

CHAPTER 1

Introduction to School Health Programs

This chapter presents overview information about establishing or enhancing *school health programs*. It also provides some background information on the evolution of school health programs in Virginia. In addition, it provides guidelines on program development.

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Describing the Components of a School Health Program

Overview

Definition. There are a variety of definitions of a school health program. The following definition of a comprehensive school health program was established by the Institute of Medicine (IOM) Committee on Comprehensive School Health Programs in Grades K-12.¹

*A comprehensive school health program is an integrated set of planned, sequential, school-affiliated strategies, activities, and services designed to promote the optimal physical, emotional, social, and educational development of students. The program involves and is supportive of families and is determined by the local community, based on community needs, resources, standards, and requirements. It is coordinated by multidisciplinary team and is accountable to the community for program quality and effectiveness.*²

Models. There are a variety of models that have been used to describe the components of a school health program. Three of the most common models are summarized below.³

- ◆ **The Three-Component Model.** Originating in the early 1900s and evolving through the 1980s, the three-component model is considered the traditional model of a school health program, consisting of the following basic components: (1) health education, (2) health services, and (3) a healthful environment.
- ◆ **The Eight-Component Model.** In the 1980s, the three-component model was expanded into an eight-component model—traditionally referred to as a “comprehensive school health program”—consisting of the following components: (1) health education; (2) health services; (3) healthy school

¹ The Committee on School Health in Grades K-12 was convened by the Institute of Medicine in late 1994 to carry out a study of comprehensive school health programs in grades K-12 to examine the structure, function, and potential of these programs. The study findings, conclusions, and recommendations are published in Allensworth, D., Lawson, E., Nicholson, L., and Wyche, J., (1997), *School & Health: Our Nation's Investment*, National Academy Press, Washington, D.C.

² Allensworth, D., Lawson, E., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (p. 2). Washington, D.C.: National Academy Press.

³ Allensworth, *School & Health*, (pp. 3, 59).

environment; (4) physical education; (5) nutrition services; (6) health promotion for school staff; (7) counseling, psychological, and social services; and (8) parent and community involvement.

- ◆ **Full-Service Schools.** In recent years, additional models, definitions, and descriptions have emerged that build on previous models, including the full-service school model. In addition to quality education, a full-service school model involves a one-stop, seamless institution, where the school is the center for providing a wide range of health, mental health, social, and/or family services.

While the most frequently encountered models and definitions of school health programs have much in common, no single model is best. A school health program should be locally tailored—with involvement of all critical stakeholders—to meet each community’s needs, resources, perspectives, and standards.

Recommendation

Essential Elements. While there is no one universally accepted definition and model of a school health program, the following essential elements should be considered in designing a school health program.⁴

- ◆ **Services**, which include *health services* (which depend on the needs and preference of the community and include services for students with disabilities and special health care needs and the traditional first aid, medication administration, and screening services), *counseling, psychological, and social services* (which promote academic success and address the emotional and mental health needs of students), and *nutrition and food services* (which provide nutritious meals, nutrition education, and a nutrition-promoting school environment).
- ◆ **Education**, which includes *health education* (which addresses the physical, mental, emotional, and social dimensions of health), *physical education* (which teaches the knowledge and skills necessary for lifelong physical fitness), and *other curricular areas* (which promote healthful behavior and an awareness of health issues as part of their core instruction).
- ◆ **School Environment**, which includes the *physical environment* (involving proper building design, lighting, ventilation, safety, cleanliness, freedom from environmental hazards that foster infection and handicaps, safe transportation policies, and having emergency plans in place), the *policy and administrative*

⁴ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation’s Investment* (p. 2-3). Washington, D.C.: National Academy Press.

environment (consisting of policies to promote health and reduce stress, and regulations ensuring an environment free from tobacco, drugs, weapons, and violence), the *psychosocial environment* (including a supportive and nurturing atmosphere, a cooperative academic setting, respect for individual differences, and involvement of families), and *health promotion for staff* (in order that staff members can become positive role models and increase their commitment to student health).

- ◆ **Community Participation**, which includes *parent and community involvement* (which consists of involving a wide range of community stakeholders—parents, students, educators, health and social service personnel, insurers, and business and political leaders—to develop and form the structure of the school health program tailored to meet each local community’s needs, resources, perspectives, and standards).

Although the schools are accountable to the community and provide a critical facility within which many agencies can work together to maintain the well-being of students, they cannot be expected to address the student’s serious health and social problems in the school setting without assistance from the community. Families, healthcare workers, the media, religious organizations, community organizations that serve children and adolescents, and young people themselves must also be involved.

Subsections

The following subsections describe key features of the three- and eight-component models for a school health program and the full-service schools model:

- ◆ Three-Component Model
- ◆ Eight-Component Model
- ◆ Full-Service Schools Model

The Three-Component Model

Traditional Model. Originating in the early 1900s and evolving through the 1980s, the three-component model is considered to be the traditional model of a school health program. According to this model, a school health program consists of the following three basic components.⁵

1. Health Instruction
2. Health Services
3. Healthful School Environment

Definitions. The definitions of each component of the traditional school health program model are presented below.

