JOURNAL OF SCHOOL HEALTH VOLUME 78 • NUMBER 2

JOURNAL OF SCHOOL HEALTH

Official Journal of the American School Health Association

SPECIAL LEGAL ISSUE

A CDC Review of School Laws and Policies Concerning Child and Adolescent Health

VOLUME 78
NUMBER 2
FEBRUARY
2008

Blackwell Publishing

American School Health Association

A CDC Review of School Laws and Policies Concerning Child and Adolescent Health

A Report From the Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, and the Public Health Law Program, Office of Chief of Public Health Practice, Centers for Disease Control and Prevention

Prepared by the Centers for Law and the Public's Health: A Collaborative at Johns Hopkins and Georgetown Universities

JOURNAL OF
SCHOOL HEALTH

Official Journal of the American School Health Association

The *Journal of School Health* (ISSN 0022-4391 [print], ISSN 1746-1561 [online]) is published monthly, except for June and July, by Blackwell Publishing with offices at 350 Main St, Malden, MA 02148 USA, and 9600 Garsington Rd, Oxford, OX4 2DQ, UK, and PO Box 378 Carlton South, 3053 Victoria, Australia. Blackwell Publishing is now part of Wiley-Blackwell.

Society and Membership Office:
The *Journal of School Health* is published on behalf of the American School Health Association. Membership requests should be forwarded to ASHA National Office, 7263 State Route 43, PO Box 708, Kent, OH 44240-0708; 330-678-1601 (phone); 330-678-4526 (fax). Professional Membership is $110. Foreign memberships add $20.

Subscription Rates for Volume 78, 2008

	The Americas†	Rest of World‡
Institutional Standard Rate**	$310	£197
Institutional Premium Rate*	$341	£217

*A Premium Institutional subscription includes online access to full text articles from 1997 to present, where available.
**A Standard Institutional subscription includes print and online access to current issues.
†Customers in Canada should add 5% GST or provide evidence of entitlement to exemption.
‡Customers in the UK should add VAT at 7%; customers in the EU should also add VAT at 7%, or provide a VAT registration number or evidence of entitlement to exemption.

For more information about Blackwell Publishing journals, including online access information, terms and conditions, and other pricing options, please visit www.blackwellpublishing.com or contact our customer service department, tel: (800) 835-6770 or (781) 388-8599 (US office), +44 (0) 1865 778315 (UK office). Prices include delivery of print journals to the recipient's address. Delivery terms are Delivered Duty Unpaid (DDU); the recipient is responsible for paying any import duty or taxes. Legal title passes to the customer on despatch by our distributors.
All orders must be paid by check, money order, or credit card. Only personal orders may be paid by personal check. Checks should be made payable to Blackwell. Checks in US dollars must be drawn on a US bank. Checks in Sterling must be drawn on a UK bank.

For new orders, renewals, sample copy requests, claims, changes of address and all other subscription correspondences please contact the Journals Department at your nearest Blackwell office (address details listed above). US office phone 800-835-6770 or 781-388-8599, Fax 781-388-8232, Email customerservices@blackwellpublishing.com; UK office phone +44 (0) 1865-778315, Fax +44 (0) 1865-471775, Email customerservices@blackwellpublishing.com; Asia office phone +65 6511 8000, Fax +44 (0) 1865 471775, Email customerservices@blackwellpublishing.com

For issues prior to March 2005, back issues are available from the American School Health Association, 7263 State Route 43, P. O. Box 708, Kent, OH 44240; 800-445-2742; fax 330-678-4526; asha@ashaweb.org. Single issues from the current and recent volumes are available at the current single issue price from Blackwell Publishing Journals.

Periodical postage paid at Boston, MA and additional offices. Mailing to the rest of the world by International Mail Express (IMEX). Canadian mail is sent by Canadian publications mail agreement number 40573520.

Postmaster: Send all address changes to *Journal of School Health,* Blackwell Publishing Inc., Journals Subscription Department, 350 Main St., Malden, MA 02148-5020.

This journal is printed on acid-free paper.

Statement of Purpose

The ***Journal of School Health***, an official publication of the American School Health Association, publishes material related to health promotion in school settings. ***Journal*** readership includes administrators, educators, nurses, physicians, dentists, dental hygienists, psychologists, counselors, social workers, nutritionists, dietitians, and other health professionals. These individuals work cooperatively with parents and the community to achieve the common goal of providing children and adolescents with the programs, services, and environment necessary to promote health and improve learning.

Contributed manuscripts are considered for publication in the following categories: **General Articles, Research Papers, Commentaries, School Health Policy, Legal Issues in School Health, Teaching Techniques**, and **Health Service Applications**. Primary consideration is given to manuscripts related to the health of children, adolescents, and employees in public and private preschools, child day care centers, kindergartens, elementary schools, middle level schools, and senior high schools. Manuscripts related to college-age young adults are considered if the topic has implications for preschool through high school health programs. Relevant international manuscripts are also considered.

Prior to submitting a manuscript, prospective authors should review the most recent "Author Guidelines" printed periodically in the ***Journal***. Copies of the Guidelines may also be obtained from the Blackwell Publishing Website for the *Journal of School Health* under submit an article located at http://www.blackwellpublishing.com/submit.asp?ref=0022-4391.

Foreword

Well-designed and effectively implemented school health policies and programs can improve students' health-related behaviors and outcomes, as well as their educational outcomes. Health promotion programs in the school setting are guided and constrained by myriad federal, state, and local laws and policies. Knowledge and understanding of the legal and policy framework in which school health programs must operate are essential to efforts to maximize the impact of these programs on health and educational outcomes.

The Centers for Disease Control and Prevention is pleased to present *A CDC Review of School Laws and Policies Concerning Child and Adolescent Health*. This report is the first of its kind to describe the breadth of health-related laws and policies under which schools operate. The report is framed around the eight interactive components of a coordinated school health program: health education, physical education, health services, nutrition services, mental health and social services, healthy and safe school environment, health promotion for staff, and family and community involvement. Although it provides an overview of the legal context under which school health programs operate, it is not an exhaustive examination of all federal, state, and local laws and policies related to these programs. This report should inspire education and public health officials, together, to learn more about the laws and policies that might already be in place, while giving them a better understanding of how they can use laws and policies to improve the health, safety, and academic performance of young people in schools.

Janet L. Collins, PhD
Director
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

Richard A. Goodman, MD, JD, MPH
Codirector
Public Health Law Program
Centers for Disease Control and Prevention

Anthony D. Moulton, PhD
Codirector
Public Health Law Program
Centers for Disease Control and Prevention

Acknowledgments

The Centers for Disease Control and Prevention's (CDC) National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health, and the CDC's Public Health Law Program, Office of Chief of Public Health Practice, would like to acknowledge the report authors and a host of important partners representing education and public health perspectives.

The following persons at the *Centers for Law and the Public's Health: A Collaborative at Johns Hopkins and Georgetown Universities* researched and drafted this report: James G. Hodge, Jr., JD, LLM, *Center* Executive Director and Associate Professor, Johns Hopkins Bloomberg School of Public Health; Julie Samia Mair, JD, MPH, former *Center* Scholar and Assistant Scientist, Johns Hopkins Bloomberg School of Public Health; and Lance A. Gable, JD, MPH, *Center* Scholar and Assistant Professor of Law, Wayne State University School of Law. Additional *Center* colleagues deserve recognition: Jessica O'Connell, JD, MPH, Stephanie Cálves, JD, MPH, Dhrubajyoti Bhattacharya, JD, MPH, Katerina Horska, and George Wakefield.

The following partners provided valuable comments and contributions on an initial outline and drafts of this report:

American Academy of Pediatrics
American Association for Health Education
American Association of School Administrators
American Nurses Foundation
American Public Health Association
American School Health Association
Association of Maternal and Child Health Programs
Association of State and Territorial Health Officials
Council of Chief State School Officers
Council of State Governments
Directors of Health Promotion and Education
National Alliance of State and Territorial AIDS Directors
National Assembly on School-Based Health Care
National Association of County and City Health Officials
National Association of School Nurses
National Association of State Boards of Education
National Coalition of STD Directors
National Conference of State Legislatures
National Environmental Health Association
National Middle School Association
National School Boards Association (including the Council of School Attorneys)
Society of State Directors of Health, Physical Education, and Recreation.

Many colleagues at the CDC also deserve recognition. They include staff from the National Center for Injury Prevention and Control; the National Immunization Program; the National Center on Birth Defects and Developmental Disabilities; National Center for Chronic Disease Prevention and Health Promotion; Office of General Counsel; National Center for Environmental Health; National Center for HIV, Hepatitis, STD and TB Prevention; Coordinating Center for Infectious Disease; and Office of the Chief Science Officer.

JOURNAL OF
SCHOOL HEALTH

Volume 78
Number 2
February 2008

Official Journal of the American School Health Association

Development of this report by the *Centers for Law and the Public's Health: A Collaborative at Johns Hopkins and Georgetown Universities* was sponsored by the Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, and the Public Health Law Program, Office of Chief of Public Health Practice, Centers for Disease Control and Prevention, with financial support under CDC Cooperative Agreement U50/CCU319118.

Information provided in this document is for educational purposes only and is not meant to provide specific legal guidance or advice. It does not represent the official legal positions of Johns Hopkins or Georgetown Universities or of the US Department of Health and Human Services, Centers for Disease Control and Prevention, or other federal, state, or local government agencies. *The findings and conclusions in this report do not necessarily represent the views of CDC*. Readers should contact their legal counsel for specific guidance concerning any information provided through this report.

Editor, *Journal of School Health*
Call for Position Applications

The American School Health Association (ASHA) is seeking an Editor for the **Journal of School Health**, an official publication of ASHA. The Association seeks a highly respected school health professional for this position, which will not be a full-time staff position at the ASHA headquarters but, rather, will be a part-time professional appointment within the field.

Qualifications: The Editor must: have national standing as a school health professional; be a member of good standing in ASHA; possess broad knowledge of professional content and research in school health; demonstrate competence in writing and/or conducting research; possess a high degree of literary competence and have a record of success in writing and/or editing articles or books; have the ability to coordinate and work cooperatively with the ASHA Executive Director, Managing Editor, Chairperson of the Editorial Board and ASHA members; and be committed to ethical professional and editorial standards.

Duties and Responsibilities: Under the guidance of the policies set forth by the ASHA Editorial Board and the general supervision of the ASHA Executive Director, the Editor will:

a) coordinate the manuscript review process;
b) critique the reviewers' comments and make final decisions regarding publication of articles;
c) work with the ASHA editorial staff and appropriate vendors to oversee the day-to-day manuscript and correspondence activity;
d) schedule articles for publication;
e) evaluate reviewers, and make recommendations for adding and removing reviewers;
f) prepare annual and midyear reports to the Executive Director;
g) prepare an annual index of the **Journal of School Health**;
h) attend ASHA Editorial Board meetings, and work closely with the Executive Director, ASHA editorial staff and Chairperson of the Editorial Board to implement the policies set forth by the Board;
i) work with guest editors and contributing editors on special issues and features;
j) handle non-routine correspondence with authors, reviewers, members and others regarding special requests to the **Journal**;
k) recommend annual revisions and updates to the **Journal of School Health Topical Packages**; and
l) represent the American School Health Association at meetings with organizations, agencies, groups and individuals who have an interest in the **Journal**.

Tenure: The Editor will be named by March 31, 2008, for a tenure of three years, with the option for renewal.

Reimbursement: The Editorship of the **Journal of School Health** will be a part-time, professional appointment within the field, and will not be a full-time salaried position. ASHA will reimburse the Editor with a monthly stipend on a 12-month basis.

Application Procedures: Applicants must submit to the ASHA Executive Director an electronic application package, containing the following: a) a letter of application that explains the reasons the applicant wishes to undertake this responsibility; b) a letter from the applicant's employer outlining provisions that can be made to permit time for the successful completion of duties of the Editor; c) a statement of the relationship between the applicant's credentials and the qualifications stated for the position; d) a current vita; e) a statement of philosophy regarding the focus of the **Journal of School Health**; f) three letters of recommendation from individuals who can speak to the applicant's capabilities for this position; and g) samples of the applicant's published works.

Applications must be submitted by February 28, 2008. Address all applications and inquiries to: Susan Wooley, Executive Director, American School Health Association, PO Box 708, Kent, OH 44240; swooley@ashaweb.org; 330/678-1601.

Abbreviations

Throughout this document, the following abbreviations are used to denote the accompanying names, terms, or other items:

ABA, American Beverage Association
ADA, Americans with Disabilities Act
ADHD, attention deficit/hyperactivity disorder
AHERA, Asbestos Hazard Emergency Response Act
AIDS, acquired immunodeficiency syndrome
BMI, body mass index
CCDF, Child Care and Development Fund
CDC, Centers for Disease Control and Prevention
CHES, Certified Health Education Specialist
CIC, clean intermittent catheterization
CLPH, Center for Law and the Public's Health
COPS, Community Oriented Policing Services
CPTED, Crime Prevention through Environmental Design
CSHP, coordinated school health program
DASH, Division of Adolescent and School Health, CDC
DGA, Dietary Guidelines for Americans
DHHS, US Department of Health and Human Services
DOJ, US Department of Justice
EAHCA, Education for All Handicapped Children Act
EAP, Employee Assistance Program
ED, US Department of Education
ELI, Environmental Law Institute
EPA, US Environmental Protection Agency
ESEA, Elementary and Secondary Education Act
FERPA, Family Educational Rights and Privacy Act
FMVSS, Federal Motor Vehicle Safety Standards and Regulations
GAO, Government Accountability Office
GED, General Educational Development test
HealthySEAT, Healthy School Environments Assessment Tool
HIPAA, Health Insurance Portability and Accountability Act of 1996
HIV, human immunodeficiency virus
IDEA, Individuals with Disabilities Education Act (including amendments)
IEP, Individualized Education Program
IHP, individualized health care plan
IOM, Institute of Medicine
LEA, local education agency
NASPE, National Association for Sport and Physical Education
NCLB, No Child Left Behind Act
NHES, National Health Education Standards
NHTSA, National Highway Traffic Safety Administration
NIOSH, National Institute for Occupational Safety and Health
NSLP, National School Lunch Program
OPA, Connecticut Office of Protection and Advocacy for Persons with Disabilities
OSH, Occupational Safety and Health
OSHA, US Occupational Safety and Health Administration
PEP, Carol M. White Physical Education Program
PHI, protected health information
PPRA, Protection of Pupil Rights Amendment
RDA, Recommended Dietary Allowances
SAMHSA, Substance Abuse and Mental Health Services Administration
SBHC, school-based health center
SBP, School Breakfast Program
SCHIP, State Children's Health Insurance Program
SEA, state education agency
SHI, School Health Index
SHPPS, School Health Policies and Programs Study
SR2S, Safe Routes to School
STDs, sexually transmitted diseases
TANF, Temporary Assistance for Needy Families
TB, tuberculosis
USCO, Unsafe School Choice Option
USDA, US Department of Agriculture.

