School Nursing Practice emphasizing evidence-based, clinically competent, quality care (NASN, 2016). A nursing baccalaureate degree best prepares nurses for school nursing practice, including the ability to lead school health programs, advocate for students and families, and provide individual and population-based care (ANA & NASN, 2017).

To enter professional registered nurse practice, nursing graduates must pass the National Council Licensure Examination for the Registered Nurse (NCLEX-RN). Licensure protects the public by indicating that a nurse successfully completed an examination that demonstrated a minimal level of competency to practice.

In addition to nursing licensure, post-baccalaureate education, including school nurse licensure or certification, may be required by state departments of education to practice school nursing. Specialty certification demonstrates expertise in a focused area of practice (Coelho, 2019). Requirements for state certification and the certifying bodies vary by individual state or territory in which a school nurse practices. In 1984, NASN developed a national certification examination and established the National Board for Certification of School Nurses (2018) to promote and recognize quality practice in school nursing and to assure that certification criteria and examinations in school nursing are determined by school nurse experts.

Registered nurses in the specialty practice of school nursing require advanced skills to competently address the complex health needs of students within a school community setting (ANA & NASN, 2017). These skills are attained through a minimum of a baccalaureate degree in nursing and validated by specialized certification in school nursing.
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Electronic Health Records:  
An Essential Tool for School Nurses to Keep Students Healthy  

Position Statement

NASN Position

It is the position of the National Association of School Nurses (NASN) that all registered professional school nurses (hereinafter referred to as school nurses) should have access to a software platform for student electronic health records (EHRs) that includes nursing language/medical terminology and complies with standards of confidentiality, security and privacy. Interoperability of records with other members of the healthcare and school-based teams facilitates optimal student/population health and academic outcomes. While educational/student data management systems may offer health data modules, these systems do not provide opportunity for documentation with nursing language or medical terminology, do not have capacity for interoperability with the student’s community-based health records, and may not have the appropriate Health Information Portability and Accountability Act (HIPAA) and Family Rights Educational Privacy Act (FERPA) standards of confidentiality.

Background

EHR programs are meant to share information from all the healthcare providers involved in the care of the patient, regardless of the health organization, and are subject to multiple federal, state and local regulations (Johnson, 2017; The Office of the National Coordinator for Health Information Technology [HealthIT.gov], 2011). EHRs are designed to document and share information appropriately beyond the originating organization (HealthIT.gov, 2011). EHRs in a school setting that have the capability to manage data and share it with members of the health care team outside of the school setting can serve to optimize coordination of care.

Documentation of health information is an expectation of professional school nursing practice (American Nurses Association & NASN [ANA & NASN], 2017). EHRs facilitate improved quality, safety and efficiency of care; lower the costs of healthcare; improve privacy of health information; and allow greater patient access to their own health records (U.S. Department of Health and Human Services [HHS]; Office of the National Coordinator for Health Information Technology, 2014). Health technology and EHRs also help organize care through improvement of clinical decision-making and facilitation of statistical evaluation (Kartal & Yazici, 2017).

The Centers for Medicare and Medicaid Services (CMS, 2019) actively promotes EHRs with the goal of improving healthcare. The American Academy of Pediatrics (AAP) considers the use of an EHR “[as] a mark of professionalism and a means to improve quality, efficiency, and safety of pediatric care” (Lehmann, O’Connor, Shorte, & Johnson, 2015, p. e8). The Institute of Medicine (2003) has indicated that EHRs should support delivery of patient care, be key evidence-based data points, improve patient safety, improve efficiency, facilitate management of chronic health conditions, provide outcome analysis, and share data across settings.

The transformation toward interoperable health information technology infrastructure and the establishment of health information exchanges (HIEs) is impacting all aspects of professional nursing, including school nursing practice. “Interoperability is the ability of different information systems, devices or applications to connect, in a coordinated manner, within and across organizational boundaries to access, exchange and cooperatively use data amongst stakeholders, with the goal of optimizing the health of individuals and populations” as proposed by the Healthcare Information and Management Systems Society (HIMSS, 2018).
Rationale

EHRs that are clinically/medically based are designed with the potential to interface within the larger healthcare interoperability ecosystem. EHRs should:

- Be encrypted, with each individual user having “his or her own unique user name and password” (NASN, 2019, p. 29), that “authenticates a legally recognized electronic signature of the entry into the record” (Johnson, 2017, p. 103);
- Have the ability to produce an audit log of changes made to an original entry (overwrite protection);
- Include a date/time stamp for each entry;
- Have a secure backup system beyond the end user’s computer (Johnson & Guthrie, 2012; Johnson, 2017);
- Have partitions that limit access to sections of the record depending on each team member’s need to document and see information;
- Map school nursing documentation to standardized coding such as SNOMED (Systemized Nomenclature of Medicine) and LOINC (Logical Observation Identifiers Names and Codes) to facilitate interoperability and care coordination (Johnson, 2017);
- Support the collection of data points as defined by NASN’s National School Health Data Set: Every Student Counts! (NASN, 2018); and
- Facilitate third party reimbursement to local education agencies for healthcare provided to students.

EHRs assist school nurses in providing population-based healthcare to the entire school community through efficient data management processes including documentation, reporting, and analysis of student health data. EHRs have the capability of aggregating data in real time, allowing the school nurse to quickly identify health trends, such as communicable diseases or students with the potential for health risks, and take swift action (Birk-Urovitz et al., 2017). For example, school nurses share aggregated absence and communicable disease data with local health departments to inform community disease surveillance. School population health data shared via EHR can track immunization compliance, incidences of environmental and chronic health conditions, and effective prevention activities (Association of State and Territorial Health Officials [ASTHO], 2016). Use of aggregate data from standardized school nurse documentation would support a national school health database that could be used to describe student healthcare needs, best outcome-based interventions, and academic success (Maughan et al., 2014).

EHRs generate a legal document of care provided by the school nurse (Kartal et al., 2017), meet the requirements for quality documentation and communication among the health care team (Akhu-Zaheya, Al-Maaitah, & Hani, 2017), and are an investment to assist improvement of student health and academic outcomes. Due to the specialized requirements of a school EHR that differ from the educational/student data management system, school nurses are integral members of the information technology selection committee. School nurses are equipped to determine EHR quality, training, policy/procedure, security, and stakeholder education.

Conclusion

EHRs in the school setting are an essential tool for the 21st century school nurse, having the potential to engage school nurses in student-centered practice. School nurse utilization of an EHR has the potential to improve the efficiency and quality of healthcare, thereby having a positive impact on the health, safety, and educational success of students.

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Emergency Preparedness

Position Statement

NASN POSITION

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 expertise in school health and is a vital member of the school team who collaborates with community agencies to develop comprehensive emergency response procedures. The school nurse knowledgeable about the pathophysiology of physical and psychological trauma and is a valuable resource for the provision of health care and support in emergencies. (Kalekas, 2017).

BACKGROUND AND RATIONALE

“School nurses have a unique role to protect and serve the nation’s children whenever disaster strikes during the school day” (Kalekas, 2017, p. 458). Every day approximately 60 million primary and secondary aged students attend public, charter, or private schools in the United States (U. S. Department of Education [USDE], 2018). It is fundamentally important that school administration, school staff, parents, and students work together to promote and maintain a safe environment for students (Accredited Schools Online, n.d.; American Academy of Pediatrics [AAP], 2015). While emergencies in the school setting are often unpredictable, those involved in the care of students should prepare to meet the needs of those students before, during, and after an event. Emergencies that may occur at school include:

- Student, staff and visitor health-related emergencies or injuries;
- Mass casualty incidents;
- Weather-related emergencies; and
- Hazardous materials emergencies (Cowell & McDonald, 2018; Kalekas, 2017).

Preparedness in schools is a process designed to protect students and staff from harm, minimize disruption, ensure the continuity of education for students, and develop and maintain a culture of safety. (National Integration Center, 2018). To maximize success, effective management of school emergencies requires training, preparation, and planning for best practices (Trust for America's Health [TFAH], 2017).

Utilizing their expertise in assessment, planning, implementation and evaluation, school nurses provide valuable insights for the four phases of school campus/district emergency management: Prevention/Mitigation, Preparedness, Response, Recovery (Doyle, 2013). The school nurse is a leader and integral partner with school staff and outside agencies in developing comprehensive school plans/procedures for injury prevention and first aid, facilitating evacuation, caring for students with special needs, performing triage, educating and training staff, providing surveillance, reporting (Doyle, 2013; Kalekas, 2017), and assisting survivors with their immediate psychological and emotional needs; and referral to appropriate mental health services for long-term support (Brymer et al., 2012; National Association of School Psychologists, 2017). School nurses recognize and respond to both minor and mass emergent situations thereby minimizing unnecessary delay in initiating an effective response (Cowell & McDonald, 2018; Hoffman & Silverberg, 2018). School nurses advocate for mass casualty triage and training that effectively addresses children’s unique physiology and psychological development (AAP, 2015).
SUMMARY

To optimize student health, safety, and learning, NASN advocates for a school nurse to be present in school all day, every day, and this presence is especially beneficial in planning for and responding to emergency situations. School nurses, as healthcare providers, are an essential member of the leadership team, bringing their unique perspective to optimization of all phases of school emergency preparedness (Davis-Aldritt, 2017).

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“To optimize student health, safety and learning, it is the position of the National Association of School Nurses that a professional registered school nurse is present in every school all day, every day”

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Head Lice Management in Schools

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that the management of head lice (Pediculus humanus capitis) infestations in school settings should not disrupt the educational process, including but not limited to the elimination of classroom screening, forced absences from school for nits and/or live lice and broad notification that a case of head lice has been found. As the leader who bridges health care and education, the registered professional school nurse (hereinafter referred to as school nurse) advocates for evidence-based head lice management strategies that eliminate exclusionary practices and promote positive student outcomes, including reduced absenteeism.

BACKGROUND AND RATIONALE

Head lice infestation is a common concern worldwide, with both social and medical implications. In the United States it is estimated that 6-12 million head lice infestations occur in children 3-11 years of age each year. The infestations are most likely to occur in preschool and elementary age students and their household members, regardless of socioeconomic status or geographic region (Centers for Disease Control and Prevention [CDC], 2019, Who Is at Risk section, para. 1).

The cost of treatment in the United States has been estimated to be $500 million dollars per year (Cummings et al., 2018). A head lice infestation is not a communicable disease and no health risks have been associated with head lice (Pontius, 2014; CDC, 2015, para. 2; CDC, 2019, Do Head Lice Spread Disease section). Current research indicates that families are over- or incorrectly treating pediculosis, which may be a contributing factor in lice resistance (Cummings et al., 2018; Koch et al., 2016). Head lice infestation, including “no live lice” and “no nit” policies, causes unnecessary school absences for students and loss of parent workdays and family wages. Exclusion from school can adversely affect students emotionally, socially and academically (Devore et al., 2015; Pontius, 2014).

Both the American Academy of Pediatrics (AAP) and the CDC advocate for the following practices to be discontinued:

- whole classroom screening,
- exclusion for nits or live lice,
- notification to others except for parents/guardians of students with head lice infestations (Devore et al., 2015; CDC, 2015b, para. 3).
Classroom screenings are often inaccurate, not cost-effective, and notification to others may be a breach of confidentiality (Pontius, 2014). Schools should not exclude students for active infestation or when nits remain after appropriate lice treatment. School nurses should advocate for evidence-based prevention measures that include assisting parents with identification of lice/nits and teaching students, parents, staff and community effective prevention measures.

Both AAP and CDC assert that treatment should only be initiated when at least one live louse has been identified (Devore et al., 2015; CDC, 2015, para. 3). Since it is likely that a child's infestation has been present for 30 days or more prior to the identification of live lice, the affected child in school poses little risk of transmission to others and should remain in class (Devore et al., 2015). Health care providers and their staff should collaborate with school nurses and families to provide safe, affordable, evidence-based treatment recommendations that ensure effective management of head lice infestations and promotion of regular school attendance (Devore et al., 2015).

Children with nits and live lice continue to be excluded from school by “no nit” and “no live lice” policies due to myths and misinformation. Parent and school staff education and re-education on the topic is the best mechanism to dispel the myths around the transmission of lice (Pontius, 2014). According to the CDC (2015), “The burden of unnecessary absenteeism to the students, families and communities far outweighs the risks associated with head lice” (para. 6). Improved attendance for children who were formerly excluded along with the decrease in stigmatism of these children and families can positively impact student learning and the school environment.

NASN recommends school nurses take an active role in the education of parents, students, providers, and school communities to promote proper evidence-based practices in the treatment and management of head lice. These actions include clarifying misinformation about how head lice are transmitted and advocating for a more supportive, less exclusionary approach to head lice management that does not disrupt the educational environment and promotes student attendance and academic success.

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“To optimize student health, safety and learning, it is the position of the National Association of School Nurses that a professional registered school nurse is present in every school all day, every day.”

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Healthy Communities - 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) should work across sectors, professions, and disciplines to build a culture of health and improve student and community health outcomes by providing leadership, advocacy, care coordination, critical thinking, and mitigation of barriers to health.

BACKGROUND
A healthy community as described by the U.S. Department of Health and Human Services (USDHHS) Healthy People 2010 report is “one that continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential” (Centers for Disease Control and Prevention [CDC], 2014a, para. 1). The Healthy Communities concept began within the 19th century public health movement. In 1986 at a World Health Organization (WHO) conference in Toronto, the attendees drafted the Ottawa Charter called the “Constitution of Healthy Cities/Healthy Communities” (CDC, 2017). The concepts covered in this charter started a movement that still exists today. For example, one of the aims of the National Quality Strategy, which was required by the Patient Protection and Affordable Care Act (2010), is “to improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care” (USDHHS/ Agency for Healthcare Research and Quality, 2013, para. 4).

The Healthy Communities Movement continues to envision a community that provides basic sanitation and hygiene needs, promotes healthier eating, increases physical activity, encourages active transportation (i.e., walking, biking), develops a sense of belonging, and accelerates economic equality (BC Healthy Communities, n.d.). To combat school health concerns such as obesity, diabetes, asthma, and anxiety in a more global and holistic way, school nurses are encouraged to partner with stakeholders, pledge support and advocate for policy, system, and environmental change to facilitate a healthier community.

RATIONALE
According to the Association for Community Health Improvement (2017, para. 4), “Only 20% of health outcomes are attributable to clinical care. Health behaviors, socioeconomic factors and the physical environment account for 80% of health.” Health is vitally linked to where people live, learn, work, and play (Brand, 2016). Schools are key, trusted institutions in the community that can bring stakeholders together to address local needs and improve health (Butler & Diaz, 2016). School nurses are community leaders who bring knowledge of social environments and health systems to mitigate, prepare, and respond to student and community needs and to promote better health outcomes (Brand, 2016). Utilizing the nursing process and the NASN’s Framework for 21st Century School Nursing™ (NASN, 2017), school nurses can serve their communities by assessing physical, psychological, cultural, and environmental information. School nurses are the critical link to address environmental and socioeconomic problems, understand political landscapes, and develop strong relationships with individuals, families, and communities to create a working plan with measurable goals. School nurses intervene by teaching health and wellness and resolving knowledge deficits. As leaders, school nurses work as change agents as they...
identify current and emerging issues, look at outcomes, evaluate where changes are needed, and advocate for that change (Gerber, 2012; NASN, 2017).

The Healthy Cities/Healthy Communities framework is the standard way in which the WHO addresses community health. According to this framework, the health of a community is affected by the social determinants of health and development—the factors that influence individual and community development. Each community is different, and addressing the needs or barriers is a unique process best evaluated at a local level. The barriers or prerequisites for health in communities include

- Peace. This can be interpreted to cover both freedom from warfare and freedom for fear of physical and/or emotional harm.
- Shelter. Shelter adequate to the climate, to the needs of the occupants, and to the extremes of weather
- Education. Education for children (and often adults as well, as in the case of adult literacy) that is free, adequate to equip them for a productive and comfortable life in their society, and available and accessible to all
- Food. Not just food, but enough of it, and of adequate nutritional value, to assure continued health and vigor for adults, and proper development for children
- Income. Employment that provides an income adequate for a reasonable quality of life and public support for those who are unable to work or find jobs
- A stable ecosystem. Clean air, clean water, and protection of the natural environment
- Sustainable resources. These might include water, farmland, minerals, industrial resources, power sources (sun, wind, water, and biomass), plants, animals, etc.
- Social justice. Where there is social justice, no one is mistreated or exploited by those more powerful. No one is discriminated against. No one suffers needlessly because she’s poor or ill or disabled. All are treated equally and fairly under the law, and everyone has a voice in how the community and the society are run.
- Equity. Equity is not exactly the same thing as equality. It doesn’t mean that everyone gets the same things but that everyone gets, or has access to, what he needs.

(CDC, 2017, para. 5)

The idea of healthy communities fosters a broad definition of health and community and creates a shared vision of improving the quality of life for everyone in the community. This vision is driven and owned by the community members who use collaborative problem-solving to create systems change (Ashby & Pharr, 2012). As members of the community, school nurses can use their knowledge, critical thinking, nursing interventions, and relationships with individuals to promote healthy living and improve health outcomes (McCollum, Kovner, Ojemeni, Brewer, & Cohen, 2017).

The school nurse supports student health and academic success by contributing to a healthy community (NASN, 2017). Utilizing the NASN’s Framework for 21st Century School Nursing™ (NASN, 2017), school nurses can inform, educate, and empower their community about health issues (CDC, 2014b) by planning and executing campaigns geared to improve community health. School nurses can mobilize community partnerships to help identify and solve problems (CDC, 2014b) by participating in Campaigns for Action or serving on a community board. School nurses can link students and their families to needed personal and preventative health services and work to mitigate barriers to attaining optimal health.

CONCLUSION

A healthy community continually builds and improves the environment by expanding resources (Ashby & Pharr, 2012). School nurses are uniquely positioned to collaboratively assess needs in the community, collect data to formulate a plan, advocate for better health, and evaluate outcomes. School nurses can expand their scope of influence by working across sectors, professions, and disciplines to build a culture of health and improve health outcomes in their communities. School nurses can do this by providing leadership, advocacy, care coordination, critical thinking, and mitigating the barriers to health.
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Human Trafficking

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that prevention, early identification, and intercession on behalf of the child/youth beset by human trafficking are essential to the student’s psychological and physical well-being, as well as academic success. The registered professional school nurse (hereinafter referred to as school nurse), utilizing astute clinical skills, is well-positioned to recognize signs and symptoms exhibited by a child/youth ensnared within the grooming/human trafficking process. Working in partnership with the school community, law enforcement, child protective services, community-based providers and social services, the school nurse serves a pivotal role by increasing public awareness of human trafficking and assisting with developing protocols for intervention.