Key Features of a Traditional School Health Program

Component	Definition
Health Instruction	Accomplished through a comprehensive health education curriculum that focuses on increasing student understanding of health principles and modifying health-related risk behaviors.
Health Services	Focuses on prevention and early identification and redemption of student health problems.
Healthful School Environment	Concerned with the physical and psychosocial setting and such issues as safety, nutrition, food services, and a positive learning atmosphere

⁵ Allensworth, D., Lawson, E., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (p. 52). Washington, D.C.: National Academy Press.

The Eight-Component Model

CDC Model. The Centers for Disease Control and Prevention (CDC) eight-component model of a comprehensive school health program consists of the following interactive components.⁶

1. Health Education
2. Physical Education
3. Health Services
4. Nutrition Services
5. Health Promotion for Staff
6. Counseling, Psychological, and Social Services
7. Healthful School Environment
8. Parent and Community Involvement

The following is a summary of CDC's definitions and descriptions of each component of a comprehensive school health program.

Key Features of a Comprehensive School Health Program

Component/Definition	Description
Health Education <i>A planned, sequential, K-12 curriculum that addresses the physical, mental, emotional, and social dimensions of health.</i>	<ul style="list-style-type: none"> ◆ Designed to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors. ◆ Allows students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills, and practices. ◆ Includes a variety of topics, such as personal health, family health, community health, consumer health, environmental health, sexuality education, mental and emotional health, injury prevention and safety, nutrition, prevention and control of disease, and substance use and abuse. ◆ Qualified, trained teachers provide health education.

⁶ Centers for Disease Control and Prevention. (1998). *A Comprehensive School Health Program*[On-line]. Available: <http://www.cdc.gov/nccdphp/dash/cshpdef.htm>.

Key Features of a Comprehensive School Health Program

Component/Definition	Description
<p>Physical Education</p> <p><i>A planned, sequential K-12 curriculum that provides cognitive content and learning experiences in a variety of activity areas.</i></p>	<ul style="list-style-type: none"> ◆ Promotes each student’s optimum physical, mental, emotional, and social development through a variety of planned physical activities. ◆ Promotes activities and sports that all students enjoy and can pursue throughout their lives. ◆ Includes such activities as basic movement skills; physical fitness; rhythms and dance; games; team, dual, and individual sports; tumbling and gymnastics; and aquatics. ◆ Qualified, trained teachers teach physical activity.
<p>Health Services</p> <p><i>Services provided for students to appraise, protect, and promote health.</i></p>	<ul style="list-style-type: none"> ◆ Designed to ensure access or referral to primary health care services or both. ◆ Fosters appropriate use of primary health care services. ◆ Prevents and controls communicable disease and other health problems. ◆ Provides emergency care for illness or injury. ◆ Promotes and provides optimum sanitary conditions for a safe school facility and school environment. ◆ Provides educational and counseling opportunities for promoting and maintaining individual, family, and community health. ◆ Qualified professionals (such as physicians, nurses, dentists, health educators, and other allied health personnel) provide these services.
<p>Nutrition Services</p> <p><i>Access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students.</i></p>	<ul style="list-style-type: none"> ◆ Reflects the U.S. Dietary Guidelines for Americans and other criteria to achieve nutrition integrity. ◆ Offers students a learning laboratory for classroom nutrition and health education. ◆ Serves as a resource for linkages with nutrition-related community services. ◆ Qualified child nutrition professionals provide these services.

Key Features of a Comprehensive School Health Program

Component/Definition	Description
<p>Health Promotion for Staff</p> <p><i>Opportunities for school staff to improve their health status through such activities as health assessments, health education, and health-related fitness activities.</i></p>	<ul style="list-style-type: none"> ◆ Encourages school staff to pursue a healthy lifestyle that contributes to their improved health status, improved morale, and a greater personal commitment to the school's overall comprehensive health program. ◆ Personal commitment often transfers into greater commitment to the health of students and creates positive role modeling. ◆ Improves staff productivity. ◆ Decreases staff absenteeism. ◆ Reduces health insurance costs.
<p>Counseling and Psychological/Social Services</p> <p><i>Services provided to improve students' mental, emotional, and social health.</i></p>	<ul style="list-style-type: none"> ◆ Includes individual and group assessments, interventions, and referrals. ◆ Organizational assessment and consultation skills of counselors and psychologists contribute not only to the health of students but also to the health of the school environment. ◆ Professionals (such as certified school counselors, psychologists, and social workers) provide these services.
<p>Healthful School Environment</p> <p><i>The physical and aesthetic surroundings and the psychosocial climate and culture of the school.</i></p>	<ul style="list-style-type: none"> ◆ Factors that influence the physical environment include the school building and the area surrounding it, any biological or chemical agents that are detrimental to health, and such physical conditions as temperature, noise, and lighting. ◆ Psychological environment includes the physical, emotional, and social conditions that affect the well-being of students and staff.
<p>Parent/Community Involvement</p> <p><i>An integrated school, parent, and community approach for enhancing the health and well-being of students.</i></p>	<ul style="list-style-type: none"> ◆ Builds support for school health program efforts through school health advisory councils, coalitions, and broadly-based constituencies for school health. ◆ Schools should actively solicit parent involvement and engage community resources.