Executive Summary

Protecting the health and safety of children and adolescents in schools (defined for the purposes of this report to include public educational institutions for children and adolescents in grades K-12) is an important part of any comprehensive education and public health plan. Through a coordinated school health program (CSHP) offering courses, services, policies, and programs designed to meet the health and safety needs of K-12 students, schools can ''provide a critical facility in which many agencies might work together to maintain the well-being of young people.''[1]

Laws and policies are important tools that can be used to improve the health and safety of children and adolescents in schools. Although some laws and policies might set limitations on health programs, laws and policies can provide education and public health leaders with valuable tools to promote programs and strategies that foster an environment in which children and adolescents can thrive and learn. Other agencies (such as environmental, zoning, food safety, mental health, justice, and law enforcement agencies) also may have legal tools that can be used to promote the health and safety of children and adolescents in schools. To date, however, no one has systematically identified the full range of relevant legal authorities pertinent to schools that may help shape the health of children and adolescents.

This report attempts to fill that gap by giving educators and public health professionals new access to information on laws and policies (as of April 2007) concerning the health of children and adolescents in schools. It is intended to help practitioners and policymakers in public health and education at the federal, state, and local levels enhance their knowledge of relevant laws and policies. This report does not attempt to document or tabulate each of the many and varied laws of all states. Nor does it attempt to provide an in-depth analysis of any particular federal, state, or local law or policy. Furthermore, the report does not recommend adoption of any particular law or policy or purport in any way to convey legal advice. Instead, the report provides an overview of the legal and policy landscape and should encourage readers to consider the potential for law and policy to contribute to students' health and safety. This potential may be best realized through partnerships between public health agencies, schools, and other organizations with complementary goals and policies. The target audiences are those federal, state, and local public health and education practitioners and policymakers who are dedicated to advancing the well-being of children and adolescents in school settings. Although the information in this report provides a useful introduction, readers should also consult with legal counsel and other experts who have in-depth understanding of the legal tools and policies relevant to a given community, state, or other jurisdiction.

The framework for this legal review is based on the eight-component model of school health programs introduced in 1987 by Allensworth and Kolbe.[2] This CSHP model has been embraced by state education agencies (SEAs) and local education agencies (LEAs) nationwide, supported by many national nongovernmental organizations that work in education and health, and championed by many as a means for advancing school health policies, instruction, and services for students and staff. CDC has advanced the implementation of this model through its funding to SEAs and uses the model's eight components as an organizing framework for its school health guidelines, surveillance systems, and recommendations for promising practices.

A CSHP is a planned, organized, and comprehensive set of courses, services, policies, and programs designed to meet the health and safety needs of students in grades K-12 and of school staff. All the eight components contribute to the health and well-being of students and are present to some extent in most schools. A successful and well-coordinated school health program is characterized by administrators, teachers, other professional staff, and school board members who view health protection and promotion as an essential part of the school's mission; a school health council composed of school, family, and community representatives to ensure a planning process for continuous health improvement; a school health coordinator responsible for organizing and managing the school health program; and school staff members who help plan and implement a full array of school health courses, services, policies, and programs.[3] Each of the eight components of the CSHP model is described below:[4]

1. *Health Education:* A planned, sequential K-12 curriculum that addresses the physical, mental, emotional,

This report was completed under the direction of Sherry Everett Jones, PhD, MPH, JD, FASHA, Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. Address correspondence to her at the Centers for Disease Control and Prevention, 4770 Buford Hwy, NE, MS K33, Atlanta, GA 30341 (SEverettJones@cdc.gov).

and social dimensions of health. The curriculum is designed to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors. It allows students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills, and practices. The comprehensive health education curriculum 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.

2. *Physical Education:* A planned, sequential K-12 curriculum that provides cognitive content and learning experiences in a variety of activity areas such as basic movement skills; physical fitness; rhythms and dance; games; team, dual, and individual sports; tumbling and gymnastics; and aquatics. Quality physical education should promote, through a variety of planned physical activities, each student's optimum physical, mental, emotional, and social development and should promote activities and sports that all students enjoy and can pursue throughout their lives. Qualified, trained teachers teach physical activity.
3. *Health Services:* Services provided for students to appraise, protect, and promote health. These services are designed to ensure access or referral to primary health care services or both, foster appropriate use of primary health care services, prevent and control communicable disease and other health problems, provide emergency care for illness or injury, promote and provide optimum sanitary conditions for a safe school facility and school environment, and provide 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.
4. *Nutrition Services:* Access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students. School nutrition programs reflect the US Dietary Guidelines for Americans and other criteria to achieve nutrition integrity. The school nutrition services offer students a learning laboratory for classroom nutrition and health education and serve as a resource for linkages with nutrition-related community services. Qualified child nutrition professionals provide these services.
5. *Mental Health and Social Services:* Services provided to improve students' mental, emotional, and social health. These services include individual and group assessments, interventions, and referrals. Organizational assessment and consultation skills of counselors and psychologists contribute not only to the health of the students but also to the health of the school environment. Professionals such as certified school counselors, psychologists, and social workers provide these services.
6. *Healthy and Safe School Environment:* The physical and aesthetic surroundings and the psychosocial climate and culture of the school. 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 physical conditions such as temperature, noise, and lighting. The psychological environment includes the physical, emotional, and social conditions that affect the well-being of students and staff.
7. *Health Promotion for Staff:* Opportunities for school staff to improve their health status through activities such as health assessments, health education, and health-related fitness activities. These opportunities encourage 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 coordinated health program. This personal commitment often transfers into greater commitment to the health of students and creates positive role modeling. Health promotion activities have improved productivity, decreased absenteeism, and reduced health insurance costs.
8. *Family and Community Involvement:* An integrated school, parent, and community approach for enhancing the health and well-being of students. School health advisory councils, coalitions, and broadly based constituencies for school health can build support for school health program efforts. Schools actively solicit parent involvement and engage community resources and services to respond more effectively to the health-related needs of students.

The report begins with a brief overview of the role of laws in schools (see section II). The legal framework for education includes a complex network of federal, state, and local laws and regulations. Constitutional principles are central to this framework. They may affirm a right to education (at least at the state level) and other rights (eg, freedom of speech, bodily integrity, and informational privacy) that must be coupled with legitimate governmental interests in providing safe and healthy schools. Structural constitutional principles (eg, separation of powers and federalism) guide distributions of power among the three branches of government in the United States and define the roles of federal, state, and local governments in regulating education and its environment. Section II also briefly discusses key federal and state

statutory laws concerning issues of discrimination, disability rights, privacy, and educational programs, as well as concepts of civil liability and immunity for the acts of governmental agents in school settings.

Building on this overview, section III describes the legal framework for each component of the CSHP. Each section begins with a brief description of the core component. The intent of each section is to provide a review of how relevant laws and policies can influence the health of children and adolescents. Considerable detail may be provided for some key federal or state laws or programs. In other cases, summary statements of the effect of laws are set forth. As noted above, while specific examples of various state or local laws are featured in each section, comprehensive tables of laws are not included (though they may be referenced from other sources in the notes). Some sections feature discussions of findings from the School Health Policies and Programs Study 2006—which assessed school health policies and programs in grades K-12 at the state, district, and school levels[5]—or other relevant studies. Also, some portions of this report refer to data that predate the enactment of the federal No Child Left Behind Act (NCLB).

The subject matter contained within section III is diverse. *Health Education* (section III.A), for example, discusses legal requirements to provide health education to students, federal incentives that shape health education (eg, team nutrition networks, abstinence, and alcohol prevention education), and the role of National Health Education Standards. *Physical Education and Activity* (section III.B) addresses similar themes concerning physical education requirements, including the impact of the NCLB and the Carol M. White Physical Education Program (PEP). Legal requirements to provide health services to students are the focus of *Health Services* (section III.C). Testing, screening, and treatment for health conditions in schools are explored, as well as issues concerning parental and student consent requirements, the use of identifiable health data, and the financing of school health services under the law.

The focus of *Nutrition Services* (section III.D) is on the laws and policies underlying the provision of nutrition services to students in school. Federal, state, and local nutrition requirements are examined. Significant discussion centers on legal restrictions surrounding the sale and distribution of alternative foods (as part of school nutrition services), food and beverage advertising in schools, and zoning as a legal tool to limit student access to off-campus fast food. *Mental Health and Social Services* (section III.E) looks closely at the legal requirements to provide counseling, psychological, and social services to students, including standards for provision of such services by staff.

Healthy and Safe School Environment (section III.F) covers a wide range of laws and policies that govern schools. This section first discusses a series of tools for assessing a healthy school environment. It then explores health-related laws and policies that relate to the physical school environment (eg, asbestos, indoor radon, pesticides, lead contamination, unintentional injuries, and school bus and pedestrian safety). Additional areas of legal concern include violence in or around school grounds, substance abuse, and emergencies.

The role of law in protecting the health of school staff (eg, teachers, administrators, and custodians) is addressed in *Health Promotion for Staff* (section III.G). Testing, screening, and examinations of staff for health conditions related to their positions are driven by legal requirements. Also discussed are health promotion activities authorized or available for public school staff, such as wellness programs, Employee Assistance Programs (EAPs), and health insurance benefits. Finally, in *Family and Community Involvement* (section III.H), various legal requirements to facilitate family and community involvement in school health are presented. This includes a look at how school health councils and coalitions have led to greater opportunities for incorporating families and communities in setting school health policies.

Many legal and policy themes emerge from this review, including the following:

- *Integration of public health and education services.* Multiple examples in law and policy documented in this report demonstrate the close ties between public health and education services in many jurisdictions. School authorities are routinely asked to assist in public health programs; public health officials are expected to protect the health of children in school environments. These respective requirements can lead to legal complications in some cases (eg, sharing identifiable health data in education records pursuant to Family Educational Rights and Privacy Act and the Health Insurance Portability and Accountability Act of 1996 Privacy Rule). However, they can also lead to tremendous opportunities for accomplishing significant improvements in child and adolescent health.
- *Division of responsibilities.* Despite many examples of attempts to integrate public health and education services through law and policy, there remains considerable division of responsibilities among many governmental and private sector entities for the health of children and adolescents in schools. In many cases, these divisions are furthered by laws or policies that assign to one entity (eg, the state public health authority or the local superintendent of schools) the primary task of accomplishing stated health goals. Assigning responsibility to one entity without a concomitant duty to work closely with other entities or persons, however, can lead to difficulties.

When laws fail to reflect the need for accountability coupled with collaboration, improvements in child and adolescent health may not be fully realized. Laws at every level of government may be improved by specifically incorporating requirements for collaboration across multiple sectors. In support of local educational agencies' efforts to develop enhanced emergency response and crisis management plans, the federal Safe and Drug-Free Schools and Communities Act, for example, requires that plans address coordination with local law enforcement, public safety, public health, and mental health agencies.

- *National primacy.* Federal laws and policies governing student health may take primacy over state and local laws; however, in the absence of federal laws or policies, opportunities exist for the development of state or local laws and policies that promote child health and academic achievement. In many ways, federal laws defer to state and local governmental discretion. For example, federal grant programs like the PEP are implemented through state or local laws that distribute resources consistent with state and local priorities. In this way, national health objectives can support efforts to protect and enhance students' health.
- *State and local innovation.* State and local officials demonstrate in multiple ways their creativity in shaping legal and policy tools for better student health. Many state and local laws apply to areas of child and adolescent health in schools where federal laws or programs may not apply. Thus, for example, while the federal government does not attempt to regulate the placement of fast-food outlets near local schools, the City of Detroit has ordained that no such restaurants be located within 500 feet of an elementary school. Protecting children and adolescents from skin cancer is an important priority in California. This led the state to pass its ''sun safety'' bill requiring every school to allow the outdoor use of sun protective clothing or sunscreen during school without a physician's note or prescription. Vermont features a legal provision requiring the construction of schools that can be used as emergency shelters. These and other examples demonstrate the capacity of state and local public health and education leaders to improve child and adolescent health through innovative laws focused on school populations or environments.

As illustrated through these legal themes, education and public health officials, their legal counsel, and partners from other relevant agencies (eg, environment, zoning, food safety, mental health, justice, and law enforcement agencies) can benefit from a greater understanding of the contribution laws and policies can make to improve health for children and adolescents in the school setting. Legal and policy tools may help refine schools' role in *protecting* the health of children and adolescents in school environments, *motivating* them to choose healthy behaviors through policies that encourage improved health and safety, and *safeguarding* them from multifarious health threats.

I. INTRODUCTION

Protecting the health and safety of children and adolescents in schools (defined for the purposes of this report to include public educational institutions for children and adolescents in grades K-12) is an important part of any comprehensive education and public health plan. Yet through a coordinated school health program (CSHP) offering courses, services, policies, and programs designed to meet the health and safety needs of K-12 students, schools can ''provide a critical facility in which many agencies might work together to maintain the well-being of young people.''[6]

Laws and policies are important tools that can be used to improve the health and safety of children and adolescents in schools. Although some laws and policies might set limitations on health programs, laws and policies can provide education and public health leaders with valuable tools to promote programs and strategies that foster an environment where children and adolescents can thrive and learn. Other agencies (eg, environment, zoning, food safety, mental health, justice, and law enforcement agencies) also may have legal tools that can be used to promote the health and safety of children and adolescents in schools. The US Department of Education (ED) also serves a vital role by ensuring equal access to education and promoting educational excellence. Nonetheless, ED is precluded by statute to exercise direction, supervision, or control over schools and their curricula.[7] Consequently, it is imperative to explore the various legal avenues through which state and local officials may achieve key policy objectives. To date, no one has systematically identified the full range of relevant legal authorities pertinent to schools that may help shape the health of children and adolescents.