BACKGROUND AND RATIONALE

Human trafficking, also termed trafficking-in-persons (TIP), and modern-day slavery is a multi-billion dollar per year criminal industry that involves exploiting a human being for labor, services, or commercial sex (U.S. Department of State Trafficking in Persons Report, 2020). It is a heinous global health crisis violating human rights (United Nations Office on Drugs and Crime [UNODC], 2020). The Trafficking Victims Protection Act of 2000 defines human trafficking as:

- Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or
- Forced labor which is the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

The Office of Juvenile Justice and Delinquency Prevention (2021) terms sex trafficking of children as Commercial Sexual Exploitation of Children (CSEC). CSEC comprises the commercial sex industry and coerced employment in sexualized jobs. Sexual exploitation includes survival sex - trading sexual acts for shelter, food, or drugs (Costa, 2019). The threat for sex trafficking is highest when both individual risk factors and societal challenges meld in a young person’s life, including poverty, homelessness, a history of maltreatment, low educational attainment, migration, identifying as gender nonconforming or sexual minority, lack of work opportunities, lack of family support, lack of connection to caring adults, and in the United States specifically, English as a second language (Miller-Perrin & Wurtele, 2017; Moore et al., 2017; Toney-Butler et al., 2021; UNODC, 2020).

Within the United States, TIP has been reported in all 50 states (National Human Trafficking Hotline [NHTH], 2019). There has been increasing recognition of a previously unidentified population of children who are US citizens/residents and have fallen prey to sex trafficking, accordingly, identified as Domestic Minor Sex Trafficking (DMST) (Moore et al., 2017). TIP including DMST permeates all communities, socioeconomic groups, and student demographics (National Center of Safe Supportive Learning Environments, 2020), albeit women and girls are disproportionately affected (UNODC, 2020). Any person, regardless of gender, race or age, may succumb to human trafficking (NHTH, 2019). Major victim risk factors driving the trafficking industry are poverty, social injustice, natural disasters, substance abuse, family breakdown, and homelessness (Okech et al., 2018; UNODC, 2020; Wolfe et al., 2018).

LGBTQ individuals are most vulnerable to DMST due to experiencing higher rates of adverse childhood experiences versus their cis-gender counterparts (Toney-Butler et al., 2021). LGBTQ youth face considerable challenges including discrimination, misconceptions, and abuse by peers, family members and the community (Polaris Project,
This subset of youth is at highest risk of being targeted by traffickers if homeless as compared to other homeless youth (National Coalition for the Homeless, 2020). Forty percent of homeless youth identify as LGBTQ and are more likely to engage in survival sex to meet basic needs such as shelter, food, toiletry and medication (Polaris Project, 2016). Minors engaged in commercial sex are considered to be trafficking victims regardless of the use of force, fraud, or coercion (Rothman et al., 2017).

Schools are one of the many settings traffickers use to recruit children (National Center on Safe, Supportive Learning Environments, 2020). The trafficker may in fact be another student (Toney-Butler et al., 2021). Social media websites, chat rooms, after-school programs, and house parties are other venues traffickers exploit to accrue victims (Moore et al., 2017; Toney-Butler et al., 2021; UNODC, 2020).

Signs of child trafficking at minimum may include unexplained absences, poor attendance, runaway behavior, boasting about frequent travel to other cities, inappropriate dress for the current weather, hunger, malnourishment, falling asleep in class, impairment from drugs and/or alcohol, poor compliance with general medical or dental care, and transitory lifestyle (Moore et al., 2017; Toney-Butler et al., 2021). Negative health consequences may involve neurologic, gastrointestinal, cardiovascular, musculoskeletal, dermatological, reproductive, sexual, dental, and mental health problems (Rothman et al., 2017). Specifically, mental health disorders such as anxiety, depression, attempted suicide and life-threatening infections are manifestations of those exploited (Charteris et al., 2018; Cockbain et al., 2018; Hemmings et al., 2016; Henry & Grodin, 2018; Ottisova et al., 2016; Ottisova et al., 2018). Trafficked persons often seek medical services at some point during their exploitation (Schwarz et al., 2016), creating an opportune time for intervention.

School nurses and other specialized instructional support professionals are well positioned to help with identification of and intervention for this concealed crime. Schools strive to create a safety net for students by building healthy environments, ensuring student safety, promoting health, and assuring readiness to learn (NASN, 2017). School nurse assessment skills provide proactive surveillance critical to the identification of signs and symptoms associated with human trafficking. Effective response to child trafficking requires a clearly defined course of action, supported by collaboration with child protective services, law enforcement, social services, and community-based service providers (Moore et al., 2017).

Utilizing NASN’s Framework for 21st Century School Nursing Practice™ (NASN, 2016) the school nurse, mobilizing the key principles of leadership and community/public health, serves as health expert for the school community to augment awareness of human trafficking by promoting education and assisting in the development of district protocols for identifying a suspected victim or responding to a disclosure from a victim. School nurses interact with children/youth daily. Understanding how TIP can manifest on school grounds as well as in the community is imperative for prevention, early recognition and intervention.

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The Trafficking Victims Protection Act of 2000 (22 U.S.C. § 7102(9)).


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“To optimize student health, safety and learning, it is the position of the National Association of School Nurses that a professional registered school nurse is present in every school all day, every day.”

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IDEIA and Section 504 Teams -
The School Nurse as an Essential Team Member

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 multidisciplinary educational teams participating in the identification, evaluation, and monitoring of students who may be eligible for services through the Individuals with Disabilities Education Improvement Act (IDEIA) (2004) and Section 504 of the Rehabilitation Act of 1973, as amended through the Americans with Disabilities Amendment Act (ADAA) in 2008. Evaluations must be comprehensive, multifactorial, and nondiscriminatory; and they must be conducted by qualified professionals (Heward, 2015; Yonkaitis & Shannon, 2017). In the school setting, the school nurse is the professional qualified to conduct a comprehensive health evaluation. The school nurse identifies needed health accommodations, outlines plans of care, provides nursing services, and evaluates the effectiveness of the health services provided to students. School nurses should be consulted regarding any information needed in the areas of health (Minchella & Brubaker, 2017; Yonkaitis & Shannon, 2017).

BACKGROUND

The Education for All Handicapped Children Act has been reauthorized over the past forty years. The latest 2004 reauthorization, titled the Individuals with Disabilities Education Improvement Act, is often referred to as IDEIA or IDEA 2004 (Yonkaitis & Shannon, 2017). IDEIA provides specific provisions for identifying and evaluating students who may need special education services. It also outlines the components for Individualized Education Programs (IEPs) as well as procedural safeguards (Yonkaitis & Shannon, 2017).

School districts are mandated to identify, locate, and evaluate all children with disabilities, regardless of severity, to determine if they qualify for special education services, including the related service of school nursing or health services (34 C.F.R. §104.32). This is referred to as Child Find and includes all children from birth to age 21. Some of the children identified through Child Find are eligible for services other than special education.

Additionally, IDEIA mandates that individuals with appropriate expertise in the area of concern should conduct the evaluation and determine additional data needed (Yonkaitis & Shannon, 2017). As a licensed healthcare professional, the school nurse is the multidisciplinary evaluation team member qualified to evaluate health concerns. Under IDEIA the student’s federal civil right to a nondiscriminatory comprehensive evaluation is not upheld if non-nursing educational professionals who are unqualified to conduct a health assessment assume this role (Shannon & Yonkaitis, 2017). If a school nurse does not conduct a health evaluation, the evaluation team lacks important information. During the health evaluation, information is obtained regarding potential health-related barriers to student learning. This information assists in determining if the student “qualifies” for special education programming or accommodations. The health evaluation also provides essential information to determine related services, programs, and accommodations and provides the basis for individualized healthcare plans (IHP) and emergency action plans (EAP) - known in some school districts as emergency care plans.

Section 504 of the Rehabilitation Act of 1973 established legal support for students with disabilities. This federal civil rights law ensures that every student is entitled to a free and appropriate public education (FAPE) (U.S. Department of Education [USDE], 2010). Under Section 504, FAPE consists of the provision of any necessary supports for the student in the general education classroom with related aids or services designed to meet the student’s individual educational needs as adequately as those needs of nondisabled students are met (USDE/
Office of Civil Rights [OCR], 2015). An individual with a disability means any person who “(i) has a mental or physical impairment that substantially limits one or more major life activities; (ii) has a record of such an impairment; or (iii) is regarded as having such an impairment” [34 C.F.R. §104.3(j)(1)]. An impairment under Section 504 standards can be a health-related condition such as diabetes, epilepsy and allergy; or it can be a disability such as low vision, impaired hearing, heart disease or chronic illness that limits that child’s ability to receive an appropriate education as defined by Section 504.

In 1975, the Education for All Handicapped Children Act was passed. It provides specialized educational programming for exceptional children, further reinforcing the rights of school children (USDE/ OCR, 2010). In an effort to broaden the definition of a disability, the Americans with Disabilities Act Amendments Act (ADAA) was passed and became effective in 2009. The Section 504 regulatory provision at 34 C.F.R. 104.35(c) requires that evaluation team members must be knowledgeable regarding the needs of the student and draw from a variety of sources (USDE/ OCR, 2015).

**RATIONALE**

The American Academy of Pediatrics (AAP) recognizes the role of the school nurse as the healthcare expert in the school setting (AAP, 2016). The Every Student Succeeds Act (ESSA) of 2015 recognizes school nurses as “Specialized Instructional Support Personnel” who provide leadership of chronic disease management as part of a comprehensive plan of services for student success (ESSA, 2015).

School nurses are the link between the healthcare and educational communities and are valuable resources to students, families, staff, and communities. School nurses use their professional knowledge to assess and identify students who have health, socio-emotional, or developmental issues that increase risks for learning problems and other school-related challenges. Input from school nurses is essential to determine the impact that health conditions have on learning and on the ability of individual students to participate in their educational programs (Minchella & Brubaker, 2017). If health-related barriers are not recognized, appropriately interpreted, and addressed, students risk academic failure. Although the referral processes for special education or Section 504 can be requested by anyone, the school nurse has the expertise and duty to identify students with health-related disabilities and should initiate an evaluation for medical/health reasons (Alfano, Forbes, & Fisher, 2017).

The school nurse uses information obtained during the process of developing an IHP to assist with eligibility determination and, when indicated, to assist IEP and 504 Plan teams to determine educational modifications and accommodations. The creation of an IHP uses the nursing process and demonstrates adherence to professional scope and standards (American Nurses Association [ANA] & NASN, 2017). Development of an IHP is strictly the responsibility and within the scope of practice of a school nurse.

**School Nurse Responsibilities**

It is the responsibility of the school nurse to understand the federal and state laws related to working with students with disabilities, long term illnesses, or other disorders (Alfano et al., 2017; Ellermeier, Will, & Strawhacker, 2017; Galemore & Sheetz, 2015; Minchella & Brubaker, 2017). State laws may require specialized licensure or credentials prior to performing IEP evaluations or for team participation in developing IEPs (Shannon & Yonkaitis, 2017).

The school nurse is the appropriate person to provide care coordination for health-related disabilities in the school setting (ANA & NASN, 2017). “While the IEP team as a whole tackles the academic, developmental, social, and emotional needs of the student, the responsibility of addressing the healthcare needs of the student falls squarely on the school nurse” (Alfano et al., 2017, p.145).

When health services are determined to be necessary for students to access their educational programs, it is the school nurse’s role to provide a direct or related service in an IEP. In those cases, the school nurse is responsible for supplying specific information describing which type of health services should be provided and how often the service(s) need to be provided (Galemore & Sheetz, 2015; Minchella & Brubaker, 2017).
The school nurse’s role in the Section 504 or IDEIA process may include:

- Assisting in identifying students who may need special educational or health-related services/accommodations (Child Find) (Gibbons, Lehr, & Selekman, 2013).
- Assessing the identified student’s functional and physical health status in collaboration with the student, parent(s)/guardian(s), teachers and other school staff, and healthcare providers (Gibbons et al., 2013).
- Developing IHPs and EAPs based on nursing assessments.
- Recommending health-related accommodations or services that may be required for the student to access the educational program.
- Assisting students, parent(s)/guardians, and teachers to identify and remove health-related barriers to learning (Gibbons et al., 2013).
- Providing in-service training for teachers and staff regarding the individual health needs of the student (Gibbons et al., 2013).
- Training and supervising unlicensed assistive personnel to provide specialized healthcare services in the school setting according to state delegation guidelines (Gibbons, Lehr, & Selekman, 2013, p. 269-270).
- Participating in transition planning, including promotion of successful post-school employment and/or education, and transition of medical care.
- Evaluating the effectiveness of the health-related components of the IEP and/or 504 plan with the student, parent(s), and other team members and revising the plan(s) as needed (Gibbons et al., 2013, p. 269-270).

The school nurse plays an integral role in planning, implementation, and evaluation of IEPs and Section 504 Plans. For a student with disabilities, it is the school nurse’s role to identify needed health accommodations, outline a plan of care, provide nursing services, and evaluate the health-related components of the IEP and/or 504 Plan. An IHP is written to meet professional school nurse standards (ANA & NASN, 2017; Ellermeier et al., 2017). The student’s IHP and/or EAP may guide the student’s Section 504 Plan health-related accommodations. As IHPs and EAPs are fluid documents, IHPs and EAPs should not be included in an IEP but might be referenced to provide rationale for the needed service(s) (Galemore & Sheetz, 2015; Ellermeier et al., 2017).

CONCLUSION

The school nurse is the recognized healthcare expert in the school setting (AAP, 2016; ESSA, 2015). School nurses have the unique knowledge and experience essential to evaluate the health of students in order to identify health-related barriers to learning and the accommodations necessary to provide access to education. School nurses work collaboratively with other team members to identify, evaluate, and develop plans for students in need of services. School nurses should be involved in and present at all meetings where an IEP and/or Section 504 plan related to a student’s health condition is being discussed and developed. School nurses are integral to ensuring the civil rights of all students so that they can achieve optimal success and well-being at school (Yonkaitis & Shannon, 2017).

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Immunizations

Position Statement

NASN POSITION

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 and that childhood vaccinations are an effective way of preventing serious childhood illnesses (U.S. Department of Health and Human Services [USDHHS], 2017). NASN supports elimination of all exemptions except those necessary for valid medical contraindications.

School nurses are leaders who use evidence-based immunization strategies, such as School Located Vaccine (SLV) clinics, parent/guardian reminders about vaccine schedules, state immunization information systems (IIS), i.e., state registries, strong support of vaccination recommendations, and vaccine education for students, staff, and families.

BACKGROUND AND RATIONALE

The CDC (2019a) currently recommends that U.S. children and adolescents be vaccinated against 17 diseases. Childhood immunizations have reduced the incidence of Vaccine Preventable Diseases (VPD) by more than 90%, and, in some cases, have spurred reductions as high as 99%. Smallpox, the only human disease ever eradicated, was eradicated through vaccination. Similarly, polio is near eradication as a result of widespread vaccination programs (American Academy of Pediatrics [AAP], 2018; Orenstein & Ahmed, 2017). In addition to reducing disease, disability and death, vaccines are credited with saving almost $69 billion in healthcare costs in the United States alone (Orenstein et al., 2017). Vaccines not only provide protection to those who are vaccinated, but also provide community protection or “herd immunity” where vaccination rates are above 95% (Eby, 2017). Herd immunity reduces the spread of disease to those who cannot be vaccinated, from the youngest infants to immunocompromised individuals of any age.

Childhood immunization has been so effective in preventing death and disease that many parents today have not encountered diseases that were common years ago. As a result, increasing numbers of parents believe that vaccine-preventable diseases are mild or “natural,” and that vaccines are no longer necessary (Navin, 2018). In the past 10 years, the number of parents refusing vaccinations or choosing alternate vaccination schedules has increased (Eby, 2017). In addition to their lack of concern about VPD, some parents cite worries about vaccine safety, fear of discomfort, and religious objections as reasons for not adhering to vaccination schedules (Navin, Wasserman, Amhmad, & Bies, 2019; Kubin, 2019). Decreasing vaccination rates, coupled with the ease of international travel and waning vaccine titers, has resulted in an increase in VPD outbreaks in the United States. Pertussis cases—which declined from over 100,000 per year to fewer than 10,000 per year between the 1940s and 1965, after the vaccine’s introduction—rose to over 18,000 in 2017 (CDC, 2017). Measles is also resurgent, with more cases confirmed in 2019 than since the disease was declared eliminated in 2000 (CDC, 2019b).

As vaccine rates in the United States decline and cases of vaccine-preventable illness increase, access for parents to reliable information about the safety and efficacy of childhood immunizations and accurate tracking of children’s vaccination records becomes even more important. School nurses are well equipped to
inform about both. School nurses have regular access to students, are trusted by parents to deliver accurate health information, and have access to state immunization registries. One of the most practical solutions to increase vaccine availability and vaccine compliance is to support school-based vaccination clinics. The CDC (2014) notes that schools are one of the most efficient systems for providing health services to children and youth, because approximately 95% of U.S. children and youth attend school. NASN supports the ACIP vaccine recommendations adopted by the CDC and states and local vaccine mandates. NASN also supports full school nurse access to state registries, an important practice tool. School nurses use state registries 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; AAP, 2006; Guide to Community Preventive Services, 2010). School nurses are strongly 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.

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Use of Individualized Healthcare Plans to Support School Health Services

**Position Statement**

**NASN POSITION**

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) initiates and develops an Individualized Healthcare Plan (IHP) for students whose healthcare needs require more complex school nursing services. An IHP is a plan of care written by the registered nurse for students with or at risk for physical or mental health needs (ANA & NASN, 2017). It is the responsibility of the school nurse to annually evaluate the IHP, as well as to update the plan if deemed appropriate, to reflect changes in the student's healthcare needs and address nursing interventions and/or student healthcare outcomes.

**BACKGROUND AND RATIONALE**

A variety of documents is used in the educational setting to support student health, safety and success. Confusion often exists in the educational and healthcare fields regarding the purpose, components and content of the IHP. Many outside the profession of school nursing have attempted to define and describe the use of IHPs (Donoghue & Kraft, 2019; Hopkins & Hughes, 2016). Educators, families, non-school healthcare professionals, and even school nurses have used the term IHP to describe a multitude of health-related plans.