The Full-Service Schools Model

Full Service School Model. A recent model in the evolution of school health programs is the full-service school. Under this model, the charge to the community is to bring into the school a wide range of services, including health, mental health, employment services, child care, parent education, case management, recreation, cultural events, welfare, community policing, and whatever else may fit into the picture based on the needs of the community. The result is a type of “one-stop” system—facilities that can offer a seamless experience for the students, parents, and staff.⁷

Seamless Institution. According to Dryfoos, the ideal full-service school encompasses both quality education and support services, where school and community agency personnel have common and shared goals and participate in joint decision making. The result of this new kind of “seamless” institution is a community-oriented school with joint governance structure that allows maximum responsiveness to the community, as well as accessibility and continuity for those most in need of services.⁸

Quality Education. According to the Institute of Medicine (IOM) Committee on Comprehensive School Health programs in Grades K-12, a full-service school provides a quality education for students, which includes individualized instruction, team teaching, cooperative learning, a healthy school climate, alternative to tracking, parental involvement, and effective discipline. The school and/or community agencies collaborate together to provide comprehensive health education, health promotion, social skills training, and preparation for the world of work.⁹

Support Services. Furthermore, according to the IOM Committee, the continuum of services to be provided by community agencies at the full-service school include health services (e.g., health and dental screening), nutrition counseling and weight management, mental health services (e.g., individual counseling, crisis intervention, and substance abuse treatment and follow-up services), family welfare, and social services (e.g., child care, parent literacy, employment training, legal services, recreational and cultural activities, and basic services for housing, food, and clothing).¹⁰

⁷ Dryfoos, Joy G. (1994). *Full-Service Schools: A Revolution in Health and Social Services for Children, Youth, and Families*. San Francisco, Calif.: Jossey-Bass Publishers.

⁸ Ibid.

⁹ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.) (1997). *Schools & Health: Our National's Investment* (p. 59). Washington, D.C.: National Academy Press.

¹⁰ Ibid.

Idealized Model of the Full-Service School. Exhibit 1 presents a summary of broad categories of services that can be put together to make a full-service school. According to Dryfoos, the components listed are based on existing program experiences and on findings of a study of one hundred successful prevention programs in the separate fields of substance abuse, teen pregnancy, delinquency, and school failure. This model represents the belief that there is no one single program or component that can significantly change the lives of disadvantaged children, youth, and families. Rather, it incorporates a variety of interventions that can result in measurable change.¹¹

Exhibit 1. Full-Service Schools: One-Stop, Collaborative Institutions.

Quality Education Provided by Schools	Support Service Provided by Community Agencies
Effective basic skills	Health screening and services
Individualized instruction	Dental services
Team teaching	Individual counseling
Cooperative learning	Substance abuse treatment
School-based management	Mental health services
Healthy school climate	Nutrition/weight management
Alternatives to tracking	Referral with follow-up
Parent involvement	Basic services: housing, food, clothes
Effective discipline	Recreation, sports, culture
	Mentoring
Provided by Schools or Community Agencies	Family welfare services
Comprehensive health education	Parent education, literacy
Health promotion	Child care
Social skills training	Employment training/jobs
Preparation for the world of work (life planning)	Case management
	Crisis intervention
	Community policing

Source: Adapted from Dryfoos, Joy G. (1994). *Full-Service Schools: A Revolution in Health and Social Services for Children, Youth, and Families* (p.13). San Francisco, Calif.: Jossey-Bass Publishers.

According to Dryfoos, there is no one particular model of school-based services. Throughout the country, a variety of models exist and are referred to by a variety of names, including school-based health clinics, youth service centers, family resource centers, full-service schools, wellness centers, student service centers, and community schools. Although such school-based services offer different services and are referred to by different names, what they all have in common is their location in or near the school.

¹¹ Dryfoos, Joy G. (1994). *Full-Service Schools: A Revolution in Health and Social Services for Children, Youth, and Families*. San Francisco, Calif.: Jossey-Bass Publishers.

Being located in or near a school opens up access to students and their family for all kinds of health and social services. In practice, “full service” is defined by a particular community and school, with an array of services that are needed, feasible to provide in or near the school, and acceptable to the school division and the community.¹²

¹² Dryfoos, Joy G. (1994). *Full-Service Schools: A Revolution in Health and Social Services for Children, Youth, and Families*. San Francisco, Calif.: Jossey-Bass Publishers.