This report attempts to fill that gap by providing information on laws and policies concerning the health of children and adolescents in schools. It is intended to help practitioners and policymakers in public health and education at the federal, state, and local levels enhance their knowledge of relevant laws and policies. This report does not attempt to document or tabulate the many and varied laws of all states. Nor does it attempt to provide an in-depth analysis of any particular federal, state, or local law or policy. Furthermore, the report does not recommend adoption of any particular law or policy or purport, in any way, to convey legal advice. Instead, the report provides an overview of the legal and policy landscape and should encourage readers to consider the potential for law and policy to contribute to students' health and safety. This potential may be best realized through partnerships between public health agencies, schools, and other organizations with complementary goals and policies. The target audiences are those federal, state, and local public health and education practitioners and policymakers who are dedicated to advancing the well-being of children and adolescents in school settings. Although the information in this report provides a useful introduction, readers should consult with legal counsel and other experts who have in-depth understanding of the legal tools and policies relevant to a given community, state, or other jurisdiction.

The framework for this legal review is based on the eight-component model of school health programs that was introduced in 1987 by Allensworth and Kolbe.[8] This CSHP model has been embraced by state and local education and health agencies nationwide, supported by many national nongovernmental organizations that work in education and health, and championed by many as a means for advancing school health policies, instruction, and services for students and staff.

A CSHP is a planned, organized, and comprehensive set of courses, services, policies, and programs designed to meet the health and safety needs of students in grades K-12 and school staff. All the eight components contribute to the health and well-being of students and exist to some extent in most schools. A successful and well-coordinated school health program is characterized by the presence of administrators, teachers, other professional staff, and school board members who view health protection and promotion as an essential part of the school's mission; a school health council composed of school, family, and community representatives to ensure a planning process for continuous health improvement; a school health coordinator responsible for organizing and managing the school health program; and school staff members who help plan and implement a full array of school health courses, services, policies, and programs.[9] CDC has advanced the implementation of this model through its funding to state education agencies (SEAs) and uses the model's eight components as an organizing framework for its school health guidelines, surveillance systems, and recommendations for promising practices. These components are (1) health education, (2) physical education, (3) health services, (4) nutrition services, (5) mental health and social services, (6) healthy and safe school environment, (7) health promotion for staff, and (8) family and community involvement.

This report begins with a brief overview of the role of law in schools (see section II). The legal framework for education includes a complex network of federal, state, and local laws and regulations. Constitutional principles are central to this framework. They may affirm a right to education (at least at the state level) and other rights (eg, freedom of speech, bodily integrity, and informational privacy) that must be coupled with legitimate governmental interests in providing safe and healthy schools. Structural constitutional

principles (eg, separation of powers and federalism) govern distributions of power among the three branches of government in the United States and define the roles of federal, state, and local governments in regulating education and its environment. Section II also briefly discusses key federal and state statutory laws concerning issues of discrimination, privacy, and educational programs, as well as concepts of civil liability and immunity for the acts of governmental agents in school settings.

This discussion helps provide the context for a review of policies and statutory, regulatory, and judicial laws at all levels of government within each of the eight components of a CSHP. Each section begins with a brief description of the component that helps frame the discussion of a host of relevant federal, state, and local laws. It then delves into how relevant laws influence the health of children and adolescents. Details of specific federal or state laws or programs may be provided. In other cases, summary statements of the effect of laws are set forth.

II. BRIEF OVERVIEW OF THE ROLE OF LAW IN SCHOOLS

Section II begins with an examination of the laws and policies at each level of government (federal, state, and local) concerning public education. It then reviews the limitations on state power to govern education, including a review of (1) religious influences on public schools, (2) constitutional limits on instructional programs, and (3) student privacy. A number of principles that limit school-based discrimination (eg, equal protection) are addressed thereafter, followed by a discussion of civil liability and immunity. Together, these subsections provide an overview of the role of law in schools and address a number of questions that arise in connection therewith, including: (1) What roles do federal, state, and local laws generally play in determining school policies? (2) What are the precise limits on state power to govern education, and what factors influence school programs and curriculum? and (3) What laws and legal principles limit potential school-based discrimination and afford protection to vulnerable children?

A. The Role of Federal, State, and Local Laws in Public Education

The nation's educational system features a complex array of public, private, and religious entities that operate schools of varying design, grade levels, populations, and quality. Public schools are the predominant component of the US educational system. There are more than 96,000 public schools in the United States responsible for educating 48 million students annually.[10] Eighty-eight percent of US school-aged children are enrolled in public schools.[11] Among US children and adolescents in school, 98% are enrolled in schools that offer comprehensive educational programs and services. The remaining 2% attend alternative schools focusing on special or vocational education or other alternative programs.[12] The nation's children and adolescents, schoolteachers, and other staff collectively spend millions of hours in school settings each year involved in not only education but also extracurricular activities, special meetings, and other community events. Accordingly, the school setting and the laws and regulations governing the public education process have an important impact on child and adolescent health as well as the health of school staff. This section provides some important background about the role of law in the school environment as a pretext for the remainder of the report that looks closely at specific health-related laws and policies affecting public schools.

1. Federal Government

Although the right to education is explicitly provided in every state's constitution,[13] there is no explicit federally guaranteed right to education within the US Constitution.[14] Federal constitutional protection of the right to education occurs through the application of the Fourteenth Amendment's guarantees of due process and equal protection to ensure that state educational laws are applied fairly and without discrimination.

Historically, the federal government has been active in using its limited powers over educational policy to protect and advance the educational rights of children. Early participation of the federal government in the provision of public education involved the issuance of land grants to establish educational institutions during the late 18th and 19th centuries and requirements that states have educational provisions in their laws.[15]

Although the US Constitution does not specifically address education, it bestows on states the principal authority to regulate education. Under the Tenth Amendment, powers not delegated to the federal government by the Constitution are reserved to the states or the people. The Tenth Amendment and underlying principles of federalism (ie, dividing powers between a central government and political subdivisions) accordingly reserve to the states the power to establish, operate, and regulate systems of public education, provided that state actions do not violate any constitutional guarantees.[16]

The federal government collaborates with state and local governments to improve the public education system. Among its delegated powers via the Constitution, the federal government has the power to regulate interstate commerce,[17] as well as to tax and spend.[18] Education is considered fundamental to commerce

among the states because of the importance of knowledge and literacy to the development of commercial activity and scientific advancement.[19] Through its interstate commerce power, Congress may, for example, regulate the distribution of illicit drugs near schools in the interest of protecting children and adolescents.[20] Federal power to regulate commerce is limited. It is consistently balanced against competing sovereign interests of states through principles of federalism and separation of powers. Several examples of this balance at work are discussed in section III.

Federal agencies, including ED, frequently use their spending power to influence or establish educational policies by conditioning the receipt of federal funds on the fulfillment of certain education policies.[21] For example, the No Child Left Behind Act (NCLB) was passed in 2001 to reauthorize the federal Elementary and Secondary Education Act (ESEA) of 1965[22] and tie federal funds to the implementation of policies outlined in the ESEA. The purpose of the NCLB is to ''ensure that all children have a fair, equal, and significant opportunity to obtain a high-quality education and reach, at a minimum, proficiency on challenging State academic achievement standards and State academic assessments'' by:

1. ''Ensuring that high-quality academic assessments, accountability systems, teacher preparation and training, curriculum, and instructional materials are aligned with challenging State academic standards.
2. Meeting the educational needs of low-achieving children in high-poverty schools, limited English proficient children, migrant children, children with disabilities, Indian children, neglected or delinquent children, and young children in need of reading assistance.
3. Closing the achievement gap between high- and low-performing children, especially the achievement gaps between minority and nonminority students, and between disadvantaged children and advantaged peers.
4. Holding schools, local educational agencies, and states accountable for improving the academic achievement of all students.
5. Identifying and improving low-performing schools that have failed to provide a high-quality education to their students.
6. Distributing and targeting resources to make a difference in local educational agencies and schools where needs are greatest.
7. Improving and strengthening accountability, teaching, and learning by using state assessment systems designed to ensure that students are meeting challenging state academic achievement and content standards and increasing achievement overall, especially for disadvantaged students.
8. Providing greater decision-making authority and flexibility to schools and teachers in exchange for greater responsibility for student performance.
9. Providing children an enriched and accelerated educational program, including the use of school-wide programs or additional services that increase the amount and quality of instructional time.
10. Promoting school-wide reform and ensuring the access of children to effective, scientifically based instructional strategies and challenging academic content.
11. Significantly elevating the quality of instruction by providing staff in participating schools with substantial opportunities for professional development.
12. Coordinating services with other educational services, and, where feasible, with other agencies providing services to youth, children, and families.
13. Affording parents substantial and meaningful opportunities to participate in their children's education.''[23]

The NCLB requires each state to develop academic standards, establish a system for assessing whether those standards have been met, and implement a single, statewide accountability system to ensure that local educational agencies and public elementary and secondary schools make ''adequate yearly progress.''[24] States must develop academic standards for all public elementary and secondary students for mathematics, reading or language arts, and science. These subjects are emphasized as the primary means of determining the yearly performance of state and local educational agencies and their schools.[25] Schools that fail to make adequate yearly progress are subjected to assistance and corrective action.[26] For example, if a school fails to make adequate yearly progress for two consecutive years, parents may transfer children to another public school (or public charter school) that is performing at a higher level.[27]

To effectuate the NCLB, Congress grants funds to SEAs and LEAs. Receipt of these funds is contingent on the implementation of policies focused on improving literacy; educating migratory children; meeting the needs of neglected, delinquent, and at-risk youth; engaging in comprehensive school reform; establishing advanced placement programs; preventing adolescents from dropping out of school; and generally improving schools.[28] The grant-making and accountability components of the NCLB are designed to bring about reform in schools in high-poverty areas and promote access to scientifically based and challenging instructional methods and content.[29] The NCLB thus seeks to improve school performance by encouraging public schools to (1) adopt challenging academic content and achievement standards, (2) establish yearly progress objectives for all students,[30] and (3) administer tests to measure the achievement of the educational goals and to make reports regarding the results.[31] States

do not have to accept the conditions attached to federal grants. In practice, however, federal funds are rarely turned down. Although the NCLB provides standards to improve overall school performance, it does not address a number of issues that affect the quality of education received by many children (see section III.C, *infra*, concerning Equal Protection and Other Principles Limiting School-Based Discrimination).

ED has principal responsibility for implementing federal educational policies and programs. It was formed with the intended purpose of supplementing the efforts of SEAs and LEAs to improve the quality of education.[32] ED is also responsible for managing federal education funds to states and localities. It provides approximately $38 billion to states and school districts (mostly through formula-based grant programs).[33] Through its Office of Elementary and Secondary Education, ED conducts independent research and evaluations to assess the quality of state-based education and to improve educational programs. It is also responsible for enforcing antidiscrimination protections and ensuring equal access to education.[34]

Other federal agencies also engage in activities affecting school environments. For example, the CDC, as part of the US Department of Health and Human Services (DHHS), assists states in the implementation and evaluation of school health programs designed to prevent health risks for children, adolescents, and young adults.[35] The US Environmental Protection Agency's (EPA) Healthy School Environments initiative focuses on preventing and resolving environmental health issues in schools. One of the EPA's most important tasks in this regard is to provide school districts with resources to assess the physical condition of school buildings and other facilities.[36] This includes assessments of chemical use and management, building design, construction and renovation, waste, water, safety and preparedness issues, and indoor and outdoor air quality.[37] (See section III.F for additional information.)

Other federal agencies also are involved in regulating various aspects of schools and public health. For example, the US Department of Agriculture (USDA) oversees the National School Lunch Program (NSLP) administered federally by the Food and Nutrition Service in cooperation with SEAs. Participating schools receive cash subsidies from the USDA for each meal they serve. The federal Office for Civil Rights implements a number of statutes, including Title VI of the Civil Rights Act that prohibits discrimination on the grounds of race, color, or national origin in denying the benefits afforded under any program receiving federal financial assistance from the ED. The US Department of Justice's (DOJ) Office of Community Oriented Policing Services (COPS) has several school-based programs including COPS in Schools, School-Based Partnerships, and the Safe Schools Initiative. In fiscal year 2002, DOJ established the Secure Our Schools program to provide schools in more than 187 jurisdictions with $15 million to address the security needs of children and adolescents on school grounds. The Department of Defense manages schools on military bases domestically and overseas and the Department of the Interior manages a national education system for American Indian children and adults.

2. State Governments

The states' powers to regulate public education emanate from their police powers and the doctrine of *parens patriae* reserved via the Tenth Amendment of the US Constitution. State police power is an essential component of state sovereignty. It is defined as the state's power to act in the interest of protecting the health, safety, and general welfare of the populace.[38] This includes the power to establish and operate educational systems.

Massachusetts was the first state to pass a compulsory education law in 1852. It required schooling for children ages 8-14 for at least 12 weeks per year. Many additional states followed suit in ensuing years with similar compulsory education laws.[39] Implementation of these laws was initially difficult, given limitations on access to educational resources and social constraints. By the 1920s, compulsory education was generally accepted.[40] Today, all states require children of specific ages (usually 6-16) to receive some form of educational instruction.[41]

The legal authority to compel school attendance is rooted in the common law doctrine of *parens patriae*. Under this doctrine, the state is considered a parent to all its citizens, especially vulnerable persons such as children and other wards of the state, and thus has a responsibility to provide for an individual's welfare.[42] Although parents have significant discretion regarding how they raise their children (consistent with constitutional principles of liberty), the doctrine of *parens patriae* allows the state to interfere to protect the welfare of children. State-sanctioned actions pursuant to the *parens patriae* power include compelling school attendance to provide for the education and social welfare of children.[43]

Specific state education regulations derive from multiple sources of law. First, all states establish the right to an education in their constitutions.[44] Thus, state governments control considerable parts of public educational systems. State legislatures are responsible for establishing a system of uniform public education,[45] including setting minimum curriculum and educational requirements for students.[46] In this context, a curriculum constitutes a written course of study that generally describes students' behavioral expectations and learning objectives for a particular subject area at a certain grade level.