In the school setting, the IHP is the counterpart of the nursing care plan. With chronic health conditions affecting nearly one in four American school children (CDC, 2019), the IHP is a necessary tool for delineating the nursing plan of care to foster academic success and support optimal attendance. The IHP is created by the school nurse for the school nurse. The IHP fosters communication among nursing staff to promote continuity of care (Sampson & Will, 2017), for example, when a substitute nurse is required, or as the student progresses though the school system (Yonkaitis & Shannon, 2019). This document is based on the nursing process, utilizes nursing language, documents standards of school nursing practice, and is driven by outcomes (Galemore & Sheetz, 2015; NASN, 2017). It is the guiding document for delivery of student-specific nursing care, illustrating the school nurse’s responsibility and accountability (NASN, 2017).

School nurses create an IHP for select students with healthcare needs that, if not addressed, may negatively affect, or have the potential to affect, attendance and/or academic performance. These students may have chronic health issues or have an acute alteration in their health status that may temporarily require specialized nursing care. Priority for IHP development must be given to those students who require significant health services at school, have a medical diagnosis that may result in a health crisis, and/or students with health conditions addressed in a Section 504 Accommodation Plan or an Individualized Educational Program (Yonkaitis & Shannon, 2019).

Depending on the health condition, IHPs may prompt the development of student Emergency Evacuation Plans (EEP) and/or Emergency Care Plans (ECP), both of which are initiated and developed by the school nurse. These plans stem from the intervention component of the IHP and provide instruction...
on addressing healthcare needs or appropriate response to a student’s emergent healthcare issue (Sampson & Will, 2017). These plans use language best suited for the non-medical educational staff.

The school nursing profession is responsible for defining its own standards (ANA & NASN, 2017) and has stipulated the purpose and content of an IHP is to:

- Document standards of school nursing practice
- Document the nursing process
- Facilitate evidence-based management of the health condition
- Outline the relevant knowledge and actions needed by school personnel to support the student’s access to a free and appropriate education
- Prepare for prompt responses to medical emergencies
- Support the health components of education plans for the student
- Support the student’s success by providing the school’s multidisciplinary team with a systematic, organized approach to meeting specific health needs” (NASN, 2017 p. 2)
- Guide care coordination for the student
- Serve administrative purposes by defining the focus of nursing, validating the nurse’s role in the school, and differentiating accountability of the nurse from other staff (Hermann, 2005)
- Provide an effective vehicle for documentation of nursing delegation when permitted by state nurse practice act and state law (Sampson & Will, 2017)

The IHP is a vital and practical tool to manage or mitigate student-specific healthcare needs. The school nurse is the sole professional qualified to generate an IHP. Utilizing NASN's Framework for 21st Century School Nursing Practice™ (NASN, 2016) the school nurse, mobilizing the key principles of care coordination and quality improvement, initiates, develops, implements, evaluates and revises the IHP to maximize student health, support academic success, and optimize school attendance.

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LGBTQ Students

Position Statement

NASN POSITION
It is the position of the National Association of School Nurses (NASN) that, to provide culturally competent care, school staff and communities should institute affirming policies that support lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) youth. These include bullying, health risk behaviors, and rejection from family and friends. Such challenges can cause adverse mental and physical health effects such as depression and suicidal ideation. Registered professional nurses (hereinafter referred to as school nurses) are uniquely positioned to help LGBTQ youth by creating LGBTQ-affirming spaces, guiding youth towards resources, advocating for school-wide protections, and assuring youth that their identities and feelings are normal and appropriate.

BACKGROUND AND RATIONALE
NASN supports comprehensive care, guided by the principles of cultural humility, in safe, inclusive, and affirming school environments for LGBTQ youth.

- In addition to increased psychological health risks from bullying, LGBTQ students also experience health disparities, such as physical violence; forced sexual encounters; and rates of alcohol, tobacco and other drug use that are nearly twice the rates of heterosexual peers (Kann et al., 2018).
- LGBTQ youth who do not have affirming parents or guardians are more likely to experience homelessness and associated risk factors than their peers (Guletkin et al., 2019).
- Safe and supportive school environments are accomplished when all school staff are familiar with current LGBTQ best practices and terminology, including use of appropriate pronouns and addressing myths and misconceptions which can contribute to inequities and violence. School staff should use gender-inclusive, non-heteronormative language (Kosciw et al., 2020).
- Barring an explicit legal obligation, school nurses should respect confidentiality and not disclose a student’s sexual orientation or gender identity to others, including parents or guardians, without permission from the student (Human Rights Campaign, 2019).
- School nurses should assess LGBTQ students carefully for signs and symptoms related to bullying, violence, and family rejection, such as frequent somatic complaints, recurrent absence from school, poor academic achievement, and signs and symptoms of depression, self-harm, and disordered eating (Hooker, 2019).
- Recognizing the substantial risk for depression in this population due to rejection and stigma, school nurses should provide education for students on depression prevention strategies such as stress management, regular exercise, and finding social support (Perron et al., 2017).
- School nurses should facilitate access to supportive medical and psychological sources of care for students who need referrals, as well as to local resources such as the nearest LGBTQ community center (Willging et al., 2016).
- School nurses should evaluate health education curricula for medical accuracy, inclusivity, and diversity to reduce risk behaviors and to support positive sexual health outcomes among teens, such as reducing teen pregnancy, sexually transmitted infection rates, and sexual violence (Kosciw et al., 2020).
• School nurses advocate for policies which ensure equitable access to school facilities and activities, as well as policies which promote safety for students who identify as transgender or gender expansive (Wernick et al., 2017).
• School nurses work with school staff, students, and families, when appropriate, to create a clear policy and plan for any students experiencing suicidal ideation with a focus on at-risk student populations, including LGBTQ students (Perron et al., 2017).
• To increase the likelihood that LGBTQ students will feel safe and seek out the support they need, school nurses should display a visible sign of LGBTQ inclusion, such as a pride flag, safe space sticker, or poster in the health office (Human Rights Campaign, 2019).
• In one survey, 42.8% of students identifying as LGBTQ had seriously considered suicide in the past year. Schools with affirming policies for LGBTQ students are associated with lower rates of suicidal ideation, alcohol and other drug use, and poor school achievement in this population (Demissie et al., 2018).

To reduce these health disparities and to provide comprehensive care, school nurses should collaborate with educational teams to create welcoming, healthier, and thus safer environments for all students, while addressing stigma, discrimination, and marginalization of LGBTQ students.

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Medication Administration 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) be responsible for medication administration in the school setting, leading the development of written medication administration policies and procedures that focus on safe and efficient medication administration at school. Well-written policies and procedures will enable schools to fulfill their obligations to provide health-related services to all children, including those with special healthcare needs under the Individuals with Disabilities Education Improvement Act (2004) and Section 504 of the Rehabilitation Act (1973) as amended through the Americans with Disabilities Amendment Act [ADAA] in 2008.

Policies and procedures should address (Ryan, Katsiyannis, Losinski, Reid, & Ellis, 2013; U.S. Food and Drug Administration [FDA], 2013):

- delegation (when permissible by state law), training and supervision of unlicensed assistive personnel (UAP);
- student confidentiality;
- medication orders;
- medication doses that exceed manufacturer’s guidelines;
- proper labeling, storage, disposal, and transportation of medication to and from school;
- documentation of medication administration;
- rescue and emergency medications;
- off-label medications and investigational drugs;
- prescription and over-the-counter (OTC) medications;
- complementary and alternative medications; and
- psychotropic medications and controlled substances.

The administration of medication by non-nursing school staff, when allowed, should be addressed (Ryan et al., 2013). These policies and procedures shall be consistent with federal and state laws including state nurse practice acts, rules, regulations, and any other laws that may apply, as well as standards and established safe, evidence-based information (Ryan et al., 2013; Bobo, 2014).

Background

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. However, as many districts and schools struggle financially, it is not uncommon for students to receive medication from non-nursing school employees who have had no medical training. This trend has caused an alarming increase in the number of medication errors made by UAP (Institute for Safe Medication Practices [ISMP], 2012). It is especially important that evidence-based medication policies and procedures be in place in those schools where a registered nurse is not present every day.

It is estimated that up to 27% of children have chronic health conditions (Van Cleave, Gortmaker, & Perrin, 2010). As more students with chronic conditions enter school systems each year, awareness of the factors which can promote and support their academic success increases. This includes the need for medications which enhance students’ overall health or stabilize their chronic health conditions.
Medications, when administered and used appropriately, can improve student health but may be harmful if administered incorrectly. Errors in medication administration are the most common medical errors (Cloete, 2015). Examples of medication errors include administering medication to the wrong person, giving the wrong dose, or not giving a dose as scheduled. For the safety of students, it is critical that evidence-based policies and procedures exist regarding medication administration. School nurses have the health expertise needed to develop, promote, and implement policies that are evidence-based; reduce errors; and increase the proper use and storage of medications in school settings (American Academy of Pediatrics [AAP], 2016; ISMP, 2012).

RATIONALE

To reduce errors and increase safety, written policies and procedures for schools should include documentation from a licensed provider for the medication; proper labeling of medications brought to school; training of other staff involved in medication administration; storage of medication; process for administering medication (including proper identification of student and medication); documentation of medication administration, errors, reactions or side effects of medication; and proper disposal of medications (National Coordinating Council for Medication Error Reporting and Prevention [NCCMERP], 2007; 2015; FDA, 2013; Ryan et al., 2013). The principles of leadership, care coordination, quality improvement, public health/community, and standards of practice guide the practice of school nurses, including their role in medication administration (NASN, 2016).

Leadership
As the expert healthcare provider in the educational setting, the school nurse is critical to the safe and effective administration of medication to students. The school nurse should lead in the development, implementation, and evaluation of medication administration policies and procedures at the school or district level. Training and supervision of UAPs who administer medications should be done by the school nurse, and consideration of safety and school nurse workload is essential. There is a decrease in errors when a culture of safety exists that includes proper oversight and written policies in place (U.S. Department of Health and Human Services [USDHHS], 2011).

School medication policies and procedures must be in accordance with all applicable laws, including nurse practice acts (NPA). For example, delegation and training are often specifically noted in states’ NPAs. Registered nurses possess the knowledge about how to comply with NPAs and issues such as over-the-counter medications, off-label usage, and alternative medications in a safe, evidence-based manner (American Nurses Association [ANA], 2012; AAP, 2016).

Care Coordination
Medication administration is often part of a larger plan for the care and management of acute and chronic health conditions. There must be communication and collaboration between parents, providers, and schools regarding each student’s medication that describes what is to be given, the purpose, frequency, and side effects of the medication (NCCMERP, 2007; American Academy of Pediatrics, American Public Health Association, & National Resource Center for Health and Safety in Child Care and Early Education, 2011). School nurses are the health professionals in the school who coordinate care for the student, including medication administration.

Quality Improvement
The necessity for student use of medication at school has risen over the last two decades because many students who attend school have complex and chronic medical problems (ISMP, 2012). Research has shown that there are fewer medication errors in schools when medications are provided by a school nurse and when evidence-based policies are routinely followed (ISMP, 2012). Medication policies and procedures should include provisions for evaluation of medication practices and policies, including reviews of documentation and occasional audits, to identify possible concerns and adjust practice or policy as needed (USDHHS, 2011).

Community/Public Health
School nurses understand the unique needs and environments of their populations, which should be addressed in schools’ medication policies and guidelines (NCCMERP, 2015). School nurses can identify and address issues that
may affect management of acute and chronic health conditions, such as environmental factors and socio-economic challenges, including obstacles to obtaining medications and delivery of medication to the school (Blaakman, Cohen, Fagnano, & Halterman, 2014). Evidence indicates that school nurses can provide culturally appropriate, sensitive information for students and families regarding management of health issues, including proper use of medications (McNaughton, Cowell & Fogg, 2014).

CONCLUSION

The school nurse should lead the development of school district policies and procedures relating to medication administration in the school setting and, where delegation of medication is permitted, the school nurse should be responsible for the delegation, training and supervision of UAP. The school nurse is the professional with the clinical knowledge and understanding of the complex issues surrounding the safe administration of medication and the responsibility to protect the health and safety of students (AAP, 2016; ANA, 2012). As the health leader in the school setting, the school nurse promotes current evidence-based practices so students requiring medication during the school day can safely have their needs met and remain in school ready to learn (Maughan, 2016).

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**Resources for Supporting Information:**
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Adopted: 1993


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Naloxone in the School Setting

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that the safe and effective management of opioid-related overdoses in schools must be incorporated into the school emergency preparedness and response plans. 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, proper management of these incidents at school is vital to positive outcomes. The school nurse is essential to the school team responsible for developing and implementing emergency response procedures. School nurses in this role should facilitate access to naloxone for quick response in the management of opioid-related overdoses in the school setting.

BACKGROUND AND RATIONALE

Opioid overdose deaths are a public health crisis according to the National Institute of Health (NIH) due to increased opioid misuse (NIH, 2019). According to the Centers for Disease Control and Prevention (CDC), drug overdose deaths are the leading cause of injury-related deaths in the United States. In 2017, more than 70,000 people died from prescription or illicit opioid misuse (CDC, 2017). In response, the US Department of Health and Human Services (HHS) is focusing its efforts on five priorities: access to treatment and recovery services, promoting overdose reversing drugs, strengthening understanding of the epidemic through better public health surveillance, providing support for cutting edge research on pain and addiction, and advancing better practices for pain management (NIH, 2019).

Deaths from opioids include those caused by prescription medications such as oxycodone, morphine or hydrocodone, and illegal drugs such as heroin or the synthetic opioid fentanyl (CDC, 2018). A crucial contributing factor regarding drug overdose deaths involves the nonmedical use of prescription painkillers—using drugs without a prescription or using drugs to obtain the "high" produced. Between 2016 and 2017, deaths from synthetic opioids increased significantly in 23 states (CDC, 2019). Many of these opioid-related deaths by overdose were due to opioids which contained fentanyl, perhaps the most dangerous synthetic opioid (CDC, 2019). In 2018, the CDC stated that deaths related to opioids consisted of over two-thirds of all overdose deaths (CDC, 2018).

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health, in 2017 there were 2.2 million adolescents ages 12 to 17 who were current illicit drug users. The CDC recognized the magnitude of this crisis in 2018 (SAMHSA, 2018) when overdoses were named as the most pressing health concerns and added to its list of top five public health challenges.

Naloxone is an opioid antagonist that will temporarily reverse the potentially deadly respiratory depressive effects for legal and illicit drugs. It is available as intramuscular or subcutaneous injection and nasal spray. When administered quickly and effectively, naloxone has the potential to immediately restore breathing to a victim experiencing an opioid overdose. Additional doses can be administered every 2-3 minutes (Selekman, 2019).

The use of naloxone as an opioid overdose reversal agent by laypeople and first responders has doubled from 2017-2018 and has proven to be an effective strategy in preventing overdose opioid deaths. The CDC (2019) estimates a co-prescribing ratio for opioids and naloxone as 70:1. For every 70 high dose opioid prescriptions written, there is only one naloxone co-prescription written, with rural areas having a much lower rate than metropolitan areas.
Schools are responsible for anticipating and preparing to respond to a variety of emergencies. 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. Thus, school nurse access to naloxone as part of their school’s emergency preparedness will improve opioid overdose response, response preparation, and harm reduction and avoid horrific outcomes such as death. With naloxone as part of an emergency protocol, a school nurse can quickly administer it to prevent overdose deaths by reversing life-threatening respiratory depression. Ensuring ready access to naloxone at schools aligns with one of the SAMSHA’s five strategic approaches to prevent overdose deaths (SAMHSA, 2018).

Naloxone saves lives and can be the first step toward opioid use disorder (OUD) recovery. Opioid overdose-related deaths can be prevented when naloxone is administered in a timely manner. As a narcotic antagonist, naloxone displaces opiates from receptor sites in the brain and reverses respiratory depression that usually is the cause of overdose deaths (SAMHSA, 2018). Emergency protocol for any suspected overdose should include administering Naloxone and transporting the individual for emergency care. The access to emergency treatment can be the first step toward a much larger course of treatment of OUD.

School nurses should be familiar with the legal implications in their state when implementing naloxone as part of their school district’s emergency response plan. Laws vary from state to state in terms prescribing, supply maintenance and who can administer naloxone in the school setting. Since 2017, every state and the District of Columbia have laws that provide protection from criminal liability for naloxone administration by laypersons or first responders (SAMSHA, 2019).

Community prevention education is key when addressing the public health crisis of opioid-related deaths. School nurses have a crucial role to play with research-based, primary prevention strategies within their school communities. Through community outreach with prescription opioid abuse, misuse and overdose awareness programs, school nurses can provide valuable education and be a useful resource for K-12 students and their families. Furthermore, school nurses can assist families in recognizing the signs and symptoms of substance abuse, support and guide them in locating resources for care, counseling, and even refer students for appropriate treatment of OUD.

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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) has the knowledge, expertise, and skills to promote the prevention and reduction of overweight and obesity among children and adolescents in schools. Grounded by standards of practice within the Framework for 21st Century School Nursing Practice™ (NASN, 2015), school nurses can identify, assess, refer, and follow-up with children and adolescents who are at risk for health problems associated with overweight or obesity. School nurses can provide cost-effective, sustainable school-based overweight and obesity interventions that address the complex physical, social, and health education needs of children and adolescents who are overweight or obese (NASN, 2013; Schroeder, Travers, & Smaldone, 2016). School nurses also lead in the development of local school health policies and district/community policies that support wellness, healthy nutrition, increased physical activity, and healthy lifestyle behaviors for all students (NASN, 2013).

BACKGROUND
Overweight and obesity among children and adolescents have emerged as one of the most serious health concerns in communities across the nation (Gungor, 2014; Segal, Rayburn, & Martin, 2017). The associated physical, psychosocial, and economic consequences of overweight and obesity have a negative impact on children, families, communities, the military, and society at large (NASN, 2013). Overweight and obesity in the United States often begin in childhood and can be largely preventable. Overweight for children is defined as a body mass index (BMI) at or above the 85th percentile and less than the 95th percentile for children of the same age and gender, and obesity is defined as a BMI greater than the 95th percentile for children of the same age and gender (Centers for Disease Control and Prevention [CDC], 2016a). From 2011-2014, the prevalence of obesity for children and adolescents, 2-19 years old, remained stable at 17% (CDC, 2016b; Ogden, Carroll, Fryar, & Flegal, 2015). In the past fifteen years, significant progress has been made towards preventing and stabilizing obesity rates (Segal et al., 2017). Signs of progress can be attributable to communities that have implemented comprehensive obesity prevention strategies to make healthy foods and beverages accessible in their schools and communities and have integrated physical activity into their daily lives (Segal et al., 2017). Despite these positive trends, obesity remains an American epidemic affecting 12.7 million (one in every six) children and adolescents ages 2-19 years old (Segal et al., 2017; CDC, 2016b; Ogden et al., 2015).