Terminology: Comprehensive Versus Coordinated

Coordinated School Health Program. There has been much discussion over the term “comprehensive” in describing a school health program. A number of organizations have proposed changing the term to “coordinated” school health program. These organizations state that “comprehensive school health programs” have been confused with “comprehensive school health education,” which relates to instruction, and that the term “comprehensive” implies a need for new expanded resources that overburdened school divisions cannot provide. The term “coordinated,” on the other hand, implies consolidating and expanding existing resources, which is more feasible for school divisions.¹³

Comprehensive School Health Program. Persons who favor keeping the term “comprehensive” believe that the change to “coordinated” would undermine the progress made in promoting the concept of a “comprehensive” school health program. They believe that while having consistent terminology is important, more important is the understanding that health must be an integral part of a school program.¹⁴

Institute of Medicine. In late 1994, an Institute of Medicine (IOM) Committee was convened to carry out a study of comprehensive school health in grades K-12. In 1995, the committee published an interim statement that included the following provisional definition of a comprehensive school health program (CSHP):

*A comprehensive school health program is an integrated set of planned, sequential, school-affiliated strategies, activities, and services designed to promote the optimal physical, emotional, social, and educational development of students. The program involves and is supportive of families and is determined by the local community, based on community needs, resources, standards, and requirements. It is coordinated by a multidisciplinary team and is accountable to the community for program quality and effectiveness.*¹⁵

¹³ Marx, E., and Wooley, S.F. (Eds.). (1998). *Health Is Academic: A Guide to Coordinated Health Programs* (pp. xii-xx). New York, N.Y.: Teachers College Press.

¹⁴ Marx, E., and Wooley, S.F. (Eds.). (1998). *Health Is Academic: A Guide to Coordinated Health Programs* (pp. xii-xx). New York, N.Y.: Teachers College Press.

¹⁵ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1995). *Defining a Comprehensive School Health Program: An Interim Statement* (p.2). Washington, D.C.: National Academy Press.

Each term printed in bold is further described and discussed in the IOM interim statement and final report. Below is a brief summary of the terms “comprehensive” and “coordinated,” as defined by the IOM Committee in its final report.

Comprehensive means inclusive, covering completely and broadly, and refers to a broad range of components. It should be emphasized, however, that programs and services actually delivered at the school site may not provide coverage by themselves but are intended to work with and complement the efforts of families, primary sources of health care, and other health and social service resources in the community to produce a continuous and complete system to promote and protect students’ health.¹⁶

Coordinated means brought into combined action to cause separate elements to function in a smooth concerted manner. Coordination implies a formal relationship and blurring of boundaries between coordinating partners, although partners can still retain identity and affiliation to their profession.¹⁷

The IOM Committee concluded in its final report that its original provisional definition of a CSHP was still valid and useful. The committee determined that its definition is flexible, not overly prescriptive, and emphasized what the committee believes are the crucial features of a CSHP—family and community involvement, multiple interventions, integration of program elements, and collaboration across disciplines. The IOM Committee believes that there is no single “best” definition or model for a CSHP but that programs must be tailored to meet each community’s needs, resources, perspectives, and standards.¹⁸

Council of Chief State School Officers (CCSSO) and the Association of State and Territorial Health Officials (ASTHO). The CSSO and the ASTHO commissioned the Academy for Educational Development (AED) to develop messages that chief school officials and state health officials (SHOs) can use to encourage support for comprehensive school health programs. Target audiences for these messages were: (1) administrators, teachers, and other school staff, and (2) parents. Results of the qualitative and quantitative research conducted by the AEO are published in a draft report entitled

¹⁶ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.) (1997). *Schools & Health, Our Nation’s Investment* (p. 60). Washington, D.C: National Academy Press.

¹⁷ Allensworth, *Schools and Health*, p. 62.

¹⁸ Allensworth, *Schools and Health*, p. 62.

*Developing Messages to Support Comprehensive School Health Programs: Results of Primary and Secondary Research.*¹⁹

Although the in-depth interview and focus group findings discussed in the report are qualitative in nature, they provide useful insights for understanding the target audience's thoughts and perceptions. The subsequent survey helped to measure the prevalence of particular sentiments expressed by participants in the qualitative research.

Because the level of awareness of the term “comprehensive school health programs” was unlikely to be high among most of the audience groups, some research questions used such phrases as “school’s approach to health” rather than “comprehensive school health program,” or for that matter, “coordinated school health program.” As anticipated, few participants were familiar with the term “comprehensive school health programs,” although, some school staff, such as the occasional principal or teacher, gave the “correct” definition of a comprehensive school health program.

Readers of this manual are encouraged to review the final report for further information on developing messages—targeted to parents, teachers and administrators—that support the comprehensive or coordinated approach (even if it is not called that) as a foundation of a successful school or a component of strengthening a school, not a complete solution.