State executive agencies also have significant powers (usually delegated via statute) concerning

public education systems. Generally, state agencies (eg, state education departments or boards of education) are responsible for implementing relevant state laws and overseeing the administration of public education systems. All states have state school regulatory agencies and boards that regulate the conduct of education in the state through minimum accreditation standards by which local school districts must abide.[47]

3. Local Governments

Although state governments retain full and complete jurisdiction over the provision of public education, most states delegate certain powers over the regulation of schools to local school districts. All states have local school boards that are responsible for the administration of public schools.[48] Nationwide, there are more than 14,500 local school districts.[49] Generally, school board officials are either appointed by local government officials or elected by popular vote. School board members are limited in their ability to act independently, as decisions are typically made by generating or determining the consensus of the entire board.

The scope of power of local school boards varies from state to state depending on the extent of state delegation. In states with a deeply rooted tradition of local control over education, such as Colorado, local boards have more latitude in making pedagogical decisions about schools. In states with more centralized educational systems, such as Florida, local school boards are subject to state legislative directives regarding schools. Local school boards generally are permitted to act with some discretion within the limits of their delegated powers, which may include the ability to determine the specifics of the curriculum, raise revenue for the purpose of maintaining schools, and hire personnel.[50] Localities may also administer related school services including the operation of a cafeteria,[51] establishment of school health inspection departments,[52] implementation of school athletic activities and sports teams, and provision of guidance counseling. Concerning curriculum, the state may set minimum standards regarding subjects to be taught; however, localities typically determine the instructional methods and materials.

B. Limitations on State Power to Govern Education

Although states generally have broad power to regulate schools, they exercise their power within certain limits. The US Constitution provides individuals with rights that cannot be abridged by state education requirements. For example, the First Amendment protects the free exercise of religion. The Fourteenth Amendment provides individuals with substantive and procedural due process protections. Furthermore, federal privacy laws restrict access to certain data about students. These and other restrictions set boundaries on states' educational and school policies that influence student health.

1. Religious Influences on Public Schools

The state's power to compel education is limited by the First and Fourteenth Amendments of the US Constitution. The First Amendment provides that ''Congress shall make no law respecting an establishment of religion [the Establishment Clause] or prohibiting the free exercise thereof [the Free Exercise Clause].'' The Establishment Clause primarily prohibits the government from taking action that advances religion. Thus, public schools may not teach religious doctrine. Conversely, the Free Exercise Clause focuses on governmental actions that dampen or infringe the practice of religion. State compulsory education laws, therefore, may not interfere with individuals' rights to practice religious beliefs or rituals or parents' abilities to determine the religious upbringing of their children.[53] Inevitable trade-offs surface in governments' attempts to respect religious freedoms without supporting specific religious beliefs. As discussed later, for example, schools must respect an individual's choice to refrain from school vaccination requirements based on religious beliefs despite the potential impact on student health.

For public educational policy to withstand scrutiny under the Establishment Clause, the US Supreme Court held in 1971 in *Lemon v Kurtzman* that a policy must have a secular purpose, have a primary effect which neither advances nor impedes religion, and avoid excessive government entanglement with religion.[54] Subsequent cases have marginalized these rules, seeking more general standards of neutrality toward religion.[55] The Establishment Clause has been used to prohibit various religious activities in schools, including coerced prayer in the classroom[56] and recitation of the Pledge of Allegiance.[57] The NCLB imposes new administrative obligations on schools regarding prayer. To qualify for NCLB funding, local educational agencies must certify that they do not have any policies that prevent or deny participation in ''constitutionally protected prayer in public elementary schools and secondary schools.''[58]

2. Constitutional Limits on Instructional Programs

Modern public school systems are built on a model of academic freedom that derives from recognizing institutional autonomy.[59] States may determine appropriate subjects for the classroom, designate the grades (K-12) in which these subjects are taught, and use a textbook adoption process to decide which textbooks can be used by teachers in public schools. Local school boards may supplement the curriculum, provided that state minimum standards are met.[60] Although some states and many districts determine the main course materials (curricula or textbooks), teachers retain

significant latitude within the defined curriculum concerning their teaching methods, presentation of ideas, setting of course assignments, and selection of course materials. Yet, even within this academic model, state-based curricula are limited by federal and state constitutional guarantees.

The principle of substantive due process applies in public schools to protect the rights of students and their families and ensure fairness and justice in the education process. Constitutional due process norms regard the right to education as a fundamental component of an individual's liberty interests, which entitles individuals to various protections from infringements of these rights under the Fourteenth Amendment (no state shall ''deprive any person of life, liberty, or property, without due process of law'').[61] In 2000, the US Supreme Court in *Troxel v Granville* reaffirmed that under the substantive due process clause, parents have a liberty interest in the ''care, custody, and control of their children.''[62] In its opinion, the Supreme Court cited two prior Supreme Court cases that addressed this right in the context of education.

In *Meyer v Nebraska* (1923), the Supreme Court found unconstitutional a Nebraska statute which made it a crime to teach a foreign language in schools until after eighth grade or to teach any subject in any language other than English, stating that parents had the power ''to control the education of their own child.''[63] In the second case, *Pierce v Society of Sisters* (1925), the Court invalidated an Oregon statute requiring parents to send their children (between the ages of 8 and 16) to public school or face criminal prosecution. The Court held that the law ''unreasonably interferes with the liberty of parents and guardians to direct the upbringing and education of children under their control''[64] and thus allowed parents to send their children to private school.

Parents have argued to courts that *Meyer* and *Pierce* give them the right to decide what topics can be taught to their children in school. Courts have rejected this claim distinguishing between the right of parents to decide where to send their child to school and the right of schools to decide upon the actual curriculum. Parental freedoms do not encompass ''a fundamental constitutional right to dictate the curriculum at the public school to which they have chosen to send their children. . . .''[65] For example, in one particularly strong decision, the Ninth Circuit Court of Appeals held that a parent's right to control a child's education ''does not extend beyond the threshold of the school door.''[66] This decision, which involved a specific challenge to a school's health curriculum, provides strong support for school health education programs. Of course, instructional methods or materials that conflict with constitutional norms are not tolerated. Thus, a school system that condones discriminatory teachings related to protected classes (eg, ethnic or religious groups) may be required to change its curriculum to avoid unwarranted infringements of rights under the First Amendment establishment and free speech clauses and the Fourteenth Amendment due process (and equal protection) clauses.

Procedural due process safeguards protect public school students from unjust denials of access to public education. They include a plethora of procedural rights including proper notice of particular violations, opportunities to be heard, and potential hearing and appellate rights. For example, in the case of a student who has violated a code of conduct, the school must afford the student a hearing and give the student proper notice before proceeding with a suspension or an expulsion.[67] Laws vary across the states concerning the precise requirements and procedures governing suspension and expulsion.

The First Amendment protects individuals' interest in freedom of speech and religion. In doing so, it limits schools' design and delivery of instructional curricula. For example, the Establishment and Free Exercise Clauses preclude states from barring public school instruction on certain issues because of an alleged conflict with religious views. Public schools cannot bar education on evolution[68] or compel education on creationism[69] for religious reasons. A 2005 federal court decision in Pennsylvania struck down a school board policy requiring teachers to make students aware of theories regarding the origin of life other than evolution and to read a statement specifically mentioning intelligent design as an alternate theory.[70] The court held that the policy was unconstitutional under the Establishment Clause because the policy constituted an establishment of religion by endorsing intelligent design, which the court interpreted to be an extension of creationism.

In *Hazelwood v Kuhlmeier*,[71] the US Supreme Court in 1988 held that a public school and its principal did not violate the First Amendment in directing a student newspaper to withhold two articles regarding students' pregnancy experiences and the impact of divorce. The Court found that the newspaper was not a forum for public expression and that educators are entitled to exercise some control over school-sponsored publications, as long as controls are reasonably related to legitimate pedagogical concerns.

The First Amendment also protects freedom of speech in support of teachers' academic freedoms of inquiry, research, teaching, and extramural utterances and actions.[72] The classroom is a marketplace for the robust exchange of ideas. Students should be able to speak freely and open their minds to new and provocative ideas.[73] However, school board decisions reflecting the ''legitimate and substantial community interest in promoting respect for authority and traditional values, be they social, moral or political''[74] may still result in censorship of some teachings. Provided school authorities do not engage in flagrant abuses of

discretion in making determinations regarding instructional curricula, First Amendment protections are not infringed.

Although the principle of academic freedom is important in protecting students' rights to learn and teachers' educational practices, teachers are not permitted to transform the prescribed curriculum into something other than what the school intends it to be,[75] especially in public schools where state and local school boards exercise a great deal of oversight over the curriculum. Public school teachers do not have broad latitude to teach outside the prescribed curriculum. For example, they may lack authority to assign texts from outside the standard curriculum or to choose their own classroom management techniques or pedagogical methods.[76] Academic freedom does not protect a teacher from limitations imposed by school policy on the nature of biological and sexual education provided to students.[77]

3. Student Privacy

The educational process necessarily involves the collection of a great deal of student data, including information regarding students' identities, test scores, grades, attendance, and extracurricular activities. During the course of providing health or special education services to students, schools also may collect health information (eg, personal health indicators and immunization records) about students. Described below are three federal laws that govern privacy protections of students' personal information: the Family Educational Rights and Privacy Act (FERPA),[78] the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule,[79] and the Protection of Pupil Rights Amendment (PPRA).[80]

FERPA, which applies to any school receiving funds from an applicable ED program, recognizes the importance of the individual student's and/or parent's right to control access to or disclosure of her educational records. Protected educational records include any identifiable information directly related to the student that is maintained by the school. For minor students, educational records covered by the statute include health records maintained by the school. The statute conditions the receipt of federal educational funds on the adoption of policies that allow parents or students (once they have reached the age of 18 or have begun postsecondary education) the right to access the student's own educational records and requires their consent prior to permitting disclosure of the records. Where a school employs an outside entity (eg, a clinic) to deliver health services, the health records will be covered under FERPA. Even if the clinic is not on school grounds, access to a student's personal identifiable health information may be predicated on parental consent. Consent is not required, however, when the information is disclosed to individuals or entities including, but not limited to, (1) school officials with a legitimate educational interest, (2) other school districts pursuant to a student transfer, (3) the authorized representative of state educational authorities, (4) state or local authorities regarding financial aid, (5) an accrediting body,[81] or (6) in emergencies, health information about a student to the appropriate persons to protect the health and safety of that student and other students and staff. Parents and students also have the right to request that the school corrects the records if they believe them to be inaccurate; if the school refuses to do so, the parent or student can request a formal hearing.

The HIPAA Privacy Rule represents the first national standard for health information privacy protections.[82] It provides comprehensive privacy protections of identifiable health data for most individuals seeking health care or health insurance in the United States. It restricts the use and disclosure of protected health information (PHI) without the consent of the individual. The rule specifically applies to PHI used or disclosed by covered entities. Covered entities include health plans (eg, health insurance companies, managed care entities, and specified government health programs), health care clearinghouses (eg, billing services, repricing companies, or community health information systems that process health data), and health care providers (eg, doctors, hospitals, and clinics) that conduct certain administrative and financial transactions electronically.[83]

Schools that operate health centers (ie, school-based health centers [SBHCs]) that deliver health care services directly to students may be considered health care providers, or as engaging in ''covered functions,'' so as to implicate Privacy Rule protections for the resulting health data. Other health care providers who provide health services to students in schools may have to adhere to HIPAA Privacy Rule requirements. However, confusion may arise over whether FERPA applies to the health data as part of the student's education record. The HIPAA Privacy Rule specifically excludes education records covered under FERPA from its protections. The distinguishing point is whether the health data produced are considered part of the student's education record. If so, FERPA (and not HIPAA Privacy Rule) would apply. Many SBHCs may be considered distinct or detached from the educational institution. Health data arising from the provision of health care to students through these centers or other non-education-based providers would not be part of the student's education record. As a result, the data may be protected via the HIPAA Privacy Rule.[84]

According to ED, PPRA applies to the programs and activities of an SEA, LEA, or other recipient of funds under any program funded by the department.

It governs the administration to students of a survey, analysis, or evaluation that concerns one or more of the following eight protected areas:

1. Political affiliations or beliefs of the student or the student's parent.
2. Mental or psychological problems of the student or the student's family.
3. Sex behavior or attitudes.
4. Illegal, antisocial, self-incriminating, or demeaning behavior.
5. Critical appraisals of other individuals with whom respondents have close family relationships.
6. Legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers.
7. Religious practices, affiliations, or beliefs of the student or student's parent.
8. Income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program).

PPRA also concerns marketing surveys and other areas of student privacy, parental access to information, and the administration of certain physical examinations to minors. The rights under PPRA transfer from the parents to a student who is 18 years old or an emancipated minor under state law.

LEAs must provide parents and eligible students effective notice of their rights under PPRA. The notice must explain that an LEA is required to obtain prior written consent from parents before students are required to submit to a survey that concerns one or more of the eight protected areas listed above if the survey is funded in whole or in part by ED. For surveys not funded in whole or in part through ED that contain questions from one or more of the eight protected areas, LEAs must notify a parent annually at the beginning of the school year of the specific or approximate date(s) of the survey and provide an opportunity to opt his or her child out of participating. LEAs must also notify parents that they have the right to review, upon request, any instructional materials used in connection with any survey that concerns one or more of the eight protected areas and those used as part of the educational curriculum.