Quality nutrition and physical activity are essential for optimal growth, development, and well-being. The global shift in diet intake of energy-dense foods that are high in fat and sugar but low in nutrients has contributed greatly to childhood obesity (World Health Organization [WHO], 2017a). More than 90% of American children have poor diets and less than half get the recommended 60 minutes of daily physical activity (Segal et al., 2017; WHO, 2017a).

Obesity also disproportionately affects low-income families in rural communities as well as certain racial and ethnic groups, including Blacks, Latinos, and Native Americans (Segal et al., 2017). Social inequities are evident in these communities and contribute to the overweight and obesity epidemic. Children have few safe outdoor spaces to play or accessible routes to walk or bike to school. Many of these communities also have small food outlets and fast food restaurants that sell and advertise unhealthy food and beverages. Fresh and healthy foods are not readily available and are unaffordable for most low-income families. Where families live, work, play, and attend school, all have a major impact on the choices they are able to make (Segal et al., 2017).
Overweight and obesity in children and adolescents may also influence their ability to be attentive and remain in class (NASN, 2013). Research has shown that children and adolescents who are obese have lower educational engagement, more behavioral problems, and more school absences (NASN, 2013; Segal et al., 2017). Recent studies have also found that students who are obese are more likely to repeat a grade, have lower grade point averages and lower reading scores (Segal et al., 2017).

The cause of overweight and obesity in children and adolescents is not completely understood but thought to be complex and have multiple contributing factors including (CDC, 2016a; National Institutes of Health [NIH], 2017; WHO, 2017b)

- diet and insufficient physical activity
- heredity/genetics
- family/social factors
- behavioral/cultural factors
- environmental/socioeconomic status
- media marketing

The immediate and long-term effects of overweight and obesity impact the physical, emotional, and social health of children and adolescents and places them at a higher risk for the following health conditions (CDC, 2016a; Hoelscher, Kirk, Ritchie, & Cunningham-Sabo, 2013; NIH, 2017):

- high blood pressure and high cholesterol (cardiovascular disease);
- breathing problems such as asthma and sleep apnea;
- type 2 diabetes, impaired glucose tolerance, insulin resistance;
- fatty liver disease, gallstones, gastro-esophageal reflux;
- psychological problems such as anxiety and depression;
- joint and musculoskeletal disorders;
- poor self-esteem and quality of life;
- social problems such as bullying; and
- some cancers.

RATIONALE

The WHO (2017b) and the CDC (2017) recognize that the prevention of overweight and obesity is the most feasible option for reversing the childhood obesity epidemic. Healthy People 2020 (USDHHS, 2017) identifies specific goals to achieve and promote maintenance of healthy body weight and daily physical activity. Since most children spend a large portion of their day at school, the school is an ideal setting and one of the most efficient systems to reach children and adolescents to provide health services and strategies to prevent overweight and obesity (CDC, 2014).

School nurses are in a position to reach a large number of children and adolescents, and they are able to address the potentially serious health problems that result from overweight and obesity. The American Academy of Pediatrics Council on School Health (2016) recognizes the important role that school nurses have in children and adolescents’ continuum of care and states that the daily presence of a school nurse may contribute to the reduction of childhood obesity.

Reducing and preventing overweight and obesity at an early age is critical considering the probability that children and adolescents who are overweight or obese will remain so in adulthood (NASN, 2013). Without intervention, children and adolescents who are overweight or obese could be the first generation to live shorter, less healthy lives than their parents (NASN, 2013; Segal et al., 2017). Research studies have demonstrated that school programs are effective in preventing childhood obesity by encouraging healthier diets and increased physical activity (Segal et al., 2017). The school nurse can create a culture of health that supports balanced nutrition and physical activity for all students within the school setting.
Overweight and obesity are sensitive issues for students and families and must be addressed with compassion, understanding, and caring (NASN, 2013). School nurses can promote and implement the following overweight and obesity prevention school-based strategies (NASN, 2013):

- identifying students who may need further evaluation by conducting BMI assessments with appropriate safeguards (Segal et al., 2017);
- assessing students for possible risk factors associated with overweight and obesity (hypertension, acanthosis nigricans, risk for type 2 diabetes, and family history) (NASN, 2013);
- making necessary referrals to healthcare providers for further assessment and treatment;
- developing Individualized Healthcare Plans that address elevated BMIs and recommendations for lifestyle modifications;
- providing individual counseling and motivational interviewing to support weight-related behavior change (Missouri Department of Health and Senior Services, 2015; Pbert et al., 2013);
- promoting individual nutrition and physical activity assessments to help children and adolescents identify healthy behaviors and set healthy goals;
- encouraging follow up for counseling and ongoing psychological support for students;
- promoting healthy messages that encourage the consumption of healthy foods and daily physical activity;
- serving as a role model and encouraging role modeling of healthy lifestyle choices by parents and teachers; and
- educating students, parents, and the school community about evidence-based overweight and obesity prevention strategies, healthy lifestyle behaviors, daily physical activity requirements, and preventable health risks associated with overweight and obesity.

School nurses also provide leadership in initiating and leading the school community to influence policy and strategies that address the prevention of overweight and obesity. School nurses can effectively improve the health of children and their families by promoting the following efforts (Alliance for a Healthier Generation, 2017):

- developing and implementing wellness policies that include healthy nutrition and physical activity;
- promoting safe walk-to-school and bike-to-school programs;
- advocating for
  - shared use of recreational facilities;
  - research to determine the behavioral and biological causes of overweight and obesity;
  - nutritional school breakfasts and lunches;
  - compliance with the United States Department of Agriculture’s Smart Snacks Nutrition Standards;
  - accessible drinking water throughout the school day and during meals;
  - daily physical education; and
  - education and resources for low income families on how to grow their own gardens.

CONCLUSION

Overweight and obesity remain an American epidemic, affecting one in every six children. Overweight and obesity prevention is an investment in our children’s ability to be healthy, safe, engaged and ready to learn. School nurses are in key positions to provide cost-effective, sustainable, overweight and obesity prevention strategies that address the needs of children and adolescents who are overweight or obese (NASN, 2013; Schroeder, Travers, & Smaldone, 2016). The principles of care coordination, community/public health, and leadership—included in the Framework for 21st Century School Nursing Practice™—guide the practice of school nurses in the identification, prevention, and treatment of children and adolescents who are overweight or obese in schools (NASN, 2015). School nurses recognize the positive impact of healthy eating and physical activity on academic success, promote a culture of health and well-being for all students, and have an important role in affecting policy change that will improve the health of our students and communities in which they live.
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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Supporting Scheduled Recess

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that scheduled recess not be withheld for any student during the school day. Recess is defined as “a regularly scheduled period within the school day for physical activity and play that is monitored by trained staff or volunteers” (Centers for Disease Control and Prevention [CDC] & SHAPE America-Society of Health and Physical Educators [SHAPE], 2017, p. 1). During recess “students are encouraged to be physically active and engaged with peers in activities of their choice, at all grade levels, kindergarten through 12th grade” (CDC & SHAPE, 2017, p. 1). Recess may be regarded as superfluous and eliminated from the school day to provide for more time for academics, or purposefully withheld as a disciplinary technique. The registered professional school nurse (hereinafter referred to as school nurse) is knowledgeable of the benefits that recess has on the student’s emotional, social, physical, and cognitive development. The school nurse undertakes a leadership role within the school community to assist in developing policies that support recess and reject withholding recess.

BACKGROUND

Recess is an opportunity for students to engage in physical activity and play with fellow students. Aerobic physical activity is positively associated with cognition, academic achievement, behavior and psychosocial functioning outcomes (Lees & Hopkins, 2013). There is clear evidence that links health and academics (Michael, Merlo, Basch, Wentzel, & Wechsler, 2015) and recess provides the student with the opportunity to exercise, thereby contributing to better health. Handyman, Benson, Lester & Telford (2017) found a positive relationship between children’s quality of life and enjoyment of recess. Fortson et al., (2013) found teacher reports of positive effects of a structured recess in students’ use of positive language and perception of safety, better behavior and control, and decreased bullying. “Recess in schools benefits students by increasing their level of physical activity improving their memory, attention, and concentration; helping them stay on-task in the classroom; reducing disruptive behavior in the classroom; and improving their social and emotional development” (CDC & SHAPE, 2017, p. 2). Withholding recess for behavior or academic reasons, however, is still prevalent across the United States (CDC, 2015; Turner et al., 2013).

RATIONALE

The CDC considers recess an essential part of the school day and encourages self-directed physical activities among students in grades K-12 (CDC & SHAPE, 2017). Many national organizations recommend that recess not be withheld from students (CDC & SHAPE, 2017; Murray et al., 2013); however, withholding recess continues to be practiced in schools as a form of punishment or as an avenue to allow for more academic endeavors (CDC, 2015). Creating and strengthening school policies on recess, especially prohibiting the elimination of recess time as punishment, will protect scheduled recess. A “strong district policy was associated with increased odds of not withholding students from recess for poor behavior or for completing schoolwork” (Turner et al., 2013, p. 533). The school nurse, as a child health content expert, advocates for policies that protect scheduled recess. The school nurse uses data, research, and evidence-based practice to affect change at the school or district level and can influence state level policy through state school board policy, legislation and the Every Student Succeeds Act (ESSA).

The school nurse supports and advocates for scheduled recess that

- Is well-supervised by staff members who receive annual professional development (CDC & SHAPE, 2017);
- Is safe and enjoyable (Hyndman, Benson, Lester, & Telford, 2017);
- Supports physical activity (Hyndman et al., 2017; Lees & Hopkins, 2013);
• Provides age-appropriate equipment and facilities, including a designated space that meets or exceeds safety requirements (CDC & SHAPE, 2017);
• Is scheduled before lunch (CDC & SHAPE, 2017); and
• Is safeguarded from being withheld as a punishment or used as punishment (CDC & SHAPE, 2017; Murray et al., 2013; Turner, Chriqui, & Chaloupka, 2013).

CONCLUSION

NASN supports daily recess. School administrators and teachers may regard recess as non-essential, using the removal of recess as a discipline tool to address student behavior. Educators, bound by time constraints of the school day, are challenged to cover academics within the allotted instructional time. Consequently, recess may be shortened or replaced with academics to compensate for the time limitations of the school day. Daily recess positively impacts student academic success and behavior. The school nurse is cognizant of the physical and academic benefits of recess as based on current research and assumes a role in educating the school community regarding these findings. Utilizing NASN’s Framework for 21st Century School Nursing Practice™ (NASN, 2016) the school nurse, mobilizing key principles and components of leadership and community/public health, develops and advocates for recess policies that promote the benefits of recess and prevent withholding scheduled recess. The school nurse collaborates with health and physical education teachers, administrators, and other stakeholders such as parent teacher organizations in supporting scheduled recess.

REFERENCES


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Reimbursement for School Nursing Services

Position Statement

SUMMARY
The National Association of School Nurses (NASN) believes school nursing services that are reimbursed in other healthcare environments should also be reimbursed in the school setting. The registered professional school nurse (hereinafter referred to as the school nurse) provides the health services in the school setting to improve the students’ ability to remain in the classroom and increase their opportunity for academic achievement. Healthcare services provided by the school nurse are reimbursable services in other healthcare settings, including hospitals, clinics, and home care settings.

Historically, local and state tax monies targeted to fund education programs have paid for school health services. School nurses are in a unique position to advocate, encourage, and facilitate improving clinical care to students. This care matches the services provided by community healthcare professionals and as such school health programs should be able to apply for to reimbursements just like their community counterparts. Restructuring reimbursement programs will enable healthcare funding streams to assist in paying for school nursing services delivered to students in the school setting. Developing innovative health funding opportunities will help to increase access, improve quality, and reduce costs. A goal of NASN is to promote a comprehensive and cost-effective healthcare delivery model that integrates schools, families, providers, and communities while at the same time keeping students healthy, safe, and ready to learn.

BACKGROUND
Historically, third-party payers—including Medicaid, the Children’s Health Insurance Program (CHIP), and private insurance companies—have provided reimbursements for healthcare services. 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 approved through the Centers for Medicare and Medicaid services that define the health services covered (National Alliance for Medicaid in Education [NAME], 1997). For Medicaid to reimburse health services, a child (student) must be eligible based on family income or disability; the provider (school nurse) must be qualified to provide such service; and the service must be reimbursable according to Medicaid guidelines. The place of service, such as the setting of a school district, should not preclude payment for a reimbursable service (Medicaid.gov., 2014).

CHIP is a program designed to cover uninsured children in families who do not qualify for Medicaid and those who cannot afford private insurance. CHIP is administered by individual states but is jointly funded by both the federal government and states (Medicaid.gov, n.d.). Individual states may choose how CHIP funding is used through one of three options: Medicaid expansion, as a separate children’s insurance, or as a combination of the two (Medicaid.gov, n.d). Medicaid sets the standard for coverage of benefits and reimbursement (Lowe, 2013). The majority of children enrolled in CHIP are covered through Medicaid (The Commonwealth Fund, 2017).

Individualized Education Program (IEP) Health-related Nursing Services
Covered reimbursable nursing services include both direct and case management services as long as the student receiving services is in special education, has a current IEP, and qualifies for Medicaid. 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).

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
Some school districts provide nursing services under 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, making needed health services available to children. EPSDT provides for the early identification, assessment, and treatment of health conditions.

Vaccines
To promote 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, such as pediatric or family nurse practitioners, as school nurses or in addition to school nurses to provide primary care services, including chronic disease management, EPSDT services and treatment of minor illnesses. 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 (SBHC)
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. Although the majority of SBHC are privately funded, approximately one-third rely on school districts for financial support (Price, 2017). Price (2017) adds that, while fee-for-service produces the largest revenue, some centers receive monthly or annual capitated payments and reimbursement for care coordination. NASN believes that 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 (NASN, 2017).

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 is a health service that is reimbursable in other healthcare delivery systems. 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. School nurses often have the tools necessary to link school staff, students, families, community, and healthcare providers to promote a healthy school environment for students with chronic health conditions (Leroy, Wallin, & Lee, 2017). 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 healthcare providers in the community. Reimbursement for nursing services is not restricted to only those services provided in community healthcare centers but is available for nursing services provided within the school setting as well (Medicaid.gov., 2014).

Administrative Claiming
Medicaid allows for the provision of administrative activities, including Medicaid outreach and facilitating Medicaid enrollment. These administrative activities are reimbursable through state Medicaid programs. 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 regimens, coordinating health-related services, and making referrals for a student to receive necessary health/medical evaluations or examinations.

**Patient Protection and Affordable Care Act (PPACA)**

Schools and school nurses are in a unique position to engage in health reform implementation. The law, known as the Patient Protection and Affordable Care Act (PPACA) (2010), has three major goals: expanding access, improving quality, and reducing costs. The PPACA 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 PPACA presents an opportunity to transform the way care is delivered 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.

**Section 504**

Section 504 of the Rehabilitation Act of 1973 (2000) is a federal civil rights statute that grants to individuals legal protection against discrimination on the basis of disability. All school districts that receive federal dollars must comply with Section 504. The U.S. Department of Education Office of Civil Rights administers Section 504. For a student with a physical or mental impairment that causes a substantial limitation of a major life activity, or major bodily function, related services must be provided without cost, 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 person with a disability (Civil Rights Act of 1964, 34C.F.R. 104.33).

**RATIONALE**

The responsibility of a school system is to provide quality education for children. However, in order for children and adolescents to be successful learners, they must have their healthcare needs met. The school setting provides a unique opportunity to enroll eligible children in the Medicaid program and to assist children who are already enrolled in Medicaid to access the benefits available to them (Medicaid.gov, n.d.). This is one example of reimbursement of professional school nursing services from a third- party payer. When reimbursement programs are restructured, revenue will be available to support essential school nursing services.

The position of NASN is school nurses must take a leadership role in making the case for innovative health financing proposals, including restructuring existing reimbursement programs to support, expand, and promote access to school 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 by keeping parents and families at work. Providing services that will enable children to 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, *Why School Nurses Are the Ticket to Healthier Communities* (2016), points out that, because school nurses are integrated into their schools and communities, they can address unmet health needs so that students can focus on learning. This statement highlights the reality that school nurses serve on the frontlines as the nation’s safety net for our most vulnerable children and is also a position that is valued by NASN. School nurses are uniquely equipped to address some of our most pressing health concerns while delivering quality, cost-effective health care.
School communities must recognize that school nurses are providing comparable, quality care to students as other healthcare providers. It is NASN’s position that school nursing services should be reimbursable through third-party payers, such as Medicaid or private insurance companies; and, in turn, those monies can provide needed revenue to support the delivery of essential school health services. This proactive thinking will ultimately help to eliminate or reduce health-related barriers to learning and improve academic achievement.

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Use of Restraint and Seclusion in the School Setting

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that restraint and seclusion should not be used in the school setting as a routine form of discipline. Restraints and seclusion should only be used when the child’s behavior poses an imminent danger of serious physical harm to self or others (United States Department of Education, 2012). In addition, the registered professional school nurse (hereinafter referred to as the school nurse) is in a position to promote positive behavioral supports in the school setting. NASN believes that the school nurse is an essential advocate for the health and well-being of all students.

BACKGROUND AND RATIONALE

The United States Government Accountability Office (USGAO, 2019) defines the types of restraint and seclusion. Physical restraint is defined as “restricting a student’s ability to freely move his or her torso, arms, legs, or head: it does not include a physical escort, such as temporary touching of the arm or other body part for the purpose of inducing a student who is acting out to walk to a safe location” (p. 2). Mechanical restraint is defined as “the use of any device or equipment to restrict a student’s freedom of movement: this does not include vehicle safety restraints or medical devices” (p. 3). Lastly, seclusion refers to “involuntarily confining a student alone in a room or area from which he or she can not physically leave: it does not include timeout,” which is defined as a behavior management technique for the purpose of calming (p.3).