Centers for Disease Control and Prevention. The CDC eight-component model of a school health program has been traditionally referred to as a “Comprehensive School Health Program,” consisting of the following interactive components: health education, physical education, health services, nutrition services, health promotion for staff, counseling and psychological services, healthy school environment, and parent/community involvement.²⁰ However, in a recently published handbook, CDC refers to the eight-component model as a “Coordinated School Health Program,” in which the following definition is presented.

***Coordinated School Health Program (CSHP).** A planned and coordinated school-based program designed to enhance child and adolescent health, which consists of eight components: healthful school environment; health services; health education; physical education; counseling, psychological, and social services;*

¹⁹ *Developing Messages to Support Comprehensive School Health Programs: Results of Primary and Secondary Research*, prepared for the Council of Chief State School Officers Association of State and Territorial Health Officials by the Academy for Educational Development, 1255 23rd St., N.W., Washington, D.C. 20037, draft—May 29, 1997.

²⁰ Centers for Disease Control and Prevention. (1998). *A Comprehensive School Health Program*[Online]. Available: <http://www.cdc.gov/nccdphp/dash/cshpdef.htm>.

*nutrition services; family and community involvement; and health promotion for staff.*²¹

The main premise of this definition of a “coordinated school health program” is that a model involving all aspects of educational agencies (both state education agencies [SEAs] and local education agencies [LEAs] and state health agencies [SHAs] and local health agencies [LHAs]) will (1) eliminate program gaps and overlaps, (2) provide more effective programming, and (3) improve the school’s ability to enhance the health of children and adolescents.²²

Virginia’s Blue Ribbon Commission on School Health. In 1994, the Governor of Virginia established the Blue Ribbon Commission on School Health to collaborate in developing, implementing, and evaluating school health programs, in response to Senate Joint Resolution No. 155, which was passed by the 1994 General Assembly. In 1995, the Commission conducted a study on school health programs in Virginia. For the purpose of its study, the Commission described a school health program in terms of the following nine components: (1) health education, (2) health services, (3) healthful school environment, (4) parent/community involvement, (5) counseling, (6) psychological and social services, (7) nutrition services, (8) physical education, and (9) health promotion for staff.²³

Virginia School Health Guidelines. This manual uses the term “school health program.” Readers of this manual are encouraged to develop a definition or model of a school health program that best meets their community’s needs, resources, perspectives, and standards.

The Virginia School Health Guidelines Task Force recommends that a school health program should:

- ◆ Be based on the premise that parents have the primary responsibility to assure the health and well-being of their children.
- ◆ Be supportive and involve families.
- ◆ Be determined by the local community and based on community needs, resources, standards, and requirements.

²¹ Centers for Disease Control and Prevention. (1997). *Coordinated School Health Program Infrastructure Development: Process Evaluation Manual*, (p. XI). Atlanta, Ga.: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

²² Centers for Disease Control and Prevention, *Coordinated School Health Program Infrastructure*, p. 2.

²³ *Findings and Recommendations of the Blue Ribbon Commission on School Health*. (1996). Senate Document No. 29, Commonwealth of Virginia.

- ◆ Be coordinated by a multidisciplinary team.
- ◆ Be accountable to the community for program quality and effectiveness.
- ◆ Include the following components: (1) parent and community involvement; (2) healthful school environment; (3) health services; (4) health education; (5) physical education; (6) nutrition services; (7) counseling, psychological, and social services; and (8) health promotion for staff.

Reviewing History: Legislative Studies

Overview

Historical Perspective. Prior to the mid-1800s, efforts to introduce health into public schools were isolated and sparse. The “modern school health era” began in the mid-1800s²⁴ after the release of the Shattuck report, which recognized the role schools could play in controlling communicable disease with their “captive audience” of children and young people.²⁵

The era of “medical inspection” began at the end of the nineteenth century when “medical visitors” went to schools and examined children thought to be “ailing.”²⁶ The role and advantages of school nurses began to be recognized around the turn of the century after Lillian Wald, in 1902, demonstrated that nurses working in schools could reduce absenteeism due to contagious diseases by 50 percent in a matter of weeks.²⁷ The range of school-linked health services was broad in the early twentieth century, and school-based medical and dental clinics were set up to provide services, especially to indigent students.

World War I marked a turning point in the history of school health programs, with the advent of the war making the problems of poverty more visible.²⁸ New health promotion philosophies and movement began to replace outmoded methods. During the years immediately following World War I, the image of modern school health programs began to emerge. Between 1918 and 1921, almost every state enacted laws related to health education and physical education for school children, and school-based medical inspection and screening continued into the 1930s. A number of school health demonstration projects and studies were carried out between the 1920s and 1940s.

²⁴ Pigg, R.M. (1992). The School Health Program: Historical Perspectives and Future Prospects. In *Principles and Practices of Student Health, Volume Two: School Health.*, H.M. Wallace, K. Patrick, G.S. Parcel, and J.B. Igoe, eds. Oakland, Calif.: Third Party Publishing.