PPRA also requires schools to work with parents to establish policies regarding the right of a parent or student to inspect a survey or evaluation and related instructional materials before it is administered, measures that must be taken to protect student privacy regarding information obtained through surveys or other evaluations, the administration of physical examinations or screenings, and the collection, disclosure, or use of personal information obtained from students for the purpose of marketing or otherwise selling that information.[85]

C. Equal Protection and Other Principles Limiting School-Based Discrimination

The Fourteenth Amendment Equal Protection Clause broadly protects similarly situated individuals from unwarranted governmental discrimination on the bases of race, ethnicity, religion, and other protected classes. As venues for government-sponsored education, public schools are subject to constitutional mandates regarding equal protection[86] and corresponding civil rights laws largely driven by cases regarding access to education. The US Supreme Court's seminal decision in *Brown v Board of Education of Topeka*[87] led to racial desegregation in public schools. Together with federal civil rights statutes, *Brown* and other desegregation cases tie equal access to education to principles of equal protection for all persons.

With regard to schools and child and adolescent health, various federal civil rights laws (and corresponding state provisions) protect individuals from unwarranted discrimination. For example, Title IX of the federal Education Amendments of 1972 protects students and employees of educational institutions, including public schools, from discrimination based on their sex.[88] Subject to exceptions, ''[n]o person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance. ... ''[89] The impact of Title IX on the level of participation in elementary and high school sports and other physical education programs has been tremendous. In 1971, prior to the passage of Title IX, approximately 3.7 million boys and only 294,000 girls participated in high school sports. In 2002, 3.9 million boys participated in high school sports; the participation of girls had increased to 2.8 million.[90]

Antidiscrimination protections for persons with disabilities are important. In 2000, 3.9 million children in public schools (K-12) had some form of disability.[91] Eleven percent of all students between ages 6 and 13 receive some form of special education services.[92]

Section 504 of the Rehabilitation Act of 1973 was the first federal statute to ban discrimination against individuals on the basis of disabilities.[93] ''No otherwise qualified individual with a disability in the United States ... shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.''[94] Section 504 applies to the federal government, federal contractors, and any recipient of federal financial assistance, including state and local public schools. As recipients of federal assistance, public school authorities are required to comply with the Rehabilitation Act with respect to students and employees.[95] Section 504 imposes an affirmative obligation on schools to develop individualized accommodation

plans for students with disabilities to ensure that the student's disability will not limit her ability to benefit from educational programs.[96]

Similar prohibitions for public and private sector disability discrimination are featured in the Americans with Disabilities Act (ADA).[97] Like section 504 of the Rehabilitation Act, the ADA prohibits discrimination against individuals with disabilities. The ADA also applies to employers, the activities of state and local governments, and public accommodations operated by private entities. Title II (''Public Services'') of the ADA prohibits discrimination by public entities, including any state or local government, or any department or agency within a state or local government.[98] Public schools are thus obliged to adhere to Title II. They must make reasonable accommodations for students with protected disabilities to participate in school activities and make their facilities and other services accessible to disabled students.[99]

The protections of section 504 of the Rehabilitation Act and the ADA extend to disabled persons who have a physical or mental impairment that substantially limits at least one of the person's major life activities,[100] individuals with a history of physical or mental impairments, and people perceived to have such impairments.[101] As to the first category of protected individuals, a diagnosis from the student's treating physician, with optional confirmation by the school nurse, must support the existence of a physical or mental impairment.[102] Determining whether an individual's ability to perform major life activities (eg, personal hygiene, seeing, hearing, walking, breathing, speaking, learning, and working[103]) is substantially limited by the impairment requires a complex evaluation of the extent of the individual's limitations. An individual is considered to have a substantial limitation when he is unable to perform the activity that the average person in the general population can perform or is significantly restricted as to the condition, manner, or duration under which he can perform a particular activity as compared to an average person in the general population.[104]

In 1975, Congress passed the Education for All Handicapped Children Act (EAHCA),[105] which focused on providing specialized education to children with special health care needs, particularly those in regular public or private school systems.[106] In 1990, EAHCA was reauthorized as the Individuals with Disabilities Education Act[107] (IDEA) to provide enhanced protections for the right of all disabled children to a public school education. IDEA was subsequently amended in 2004 as the Individuals with Disabilities Education and Improvement Act (for the purpose of reference, the use of ''IDEA'' hereinafter denotes the Act, including its 2004 amendment). IDEA establishes that all children have a right to a ''free and appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living.''[108]

The Act concentrates on children's educational needs as related to their physical, mental, emotional, developmental, and learning disabilities. Federal enforcement of IDEA is overseen by the ED's Office of Special Education and Rehabilitation Services.[109] State and local boards of education typically oversee and implement their own special education programs. IDEA overlaps with section 504 of the Rehabilitation Act because students entitled to special education services generally qualify as disabled students under the Rehabilitation Act.[110]

Under IDEA, a disability is defined as ''mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, ... orthopedic impairments, autism, traumatic brain injury, or other health impairments or specific learning disabilities.''[111] A child who is diagnosed with any of the aforementioned conditions is eligible for special education and related services.

Students who do not qualify for services under IDEA may still be eligible for equal access accommodations under section 504, which does not require that a child needs special education to qualify for accommodations. Several legal principles form the foundation of IDEA, briefly summarized below:

- *Zero reject*—Local school districts are not permitted to exclude or discipline disabled students from public schools due to the nature of their disabilities.[112]
- *Child find*—Local school districts are required to seek out children with disabilities and inform parents of available special education services. School districts must locate, evaluate, and provide appropriate educational programs to all disabled students (from birth to age 21).[113]
- *Nondiscriminatory testing*—To provide children with disabilities with an appropriate diagnosis, educational plan, and placement, they must be assessed in a nondiscriminatory manner.[114] Special education testing, evaluation materials, and procedures must not be racially or culturally discriminatory.[115] Evaluation procedures must be sufficiently comprehensive and validated for the purpose for which they are being used and be administered by trained personnel.[116]
- *Individualized education program*—Every child with a disability is entitled to an individualized education program (IEP),[117] which includes two core components: a defined process for developing the educational program and the educational program itself to guide the course of the child's education.[118] IEPs are developed in collaboration with the parents, the child's general and special education teachers, and

the school district[119] and are based on an evaluation of the child's special education needs.[120]

- *Least restrictive environment*—The underlying assumption of IDEA is that the ''preferred placement for students with disabilities is in the regular classroom.''[121] Placements outside the regular classroom should only be considered when the nature or severity of the child's disability would require significant alterations of the regular educational setting.[122]
- *Procedural due process*—IDEA sets forth procedures for notification of school educational decisions and for mediation that are essential to facilitating the resolution of conflicts between parents, school officials, and other educational professionals.[123]
- *Parental participation*—Parents are considered to be an integral part of the education process. Their participation is fostered through IDEA via requirements for informed consent regarding the initial consideration for child placement in special education, participation in IEP development, and rights to challenge decisions of the school through mediation and other procedures.[124]

The IDEA is a model of cooperative federalism in that it grants states flexibility to develop and execute programs for children with disabilities. At the same time, it imposes strict requirements including cooperation and reporting between state and federal educational authorities. Accordingly, it can be challenging for school districts and parents to determine the extent of services to provide all children who may have special health care needs.

In the early 1990s, the federal Maternal and Child Health Bureau's Division of Services for Children with Special Health Care Needs created a working group to recommend a preferred conceptual definition of children with special health care needs. The group developed the following definition: ''Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.''[125] Under this intentionally broad definition, approximately 12.8 million minors (15.6%) in the United States had a special health care need in 2001.[126]

There is an overlap between the definition of children with special health care needs proffered by the Material and Child Health Bureau and the definition of a disabled child under the IDEA. Aside from the specific ailments from which a child may suffer (eg, speech and visual impairment, autism, and brain injury), a disability may encompass ''other health impairments.'' There is no doubt that children with special health care needs suffer from ''health impairments.'' Notwithstanding, the extent to which a school is required to provide specific health-related services is debatable. Identifying what constitutes a legitimate disability under the IDEA has been problematic because of difficulties in distinguishing between specific learning disabilities, serious emotional disturbance, and mild mental retardation.[127] Moreover, the US Supreme Court in *Schaffer v Weast* (see section III.H.2) determined that the burden of demonstrating whether an IEP is valid rests with the parents of the disabled child.

The second consideration is that the distribution of children with a specific disability or special health care need may vary across states depending on its prevalence in a particular geographic area and other factors. Thus, seemingly disparate treatment plans that may suggest a violation of equal protection rights may be found upon legitimate, albeit complex, decisions that contemplate the actual costs affiliated with establishing an appropriate IEP for each and every eligible student.

Factors such as geographic diversity and the large expenditure of health care resources for children with special health care needs obfuscate whether a particular state is allocating its resources in an efficient and just manner. For school districts, it is imperative that their policies meet the legal threshold for purposes of statutory compliance. In *Irving Independent School Dist. v Tatro*,[128] the US Supreme Court did not consider cost as a viable factor to deter the school district's requirement to provide a disabled child with a particular health-related service.

D. Civil Liability and Immunity

Within the school environment, two legal principles guide teachers' obligations: reasonableness and *in loco parentis*. Teachers are authorized to act in a reasonable fashion as necessary to foster and develop an appropriate learning environment.[129] The bounds of reasonableness limit the jurisdictional reach of the school's authority beyond school grounds and the nature and degree of discipline exercised by the school.[130] The principle of *in loco parentis* (''in place of the parent'') refers to the supervisory relationship between teachers and students. It supports the ability of teachers to broadly oversee students in a variety of ways.[131] The principle of *in loco parentis* was further defined by a Nebraska court in 1933:

> General education and control of pupils who attend public school are in the hands of school boards, superintendents, principals and teachers. This control extends to health, proper surroundings, necessary discipline, promotion of morality and other wholesome influences, while other parental authority is temporarily superseded.[132]

Though the nature and extent of authority over students by teachers and school authorities are critical to the educational environment, they also lend to

themes of liability under tort law when students are harmed or injured. The law of torts involves the rights of private parties to obtain compensation from those who cause them harm. School tort actions typically fall into three categories: negligence, intentional torts, and defamation. Negligence suits are most often brought against schools or individual personnel when children sustain physical injuries on school grounds.[133] Claims of negligence require proof that the school or its agents breached a duty of supervisory care toward the student, that the breach caused the student's injury, and that breach resulted in damages. Negligence themes (consistent with medical malpractice) may also support a case against a school health provider regarding the provision of medical services to students.

Intentional torts arise when one person takes purposeful, wrongful actions that injure another. Common intentional torts in the context of schools include assault, battery, false imprisonment, and intentional infliction of emotional distress.[134] An assault occurs when an individual places another person in fear of bodily harm.[135] A battery requires physical contact that typically leads to injury.[136] Assault and battery claims in the school setting may arise in cases of corporal punishment or where children are injured as a result of bullying or physical aggression toward one another.[137] Concerning corporal punishment, a teacher is permitted to use *reasonable* force against students to control their behavior[138] or in self-defense.[139]

False imprisonment involves the use of a physical action to restrain or detain an individual against her will.[140] Such actions need not involve the use of physical force to detain the victim; intimidation through verbal commands or the deprivation of a means to flee (eg, blocking doors) may suffice. False imprisonment may be claimed against a school or its agents for unjustified use of a physical or other restraint against students.[141] A claim for intentional infliction of emotional distress requires outrageous conduct by an individual that intentionally causes or recklessly disregards the probability of causing emotional distress.[142] Some jurisdictions require a physical injury to accompany an individual's emotional distress.[143] Such claims often apply in cases of discrimination, harassment, student discipline, or physical aggression between students.[144]

The tort of defamation may also arise in a school context. Defamation claims, which include slander (spoken defamation) or libel (written defamation), involve four elements: (1) a false and defamatory statement concerning another person, (2) the unprivileged publication (written or spoken) of the statement to a third party other than the person defamed, (3) fault amounting to at least negligence on the part of the person who communicated the information, and (4) damage to the person asserting defamation.[145] Defamation cases are often brought in the school context in cases of teachers who publicize a student's poor marks to members of the public or who disseminate negative school board comments about a teacher or administrator.[146]

Despite these and other liability themes, most public schools (as government entities) are protected from liability to some degree through the legal doctrine of sovereign immunity. State governmental immunity is grounded in tradition and reflected in the Eleventh Amendment to the US Constitution, which prohibits individuals from bringing private claims against the state. Many states' statutes specifically define the limits of the state's sovereign immunity. Some states have abolished general sovereign immunity but reserve its protections for specific circumstances.[147] Others retain sovereign immunity in most instances, subject to limited exceptions.[148] Washington is the only state to completely dispense with sovereign immunity for tort actions against the state.[149] In virtually every other state, tort claims acts waive the traditional sovereign immunity of government agents acting within their official duties. Governmental immunity provided for by statute generally extends to local governmental entities, including school districts, because they are considered subdivisions of the state.[150] State or local school districts that are not protected by sovereign immunity may still raise a number of applicable defenses against any claim.

III. LAW AND COORDINATED SCHOOL HEALTH PROGRAMS (CSHPs)

This section reviews laws and policies in each of the eight components of a CSHP.[151] A CSHP is a planned and organized set of courses, services, policies, and interventions designed to meet the health and safety needs of K-12 students. Schools that adopt a CSHP promote optimal physical, emotional, social, and educational development of students by providing health education, physical education, health services, nutrition services, mental health and social services, and a healthy and safe environment and by promoting family and community involvement and staff wellness.[152] A successful and well-coordinated school health program is characterized by the presence of administrators, teachers, other professional staff, and school board members who view health protection and promotion as an essential part of the school's mission; a school health council composed of school, family, and community representatives to ensure a planning process for continuous health improvement; a school health coordinator responsible for organizing and managing the school health program; and school staff who help plan and implement a full array of school health courses, services, policies, and programs.

Each lettered section below first introduces the scope of the specific CSHP component to frame the

following discussion of relevant federal, state, and local laws and policies. Specific examples of state or local laws are given although comprehensive tables of laws are not provided (these may be referenced from other sources). Some sections also present findings from relevant studies, including the School Health Policies and Programs Study 2006 (SHPPS 2006), which examined school health policies and programs in grades K-12 at the state, district, school, and classroom levels.