The Every Student Succeeds Act (ESSA) (2016) states that school nurses play an important role in providing a safe and supportive learning environment. School nurses are Specialized Instructional Support Personnel (SISP) who provide related services to students in school. In this role, school nurses deliver school-wide approaches to school safety and assist in providing programs that promote supportive discipline practices (ESSA, 2016). ESSA also stipulates that local education agencies must improve school conditions that promote student learning and decrease disciplinary practices that remove students from the classroom and discontinue the use of aversive behavior interventions such as restraint and seclusion (Trader et al., 2017).

Seclusion in the form of time-out is the only discipline strategy recommended by the American Academy of Pediatrics (AAP) for all children. On the AAP Healthy Children site, a general guideline for time-out is advised not to exceed more than one minute per year of age (2020). AAP recommends healthy forms of discipline, such as “positive reinforcement of appropriate behaviors, setting limits, redirecting, and setting future expectations” (Sege & Siegel, 2018). School nurses should advocate that when time-out is part of a student’s Individualized Education Program (IEP), appropriate implementation must be clearly outlined.

Data support that there is disproportionate use of seclusion and restraint against students with disabilities (Prince & Gothberg, 2019). The most recent government data available from school year 2017-2018 showed that 13% of all public school students were labeled as having an IDEA disability, but they accounted for 41% of students mechanically restrained, 80% of students physically restrained, and 77% of those secluded during that particular school year. Additionally, African American students comprise 18% of students with an IDEA disability but make up 26% of students with physical restraints, 34% of mechanical restraints, and 22% of seclusion. Hispanic or Latino students comprise 27% of all IDEA students and were only subjected to 14% of physical restraint, 28% of mechanical restraint, and 9% of seclusion. By contrast 48% of students with IDEA disabilities are Caucasian. They comprise 52% of physical restraint cases, 33% of mechanical restraint, and 60% of seclusions. In addition, gender differences were also noted. Boys comprise 66% of all IDEA eligible students; and yet they were subjected to 83% of physical restraint, 82% of mechanical restraint, and 84% of seclusion (United States Department of Education, 2020).

The most recent Department of Education initiative to address the inappropriate use of seclusion and restraint involves three components: compliance reviews through the Office of Civil Rights (OCR), Civil Rights Data Collection
(CRDC), and technical support for recipients of federal funding mandated to comply through OCR or Office of Special Education and Rehabilitative Services (OSERS) (U.S. Department of Education, 2019).

The Individuals with Disabilities Education Improvement Act of 2004 mandates that schools provide a free and appropriate public education (FAPE) and that those services are in the least restrictive environment (LRE). It also states that children should be in the general education setting for the maximum time possible and that intensive support may be necessary and must be provided (Trader et al., 2017). According to guidance given by OSERS, IEP teams must consider the use of positive behavioral interventions and supports, and other strategies, to address behavior that impedes the student’s learning or the learning of others (Swenson & Ryder, 2016). School nurses are key members of the IEP team and should lend their expertise and consider the health needs of a student when Functional Behavior Assessments (FBA) are done and Behavior Support Plans (BSP) are written (Trader et al., 2017).

Positive behavioral supports should be universally adopted to avoid the use of restraint and seclusion and promote justice and equity for all students. School nurses must aid in ameliorating race and gender-based disparities in school discipline through changes in professional practice and the development of equitable policies. The Framework for 21st Century School Nursing Practice (NASN, 2016) states that our guiding principles should ensure that students are healthy, safe and ready to learn. Promoting a safe and secure environment is vital to the educational success and emotional development of children (NASN, 2016).

REFERENCES


To optimize student health, safety, and learning, it is the position of the National Association of School Nurses that a professional registered school nurse is present in every school all day, every day.

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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 55.9 million students in public and...
private 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 & Selekman, 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


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The School Health Services Team: Supporting Student Outcomes

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that the registered professional nurse (hereinafter referred to as “school nurse”) collaborates to lead the school health services team in the identification of and intervention for health-related barriers to improve student learning (American Nurses Association [ANA] & NASN, 2017, p. 84).

BACKGROUND AND RATIONALE

School nurses are part of a team of Specialized Instructional Support Personnel (SISP) defined by the Every Student Succeeds Act (ESSA) (2015) as qualified professional personnel involved in providing assessment, diagnosis, counseling, educational, therapeutic, and other necessary services. SISP work as a multidisciplinary team possessing a wide range and depth of expertise to meet critical student needs while supporting the whole child (National Alliance of Specialized Instructional Support Personnel, 2019). The school nurse functions in a pivotal role that bridges healthcare and education through provision of care coordination, advocacy for quality student-centered care, and collaboration to design systems that allow individuals and communities to develop their full potential (NASN, 2017).

School nurses lead teams that provide health services to students. In addition to school nurses, the teams may include licensed practical nurses/licensed vocational nurses (LPN/LVN), unlicensed assistive personnel (UAP) and/or assistive personnel (AP), and SISP professionals. As health team leaders, school nurses play a significant role in student success, as access to school health services has been associated with better health for all students (Allison & Attisha, 2019). Student health is linked to academic achievement related to grades, test scores, school attendance, and student behavior (Kocoglu & Emiroglu, 2017; Michael, Merlo, Basch, Wentzel, & Wechsler, 2015).

The American Academy of Pediatrics (2016) recommends that all schools have a minimum of one registered professional school nurse to provide health services. The authority to practice nursing is granted to registered nurses (RNs) and LPN/LVs through a state nursing license which protects the public by setting minimum qualifications and competencies for entry-level practitioners (National Council of State Boards of Nursing [NCSBN], 2019). The LPN/LVN performs primarily procedural nursing functions and some shared nursing responsibilities in accordance with their educational preparation and state Nurse Practice Act, which includes working under the supervision of an RN or other designated healthcare professional such as a physician or advanced practice registered nurse (American Association of Occupational Health Nurses [AAOHN], 2017; Benbow, Abel, Benton, & Hooper, 2014). It is important to note how a state Nurse Practice Act defines supervision of the LPN/LVN, which differentiates between on-site (direct) supervision and remote (consultative) supervision. LPNs/LVNs should not be placed in positions in which supervision by a designated healthcare professional is not available (AAOHN, 2017).

UAP/AP are school personnel who do not hold a healthcare license. They often serve in the role of paraprofessionals, health aides, nursing assistants, health clerks, or teacher aides (Bobo, 2018). As allowed by state Nurse Practice Acts and with proper training and oversight, tasks that may be performed by and delegated to UAP/AP may include first aid, school health screenings, maintaining student health records, non-complex daily procedures, and other health office duties. Responsibilities that cannot be delegated to UAP/AP include assessments, nursing diagnosis, establishing expected outcomes, care evaluation and all other tasks and aspects of care including, but not limited to, those that involve critical thinking, professional nursing judgment and professional knowledge (NCSBN, 2016). The school nurse conducts and documents UAP/AP training, provides
ongoing supervision, performs performance evaluation, and is in control of the decision to assign healthcare tasks (Bobo, 2018; Combe & Clarke, 2019).

School physicians, if available, have a broad range of roles and types of relationships with the schools they serve. They may be providers of direct services, such as mandated physical examinations; advisors to a school health advisory group; or consultants to the school nurse, the superintendent of the district, or the Board of Education. School physicians function based on the medical and social needs or demands of the community, the school district’s priorities, and state laws (American Academy of Pediatrics Council on School Health, 2016).

The school health team, led by the school nurse, provides support for positive student academic and health outcomes. Members of the team vary and may include LPNs/LVNAs, UAPs/APs, school physician, and SISP professionals who provide services to students to meet increasing numbers and acuities of healthcare needs. Being knowledgeable of state Nurse Practice Acts and regulations ensures team members work within their scope of practice. Together, team members’ combined efforts aim to improve student outcomes.

REFERENCES


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“To optimize student health, safety and learning, it is the position of the National Association of School Nurses that a professional registered school nurse is present in every school all day, every day.”

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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], 2017), is an important public health objective. NASN further recognizes that challenges still remain in meeting this goal and schools can play a key role in the deterrence of vaccine preventable diseases (VPD).

The National Vaccine Plan, 2015-2016 Mid-Course Review, states that there are still opportunities to eliminate financial and system barriers for providers and consumers to facilitate access to routine, recommended vaccines. Highlighted in Goal #4, health care providers must continue to improve access to and acceptance of vaccination providers in nontraditional healthcare settings. School-located vaccination (SLV) can augment other emerging alternative vaccination sites (USDHHS, 2016).

The registered professional school nurse (hereinafter referred to as the school nurse) is in a critical position to create awareness, influence action, and provide leadership in the development of SLV programs. School nurses are trusted professionals within the school and community settings and can play a pivotal role in the success of SLV. They are ideally placed to identify students who have missed vaccines (Swallow & Roberts, 2016). Studies also show that SLV is key for adolescents who have significantly lower rates of vaccination due to lower rates of office-based visits (Bernstein & Bocchini, 2017).

BACKGROUND

Historically, SLV has been shown to enhance vaccination rates. 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, in the 1990s to conduct hepatitis B catch-up clinics, and again in 2009 for varicella and H1N1 vaccines (Mazyck, 2009; Lambert & Merkel, 2000; Hodge & Gostin, 2002). In the 2012-13 school year, an SLV project in rural Kentucky administered the HPV vaccine, significantly improving vaccination rates (Vanderpool et al., 2015).

However, broad adoption of SLV has been slow. Reasons for this are varied, but a major reason is that the beliefs of widespread morbidity and mortality caused by vaccine-preventable diseases have faded from memory. VPDs in a variety of locations remind us that they have not been completely eradicated and that there is continued vulnerability of VPDs. Other factors that may be influencing SLV are informed consent, privacy and confidentiality, and harm from fear and anxiety (Braunack-Mayer et al., 2015). The shift to the use of SLV in administering routinely recommended vaccines will require careful planning to implement known strategies designed to assure appropriate reimbursement for cost-effective services. SLV provides an important opportunity to immunize youth with limited access to healthcare services in the community at large (Middleman, 2016).

In November 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 DC. 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 and 2) documentation (Bobo, Etkind, & Talkington, 2010). These challenges still exist today.

In a recent study, Illinois Medicaid managed care providers and billing personnel lacked clarity in how to obtain coverage for immunizations that are administered outside of the medical home (Limper & Caskey, 2016).

RATIONALE

SLV has a long history in the United States and has successfully contributed to lower morbidity and mortality due to vaccine-preventable diseases (Limper et al., 2014). The school is an ideal place to reach 52 million children from all cultures, socioeconomic groups, and age groups that attend each day; and the school is conveniently located in a familiar and trusted community environment. SLV also offers a convenient option for parents to have their children receive needed vaccinations without having to arrange for a healthcare provider visit or take off time from work (Shlay et al., 2015).

One strategy to improve immunization rates in the United States is to capitalize on the trusted position of schools and school nurses to establish SLV. The school nurse can play a critical role in planning SLV because of understanding both the needs of the community and the school. 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.
- 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.
- can provide accurate information and dispel myths about vaccines.
- are familiar with the health status of students and thus able to mitigate potential contraindications for vaccines.
- understand the implications of Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) related to recording and sharing immunization records.

In addition, schools and school nurses can provide significant logistical assistance in implementing SLV. Some of these include the following:

- Schools have the space and capacity to host SLV (e.g. gymnasium, library, cafeteria). Schools can also provide a space for safe storage of vaccines in a controlled environment.
- School start and dismissal times provide the framework for scheduling SLV with the least disruption of the school day.
- Schools can assist with securing volunteers such as parents, nursing students and other community partners to participate with SLV.
- School nurses understand mandated and recommended vaccination schedules and the complexities of vaccine administration.
- School nurse relationships with parents/families can be critical in obtaining consent for vaccination.
- School nurses can create SLV as the norm to enhance community-wide emergency preparedness.

CONCLUSION

SLV can reach children in the school environment and can complement the work of office-based healthcare providers. School nurses are well-versed in the importance of deterring and eradicating vaccine preventable diseases and the issues that are unique to their school community. NASN supports the continued efforts of school
nurses and their community partners in developing SLV opportunities when it is appropriate for the health and well-being of their students and the community at large.

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Acknowledgment of Authors:
School Nurse Workload: Staffing for Safe Care

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that access to a registered professional nurse (hereinafter referred to as a school nurse) all day, every day can improve students’ health, safety, and educational achievement. Student acuity and school community indicators should be assessed to determine appropriate staffing levels. Access to a school nurse may mean that more than one school nurse is necessary to meet the needs of the school population. School nurse workloads should be evaluated on at least an annual basis to meet the health and safety needs of school communities (Jameson et al., 2018).

BACKGROUND AND RATIONALE

Since 1902, school nurses have contributed to individual and population health, in ever-expanding ways (Rogers, 1903/2014). Laws implemented in the 1970s established the rights for all students, even those with significant health needs, to attend public school, and led to recommendations for school nurse-to-student ratios. These laws included the Rehabilitation Act of 1973, Section 504 (1973), 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). Changes in these laws increased the role and responsibilities of the school nurse.

Appropriate staffing is necessary in order to provide safe care and ensure quality outcomes, and is accomplished through understanding and considering the complexities of the role of the nurse and the care that is provided (American Nurses Association [ANA], 2020). Using ratio of nurse to student alone is not evidence-based or appropriate. Other factors that should be considered include:

- Safety, medical acuity, and health needs of a student;
- Characteristics and considerations of student or population including individual social needs as well as the infrastructure that creates inequities in social determinants of health;
- Characteristics and considerations of the school nurse and other interprofessional team members; and
- Context and culture of the school or school district that influences nursing services delivered (Jameson et al., 2018).

Evaluation of staffing plans, overall costs, effectiveness, and resources expended also influences staffing decisions. Safe and appropriate staffing has an impact on population and community health outcomes, enriching the patient experience of care, reducing health care costs, and enhancing the work life of the healthcare provider (American Association of Critical-Care Nurses [AACN], 2016; Bodenheimer & Sinsky, 2014). Consistent with the research in acute care settings (Aiken et al., 2017; Brooks Carthon et al., 2019; Kelly & Todd, 2017; AACN, 2016), multiple studies suggest that appropriate school nurse staffing
has an impact on the health and academic outcomes of the students and the school community and contributes to reduced health care costs and a healthier population (Arimas-Macalino et al., 2019; Best et al., 2017; Daughtry & Engelke, 2017; Gormley, 2018; Hill & Hollis, 2012; Jacobsen et al., 2016; Nikpour & Hassmiller, 2017; Wang et al., 2014).

Little data exists on validated tools to determine school nurse staffing. Current best practice for staffing involves analyzing complex factors including number of students, social determinants, acuity levels, other responsibilities, barriers to care, current use of technology, and health care to adequately meet the health and safety needs of the children whose care is entrusted to schools (Jameson et al., 2018).

Such a structure helps detail a 21st-century context for nurse staffing that recognizes the individual contribution and added value of each individual nurse as a provider of care (ANA, 2020). NASN recommends ongoing research to develop evidence-based health assessment and other tools that consider multiple factors for the development of staffing and workload models.

The school nurse provides the critical link to address gaps in healthcare by serving students and the school community as the health expert. School nurses can navigate and address socio-economic issues, physical health needs and health behavior factors; respond to student and community needs; and work as advocates and change agents.

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. NASN recommends continuing research developing evidence-based tools using a multifactorial health assessment approach for evaluating factors that influence student health and safety and developing staffing and workload models that support this evidence. All students need access to a school nurse every day. In addition to the number of students covered, staffing for school nursing coverage must include acuity, social needs of students, community/school infrastructure, and characteristics of nursing staff.

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School-sponsored Trips - 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) is the expert healthcare provider in the school setting who can support and guide students and staff in meeting the healthcare needs of students both at school and on school-sponsored trips such as extracurricular activities, field trips, intramural athletic events, and interscholastic athletic events (NASN 2016; Connecticut State Department of Education, 2014). All students, including students with special needs, have the right to participate in school-sponsored trips (U. S. Department of Education [USDE]/ Office of Civil Rights [OCR], 2016). The school nurse's role is critical in planning, coordinating, and educating staff, families, and students to assure appropriate care for all students every day at school and during school-sponsored trips (NASN, 2016; Yonkaitis & Shannon 2017).

BACKGROUND

School-sponsored trips are offered to complement and enhance the educational experience for students. A trip may be as simple as a local excursion for just a few hours or as complicated as a trip for several days/night to a different city, state, or country. While schools may invite the parents/guardians of a student with special healthcare needs to accompany the student on the trip, school officials cannot require that a parent/guardian of a child with special healthcare needs attend if parents of students without special healthcare needs are not required to accompany their children (USDE/OCR, 2016).

Beginning in the 1960’s, the United States began enacting laws to support students with special needs (Galemore & Sheetz, 2015). The rights of students with disabilities are protected through the Individuals with Disabilities Education Improvement Act (IDEIA) (2004) and Section 504 of the Rehabilitation Act of 1973 (Yonkaitis & Shannon, 2017). All schools that receive federal funds are subject to Section 504 and the American with Disabilities Act (ADA) of 1990 (USDE/OCR, 2017). Under Section 504 regulations, equal access includes serving students with disabilities in the academic and non-academic settings, including school-sponsored trips. To guarantee that students with disabilities have equal access to school programs, Section 504 requires that schools provide modifications and/or accommodations. If a student with a disability needs an accommodation or related aids or services to participate in the field trip, those services must be provided (USDE/OCR, 2016). Local school districts are responsible for providing the needed accommodations to students with disabilities to safely participate alongside their classmates on school-sponsored trips.

In 2015, the Every Student Succeeds Act (ESSA) identified the school nurse as the healthcare expert to manage students with chronic healthcare needs, including those with disabilities (ESSA, 2015). In 2011-2012 approximately 25% of children aged 6 to 17 years were reported to have a special health care need (Child Health USA, 2014). School nurses are responsible for informing educational communities about the medical needs of students so that they may safely participate in school-sponsored trips.
RATIONALE

A system should be present which engages the school nurse in all planning phases of the school-sponsored trip to ensure that a comprehensive plan for student care and safety is in place. According to federal mandates, schools must provide equal opportunities to access participation in all activities, both academic and extracurricular, including access to health services (Erwin, Clark, & Mercer, 2014). To promote proper access to health services, the school nurse should perform individual health assessments and develop or update individual health plans (IHPs) annually. These timely plans will enable appropriate, safe care for students with special healthcare needs throughout the school year, including for potential school-sponsored trips. The student’s healthcare needs on school-sponsored (field) trips are determined through a collaborative process coordinated by the school nurse (NASN, 2016). 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 or ECPs (Erwin, Clark & Mercer, 2014).