²⁵ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (pp. 33-76). Washington, D.C.: National Academy Press.

²⁶ Means, R.K. (1975). *Historical Perspectives on School Health*. Thorofare, N.J.: Charles B. Stack.

²⁷ Lynch, A. (1977). Evaluating School Health Programs. In *Health Services: The Local Perspective*. A. Levin, ed. New York, N.Y.: Academy of Political Science; *Proceedings of the Academy of Political Science*, 32(3):89-105.

²⁸ Means, R.K. (1975). *Historical Perspectives on School Health*. Thorofare, N.J.: Charles B. Stack.

Although the Great Society programs of the 1960s and 1970s brought an influx of funding for school health, most of these programs focused on disadvantaged and special populations.²⁹ During the 1980s, the role of health and physical education in the curriculum, as well as the perceived importance of school health for mainstream students, came under question. However, since the mid- to late-1980s there has been a renewed focus on the potential for schools to address health and social problems.³⁰

Evolution of Comprehensive School Health Programs in Virginia. The evolution of school health programs in recent years in Virginia can be followed by reviewing recent school health-related legislation and legislative studies. Key state laws related to school health are cited throughout this manual and are contained in Appendix A. In addition, summaries of key school health-related legislative studies are provided in the following five subsections.

Subsections

The next five subsections contain summaries of the following school health-related legislative studies that were conducted in Virginia, including background information and recommendations.

- ◆ *The Health Needs of School-Age Children*, Senate Document No. 22, Commonwealth of Virginia, 1987.
- ◆ *A Study on Ways to Encourage Local School Divisions to Recognize the Importance of School Nurses and the Feasibility of Establishing Standards for School Health Services*, House Document No. 19, Commonwealth of Virginia, 1989.
- ◆ *Current Health Programs in the Public School of Virginia and the Efficacy and Appropriateness of Adopting a Comprehensive Approach to Health Education*, House Document No. 21, Commonwealth of Virginia, 1992.
- ◆ *Report on the Needs of Medically Fragile Students*, Senate Document No. 5, Commonwealth of Virginia, 1995.
- ◆ *Findings and Recommendations of the Blue Ribbon Commission on School Health*, Senate Document No. 29, Commonwealth of Virginia, 1996.

²⁹ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (p. 46). Washington, D.C.: National Academy Press.

³⁰ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (pp. 46-47). Washington, D.C.: National Academy Press.

Copies of Legislative Reports. To obtain a complete copy of any of the above reports, please contact the Virginia General Assembly, Legislative Services, at telephone (804) 786-3591. (Ask for each publication by document number and date of publication; e.g., “Senate Document No. 19, published in 1996.”)

The Health Needs of School-Age Children (Senate Document No. 22, 1987)

Background

In 1986, the Secretary's Task Force on the Health Needs of School-Age Children was assembled as an outgrowth of Senate Joint Resolution No. 76. The resolution requested the Secretary of Human Resources to study the health needs of school-age children. The recommendations are summarized below.

Recommendation

1. The number of school nurses providing school health services should be increased to allow for at least one school nurse in every school or a ratio of one school nurse per 1,000 students.
2. Minimum standards for school health services in Virginia should be developed jointly by the Departments of Education and Health.
3. The Departments of Education and Health should establish a nursing position within the State Department of Education to supervise and coordinate the provision of school health services in the Commonwealth.
4. The Department of Education should mandate family life education curriculum in grades K-12 with an emphasis on promoting parental involvement and the fostering of positive family living skills in all public schools in the Commonwealth.
5. The Departments of Health and Education along with the Virginia Dental Association should work together on a state and local level to coordinate dental care resources and to increase dental screenings and educational programs.
6. A formal memorandum of agreement should be developed between the Secretary of Human Resources and the Secretary of Education to address overlapping concerns related to the health needs and care of school-age children.
7. The Boards of the Departments of Education and Health should establish a formal agreement to meet jointly at a minimum of twice yearly to advise each of the designated agencies on matters pertaining to school health services policy.
8. The Governor's Task Force on indigent care as well as the Secretary of Human Resources should specifically address the special health care needs of the school-age child especially the medically indigent.

9. The Departments of Education, Health, and Mental Health and Mental Retardation should co-sponsor at regular intervals continuing education opportunities for school nursing personnel on a regional basis.
10. The Departments of Health, Education, and Mental Health and Mental Retardation should provide for school personnel continuing education opportunities about the new morbidity facing today's school-age children.
11. Every school division within the state should have a school health advisory body composed of public and private sector representatives to assist with school health policy.
12. An interdisciplinary health care plan for school-age children at the local level should be developed with technical assistance from the State Departments of Education, Health, and Mental Health and Mental Retardation as requested. Such a plan should include a component on methods of financing health care services to school-age children.
13. Each school division within the state should establish formal interagency agreements with appropriate community resources involved in the provision of health care to school-age children. Appropriate community resources may include, but should not be limited to, local health departments, community services boards, social services agencies, institutions of higher education, private sector health professionals, and others.
14. Local school boards should develop, whenever possible, strong relationships with volunteer organizations and the business community for improving the delivery and financing of health care for school-age children.
15. The Virginia Chapter of the American Academy of Pediatrics should encourage its membership to provide a leadership role at the local level in advocating for and providing a coordinated system of health care for school-age children.
16. The Virginia Congress of Parents and Teachers (PTA) and all other parent organizations should vigorously undertake a parent awareness campaign to educate parents about the health needs of school-age children and to increase parental involvement in their children's health.
17. Every school division should establish a cooperative agreement with a health care provider to serve in the capacity of consulting medical director to provide medical care consultation and backup to nursing personnel.
18. Formal, written emergency medical procedures should be developed in every school division within the state.