A. Health Education

In the CSHP model, health education is defined as a planned, sequential K-12 curriculum that addresses the physical, mental, emotional, and social dimensions of health. The curriculum is designed to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors. It allows students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills, and practices. The comprehensive health education curriculum 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.[153]

In its Compendium of National Health Goals, *Healthy People 2010*,[154] the DHHS addressed school health education in objective 7-2, which states the need to ''[i]ncrease the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health.''[155] Objective 7-2 calls for increasing the percentage of schools providing health education in these priority areas from 28% at baseline year 1994 to 70% by 2010 (an overall increase of 150%).

Health education is essential to child and adolescent health because it enables children to make decisions that can maintain and improve their health over their lifetime. This section explores what is legally required of public schools concerning student health education through these questions: Do federal, state, or local laws or policies require public schools to provide health education to students? What are the legal restrictions on providing health education to students? Do parents have the right to control what schools teach in health education courses? Does the federal government offer incentives to encourage particular types of health education? What is the role of National Health Education Standards (NHES)? Must schools follow a particular curriculum with respect to health education? Who is legally qualified to teach health education?

1. Legal Requirements to Provide Health Education to Students

SHPPS 2006 assessed health education policies and programs in grades K-12 at the state, district, school, and classroom levels.[156] The study found that more than 85% of states had adopted a policy stating that elementary, middle, and high schools will teach at least 1 of 14 health topics (chosen to reflect the leading causes of mortality and morbidity among both youth and adults and other important public health issues).[157] The most common health topic taught by elementary, middle, and high schools was alcohol use or other drug use prevention. Other subjects that may be required include injury prevention and safety, nutrition and dietary behavior, tobacco use prevention, and human sexuality.

As one illustration, Iowa law requires that high school students receive at least ''[o]ne unit of health education which shall include personal health; food and nutrition; environmental health; safety and survival skills; consumer health; family life; human growth and development; substance abuse and nonuse; emotional and social health; health resources; and prevention and control of disease, including sexually transmitted diseases and acquired immune deficiency syndrome. . . . ''[158] Iowa further provides that a student may be excused from a health course if the student's parent (or guardian) delivers to the school principal a written statement that the course conflicts with the student's religious beliefs.[159]

According to SHPPS 2006, 22% of states had adopted a policy stating that each school district will have someone oversee or coordinate school health education and 14% of states had adopted a policy stating that each school will have someone perform this function at the school (eg, a lead health education teacher). Among all districts, 43% had adopted a policy stating that each school will have someone oversee or coordinate health education at the school; nationwide 68% of schools designated someone in this capacity.[160]

Among the many potential subjects of health education, the topic of human sexuality is unique in its degree of regulation. Federal restrictions on sex education (under 20 USC §7906) prohibit recipients of federal funding under ESEA, as amended, to:

1. develop or distribute materials or operate programs or courses of instruction directed at youth that are designed to promote or encourage sexual activity, whether homosexual or heterosexual;
2. distribute or to aid in the distribution by any organization of legally obscene materials to minors on school grounds;

3. provide sex education or human immunodeficiency virus (HIV) prevention education in schools unless that instruction is age-appropriate and includes the health benefits of abstinence; or
4. operate a program of contraceptive distribution in schools.[161]

Although the US Secretary of Education may generally waive statutory or regulatory requirements for funding under ESEA, the secretary is explicitly prohibited from doing so with respect to restrictions on providing sex education under section 7906.[162]

2. Parental Rights Concerning Health Education

Courts have held that parents do not have the federal constitutional right (at least under substantive due process principles) to exempt their children from a required health education class[163] or an acquired immunodeficiency syndrome (AIDS) awareness assembly program.[164] However, state or local laws may give parents more rights. For example, West Virginia state law requires that the parent (or guardian) of a child who is to receive instruction on the prevention, transmission, and spread of AIDS and other sexually transmitted diseases (STDs) be given an opportunity to examine the course curriculum and instructional materials. Parents may exempt their children from participating in the instruction.[165] Penalties for failing to allow parents an opportunity to review the curriculum include misdemeanor charges and automatic termination for public school teachers, with no opportunity for reappointment to their existing or similar position for a year.[166]

New Jersey requires that sex education ''stress that abstinence from sexual activity is the only completely reliable means of eliminating the sexual transmission of HIV/AIDS and other sexually transmitted diseases and of avoiding pregnancy.''[167] In addition, instruction on using contraceptives or condoms must ''also include information on their failure rates for preventing pregnancy, HIV and other STDs in actual use among adolescent populations and shall clearly explain the difference between risk reduction through the use of such devices and risk elimination through abstinence.''[168] A parent (or guardian) may excuse his or her child from segments of courses on health, family life education, or sex education if the instruction conflicts with the parent's ''conscience, or sincerely held moral or religious beliefs.''[169]

California has enacted the ''California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act,''[170] which, among other things, allows parents (or guardians) to excuse their children from ''all or part of comprehensive sexual health education, HIV/AIDS prevention education, and assessments related to that education''[171] and explicitly recognizes ''the rights of parents or guardians to supervise their children's education on these subjects.''[172] Arizona,[173] Nevada,[174] and Utah[175] also have laws giving parents control over whether their children receive instruction on certain health-related topics (eg, prior notification and ability to withdraw their child from a class discussion of AIDS).

According to SHPPS 2006, among the 61% of districts that required schools teach about HIV prevention, human sexuality, other STD prevention, or pregnancy prevention, 85% had adopted a policy stating that elementary schools will notify parents or guardians before students receive the instruction and 92% had adopted a policy stating that elementary schools will allow parents or guardians to exclude their children from receiving the instruction.[176] Among the 86% of districts that required middle schools to teach HIV prevention, human sexuality, other STD prevention, or pregnancy prevention, 73% had adopted a policy stating that these schools will notify parents or guardians before students receive the instruction and 86% had adopted a policy stating that middle schools will allow parents or guardians to exclude their children from receiving the instruction. Among the 91% of districts that required high schools to teach HIV prevention, human sexuality, other STD prevention, or pregnancy prevention, 60% had adopted a policy stating that these schools will notify parents or guardians before students receive the instruction and 76% had adopted a policy stating that high schools will allow parents or guardians to exclude their children from receiving the instruction.

Although parents may not have a federal constitutional right to exempt their child from health education classes, the federal PPRA gives parents federal statutory rights concerning certain activities in schools that receive funding from the ED. For example, schools must develop and adopt policies (and notify parents of these policies) concerning a parent's right to inspect any instructional material used in the educational curriculum,[177] any survey that will be administered or disseminated by the school, and any instructional materials used in connection with any survey, analysis, or evaluation. Moreover, no student can be required to participate in a survey, analysis, or evaluation funded in whole or in part by ED that reveals information concerning, among other areas, mental or psychological problems of the student or the student's family or sex behavior or attitudes without prior written consent of a parent or prior consent of the student if the student is an adult or an emancipated minor.[178] For surveys that address the same topics but are not funded in whole or in part with ED funds, LEAs must notify a parent at least annually, at the beginning of the school year, of the specific or approximate date(s) of the survey and provide an opportunity to opt his or her child out of participating. Three states' laws (Alaska, New Jersey, and Utah) feature active permission requirements for

school surveys;[179] three additional states' laws (Colorado, Indiana, and Nevada) have active permission requirements if the survey is ''required.''[180]

3. Federal Incentives to Shape Health Education in Public Schools

Team Nutrition Network

The US Secretary of Agriculture, in consultation with the Secretary of Education, may award grants to state agencies ''to establish team nutrition networks to promote nutrition education through: (i) the use of team nutrition network messages and other scientifically based information; and (ii) the promotion of active lifestyles.''[181] The term ''team nutrition network'' refers to ''a statewide multidisciplinary program for children to promote healthy eating and physical activity based on scientifically valid information and sound educational, social, and marketing principles.''[182] ''Nutrition education'' is an important component of the program and features prominently in its stated purposes.[183] Among other things, a state may use program funding to develop model elementary and secondary education curricula that incorporate team nutrition network messages and material developed by the Secretary of Agriculture to create a comprehensive coordinated nutrition and physical fitness awareness and obesity prevention program.[184]

The Child Nutrition and Women Infants and Children (WIC) Reauthorization Act of 2004 (discussed later in section III.D.2) provides children with increased access to food and nutrition assistance. Under the Act, schools are required to adopt Local Wellness Policies that provide, at a minimum, (1) goals for nutrition education and physical activity, and other school-based activities, (2) nutrition guidelines for all foods available on school campus, (3) assurance that the guidelines for reimbursable school meals are not less restrictive than current guidelines issued by the Secretary of Agriculture as pertains to schools, (4) a designated person(s) charged with ensuring compliance with the wellness policy, and (5) involvement with community members, including parents, students, representatives of the school food authority, the school board, school administrators, and the public in the development of the policy.

Abstinence Education

Federal law establishes a program giving funding to states to provide abstinence education, and at the state's option, funding for mentoring, counseling, and adult supervision ''to promote abstinence from sexual activity.''[185] ''Abstinence education'' refers to an educational or motivational program that:

- Has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity.
- Teaches abstinence from sexual activity outside of marriage as the expected standard for all school-aged children.
- Teaches that abstinence from sexual activity is the only certain way to avoid pregnancy, STDs, and other associated health problems.
- Teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity.
- Teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects.
- Teaches that bearing children outside of marriage is likely to have harmful consequences for the children, the parents, and society.
- Teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances.
- Teaches the importance of attaining self-sufficiency before engaging in sexual activity.[186]

Funding for abstinence education programs became available in 1998. A multiyear review of the program was released in 2005.[187] A Government Accountability Office (GAO) report released in 2006 describes the oversight of federally-funded abstinence-until-marriage education programs. Specifically, the document reports on efforts by DHHS and states to assess the scientific accuracy of materials used in abstinence-until-marriage education programs and efforts by DHHS, states, and researchers to assess the effectiveness of abstinence-until-marriage education programs.[188]

Alcohol Prevention Education

The federal Safe and Drug-Free Schools and Communities Act authorizes state and local educational agencies[189] to receive federal funding for alcohol education in public schools through state grants and/or national programs.[190] For example, the Secretary of Education, in consultation with the Substance Abuse and Mental Health Services Administration (SAMHSA), may award grants to local educational agencies for development and implementation of ''innovative and effective programs to reduce alcohol abuse in secondary schools.''[191] In addition, a state can award part of its federal funding under the Act to local educational agencies for drug (and alcohol) use[192] and violence prevention and education programs and activities.[193] Authorized activities include those that teach students that most people do not illegally use alcohol and to recognize social and peer pressure to use alcohol illegally and the skills for resisting illegal alcohol use.[194] The Secretary of Education is explicitly precluded from prescribing the use of specific curricula for programs funded under the Act.[195] Local educational agencies must make reasonable efforts to inform parents (or guardians) of the content of programs or activities

funded under this Act other than classroom instruction. Parents may withdraw their children from any program or activity with a written notification to the local educational agency.[196]

As a condition of receiving funds under any federal program administered by the ED, schools are required to maintain a plan that includes appropriate discipline policies prohibiting the possession, distribution, or sale of alcohol.[197] Schools receiving Title IV funds should also implement a code of conduct policy that is distributed to the students and clearly states their responsibilities to maintain a safe and healthy educational environment.[198]

4. Role of National Health Education Standards (NHES)

According to SHPPS 2006, 75% of states and 79% of districts had adopted a policy stating that districts or schools will follow national or state health education standards or guidelines.[199] Most of these jurisdictions base their requirements or recommendations on the NHES,[200] updated in 2006 by the Joint Committee on National Health Education Standards and funded by the American Cancer Society.[201] The NHES seeks to educate students and improve health in the United States ''by providing a foundation for curriculum development, instruction, and assessment of student performance''[202] through eight core standards. A rationale is provided for each standard, and ''performance indicators'' are listed separately for grades K-4, 5-8, and 9-12. The performance indicators state what the students should know and be able to do as a result of their health instruction:

1. Comprehend concepts related to health promotion and disease prevention to enhance health.
2. Analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.
3. Demonstrate the ability to access valid information, products, and services to enhance health.
4. Demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.
5. Demonstrate the ability to use decision-making skills to enhance health.
6. Demonstrate the ability to use goal-setting skills to enhance health.
7. Demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.
8. Demonstrate the ability to advocate for personal, family, and community health.

5. Required Health Education Curriculum

SHPPS 2006 found that 6% of states required and 16% recommended that districts or schools use one particular curriculum for elementary school health education, 8% of states required and 10% recommended that districts or schools use one particular curriculum for middle school health education, and 8% of states required and 12% recommended that districts or schools use one particular curriculum for high school health education. Curriculum requirements were more common at the district than at the state level. Among all districts that provided elementary school instruction, 31% required and 27% recommended that schools use one particular curriculum for elementary school health education. Among all districts that provided middle school instruction, 37% required and 26% recommended that schools use one particular curriculum for middle school health education. Among all districts that provided high school instruction, 38% required and 25% recommended that schools use one particular curriculum for high school health education.[203] Teachers may be explicitly required to follow specific curricula. For example, under South Carolina's Comprehensive Health Education Act,[204] any public school teacher ''who refuses to comply with the curriculum prescribed by the school board'' can be dismissed.[205]

Though most schools provide a health education curriculum, the amount of classroom time allotted for health education, as well as grading and testing requirements, varies substantially among schools. Missouri, for example, requires its public schools to provide ''comprehensive health instruction, including tobacco, alcohol, and other drug prevention and HIV/AIDS prevention education'' through the Missouri School Improvement Program adopted by the Missouri State Board of Education.[206] Specifically, elementary school students ''must receive regular instruction,'' middle/junior high school students must receive at least 1500 minutes of instruction each year, and high schools must offer at least a one half credit for graduation.