The school nurse’s knowledge of the individual needs of students places the school nurse in a unique position to coordinate care that enables the student to fully participate in a safe and healthy school-sponsored trip experience (NASN, 2016).

Planning steps may include

● assessing trip plans, including transportation methods, student’s dietary issues and needs; accompanying staff; layout/structure of the planned visitation site(s); duration of the trip; and proximity/access to emergency medical care;
● addressing medical issues such as medication, medical treatments, and procedures required during the trip, as well as the potential for health emergencies; and
● determining the cost of accommodations. Currently, the costs associated with providing accommodations are the responsibility of the school district and must be considered in the initial planning phases of a proposed school-sponsored trip (USDE/OCR, 2016).

For in-state school-sponsored trips, depending on state regulations, the school nurse may be able to consider delegating some tasks required during the trip to a non-nurse staff member, such as a teacher (Bobo, 2014). The school nurse will utilize appropriate principles of nursing delegation as described in the national guidelines written by The National Council of State Boards of Nursing (NCSBN, 2017), the state Nurse Practice Act, and other state school nurse delegation guidelines. If the school nurse determines that medical care cannot be legally or safely delegated, the school nurse will need to determine and coordinate the nursing staff required to accompany the student.

If the school-sponsored trip takes place in a different state or country and requires the presence of the school nurse, licensing laws need to be considered, so that the school nurse can legally provide nursing services in 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 compact states (NCBSN, 2017). Some states do not participate in this agreement. Each state board of nursing regulates nursing practice issues (i.e. delegation and medication administration) in their individual state (Erwin, Clark & Mercer, 2014). It is critical to understand the state board of nursing regulations, scope of practice and laws governing care in the state where the services will be provided (Erwin, Clark & Mercer, 2014). For trips occurring out of the United
States, the nurse or a school representative should contact the U.S. State Department, which will direct the inquiry to the appropriate international contact (Erwin, Clark & Mercer, 2014).

CONCLUSION
School-sponsored trips may be common occurrences in the educational lives of students and can be some of their most enjoyable. School districts that receive federal funding are legally bound to assure that all students have access to these opportunities (USDE/OCR, 2016), regardless of disability or healthcare needs. It is the position of NASN that the school nurse’s role is critical in the planning, coordination, and education of staff, families, and students. Providing appropriate care and protecting the needs and rights of ALL students, allows for a safe, enjoyable educational experience for each person participating in these trips.

REFERENCES


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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 registered professional school nurses (hereinafter referred to as school nurses) advance and encourage safe school environments by promoting the prevention and reduction of school violence. School nurses serve on the front line and are readily able to identify potential violence and intervene to diminish the effects of violence on both school children as individuals and populations in schools and the community (King, 2014). School nurses collaborate with school personnel, healthcare providers, parents, and community members to identify and implement evidence-based programs promoting violence prevention. These evidence-based programs promote violence prevention through early intervention, communication, positive behavior management and conflict resolution. As identified in the Framework for the 21st Century School Nurse Practice™ (NASN, 2015), the school nurse supports evidence-based practices and care coordination to provide an environment where students can be healthy, safe, and ready to learn.

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, 2017, 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 (Centers for Disease Control and Prevention [CDC], 2016). Selekman, Pelt, Garnier, and Baker, (2013) describe school violence as including 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. 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. The CDC (2016) found that violence and bullying may have a negative effect on health throughout life.

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 may be able to identify students at risk. The CDC (2017) has identified potential risk factors and protective factors that may be considered when assessing student characteristics that are common among others that become a perpetrator or victim, including individual and family characteristics. These factors include a history of victimization, disabilities, emotional problems, substance abuse, low IQ, authoritarian parenting, low family involvement, low-income family functioning, gang involvement, school failure, transient lifestyle and diminished economic opportunities. By recognizing these social determinants and assessing the child, the school nurse may be able to identify those at greatest risk of being involved in violence as the victim or the perpetrator. Once identified, these students can be supported by school staff and encouraged to be involved in school activities and social engagements. If students feel connected and supported by their non-deviant peers and school staff, they are less likely to commit a violent act or be in a setting where they can be victimized.

The authors of Indicators of School Crime Safety: 2016 state:

In 2015, three percent of students ages 12-18 reported that they were afraid of an attack or harm at school, and five percent of students avoided either a school activity or one or more places in school because of fear of being attacked or harmed by someone. From July of 2013 to June of 2014, there were 48 school-associated violent deaths including 26 homicides, 20 suicides, 1 legal intervention death, and
one undetermined violent death (of those 48 violent deaths, 12 homicides and 8 suicides were school-age children). In the 2013-2014 school year, 65 percent of public schools reported one or more incidents of violence translating to around 15 crimes per 1000 students. In 2015, there were about 84,100 nonfatal victimizations at school (Musu-Gillette, Zhang, Wang, Zhang, & Oudekerk, 2017, pp. iii-iv).

The CDC (2016, para. 2) reports the following:
- Approximately 9% of teachers report that they have been threatened with injury by a student from their school.
- Five percent of school teachers reported that they had been physically attacked by a student from their school.
- In 2013, 12% of students ages 12–18 reported that gangs were present at their school during the school year.
- In a 2015 nationally representative sample of youth in grades 9-12
  - 7.8% reported being in a physical fight on school property in the 12 months before the survey.
  - 5.6% reported that they did not go to school on one or more days in the 30 days before the survey because they felt unsafe at school or on their way to or from school.
  - 4.1% reported carrying a weapon (gun, knife, or club) on school property in one or more days in the 30 days before the survey.
  - 6.0% reported being threatened or injured with a weapon on school property one or more times in the 12 months before the survey.
  - 20.2% reported being bullied on school property, and 15.5% reported being bullied electronically during the 12 months before the survey.

Musu-Gillette et al., 2017 in *Indicators of School Crime and Safety: 2016* cites that in public schools
- sixteen percent during the 2013-2014 school year reported that bullying occurred among students on a daily or weekly basis (p. vi).
- seven percent of students in 2013 reported cyberbullying anywhere during the school year (p. 80).
- in the 2013-2014 school year, five percent reported student verbal abuse of teachers occurred on a daily or weekly basis, and 9 percent reported student acts of disrespect for teachers other than verbal abuse on a daily or weekly basis (p. vi).
- eleven percent reported gang activities during the 2015 school year (p. 64).

Less visible statistically are the effects of witnessed violence and increased prevalence of violence as a coping mechanism in schools and the community. Children who witnessed violence, even as infants, have been shown to experience mental health distress, resulting in behavior and mental health issues during the school day (Selekman et al., 2013). Violence has become a significant health risk and is not limited to violent acts committed in the school setting but also in homes, neighborhoods, and communities which affect the learning and behaviors of children at school (Selekman et al., 2013).

**RATIONALE**

School nurses also play a vital role in violence intervention. Hassey and Gormley (2017) identified eight types of violence and the role of the school nurse in each type. The eight types of violence include bullying, mental health crisis, physical assault, sexual assault, student on student, student on staff, staff on the student, and escalating violence/violent intruder. Each type may begin with the school nurse assessing the situation, followed by appropriate actions and referrals deemed necessary for the situation. The school nurse works with students, families, and the school community to implement a multi-strategy approach to school violence (David-Ferdon et al., 2016). For individual students and families, 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:
- Identify behaviors that could be purposeful misbehavior—such as bullying, outbursts, sleeping in class or running away—and physical symptoms—such as headaches, stomachaches, and frequent trips to the clinic as possible effects of violence (King, 2014).
• Facilitate programs that engage parents in school activities that promote connections with their children and foster communication, problem-solving, limit setting, and monitoring of children.
• 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).

Creating protective community environments is necessary for a multi-strategy, multi-disciplinary approach to violence prevention (David-Ferdon et al., 2016). School nurses contribute expertise in creating a protective environment in schools by
• serving on school safety and curriculum committees, identifying, advocating, and implementing universal school-based prevention programs within the school community (David-Ferdon et al., 2016).
• supporting the efforts of administration by collaborating with a multi-disciplinary team of colleagues in the areas of social work, counseling, school discipline, and law enforcement to provide and maintain security.
• assisting in the development of district and school discipline policy, including zero tolerance for weapons on school property and buses, and code of conduct documents.
• supporting activities and strategies to help establish a climate that promotes and encourages respect for others and the property of others.
• advocating for adult presence in high-risk areas and times, such as in hallways during class changes and before and after school and outside of the building before and after school.
• facilitating partnerships between the school and local healthcare agencies.

When violence occurs, school nurse interventions to address violent behaviors include their ability to
• coordinate emergency response until rescue teams arrive.
• provide nursing care to 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.
• participate in crisis intervention teams.

CONCLUSION

School nurses promote violence prevention by facilitating a school environment that values connecting students, families and the community in positive engagement and creating a school environment of safety and trust where students are aware that caring, trained adults are present and equipped to take action on their behalf. They engage in classroom discussions that facilitate respectful communication among students and staff and advance the education of the school community to build skills in communication, problem-solving, anger management, coping and conflict resolution. The expertise of school nurses in evidence-based practice of health care in the school setting is beneficial in violence prevention in schools.

School nurses advance and encourage safe school environments by promoting the prevention and reduction of school violence through evidence-based practice methods. The school nurse recognizes potential threats and collaborates with the appropriate personnel to get students the resources and supports they need to be healthy, safe and ready to learn.

REFERENCES


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Service Animals in Schools

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that service animals allow some students with disabilities access to their education while enabling greater independence. The registered professional school nurse (hereinafter referred to as school nurse) as a member of the school planning team, facilitates the integration of service animals into the school by leading the development of inclusive policies and practices. As school health care professionals, school nurses ensure the health and safety needs of all students are met, while conforming to federal accessibility laws.

BACKGROUND AND RATIONALE

Americans with Disabilities Act (ADA) regulations, Section 504 of the Rehabilitation Act of 1973, Individuals with Disabilities in Education Act, as well as state and local laws, support children who may require a service animal in school (Brennan & Nguyen, 2014). The Americans with Disabilities Act 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, para 3). A separate provision includes miniature horses in the definition of a service animal (USDJ, 2011). Disabilities for which service animals are used include physical, sensory, psychiatric, intellectual, or other mental disability. Service dogs and horses can be especially beneficial in improving the educational experience of children with special needs (Harris & Sholtis, 2016).

The service animal must be trained to take a specific action when needed to assist the person with a disability (USDJ, 2015). These actions include, but are not limited to, guide dogs for sight impaired, hearing or signal dogs for alerting those with hearing loss, Psychiatric Service Dogs (PSD) to detect the onset of psychiatric episodes, Sensory or Social Signal Dogs (SSig) trained to assist a person with autism, Seizure Response Dogs trained to assist a person with a seizure disorder, and service dogs trained to identify low blood sugar levels (Catala, Cousillas, Hausberger, & Grandgeorge, 2018). There is a distinction between psychiatric service animals and emotional support animals. If the service animal has been trained to sense the onset of an anxiety attack and takes a specific action to help avoid the attack or lessen its impact, that would qualify as a service animal (USDJ, 2011; Krause-Parello, Sarni, & Padden, 2016). If a dog’s mere presence provides comfort, the ADA would not consider this performing work or a task (USDJ, 2015; Schoenfeld-Tacher, Hellyer, Cheung, & Kogan, June 2017).

Schools have a legal responsibility to provide planning and services for children with special healthcare needs, including allowing service animals into schools (Towle, 2017). School nurses provide care coordination for students with service animals to ensure the smooth transition of a service animal to school, as well as monitoring the effectiveness of the animal for the task it is to perform.
SUMMARY

Students with disabilities utilize service animals for a variety of tasks, allowing greater access to education (Harris & Sholtis, 2016). Communication and planning with all stakeholders is 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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SUMMARY

It is the position of the National Association of School Nurses (NASN) that developmentally appropriate evidence-based sexual health education should be included as part of a comprehensive school health education program and be accessible to all students. NASN recognizes the role of parents and families as the primary source of education about sexual health. The registered professional school nurse (hereinafter referred to as school nurse) is a valuable resource to parents and educators in this area and supports the implementation of evidence-based sexual health education programs that promote healthy sexual development for all students.

BACKGROUND

The social and health risks of adolescent sexual activity are well known (Dee et al., 2017). While teen pregnancy and birth rates in the United States continue to decline, rates remain higher than in other industrialized countries; and racial, ethnic and geographic disparities persist (Centers for Disease Control and Prevention [CDC], 2016a). In addition, the rates of sexually transmitted infections (STIs) are at an unprecedented high in the United States, and more than half of newly acquired infections occur among adolescents and young adults (CDC, 2016b).

Sexual health as defined by the World Health Organization (WHO) is “... a state of physical, emotional, mental and social well-being in relation to sexuality...” (WHO, 2015, pp. 5), suggesting a whole child approach to sexual health education and not merely the absence of unplanned pregnancy or sexually transmitted infections. For decades, studies have shown that the majority of parents in the United States support sexual health education in schools. In addition, findings indicated that most parents supported abstinence-based rather than abstinence-only programs (Barr et al., 2014). Finally, a May 2016 nationwide survey of middle and high school parents found that 70% believe sex education and pregnancy prevention should “definitely be covered” in sexual health education programs (Singer, 2016).

According to the 2014 School Health Policies and Practices Study (CDC, 2015a), 72% of high schools in the United States required students to receive education on pregnancy prevention, and 83.1% required instruction on STI prevention. Topics listed as part of required instruction by order of frequency included abstinence as the most effective method to avoid pregnancy and STIs, the relationship between alcohol or other drug use and risk for STIs and pregnancy, and resisting peer pressure to engage in sexual behavior. A worrisome trend is that the percentage of schools in which students are required to receive instruction on human sexuality, pregnancy, and STI prevention has steadily declined since 2000 (CDC, 2015a).

Healthy students are more likely to achieve academic success (CDC, 2014). Szydlowski (2015b) asserts that when teens receive accurate sexual health education information and skills, they can reduce health risk factors that may impact their success in school. Data from the 2015 Youth Risk Behavior Surveillance Survey (YRBSS) indicated that, among high school students, 41% have had sexual intercourse at least once; and 30% had sexual intercourse in the three months prior to participating in the survey, reflective of a decline from previous surveys (CDC, 2015b).
Although teens may be having less sex, condom use and HIV testing are declining (CDC, 2015b). Of those who had intercourse in the past three months, 43% did not use a condom the last time they had sex; 14% did not use any method to prevent pregnancy; and 21% used substances before last sexual intercourse (CDC, 2015b).

For the first time, the CDC analysis of national data gathered from the 2015 YRBS included information on the health risks of lesbian, gay, and bisexual (LGB) high school students. These findings demonstrate that LGB youth report a higher incidence of bullying at school or online, physical and sexual dating violence, drug and alcohol use, and suicide-related behaviors than their straight peers (Kann, Olsen, & McManus, 2016). In the most recent Gay, Lesbian, and Straight Network (GLSEN) National School Climate Survey, over 31% of LGBTQ students reported missing at least one day of school during the past month due to safety concerns. Students who attended schools with LGBTQ-inclusive curriculum were less likely to miss school (18% vs. 35%) for safety reasons (Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016). Although not a direct measure of school performance, absenteeism has been linked to low graduation rates, which can impact future success in life (CDC, 2014).

In addition to the disparities of risk for sexual minority youth, there are racial/ethnic differences. Black high school students are more likely to have had intercourse than white and Latino students; and more black high school students and Latino students initiated sex before the age of 13 compared to white students (Kaiser Family Foundation, 2014).

Students with disabilities defined as “… a physical or mental impairment that substantially limits one or more major life activities” (Americans with Disabilities Act of 1990 [ADA], Title II Regulations, 2016, p. 187), and those with intellectual disabilities (ID) as characterized by “…significant limitations both in intellectual functioning and in adaptive behaviour as expressed in conceptual, social, and practical adaptive skills” (Luckasson & Schalock, 2013, pp. 96) benefit from sexual health information. Low levels of knowledge can impede the recognition of sexual abuse situations, safe sex practices, and the development of positive attitudes toward sexuality (Schaafsma, Kok, Stoffelen, & Curfs, 2015). Szydlowski (2016) compiled general guidelines for sexual health educators for those with disabilities. Sexual health education needs to be tailored to the students with disabilities based on their ability, learning style, and maturity, in addition to parent values and beliefs (Szydlowski, 2016).

RATIONALE

School nurses support sexual health education that is accessible, inclusive, and developmentally and culturally appropriate for all students. Academic achievement is linked to student health (CDC, 2014). Health risk behaviors, such as early sexual initiation, are associated with lower grades and test scores, and lower educational attainment (CDC, 2016c). Evidence-based sexual health education provides accurate, complete, and developmentally appropriate information and skill development that allow young people to make decisions that are informed, responsible, and healthy (Szydlowski, 2015b). Evidence-based sexual health education can improve academic success; prevent dating violence, and bullying; help youth develop healthier relationships; delay sexual initiation; reduce unplanned pregnancy, HIV, and other STIs; and reduce sexual health disparities among LGBTQ youth (Szydlowski, 2015b). Evidence-based sexual health education reduces sexual risk behavior by delaying sexual initiation, reducing pregnancy and STIs, and increasing contraceptive use -- thereby protecting student health (Szydlowski, 2015b).

The National Sexuality Education Standards (Future of Sex Education Initiative [FOSE], 2012) support a strategic and coordinated approach that includes family and community involvement, skill development and school health
services. Furthermore, the Sexuality Information and Education Council of the United States (SIECUS) (2017) supports sexual health education that is appropriate to the student’s age, developmental level, cultural background, and community values. SIECUS further advocates for sexual health education to augment the sexual health education provided by the family and their healthcare professionals. SIECUS specifies that sexual health education provided in an educational setting needs to be taught by an instructor trained on the principles, content and best practices of sexual health education. On behalf of Advocates for Youth, Szydlowski (2015a) emphasizes youth friendly sexual health education to assist with the positive development of sexual health, beginning in youth and continuing throughout adulthood.