19. The State Department of Education should direct all school divisions to maintain appropriate documentation on all student injuries as part of a program of comprehensive risk management.
20. The State Department of Education should continue to monitor and insist that all schools comply with state laws pertaining to vision and hearing assessments.
21. The Department of Education should direct all school divisions to provide time in the curriculum for health education. Further, there should be a strong emphasis on health promotion and disease and injury prevention programs.
22. The Department of Education should assist all school divisions with guidance on the physical education curriculum to develop and emphasize individual fitness programs.
23. The Department of Education should encourage all school divisions to establish after-school programs addressing health issues and concerns.

A Study on Ways to Encourage Local School Divisions to Recognize the Importance of School Nurses and the Feasibility of Establishing Standards for School Health Services (House Document No. 19, 1989)

Background

The Department of Education, in cooperation with the Department of Health, was requested by the 1988 General Assembly of Virginia to study ways to encourage local school divisions to recognize the importance of school nurses and the feasibility of establishing standards for health services in the public schools in the Commonwealth (House Joint Resolution Number 33 [HJR 33]). A study committee was established to respond to the task as defined by HJR 33.

Recommendation

1. Qualified school nurses should be required in every school division contingent upon appropriate funding.
2. The goal for nurse/student ratios should conform to the standards set by the National Association of School Nurses, American Nurses Association, and the American School Health Association.
3. School health advisory boards, composed of public and private sector representatives, should be established to enhance community support for school health services and to assist in the development of local school health policy.
4. Minimum standards for school health services in Virginia should be developed jointly by the Departments of Education and Health.
5. A nursing position should be established by the Departments of Education and Health within their respective departments to supervise and coordinate the provision of school health services.
6. School nurses should be involved as members of school teams to facilitate learning by providing care and treatment to students with chronic and handicapping conditions.
7. Students and school personnel should be counseled as a means of reducing the “new morbidities.”

8. A cooperative agreement should be established in every school division with a health care provider to serve in the capacity of consulting medical director to provide medical care, consultation, and backup to nursing personnel.
9. Formal written emergency medical procedures should be developed in every school division within the state.
10. Appropriate documentation on all student injuries should be maintained by all school divisions as part of a program of comprehensive risk management.
11. Continuing education opportunities, especially in the new morbidities, should be co-sponsored by the Departments of Education, Health, Mental Health and Mental Retardation on a regional basis, and at regular intervals for school nursing personnel.
12. Qualifications for school nurses should be developed jointly by the Departments of Education and Health.

Current Health Programs in the Public School of Virginia and the Efficacy and Appropriateness of Adopting a Comprehensive Approach to Health Education (House Document No. 21, 1992)

Background

This study was conducted during the spring and summer of 1991 in response to House Joint Resolution (HJR) 343 (1991 session). The resolution requested that the Department of Education study current health education programs, as well as the efficacy and appropriateness of adopting a comprehensive approach to health education in the public schools. The study was conducted in conjunction with the study required by HJR 437 (1991 session) on HIV/AIDS education.

Recommendation

1. All persons teaching health education in the elementary and middle school grades without a health education endorsement should be encouraged to complete training essential for quality instruction. This training should be a minimum of one undergraduate or graduate course in health education.
2. Minimum standards for school health education curricula and health services should be developed jointly by the Departments of Education and Health, in conjunction with school divisions in Virginia.
3. The Department of Education should design and implement a plan for evaluating the effectiveness of comprehensive school health programs.
4. The Board of Education and the Department of Education should commit to the further development of Comprehensive School Health Programs, addressing all health education and health service needs in a coordinated and comprehensive manner, and to the promotion of the program in the public schools of Virginia. This would include consideration for expanding the Health Standards of Learning to include grades 11 to 12 and developing a K-12 health education curriculum guide using the Health Standards of Learning Objectives as a foundation. To be funded in the 1994-96 biennium.
5. The Department of Education should continue to provide on-going education on timely health topics. This should be accomplished through the Blue Ridge School Health Conference and regional and local conferences.

Report on the Needs of Medically Fragile Students (Senate Document No. 5, 1995)

Background

During its 1993 legislative session, the Virginia General Assembly adopted a senate resolution (SJR 306) requesting that the Department of Education in conjunction with the Department of Health study the needs of medically fragile children in Virginia.