6. Teacher Preparation and Professional Development Requirements

Health education is taught by various school staff members including regular classroom teachers in elementary schools, teachers of other subjects (eg, science and social studies) and health education teachers in secondary schools, physical education specialists or teachers, and Certified Health Education Specialists (CHES).[207] According to SHPPS 2006, 94% of states offer some type of certification, licensure, or endorsement to teach health education. In addition, 34% of all states and 34% of all districts had adopted a policy stating that newly hired staff who teach health education at the elementary school level will have undergraduate or graduate training in health education, 72% of states and 59% of districts had adopted this policy for newly hired staff who teach health education at the middle school level, and 82% of states and 78% of districts had adopted this policy for newly hired staff who teach health education at the high school level. Only 16% of

all states and 35% of all districts had adopted a policy stating that newly hired staff who teach health education at the middle school level will be CHES, and 18% of states and 41% of districts had adopted it for newly hired staff who teach health education at the high school level.[208]

B. Physical Education and Activity

In a CSHP model, physical education and activity is defined as a planned, sequential K-12 curriculum that provides cognitive content and learning experiences in a variety of activity areas such as basic movement skills; physical fitness; rhythms and dance; games; team, dual, and individual sports; tumbling and gymnastics; and aquatics. Quality physical education should promote, through a variety of planned physical activities, each student's optimum physical, mental, emotional, and social development and should promote activities and sports that all students enjoy and can pursue throughout their lives. Qualified trained teachers teach physical activity.[209]

Healthy People 2010 addresses school physical education in several objectives that recommend increasing: (1) ''the proportion of the Nation's public and private schools that require daily physical education for all students'' (objective 22-8), (2) ''the proportion of adolescents who participate in daily school physical education'' (objective 22-9), (3) ''the proportion of adolescents who spend at least 50 percent of school physical education class time being physically active'' (objective 22-10), (4) ''the proportion of schools that require students participating in school-sponsored physical activities to use head, face, eye, and mouth protection'' (objective 15-31), and (5) ''the proportion of schools that provide access to their physical activity facilities and spaces for students and others outside of regular school hours'' (objective 22-12).[210]

This section explores what is legally required of public schools concerning the provision of physical education to students and addresses such issues as whether federal, state, or local laws require public schools to provide physical education to students and whether students may be exempted from participating in physical education, federal incentives to encourage physical education in public schools, the role of national physical education standards and required physical education curriculum, teacher preparation and professional development programs, and the required use of protective gear.

1. Legal Requirements to Provide Physical Education to Students

According to SHPPS 2006, most states and districts had adopted a policy stating that elementary, middle, and high schools will teach physical education.[211] Florida law requires, for example, one credit in physical education in grades 9 through 12 ''to include assessment, improvement, and maintenance of personal fitness.''[212] The one-credit requirement can be satisfied with two full seasons of participation in a junior varsity or varsity-level interscholastic sport if the student passes a competency test of personal fitness developed by the state board of education.

Recess between classes, in which additional physical activities are often possible, is distinct from formal physical education requirements. Although most states and districts do not require recess for elementary school students, 97% of elementary schools provided regularly scheduled recess for students in at least one grade.[213]

Exemptions from physical education are common at the state, district, and school levels. For example, among the 80% of states that required elementary school physical education, 25% had adopted a policy describing reasons for which students could be exempted from physical education; among the 78% of states that required middle school physical education, 34% had adopted a policy describing reasons for which students could be exempted; and among the 86% of states that required high school physical education, 25% had adopted a policy describing reasons for which students could be exempted. Long-term physical or medical disability and religious reasons were the two most common exemptions allowed by states.[214] Massachusetts law provides:

> Physical education shall be taught as a required subject in all grades for all students in the public schools for the purpose of promoting the physical well-being of such students. Instruction in physical education may include calisthenics, gymnastics and military drill; but no pupil shall be required to take part in any military exercise if his parent or guardian is of any religious denomination conscientiously opposed to bearing arms, or is himself so opposed, and the school committee is so notified in writing; and no pupil shall be required to take part in physical education exercises if a licensed physician certifies in writing that in his opinion such physical education exercises would be injurious to the pupil.[215]

In addition to the requirements imposed by ADA, IDEA, and section 504 of the Rehabilitation Act, as discussed in section II, most states and districts also require schools to provide some form of physical education to students with permanent physical or cognitive disabilities. State and local laws may not reduce the rights afforded to children under federal law but may supplement those accommodations by requiring additional rights and protections. Specifically, most states and districts require schools to provide adapted physical education as appropriate for disabled students, include physical education in their individual education plans, and include mainstream disabled students into regular physical education classes as appropriate. Additionally, more than one half of states

and districts require schools to provide modified equipment, modified facilities, and teaching assistants in regular physical education for disabled students if required.[216]

SHPPS 2006 found that 14% of states had adopted a policy stating that all districts will have someone to oversee or coordinate physical education.[217] Among all districts, 54% had adopted a policy stating that each school will have someone to oversee or coordinate physical education at the school.

Federal law requires public schools to provide equal athletic opportunities to students. Title IX of the Education Amendments of 1972 protects students and employees of educational institutions, including public schools, from discrimination based on their sex.[218] Concerning athletics in particular, ED regulations promulgated pursuant to Title IX state that ''[n]o person shall, on the basis of sex, be excluded from participation in, be denied the benefits of, be treated differently from another person or otherwise be discriminated against in any interscholastic, intercollegiate, club or intramural athletics offered by a recipient, and no recipient shall provide any such athletics separately on such basis.''[219]

Schools must provide ''equal athletic opportunity'' to students of both sexes. Under the federal regulations, equal athletic opportunity is determined by considering multiple factors, including the provision of equipment and supplies, locker rooms, practice and competitive facilities, and medical and training facilities and services.[220] Another factor includes whether ''the selection of sports and levels of competition effectively accommodate the interests and abilities of members of both sexes.''[221] Schools can demonstrate that they have accommodated the interests and abilities of students of both sexes by showing substantially proportionate athletic opportunities for male and female students, a history and continuing practices of program expansion for members of the sex who has been underrepresented in athletic opportunities, and full and effective accommodation of the underrepresented sex's interests and abilities.[222]

2. Federal Incentives to Promote Physical Education in Public Schools

Carol M. White Physical Education Program

The Carol M. White Physical Education Program (PEP) was established under the NCLB and replaces the Physical Education for Progress Act. The program is administered by ED's Office of Safe and Drug-Free Schools. Its express purpose is to ''award grants and contracts to initiate, expand, and improve physical education programs for all kindergarten through 12th-grade students.'' Grants may be awarded to local educational agencies (and community-based organizations) to pay the ''federal share'' (90% of the program for the first year and 75% for the second and subsequent years) of the costs of initiating, expanding, and improving physical education programs. PEP provides equipment and support so that students can actively participate in physical education and activities and provides funds for teacher and staff training and education. A physical education program funded under this law may have one or more of six specified elements, including, for example, ''fitness education and assessment to help students understand, improve, or maintain their physical well-being'' and ''opportunities to develop positive social and cooperative skills through physical activity participation.''[223]

President's Council on Physical Fitness and Sports

The President's Council on Physical Fitness and Sports[224] is an advisory committee of 20 volunteer citizens that advise the President through DHHS' Secretary about physical activity programs. The President's Challenge is a program that supports children, teens, adults, and seniors incorporating physical activities as part of their everyday lives. Individuals are encouraged to sign up for a variety of activities and keep a personal activity log to track their progress.

3. Role of National Physical Education Standards

Standards for students' physical education are issued by the National Association for Sport and Physical Education (NASPE) and by SEAs. The National Standards for Physical Education are published by NASPE, a ''nonprofit professional organization comprised of individuals engaged in the study of human movement and the delivery of sport and physical activity programs.''[225] Its focus is on educating Americans on the importance of physical education for all children and youth. The standards ''define what a student should know and be able to do as result of a quality physical education program.''[226] A physically educated individual:

1. Demonstrates competency in motor skills and movement patterns needed to perform a variety of physical activities.
2. Demonstrates understanding of movement concepts, principles, strategies, and tactics as they apply to the learning and performance of physical activities.
3. Participates regularly in physical activity.
4. Achieves and maintains a health-enhancing level of physical fitness.
5. Exhibits responsible personal and social behavior that respects self and others in physical activity settings.
6. Values physical activity for health, enjoyment, challenge, self-expression, and/or social interaction.[227]

SHPPS 2006 found that 71% of states had adopted a policy stating that districts or schools will follow national or state physical education standards or guidelines. Among all states, 76% required or encouraged districts or schools to follow physical education standards

or guidelines based on NASPE's National Standards for Physical Education[228] (see eg, Louisiana).[229]

4. Required Physical Education Curriculum

SHPPS 2006 found that 8% of all states required and 4% recommended that districts or schools use one particular curriculum for elementary school physical education, 10% of all states required and 6% recommended that districts or schools use one particular curriculum for middle school physical education, and 14% of all states required and 2% recommended that districts or schools use one particular curriculum for high school physical education.[230] Curriculum requirements were more common at the district level. Among all districts, 30% required and 34% recommended that schools use one particular curriculum for elementary school physical education; among all districts that provided middle school instruction, 36% required and 23% recommended that schools use one particular curriculum for physical education; and among all districts that provided high school instruction, 34% required and 27% recommended that schools use one particular curriculum for physical education.[231]

On June 1, 2005, South Carolina enacted the Students Health and Fitness Act of 2005, which sets a goal to provide all elementary school students with 30 minutes of physical activity and/or physical education each day.[232] In 2006-2007 school year, K-5 students must receive a minimum of 60 minutes each week of physical education and 90 minutes of physical activity. Fitness status must be reported to parents (or guardians) of students in grades 5, 8, and high school.[233]

When it comes to physical education, most states and districts do not require students to take skill performance tests or written exams, preferring instead physical fitness tests.[234] The Oklahoma Kids Fitness Challenge Act requires, among other things, the state board of education to establish a physical activity program for fifth-grade public school students that each school district may elect to implement.[235] The program is required to incorporate the fitness challenges adopted by the President's Council on Physical Fitness and Sports.[236] Oklahoma encourages its students to perform 25 sit-ups in 2 minutes at least three times per week every week during the school year and to walk a minimum of 25 miles per week every week during the school year.[237] Students with physical limitations that prevent them from complying with the program are legally exempted from the program.[238]

5. Teacher Preparation and Professional Development Requirements

According to SHPPS 2006, 65% of states and 77% of districts had adopted a policy stating that newly hired staff who teach physical education at the elementary school level will have undergraduate or graduate training in physical education, 86% of states and 81% of districts had adopted this policy for newly hired staff who teach physical education at the middle school level, and 88% of states and 89% of districts had adopted this policy for newly hired staff who teach physical education at the high school level. SHPPS 2006 also found that all states offered at least one type of certification, licensure, or endorsement to teach physical education.[239]

6. Required Use of Protective Gear

To prevent injury, some states and districts require students to wear protective gear while participating in school-related physical activity. SHPPS 2006 found that 12% of states and 44% of districts had adopted a policy requiring students to wear appropriate protective gear during physical education, 14% of states and 45% of districts had adopted this policy for students engaged in intramural activities or physical activity clubs, and 49% of states and 84% of districts had adopted this policy for students engaged in interscholastic sports.[240]

C. Health Services

In a CSHP model, health services is defined as services provided for students to appraise, protect, and promote health. These services are designed to ensure access or referral to primary health care services or both, foster appropriate use of primary health care services, prevent and control communicable disease and other health problems, provide emergency care for illness or injury, promote and provide optimum sanitary conditions for a safe school facility and school environment, and provide 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.[241]

School health services might include health screening and assessment; care plan development and implementation; health education; health counseling; acute, chronic, episodic, and emergency care; provision of nursing interventions and case management; medication administration; assisting with access to an ongoing source of health care in the community; medical case management and referral; outreach to students and families; and provision of professional development for school staff and families. Activities also include participating in interdisciplinary teams to ensure appropriate adaptations for the health needs for students (such as IEP teams required by the IDEA and accommodation teams required by section 504 of the Rehabilitation Act). High-quality health services may also include coordination with students and family health care providers and other community health service providers to ensure that students have

appropriate and continued health care beyond the school setting.

As discussed in this section, the composition of health services offered in a particular school is dictated by legal requirements, assessments of student needs, and the availability of resources. Federal law does not impose a requirement to provide health services in schools, but schools receiving funding from IDEA must provide health services to qualifying students. State laws increasingly outline a range of legal issues related to health services in schools, including the types of services that may, or must, be provided in schools, how these health services are provided, and who may deliver the services. Federal and state legal provisions also control the use of and access to health information concerning students. Generally, this information is subject to strong privacy protections and may only be released under limited circumstances.[242]

1. Legal Requirements to Provide Health Services to Students

The regulation of school health services is left predominantly to state and local governments and in many cases to individual school districts. Students with disabilities, however, may find health services guaranteed under federal antidiscrimination and equal protection provisions such as the IDEA,[243] the ADA,[244] and section 504 of the Rehabilitation Act.[245] For example, the IDEA ''emphasizes special education and related services designed to meet [the] unique needs'' of children with disabilities.[246] States that receive federal funding under the IDEA must provide ''related services,'' which include health services such as school nurse services that are a component of a student's IEP, orientation and mobility services, and medical services for diagnostic and evaluation purposes only.[247] The Supreme Court has construed related services to encompass a broad range of health services. Services provided by a physician (other than for diagnostic and evaluation purposes) may be excluded, but services that can be provided by a nurse or qualified layperson must be covered.[248] Efforts toward early identification and assessment of disabling conditions in children also are required under the IDEA. Many states have adopted laws and regulations implementing the requirements of the IDEA in state and local school districts[249] (discussed in section II.C).