The National Sexuality Education Standards recommend that an evidence-based sexual health education program include the following characteristics (FOSE, 2012, p.9):

- Focuses on specific behavioral outcomes;
- Addresses individual values and group norms that support health-enhancing behaviors;
- Focuses on increasing personal perceptions of risk and harmfulness of engaging in specific health risk behaviors, as well as reinforcing protective factors;
- Addresses social pressures and influences;
- Builds personal and social competence;
- Provides functional knowledge that is basic, accurate and directly contributes to health-promoting decisions and behaviors;
- Uses strategies designed to personalize information and engage students;
- Provides age- and developmentally appropriate information, learning strategies, teaching methods and materials;
- Incorporates learning strategies, teaching methods, and materials that are culturally inclusive;
- Provides adequate time for instruction and learning;
- Provides opportunities to reinforce skills and positive health behaviors;
- Provides opportunities to make connections with other influential persons; and
- Includes teacher information and plan for professional development and training to enhance effectiveness of instruction and student learning.

In addition, in terms of specific content, an emerging model for sexual health education is the rights-based approach, which employs a vast, comprehensive sexual education program with a focus on human rights, gender equality, access to healthcare services, and critical thinking (Constantine et al., 2015). Preliminary findings have supported that education based on theories of human rights, gender equality, and sexual development can positively impact healthy sexual behavior among adolescents (Constantine et al.).

CONCLUSION

Health education and promotion, disease prevention, and risk reduction are essential practice components for the 21st century school nurse to help students stay healthy, safe and ready to learn (NASN, 2016). School nurse leaders advocate for and support the delivery of evidence-based sexual health education that is “...medically accurate, developmentally appropriate, and ... provides students with the skills and resources that help them make informed and responsible decisions” (FOSE, 2012, p.8). School nurses -- working in collaboration with parents, students, health educators, curriculum specialists, and other school and community stakeholders -- strive to dismantle barriers and support access to evidence-based sexual health education that allows all students to make informed, responsible, and healthy decisions.
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Prevention of Skin Cancer due to Ultraviolet Ray Exposure -
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) is an essential member of the school health team when addressing the issue of student exposure to ultraviolet (UV) rays. The school nurse is in a key position to empower students to make informed choices regarding health-related behaviors (Banfield, McGorm, & Sargent, 2015) and to provide sun protection education to students, families, and school staff.

BACKGROUND
Overexposure to the sun’s UV rays or to artificial sources like tanning beds can cause harmful effects to the body (Centers for Disease Control and Prevention [CDC], 2017). The most common harmful effect is skin cancer. Skin cancer, a preventable cancer, is the most common type of cancer in the United States; more than five million annual cases of skin cancer can be prevented by skin protection and avoidance of tanning beds (American Cancer Society, 2017). Each year in the United States, the cost of treating skin cancer exceeds $8.1 billion (United States Department of Health & Human Services [USDHHS], 2014). Sun exposure is the leading cause of melanoma skin cancer (Kleier, Hanlon, & MacDougall, 2017). Pediatric melanoma, the most serious form of skin cancer, increased by 2% each year between 1973 and 2009 (Kleier et al., 2017; Wong, Harris, Rodriguez-Galindo, & Johnson, 2013). Approximately 25% of UV exposure occurs during childhood and adolescence because of increased opportunities for exposure. Exposure to UV radiation during childhood plays a very important role in the future development of skin cancer, especially melanoma and basal cell cancer (Kleier et al., 2017). People who have a history of one blistering sunburn during childhood have double the risk of developing melanoma later in life compared to those who did not have such exposures (Kleier et al., 2017).

Sunscreen is considered an over-the-counter medication by the Food and Drug Administration (U.S. Food and Drug Administration, 2017). FDA recommends sunscreen products to be used as directed by the Drug Facts label. NASN recommends that school nurses provide their professional expertise in assisting school boards or other governing bodies in writing medication administration policies and procedures that focus on safe, efficient medication administration to all students in accordance with each state’s nurse practice act (NASN, 2017). Currently seven states have laws that allow students’ use of sunscreen at school without a physician’s order, and six additional states have pending legislation (Farquhar, 2017). It is important for school nurses and other school staff to be aware of pending legislation as each state’s requirements are different, and not all legislation addresses school district or school employees’ liability (Moore, 2017).

Tanning beds, unlike sun exposure, provide concentrated UV exposure despite location, or time of day, causing further risks of skin cancer (USDHHS, 2014). According to the National Conference of State Legislatures, 14 states and the District of Columbia currently ban the use of tanning beds by minors, and 42 states and the District of Columbia regulate use of tanning beds by minors (Moore, 2017).

RATIONALE
School nurses are in an ideal position to promote, model and educate students, staff and families about the need for conscientious UV ray protection. Children and adolescents spend most of their waking hours during the week at school. Some of that time is spent in outdoor activities, usually during the time of day when sun exposure is most
damaging (Guy, Holman, & Watson, 2016). Early education about the dangers of sun and the protection of oneself is critical. Sunburn can be prevented, and preventative measures should become part of a daily self-care practice. The CDC’s Skin Cancer Prevention Progress Report (2017a) highlights several education programs that school nurses can access to teach students about the effects of UV radiation, the types of skin cancers it can cause, and the importance of protecting themselves from too much UV exposure.

School-based health education to promote skin cancer prevention is most effective when it is provided consistently and introduced sequentially in every grade from preschool through twelfth grade. School nurses are in the position to support preventive exposure to UV rays by providing students, families and policy makers with information on the following:

- wearing of sunglasses, hats, and protective clothing
- avoiding outdoor play during peak sun intensity hours when UV ray exposure is greatest
- playing in shaded areas (whether by natural or installed shading devices)
- using sunscreen properly and consistently (CDC, 2017b; American Academy of Pediatrics [AAP], 2017)
- avoiding sun tanning and tanning beds (AAP, 2011)

The AAP (2017) and CDC (2017b) both recommend that a broad-spectrum sunscreen be at a minimum sun protective factor (SPF) of 15 or higher and be applied before going outside (even on cloudy days) and every two hours, especially after swimming or sweating.

As a member of the school health team, the school nurse is in a position to influence policy development to help limit exposure to UV rays. School nurses need to be aware of state legislative efforts to minimize childhood exposure to UV rays, related both to application of sunscreen and banning of tanning beds by minors. School nurses need to work with legislators and other stakeholders to help them understand nurse practice acts and requirements for safe and efficient medication administration in a school setting.

CONCLUSION

Skin cancer can be prevented through education and proper protection. School nurses are in a position to provide education to students, school staff, community members, and policy makers that can help reduce student exposure to harmful UV rays whether it be through sun exposure or artificial sources (tanning beds). School nurses should advocate for preventative measures, such as use of sunscreen (according to district policy and state nurse practice act); use of protective clothing, wide brim hats, and sunglasses; the installation of shading devices for play areas; and laws that reduce UV ray exposure from artificial sources.

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SUMMARY

It is the position of the National Association of School Nurses (NASN) that the practice of the registered professional school nurse (hereinafter referred to as the school nurse) be supervised and evaluated by a registered nurse knowledgeable of school nurse practice in accordance with the School Nursing: Scope and Standards of Practice (American Nurses Association [ANA] & NASN, 2017) and the Framework for 21st Century School Nursing Practice™ (NASN, 2016a). To promote proficiency, professionalism and quality improvement initiatives, supervision and evaluation of school nurse performance should support the specific roles and responsibilities necessary to promote the health, safety, and learning of individual students and unique school communities.

BACKGROUND

Many school nurses practice autonomously as the only healthcare provider in the educational environment with limited or no access to a nurse supervisor. Only 36.2% of school nurses report being supervised by a registered nurse (Mangena & Maughan, 2015). Therefore, many school nurses are supervised and evaluated by non-nursing personnel, such as school administrators, who may have limited understanding of the role of the registered nurse in the school setting.

Clinical nursing competency should be evaluated based on established practice standards. These standards provide a framework through authoritative statements and associated performance competencies of the duties and responsibilities of the school nurse (ANA & NASN, 2017).

RATIONALE

Competence in nursing practice requires evaluation by the individual nurse (self-assessment), nurse peers, and nurse supervisors, mentors, or preceptors. Supervision and evaluation should also be distinguished between clinical supervision and administrative supervision (ANA, NASN, 2017). Practice documents, such as the School Nursing: Scope and Standards of Practice (2017), suggest that non-nurse supervisors may contribute to the supervision and evaluation of non-nursing activities, such as “interpersonal and communication skills, team collaboration and networking, and classroom teaching” (ANA & NASN, 2017, p. 32); however, these professionals do not have the qualifications to evaluate clinical nursing competency. In fact, some state boards of nursing offer specific language prohibiting non-nurse personnel from evaluating the clinical skills of nurses (Kansas Board of Nursing, 2011).

McDaniel, Overman, Guttu, and Engelke (2013) also suggest that, when the standards are fully integrated into practice, school nurses are more likely to adhere to them and are less likely to focus only on the tasks hence further advancing their competency. Finally, collaborative, interprofessional, clinical, and administrative evaluation processes may also help to increase non-nursing administrators’ knowledge and appreciation of the expansive role of school nurses (Haffke, Damm, & Cross, 2014; McDaniel, Overman, Guttu & Engelke., 2013).

Clinical supervision

“Clinical supervision 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” (CSDE, 2014, p. 13). Ideally, clinical supervision begins with an alignment of the job description, the school nurse’s orientation and professional development, and an evaluation tool reflective of both the Scope and Standards of School Nursing Practice (ANA & NASN, 2017) and the Framework...
Clinical supervision fosters professional and clinical development by supporting and evaluating the school nurse’s response to the healthcare needs of students and school community and attention to best practice and evidence-based protocols (Campbell & Minor, 2017a). Evaluation processes and tools should reflect the wide array of roles and responsibilities of school nursing practice, as well as goals for professional growth and development in accordance with national standards and state nurse practice acts (Connecticut State Department of Education [CSDE], 2014; McDaniel, et al., 2013; Southall et al., 2017).

**Administrative supervision**

Administrative supervision, i.e., supervision of non-clinical skills, may be provided by the registered nurse or by school administrators, such as a building principal or district administrator (ANA, 2014). Activities and attributes, adherence to school policy and state and federal regulations, organizational skills, oral and written communication skills, teamwork, collaboration, and the day-to-day nonclinical duties are examples of areas of practice that are appropriately supervised by non-nursing administrators.

**Supervision and evaluation models**

According to ANA (2014), “there is not one tool or model that can guarantee competency; ... employers are responsible and accountable to provide an environment conducive to competent practice” (p.6). Evaluation and performance appraisal processes, methods, and tools include the following:

- Measurable objectives based on job descriptions, scope and standards of practice, competencies, and applicable state laws;
- Input and goal-setting by school nurses, school nurse supervisors (if available), and school administrators;
- Evidence-based protocols, state and/or national certification, nursing practice portfolios, and outcomes from continuing education; and
- Performance review at least annually, or sooner if indicated, within a continuous quality improvement context (ANA, 2014; Campbell & Minor, 2017a, 2017b; CSDE, 2014; McDaniel et al., 2013; Southall, et al., 2017; Wisconsin Department of Public Instruction, 2016).

**CONCLUSION**

School nursing clinical competency and professional performance should be evaluated by an experienced registered nurse who is competent in the specialty practice of school nursing and accompanied by self- and peer-evaluation. Input from school administrators regarding non-nursing responsibilities contributes to a well-rounded interprofessional evaluation of the nurse employed in a school system. Clinical supervision and evaluation of nursing practice require nursing knowledge and skill. Evaluation of school nurse practice by school nurses is crucial to promote safe, high quality, competent care for all school children and their school communities. Quality school nursing care in every school all day will optimize student health, safety, and learning (NASN, 2016b).

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SUMMARY

It is the position of the National Association of School Nurses (NASN) that utilization of telehealth technology may be a valuable tool to assist registered professional school nurses (herein referred to as a school nurse) to provide school health services. The health of many students is impacted by lack of access to primary care and specialty services due to health disparities caused by poverty and other social determinants of health. Technology and telehealth can assist the school nurse in addressing these issues. The school nurse is on the frontlines of school health services and has the expertise to provide the critical link and oversight to successfully implement and utilize telehealth/telemedicine technology in the school setting.

BACKGROUND

The terms telehealth and telemedicine are often used interchangeably although telehealth is considered a broader term that includes not just clinical services but education and training (Institute of Medicine [IOM], 2012). The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) (2015) defines telehealth as:

The use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

The use of telehealth often focuses on populations who have barriers to access health care such as those in rural communities, those living in poverty, or those who are homebound (IOM, 2012). Telehealth provides a potential strategy to remove barriers by:

- Providing extended health and mental health care,
- Providing timely access to meet urgent and emergent healthcare needs,
- Promoting collaboration between regional health centers and healthcare providers in remote areas,
- Decreasing absenteeism and time out of class, and
- Decreasing lost work time for parents/caregivers

(Children’s Health Fund, 2016; Ollove, 2017; Reynolds & Maughan, 2015).

Telehealth in schools has mainly focused on primary care services. The Centers for Disease Control and Prevention (CDC) and ASCD recommend a broader, coordinated, collaborative approach to student health. School nurses are well positioned to integrate telehealth into the Whole School, Whole Community, Whole Child model of care (ASCD & CDC, 2014). According to the American Academy of Pediatrics (2015), telehealth should be utilized as part of a coordinated system to decrease fragmentation and piecemeal approaches to care.

Challenges exist related to telehealth technology such as sustainability, cost to implement and maintain equipment, privacy, liability, and provider reimbursement (IOM, 2012). When creating budgets for implementing and sustaining a telehealth program, developers and providers should include funding for schools and school nurses. New funding reimbursement models which include team approaches to reimbursements that include school nurse services should be considered. In states which do not currently have provision for Medicaid
reimbursement for telehealth services, school nurses and stakeholders should advocate for establishing this provision.

RATIONALE

School nurses collaborate with other school health services team members to address the health needs of the entire school population (NASN, 2016). Telehealth can be used for health education and health promotion. As a primary care partner, telehealth can assist the school nurse in decreasing communicable disease outbreaks through availability of providers to quickly diagnose and treat illness (Ollove, 2017) and improve student attendance by assisting school nurses in the management of chronic conditions (Reynolds & Maughan, 2015). The use of telehealth to address physical or mental/emotional health can improve student attendance and may enhance parents’ and caregivers’ work productivity (Ollove, 2017). Researchers have found that collaboration between healthcare providers/specialists and school nurses and others via telehealth was efficient, decreased miscommunications between parties, improved student health, and increased parent resources and connections (Mackert & Whitten, 2007; Young & Ireson, 2003; Reynolds & Maughan, 2015).

School nurses are responsible for student health and health issues arising in school and understand the priorities of both health and education in the school setting (NASN, 2016). Advances in technology and the availability of telehealth services can assist school nurses to improve both healthcare access and health in student populations, particularly those who are underserved. School nurses should be involved with other health and education leaders in the development of telehealth policies, standards, and guidelines related to:

- Enrolling students in telehealth programs,
- Ensuring proper consent and parent/caregiver involvement,
- Triage and coordinating students who would benefit from a consultation via telehealth (including decision tree protocols),
- Sharing of confidential information that meets both HIPAA and FERPA requirements,
- Monitoring appropriate outcomes and evaluation,
- Following up telehealth-visit/consultation, and
- Coordinating school nursing services with other healthcare services.

Telehealth may also facilitate communication and consultation between school nursing colleagues regarding complex cases (Mackert & Whitten, 2007). Telehealth in the school can be used as a conduit for individual and population-based education for students, families, and staff as part of a larger coordinated school health services effort (Reynolds & Maughan, 2015). Telehealth has the potential for future use in areas such as remote connections for school nurses to help students access dental and eye exams, voice disorder treatments, nutritional and obesity counseling and behavioral/mental health counseling and assessment (Kelchner et al., 2014). The use of telehealth services is expected to grow from 250,000 persons in 2013 to 3.2 million persons in 2018 (National Conference of State Legislators Partnership Project on Telehealth, 2015). Technology continues to advance and school nurses must stay current and embrace innovative technologies as they explore new ways to keep students healthy, safe, and ready to learn.

CONCLUSION

Students will continue to have complex social, emotional, and physical health needs which must be addressed to ensure their success in school. Functioning as the bridge between health and education, school nurses address a wide range of student needs and are uniquely qualified to focus on the needs of students at greatest risk of health disparities. School nurses are the vanguard of individual and population-based student health care and have the expertise to utilize telehealth technology. While neither telehealth nor any other technology replaces the registered professional school nurse, the availability of telehealth provides a valuable tool to assist the school nurse in providing a more complete, coordinated approach to student health services in school.

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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.*
NASN POSITION

It is the position of the National Association of School Nurses (NASN) that all students with healthcare needs should receive coordinated and deliberate transition planning to maximize health and well-being. As an essential member of the multidisciplinary school-based team, the registered professional school nurse (hereinafter referred to as school nurse) is ideally placed to provide care coordination and lead the planning team in addressing transitions for students with healthcare needs (American Nurses Association [ANA] & NASN, 2017). The goal of transition planning is to maximize student health and academic success.

BACKGROUND

Historically, school-based transition planning focused on preparing students for the transition beyond secondary school. We now recognize that transition planning refers to a coordinated set of activities that assist students when entering school, re-entering school, between schools and beyond secondary school for all students, with additional attention to those students with chronic or acute healthcare conditions. Due to advances in medicine and health care, more students are surviving chronic health conditions and disabilities and attending or returning to school (Bargeron, Contri, Gibbons, Ruch-Ross, & Sanabria, 2015).

Transition planning is one of the concepts central to the discipline of nursing (Schumacher & Meleis, 1994) and is supported by the Framework for 21st Century School Nursing Practice (NASN, 2016; ANA & NASN, 2017). Planning requires identification of the problems, issues, and needs of the student in collaboration with the student, family, and the student’s educational and healthcare teams to meet the student’s healthcare needs and serves to decrease stress associated with transition (Selekman, Bochenek, & Lukens, 2013; Schumacher & Meleis, 1994; ANA & NASN, 2017).

Federal laws also provide guidance for transition planning. For students with Individual Education Program (IEP) plans, support strategies for transitioning beyond high school planning must be in place by the time the student is 16 years old (Americans with Disabilities Act Amendments [ADAA], 2010). Students who qualify under Section 504 of the Rehabilitation Act (1973) for accommodations to support their academic achievement may benefit from transition planning (Rehabilitation Act of 1973 [§504], 2000; Alfano, Forbes, & Fisher, 2017).