Recommendation

1. Local school divisions should develop policies that address the provision of services to students who are medically fragile to include staff selection and training, roles, and responsibilities.
2. Local school divisions should develop policies to address the emergency medical needs of students, including those who are medically fragile.
3. The local school health advisory board, required by §22.1-275.1 of the Code of Virginia, should take an active role in assisting school divisions in developing policies related to children who are medically fragile.
4. School divisions should provide periodic in-service or opportunities for school staff to attend programs to increase staff awareness and understanding of the general health issues faced by schools and the needs of medically fragile students, specifically.
5. For risk management purposes, school divisions should document the health services provided to any medically fragile or other students.
6. Nursing homes in the Commonwealth that elect to establish pediatric units should be licensed under both Chapter 5 of Title 32.1 of the Code of Virginia and under Chapter 10 of Title 63.1 of the Code.
7. School divisions should review and evaluate their policies and procedures relative to Section 504 of the Rehabilitation Act of 1973.
8. The Department of Education, in conjunction with the Attorney General's Office, should review and evaluate the need for legislation establishing statutory immunity for school personnel performing acts within the scope of their employment while providing health-related services to the medically fragile population.
9. The Department of Education, in collaboration with the Department of Health, should develop and update procedural guidelines.
10. The General Assembly may wish to consider further study, focusing on the needs of families with medically fragile children.

Findings and Recommendations of the Blue Ribbon Commission on School Health (Senate Document No. 29, 1996)

Background

The Blue Ribbon Commission on School Health Study was conducted during 1995 in response to Senate Joint Resolution No. 155, requesting the Governor to establish a Blue Ribbon Commission on School Health to collaborate in developing, implementing, and evaluating school health programs (1994).

Recommendation

1. School superintendents should recognize the importance of school health advisory boards as a means of parent and community involvement and of assisting with the development of school health policies and the evaluation of school health programs.
2. The Department of Education, in collaboration with the Department of Health, should provide periodic training and technical assistance to school health advisory board members and school health administrators to assist them in strengthening the boards' effectiveness in localities.
3. Recommendations Nos. 1-6 and 8 of Senate Document No. 5, "Report on the Needs of Medically Fragile Students (1995)," should be implemented:
 - ◆ School divisions should develop a "health service plan" for each student who is a medically fragile child as defined by Senate Document No. 5 (1995).
 - ◆ Local school divisions should develop policies that address the provision of services to students who are medically fragile, including staff selection and training and roles and responsibilities.
 - ◆ Local school divisions should develop policies to address the emergency medical needs of students, including those who are medically fragile.
 - ◆ The local school health advisory board, required by §22.1-275.1 of the *Code of Virginia*, should take an active role in assisting school divisions in developing policies related to children who are medically fragile.
 - ◆ School divisions should provide periodic in-service education or opportunities for school staff to attend programs to increase staff awareness and understanding of the general health issues faced by schools and the needs of students who are medically fragile.

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- ◆ For risk management purposes, school divisions should document school health services provided to all students, including those who are medically fragile.
 - ◆ School divisions should review and evaluate their policies and procedures relative to Section 504 of the Rehabilitation Act of 1973.
4. Students with special health care needs and chronic illnesses should have their medical care managed at school by a professional nurse in collaboration with the child's parents and primary health care provider.
 5. The Virginia Board of Nursing efforts to address delegation of nursing services in the school setting to unlicensed assistive personnel while ensuring that the professional nurse retains authority for nursing assessment, nursing evaluation, and nursing judgment should be supported.
 6. The Department of Health, in collaboration with the Department of Education, should distribute guidelines to assist qualified personnel in the assessment and ongoing management of students with specialized health care needs in the school setting. Such guidelines should be sent to all public and private schools in the Commonwealth.
 7. School divisions should require that specialized health care procedures be provided by licensed health care professionals or by personnel who have received training from persons qualified to provide such training and are certified or licensed to perform the procedure being taught.
 8. School divisions are encouraged to devote a portion of their professional development resources to assist staff in developing skills and strategies for working with parents and increasing parental involvement in the planning and implementation of school health programs.
 9. School divisions are encouraged to review physical education, grades K-I 2, and determine ways by which the program could be improved.
 10. The Department of Medical Assistance Services' studies on Virginia managed care Medicaid programs—MEDALLION II and OPTIONS—should include the impact of these programs on school health services.
 11. The Department of Medical Assistance Services should study the appropriateness and feasibility of contracting for school health services, including school nursing services, especially in medically underserved areas or health manpower shortage areas.
 12. School divisions, especially those in medically underserved areas, are encouraged to develop public-private contracts (e.g., HMO-Health Maintenance Organization, CHIP-Comprehensive Health Investment Project of Virginia) that include formal reimbursement for school health services (e.g., school nursing services) provided by qualified personnel.