School nurses are well positioned to support both the health and academic success of students with healthcare needs during periods of transition. School nurses are uniquely qualified to:

- facilitate communication and information sharing across systems and among key stakeholders;
- interpret medical orders and incorporate them into a student’s IHP and other accommodation plans;
- facilitate the implementation of a student’s IHP and/or accommodation plans across transitions;
- monitor and assess the impact of the transition plan on the identified student health and academic outcomes; and
- connect families with resources to meet existing or emerging student needs (Bargeron et al., 2015).

RATIONALE

Transition planning includes coordinated, deliberate, and community-based strategies to ensure a seamless approach to achieving positive health and academic outcomes for students with chronic medical, behavioral, or developmental conditions (Bargeron et al., 2015). Transition plans should focus on providing the needed accommodations and services to meet health, academic, social, and emotional needs; stimulate academic
motivation; and promote adjustment to the school setting (Leroy, Wallin, & Lee, 2017). The planning for adolescents with healthcare needs transitioning to adulthood includes the development of self-management and decision-making skills to foster active participation in maintaining their own health to attain their goals for quality of life (American Academy of Pediatrics [AAP], 2016; ANA & NASN, 2017). Communication among members of the student’s healthcare team outside the school and the school multidisciplinary team, including the school nurse, is critical to identifying the transition needs of the student and determining how to best address those needs (AAP, 2016).

Transitions are often difficult and associated with behavioral health exacerbations and social/emotional changes, and students undergoing transition, as well as their families, may not know what to expect. Because of this, students may feel overwhelmed, defeated, and isolated (Finch, Finch, W.H., McIntosh, Thomas, & Maughan, 2015; Schumacher & Meleis, 1994). The school nurse can improve the quality of life for students and families through development and implementation of a transition plan to promote student health, academic success, and success in postsecondary endeavors.

It is important that the school system considers the following issues when transition planning for students who have healthcare needs:

- privacy of student health information as it applies to Health Insurance Portability and Accountability Act and Family Education Rights Privacy Act;
- the role of the school nurse in delegation in accordance with state law (ANA & NASN, 2017);
- identification of students with healthcare needs that would benefit from targeted transition planning; and
- advocacy for clear school policies and guidelines that maintain continuity of education for students with healthcare needs who may experience intermittent and extended absences (Legislative Alliance for Students with Health Conditions, 2017).

To effectively support transitions for students with healthcare needs, school nurses should:

- be knowledgeable about applicable local, state, and federal laws that impact the development and implementation of transition plans;
- maintain clinical competence to provide direct care and/or delegate care to effectively implement, monitor, and evaluate impact of the transition plan (ANA & NASN, 2017);
- identify the training needs of school personnel regarding how to mitigate the impact of healthcare needs on student health and academic outcomes during periods of transition (Morley, 2016);
- develop a relationship with the student’s healthcare provider(s) and family to ensure that the medical orders and resulting individualized health and accommodation plans are implemented, monitored, and evaluated (Zhou, Roberts, Dhaliwal, & Della, 2016); and
- provide consultation and/or referral to the medical home and community resources (AAP, 2016).

CONCLUSION

Transition periods greatly impact students, families, and the health and education systems. This can be especially true of students transitioning from acute or prolonged hospitalizations, entering school, re-entering school, moving between schools or engaging in post-secondary academic or employment pursuits. Planning for timely and seamless transitions can prevent interruptions in student access to medical services and other educational opportunities that support their academic success. The school nurse is uniquely qualified to provide care coordination and lead transition planning teams, including the facilitation of student movement between healthcare and educational settings and beyond (Bargeron et al., 2015).

REFERENCES


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This document replaces the position statement *Transition Planning for Students with Chronic Health Conditions* (adopted January 2014).


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.
Whole School, Whole Community, Whole Child: Implications for 21st Century School Nurses

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) be knowledgeable about and participate in the implementation of Whole School, Whole Community, Whole Child (WSCC) approach in the educational setting (ASCD & Centers for Disease Control and Prevention [CDC], 2014). The WSCC approach combines and builds upon the Coordinated School Health (CSH) model and the ASCD’s (formerly known as the Association for Supervision and Curriculum Development) Whole Child approach to learning and promotes greater alignment between health and educational outcomes. WSCC is student centered, with the overarching goal of keeping students healthy, safe, engaged, supported, and challenged. The WSCC model emphasizes the need to coordinate policy, process, and practice to achieve improved student health and education outcomes. This collaboration in support of students encompasses health services, health education, employee wellness, counseling, psychological and social services, nutrition environment and services, physical education and physical activity, physical environment, social emotional climate, family engagement, and community involvement. WSCC recognizes the critical role of ongoing collaboration between school and community in fostering student success (Lewallen, Hunt, Potts-Datema, Zaza, & Giles, 2015). The school nurse occupies a pivotal position as a leader who uses professional education and skills to assist schools and communities in the implementation and evaluation of the WSCC model (Galemore, Bowlen, Combe, Ondeck, & Porter, 2016).

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 CDC incorporated this concept into the CSH model. 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 (Allensworth & Kolbe, 1987). In 2013, ASCD and the CDC convened experts from the field of education and health to discuss lessons learned from implementation of the CSH and Whole Child approaches, resulting in the development of the WSCC model (ASCD & CDC, 2014). The new WSCC model serves as a blueprint for integrating programs guiding policy development and practices in the school setting (Galemore et al., 2016). School nurses utilizing the WSCC approach have reported successful outcomes in the areas of student and employee wellness, health advocacy, professional learning communities, and community support (Galemore et al., 2016).

RATIONALE

The WSCC approach offers important opportunities to improve the health and education outcomes of students by highlighting the five whole child tenets and by noting the importance of coordination between the ten school
School nurses work collaboratively within the context of the WSCC model when they implement the principles of the NASN Framework for 21st Century School Nursing Practice™ which include Standards of Practice, Care Coordination, Leadership, Quality Improvement, and Community/Public Health(Maughan, Duff, & Wright, 2016; NASN 2016). School nurses, collaborating with stakeholders across the WSCC model, utilize the full range of Framework principles to influence student health and academic achievement.

**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 health-related barriers to student learning. The NASN Framework provides guidance for student-centered nursing care that occurs within the context of the students’ family and school community and provides guidance for the practicing school nurse to reach the goal of supporting student health and academic success by contributing to a healthy and safe school environment (NASN, 2016).

**Health Education**: The school nurse provides education to small groups and individuals on topics such as asthma and diabetes to promote healthy life choices, increase compliance with prescribed regimens and improve student attendance and academic outcomes. The school nurse reviews and recommends evidence-based 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, and adopt health-enhancing behaviors. The school nurse uses data from local, state, and national sources to determine the current risks and protective factors for students.

**Employee Wellness**: The school nurse works collaboratively with the school health services team to provide health information and health promotion activities, may monitor chronic conditions, provide health resources, and referrals.

**Counseling, Psychological, and Social Services**: The school nurse collaborates with school counseling, psychology and social work staff to identify student psychosocial problems and provide input and supportive interventions. 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.

**Nutrition Environment and Services**: The school nurse promotes the integration of nutritious, affordable, and appealing meals, nutrition education, and an environment that promotes healthy eating behaviors for all students. The school nurse provides education about nutritious foods, monitors menus, and encourages the inclusion of healthy foods on menus, in vending machines, in fundraising and classroom parties/snacks. The school nurse provides information to food service regarding students’ special nutritional needs, including food allergies and potential anaphylaxis to promote student safety.

**Physical Education and Physical Activity**: The school nurse collaborates with physical educators to meet physical education goals, provides information to students about physical activity, helps design appropriate programs for students with special health concerns, and advocates for planned, sequential K through 12 curricula that promote lifelong physical activity.
Physical Environment: The school nurse promotes a safe physical and psychological school environment that is supportive of learning by monitoring, reporting and intervening to correct hazards; collaborating with the development of crisis intervention/disaster plans; and advocating for adaptations for students with special needs.

Social and Emotional Climate: The school nurse promotes a positive social and emotional school climate that is safe, healthy, and supportive of learning by advocating for evidence-based K through 12 curricula that provide ongoing education to support psychosocial understanding and support for all students.

Family Engagement: The school nurse promotes family and school partnerships working together to support and improve learning by sharing opportunities to get involved at school and within the broader community.

Community Involvement: The school nurse takes a leadership role in collaborating with community partners to identify and provide programs to meet the physical and mental health needs of children and families. The school nurse can help strengthen collaboration among agencies and stakeholders to review and analyze community data to help make informed decisions.

CONCLUSION

The implementation of the WSCC model requires collaboration between health and education leaders who understand the importance of the link between student health and academic success. The school nurse is an important member of this interprofessional team. School nurses utilize 21st Century School Nursing Framework™ principles to operationalize the WSCC model in the day-to-day policies and practices focused on the student. “By focusing on children and youth as students, addressing critical education and health outcomes, organizing collaborative actions and initiatives that support students, and strongly engaging community resources, the WSCC approach offers important opportunities for school improvements that will advance educational attainment and healthy development for students.” (Lewallen et al., 2015, p.737). School nurses have access to the entire school community and are in a unique position to bring stakeholders together to focus on the child through WSCC (Galemore et al., 2016) With careful planning, implementation, and evaluation efforts, use of the WSCC model and the Framework for 21st Century School Nursing Practice™ has the potential to improve school and community life in the present and in the future (Rooney, Videto, & Birch, 2015).

REFERENCES


Cannabis/Marijuana

Position Brief

Summary

Cannabis continues to be classified federally as a Schedule I Controlled Substance (Drug Enforcement Administration [DEA], n.d.); however, with growing cultural acceptance of cannabis, increasing numbers of states have legalized medical and/or recreational usage (National Conference of State Legislatures [NCSL], 2017). This contradiction between federal and state laws has created uncertainty for the school nurse when cannabis products are brought into the school setting for administration to students.

Therefore: it is the position of the National Association of School Nurses (NASN) that only FDA approved cannabis/marijuana medications be allowed in the school setting.

In addition, NASN recommends that school nurses should be knowledgeable in the following principles, which create a foundation for safe and informed nursing care of patients using medical or recreational cannabis (adapted from National Council of State Boards of Nursing (NCSBN) Guidelines for the Nursing Care of Patients Using Marijuana, 2018):

1. The school nurse shall have a working knowledge of the current state of legalization of medical and recreational cannabis use in the state/jurisdiction in which they practice.
2. The school nurse shall have a working knowledge of their state/jurisdiction’s medical marijuana program, if applicable.
3. The school nurse shall have an understanding of the endocannabinoid system, cannabinoid receptors, cannabinoids, and the interactions between them.
4. The school nurse shall have an understanding of cannabis pharmacology and the research associated with the medical use of cannabis, and any Federal Drug Administration (FDA) approved cannabis-type medications.
5. The school nurse shall be able to identify the safety considerations for patient use of cannabis as it relates to the school setting.
6. The school nurse shall approach the student and family without judgment regarding their choice of treatment or preferences.

Rationale

The NCSBN has provided guidance for nurses across the country regarding the administration of cannabis in a professional setting. School nurses can also benefit from this guidance (NCSBN, 2018).

Considerations for the NASN position include:

- Substances classified as Schedule I Controlled Substances are considered to have no accepted medical value and present a high potential for abuse. Cannabis and its derivatives have been classified as Schedule I Controlled Substances since the enactment of the Controlled Substance Act in 1970. This Drug Enforcement Administration classification not only prohibits practitioners from prescribing cannabis; it also prohibits most research using cannabis except under rigorous oversight from the government’s National Institute on Drug Abuse.
• Research on the efficacy of cannabis for treatment of certain medical conditions is limited and lacking, specifically related to indications, dosage, route, safety, adverse effects, and long-term effects of cannabis (NCSBN, 2018).

• There are limited studies that might show some efficacy for a narrow range of symptoms. Without evidence that is scientifically rigorous, reportable, and based upon the student population, safe administration of cannabis has not been established for use in the school setting (NCSBN, 2018).

• School nurses must be well-informed about cannabis and how it affects the body, so safe nursing care can be provided at school.

• The school nurse must work closely with parents who are using cannabis-based products for their children, so that appropriate planning and care coordination may occur, as based on the foundation of the 21st Century Framework for School Nursing Practice (NASN, 2016).

Adopted: January 2019

References


Suggested Citation: National Association of School Nurses. (2019). Cannabis/Marijuana (Position Brief). Silver Spring, MD: Author.

*All position briefs from the National Association of School Nurses will automatically expire 18 months after publication unless renewed and recommended for position statement or other NASN document development.*
Eliminate Racism to Optimize Student Health and Learning

Position Brief

SUMMARY

It is the position of the National Association of School Nurses (NASN) that systematic racism must be eliminated from the United States and this elimination can begin with school systems, school staff, families and children. Racism, a public health crisis, threatens the health, educational attainment, and well-being of children and adolescents. School systems hold a profound formative influence in the lives of students. Where racism exists, students of color experience adverse impacts on their health, well-being, and learning. Schools must be systems within communities where antiracism is the default culture and climate.

RATIONALE

Racism exists when institutions and laws support attitudes or beliefs that discriminate with regards to individuals or groups on skin color or ethnicity (University of Kansas, 2014). Jones’ (2000) theory presents three levels of racism

1) institutionalized, e.g., structural;
2) personally mediated, e.g., prejudice and discrimination; and
3) internalized, e.g., helplessness, hopelessness, and devaluing self.

All children and adolescents deserve to be supported as they develop and grow. Racism is a social determinant of health (Trent, et al., 2019). An example of the impact of racism is residential segregation that results in segregated schools that limit diversity and equity (Reardon, 2016). Psychosocial stress experienced by youth of color is associated with chronic disease, including behavioral disorders, and mental health conditions (Pachter, et al, 2018, Trent, et al., 2019).

To provide all students with an environment where they are healthy, safe, engaged, and challenged, a collaborative approach to health and learning must be in place (ASCD & CDC, 2014). NASN holds that to optimize student health, safety, and learning, students and adults in schools and school systems must model antiracist systems and behaviors. As school and community healthcare providers, school nurses advocate and act as change agents to support students and their families. School nurses and other school and school system staff individually assess their own explicit and implicit biases via partnerships with community providers and agencies. Cultivating change in schools and school systems include actions such as

- Review school policies and practices to uncover and eliminate racism, for example;
  - Examine relationship between racial achievement gaps and racial discipline gaps and propose interventions (Pearman et al., 2019)
  - Address racism in bullying and violence policies
- Advocate for system changes that celebrate diversity, equity, and inclusion;
• Annually engage school staff on education on cultural diversity, discrimination and racism
• Hire and retain staff with diverse backgrounds

• Provide evidence-based curriculum that teaches students and families how to recognize implicit bias and address racism;
• Promote empathy by actively listening to lived experience of racism as told by students, families, colleagues, and community members;
• Improve student and teacher interactions to increase students sense of belonging and connectedness

REFERENCES


Adopted: June 2020


“To optimize student health, safety and learning, it is the position of the National Association of School Nurses that a professional registered school nurse is present in every school all day, every day.”

All position briefs from the National Association of School Nurses will automatically expire 18 months after publication unless renewed and recommended for position statement or other NASN document development.
Safe and Humane Treatment of Refugee and Immigrant Children

Position Brief

The National Association of School Nurses calls on the Departments of Justice and Homeland Security to ensure that refugee and immigrant children and families have access to clean, safe housing, hygiene and other supplies necessary to maintain health, and to accelerate the reunification of refugee and immigrant children who have been separated from their families. Children subjected to unsafe and inhumane conditions may experience trauma, resulting in irrevocable damage for a vulnerable population deserving of our protection regardless of their immigration status. Studies show that adverse childhood experiences have long-term physical and mental health consequences (Metzler et al., 2016; Nurius et al., 2015). School nurses practice ethically, which is demonstrated by showing compassion and respect for all people and advocating for the rights, health and safety of children and youth (ANA & NASN, 2017).

Adopted: August 2019

References


All position briefs from the National Association of School Nurses will automatically expire 18 months after publication unless renewed and recommended for position statement or other NASN document development.
SUMMARY
It is the position of the National Association of School Nurses (NASN) that all students should have access to health care. Quality healthcare services are critical for health promotion and prevention, health maintenance, disease prevention and management, and health equity among individuals (Healthy People 2020, 2019). Absence of health insurance contributes to lack of access to healthcare, which directly impacts student’s ability to learn.

RATIONALE
Healthy People 2020 defined access to health services as “the timely use of personal health services to achieve the best health outcomes” (Healthy People 2020, 2019). Overall health is fundamental to a student’s growth and development. Students with unmet health-related needs have difficulty engaging in the educational process (American Academy of Pediatrics, 2016). Lack of insurance coverage, in addition to family violence, homelessness, lack of preventative healthcare, poor nutrition, poverty, and substance abuse, are all barriers that negatively affect students' health and learning (The Annie E. Casey Foundation, 2018). Geographic, informational and economic limitations must be removed to allow for smooth access to healthcare (Children’s Health Fund, 2016). Health literacy and personal understanding of healthcare insurance policies are examples of informational challenges for families. According to the Kaiser Foundation (2018), most uninsured people cite the high cost of health insurance as the primary reason for lack of insurance. Additionally, Kaiser (2018) notes that lack of U.S. residency is also a barrier. Undocumented immigrants qualify for emergency Medicaid only. Permanent immigrants are not eligible, even if they meet program qualifications for Medicaid, until they have been a U.S. resident for 5 years. Refugees and asylees do not have to wait 5 years to qualify for Medicaid or the Children’s Health Insurance Program (CHIP) (Kaiser, 2018). Policies to ensure students maintain insurance coverage without gaps can improve access to health care (Leininger & Levy, 2015).

Healthcare access by all students is an essential factor that can improve the overall health and wellness of society. School nurses remove barriers to healthcare access and provide direct care, care coordination and case management to students in need (Maughan, Duff & Wright, 2016). It is the position of NASN that all students have equitable access to healthcare.

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This position brief replaces the position statement titled Patient Protection and Affordable Care Act: The Role of the School Nurse.


“To optimize student health, safety and learning, it is the position of the National Association of School Nurses that a professional registered school nurse is present in every school all day, every day.”

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Early School Start Times

Joint 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).
- Sufficient sleep on a regular basis provides the opportunity for better attention, behavior, emotional control, and quality of life (Paruthi et al., 2016).
• Sleeping less than the recommended 9-10 hours can result in learning problems, injuries, obesity, and hypertension (Paruthi et al., 2016).

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


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