State and local regulation of health services, in contrast, is much more extensive and covers the provision of multiple services for all students. All states authorize the provision of health services in school settings, and some states require the provision of specific health services.[250] Decisions regarding which health services are available in schools and the methods of their delivery typically are left to individual school boards.[251] Many states or school boards mandate the availability of health services personnel within schools, usually in the form of a school nurse or other qualified health professional. Health professionals must meet state professional licensure requirements to provide health services.[252] Lawmakers in at least 12 states have statutorily implemented nurse-to-student or nurse-to-school ratios.[253] *Healthy People 2010* objectives and the National Association of School Nurses (along with the American School Health Association) recommend a nurse-to-student ratio of 1:750.[254] The provision of school nurses and SBHCs is not mutually exclusive. Some school districts have adopted the model of an SBHC without school nurses (although many retain their services), which are independently operated health centers located on or near school grounds.[255] These centers often provide extensive health care and other social services to the student population. SBHCs have expanded rapidly over the past decade to include nearly 1500 centers in 45 states, with many states providing direct funding for the centers.[256]

2. Testing and Screening for Health Conditions in Schools

All states mandate some basic health prerequisites for attending public schools. Prior to matriculation, children must prove that they meet state and local health requirements. All states require proof of immunization for specific diseases, and many states insist that students undergo physical examinations. In most jurisdictions, exemptions to immunization requirements are available on the basis of health contraindications or religious (or philosophical) objections.[257] States retain the discretion to deny exemptions or restrict exempted students from attending school when the public's health is at risk.[258] Students who are homeless may be permitted to forgo immunization requirements pursuant to the McKinney Vento Homeless Services Act.[259] Physical examination requirements also fit within this pattern—religious exemptions to these requirements may be permitted under statute, but they may be overruled to protect public health.[260]

State and local laws may also authorize school health officials to conduct testing and screening for a variety of health conditions. School testing and screening provisions cover five major areas: communicable diseases or nuisance conditions (eg, tuberculosis [TB], unidentified rashes, flu, chicken pox, pertussis, hepatitis, and meningitis), chronic conditions (eg, hearing loss, visual problems, developmental delays, autism, scoliosis, and dyslexia), injuries and unhealthy behaviors (eg, tobacco use), monitoring for child abuse or neglect, and body mass index (BMI) screening. In some states, testing and screening requirements are uniformly applied to all state public schools. Texas requires all schools to screen and treat for dyslexia.[261] Other states leave more discretion to individual school districts with regard to certain conditions. The timing and process for health testing and screening also vary widely across states and school districts. Some health conditions are screened periodically.

For example, Virginia mandates annual scoliosis testing for students in grades 5-10[262] and testing for hearing loss at regularly determined intervals.[263] Students are tested for other health conditions, particularly communicable diseases such as chicken pox or meningitis, only when symptomatic indications warrant testing.

Some states have enacted laws that require or encourage reporting of BMI to parents. In Arkansas, for example, schools are required to include an annual BMI percentile by age for each student as part of a student health report to parents.[264] Schools must annually provide parents with an explanation of the possible health effects of BMI, nutrition, and physical activity.[265] Similarly, in Tennessee, schools may complete a BMI examination with parental approval and subsequently provide parents with a confidential health report card and related information concerning their child's results.[266]

Many school districts obligate students to undergo a physical examination before engaging in extracurricular activities. Students who do not meet the stated requirements may not be permitted to participate in these activities.[267] Prerequisites for participating in sporting events may also include drug testing. Random drug testing requirements for students engaged in extracurricular activities, though controversial, have been upheld by courts. Students have a lower expectation of privacy in the school setting generally and in athletics and extracurriculars specifically. Student participation in voluntary school activities implicates less significant privacy interests than their participation in the curricular program.[268]

3. Treatment for Health Conditions in Schools

Students may need to receive treatment for various health conditions during school. When unforeseen health emergencies arise, school officials may need to provide first aid and other health services. Students with chronic health conditions—such as diabetes, asthma, and seizure disorders—may need ongoing health monitoring (eg, periodic monitoring of blood sugar for diabetics) and access to medications. State and local laws authorize the provision of a range of health services in schools. For example, California authorizes registered nurses to provide vaccination services to students under the supervision of a physician.[269] Schools may require students with communicable diseases to either undergo treatment or stay home without violating students' right to education.[270] As enunciated in *Healthy People 2010* objectives, nurses manage care and provide services to support and sustain a healthy school environment. Nurses are integral in developing the individualized health care plan (IHP), which describes the nursing interventions that the student needs for care. They also assist students to attain independence in managing their health.

Students with special health care needs are guaranteed access to appropriate health services under federal and state laws. IDEA requires the creation of IEPs (including needed health services) for children whose disabilities interfere with their educational performance. Similarly, for children with disabilities, schools also may provide health services to students under section 504 plans or IHPs.[271]

Administration of medication to students is a core component of school health services.[272] State laws have increasingly focused on self-administration of some medications by students and delegation of responsibility for administering medicine to nonmedical personnel. A variety of state laws regulate self-administration of medication. States and school boards may permit students to possess and self-administer medications. [273] In 2004, Congress authorized preferential federal funding for states that explicitly permit students to possess and self-administer asthma medication, resulting in most states authorizing these practices.[274] Maine, for example, requires public and private schools to develop local policies that allow students to possess and administer asthma inhalers and epinephrine pens.[275] Furthermore, ''three federal laws require schools to accommodate students whose asthma qualifies as a disability under the IDEA, Section 504, or Title II of the ADA.''[276] Under such laws, students may be allowed to carry their inhalers for purposes of self-medication as provided in their asthma management plans.[277] Also, ED's Office of Safe and Drug-Free Schools issued guidance providing that ''a student's prescription drugs, and related equipment, are not illegal drugs and are not prohibited by the [Safe and Drug-Free Schools and Communities Act].''[278]

In other circumstances, when students require assistance in the administration of medications (eg, auto-inject epinephrine, oral medications, and injected medications that require safe handling of needles and blood), school health officials or other staff may be authorized to administer the medications.[279] State regulations for dispensing prescription medications typically restrict this practice to specific licensed professionals, but some states (eg, Iowa and Massachusetts) permit nonlicensed assistants to administer medication in the school setting.[280] States have also demonstrated concern over access to health services for students with diabetes and serious allergies by authorizing trained nonmedical personnel to administer glucagon and provide other necessary services to diabetic students[281] and to administer epinephrine to students experiencing anaphylaxis.[282]

4. Parental and Patient Consent for Health Services

Strong parental and student consent requirements are a hallmark of federal and state laws related to school health services. The default assumption is that parental consent is needed prior to providing any health service to a student, subject to many exceptions. Federal laws and regulations provide explicit protections for parental consent in some circumstances.

State laws and school board policies control the process for obtaining consent for treatment in the school setting. Some states explicitly apply parental consent requirements to school health services offered to minor students. For example, Arkansas law provides that ''no child shall receive school-based health clinic services without parental consent.''[283] Florida mandates parental authorization prior to student access to inhalers, contraceptives, and epinephrine injectors.[284]

By contrast, some states allow minor students to obtain health services without obtaining parental consent. Louisiana permits schools to provide preventive counseling or treatment to a student without parental consent, provided that the student requests such preventive counseling or treatment, withholds permission to seek parental consent, and provides an explanation for seeking these services and written consent from the student and provided that a ''qualified professional reasonably determines in good faith and based on independent evidence that seeking parental consent would not be helpful and would be harmful'' to the student.[285] Parents may refuse consent for physical examinations of their child under California law,[286] but if the child ''is suffering from a recognized contagious or infectious disease,'' the child ''shall be sent home and shall not be permitted to return until the school authorities are satisfied that any contagious or infectious disease does not exist.''[287] All state consent provisions allow exceptions when a student's health is in imminent danger and parental consent cannot be obtained.

The report, *State Minor Consent Laws: A Summary*, prepared by the Center for Adolescent Health and the Law, provides additional discussion of the scope of minor consent laws and specific state-based analyses.[288]

5. Use of Identifiable Health Information for School Health Services

Access to Information

As discussed in section II, two prominent federal laws (ie, HIPAA Privacy Rule and FERPA) limit access to identifiable health information about students. FERPA controls access to most student education records, including those containing health information.[289] While school health records covered under FERPA are excluded from the HIPAA Privacy Rule,[290] student health records held by SBHCs, which are often run by external entities, may be subject to HIPAA Privacy Rule requirements[291] (discussed in section II.B.3).

Other federal laws may be implicated for purposes of acquiring specific types of information, such as contact information of students receiving treatment for a mental illness or disability. Recent case law has suggested that third parties authorized to acquire such records would be bound by the confidentiality provisions of FERPA and IDEA (discussed in section III.E.4).

At the state level, parents typically are explicitly authorized to inspect their children's school records, including health records.[292] However, students who reach majority may seek to prevent their parents from accessing school records. Under FERPA, whenever a student has attained 18 years of age or is attending an institution of postsecondary education, the permission or consent required of and the rights accorded to the parents shall thereafter only be required of and accorded to the student.[293] If a student is still designated as a dependent for tax purposes, however, a school may disclose her health information to the parents. Within the school setting, local district policies often determine who within the education environment has access to educational records containing identifiable health information.[294]

Reporting Requirements

Reporting requirements related to student health vary across states. All states have disease-reporting provisions that mandate health care providers, laboratories, and others to report the occurrence of certain diseases and health conditions to the state health department. These disease-reporting requirements frequently do not apply explicitly to school officials but may apply to licensed health care practitioners delivering services in a school or SBHC. Other reporting requirements guarantee that parents will be notified if their child is ill. New Hampshire, for example, requires school health personnel to inform a student's parent (or guardian) of ''any defects or disabilities discovered and identified through observation, screening procedures, or physical examinations.''[295] Child welfare laws mandate that school officials report any evidence of child abuse or neglect.[296] In the course of child abuse investigations, school officials may be required to share information directly with law enforcement officials and without parental consent when necessary.[297]

6. Financing School Health Services

A variety of federal or state education resources may be used to fund school health services. Health insurance programs at the federal and state levels are also available to cover the cost of many school health services. As of 2000, schools in 47 states and the District of Columbia received $2.3 billion in Medicaid payments for school-based health services and administrative activities.[298] Some states, such as Colorado, have developed sophisticated centralized mechanisms for administering these Medicaid reimbursements for school health services.[299] Health services for children qualifying for IDEA services may be covered under Medicaid,[300] although a recent study suggests that only 44% of school districts receive Medicaid funding for special education.[301] Many state governments fund school health services through grants attached to pilot programs, including those targeting underserved areas[302] and establishing SBHCs.[303]

Some schools may find it favorable to enter into collaborative agreements with local health care providers to control the costs affiliated with the provision of basic services. Yet, schools may be reluctant to enter into such partnerships because of the high costs associated with the treatment necessary for particular groups of children (eg, those with disabilities or special health care needs).[304]

In addition to Medicaid, the State Children's Health Insurance Program (SCHIP) is an important source of financing for SBHCs. The National Assembly on School-Based Health Care proffers a number of recommendations to protect and promote the role of SBHCs in meeting Medicaid and SCHIP access goals for children and adolescents. These include (1) recognizing that SBHCs are an eligible provider or primary care service type (ie, by linking standards and reimbursement to the health centers' sponsoring organization), (2) facilitating participation of SBHCs as primary care providers in Managed Care Organizations and provider networks, (3) establishing reimbursement methodologies that compensate interdisciplinary, comprehensive, school-based health services at 100% of cost, (4) emphasizing access to preventive care, routine assessment and screening, early intervention for medical and behavioral problems, and effective management of chronic illnesses, and (5) prohibiting cost sharing for primary care services and eliminating SBHC requirements to seek payment from low-income families ineligible for Medicaid.[305]

Schools also may be able to procure funding through the Temporary Assistance for Needy Families (TANF) program, which grants states federal funds to develop and implement welfare programs. The program may include a number of activities that qualify as ''community service activities,'' such as serving as a teacher's aide at a school or funding after-school programs for eligible participants. TANF funds can be transferred into a state's Child Care and Development Fund (CCDF), and some states, such as Georgia, have allocated up to 50% of their CCDF funds to after-school programs.[306]

D. Nutrition Services

In a CSHP model, nutrition services is defined as access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students. School nutrition programs reflect the US Dietary Guidelines for Americans (DGA) and other criteria to achieve nutrition integrity. The school nutrition services offer students a learning laboratory for classroom nutrition and health education and serve as a resource for linkages with nutrition-related community services. Qualified child nutrition professionals provide these services.[307]

During the school year, some students may eat most of their meals and snacks at school. Moreover, eating behaviors acquired in school—healthy or not—may influence eating choices when a child or adolescent is not in school. *Healthy People 2010* recognizes the potential role of schools in improving children's eating habits. Objective 19-15 seeks to ''[i]ncrease the proportion of children and adolescents aged 6 to 19 years whose intake of meals and snacks at school contributes to good overall dietary quality.''[308]

This section explores what is legally required of public schools in providing nutrition services to students by addressing several questions: Are public schools required to provide nutritious food and beverages to students? Are there any restrictions on the types of foods and beverages available to students? Who decides which foods and beverages are available to students? Are there any restrictions placed on food and beverage companies concerning advertising their products in school or to students? Can zoning be used to limit off-site fast-food sales to students?

1. Legal Requirements to Provide Nutrition Services

The federal government makes two main meal programs available to public schools serving grades K-12 (and to nonprofit private schools and residential child care institutions): the NSLP[309] and the School Breakfast Program (SBP).[310] These programs are voluntary for states. To participate, states must enter into a written agreement with the USDA.[311] Participating schools in the NSLP must serve lunches that meet federal nutritional requirements and offer free or reduced-priced meals to children whose eligibility is based on household income. Any student, however, can purchase a meal through the NSLP. In return, participating schools and institutions receive cash subsidies and donated commodities from the USDA for each meal served.[312] In 1998, Congress expanded the NSLP to reimburse participating schools for snacks served to children and adolescents in after-school educational and enrichment programs.[313] In fiscal year 2004, more than 94,600 schools (K-12) participated in the NSLP. School cafeterias served 4.8 billion lunches and 154 million after-school snacks at a cost of $7.6 billion.[314]

The SBP, initially established in 1966 as a 2-year pilot program and made permanent in 1975, provides states with cash assistance to operate nonprofit breakfast programs in public schools (and other selected institutions).[315] Participants must serve breakfasts that meet federal nutritional requirements at no cost or at a reduced price to eligible children under the same terms and conditions set forth for the NSLP.[316] In fiscal year 2004, the SBP operated in more than 74,000 schools (including some child care institutions), delivering over 1.5 billion breakfasts and serving an average of 8.9 million children each day.[317]

Although the federal government cannot require states to participate in federal school meal programs, states can make school participation mandatory. For example, on February 15, 2005, Illinois enacted the

Childhood Hunger Relief Act,[318] which makes the SBP mandatory in all Illinois schools in which at least 40% of students are eligible for free or reduced-priced lunches under the NSLP.[319] The legislative findings show, in part, that ''low-income children [in Illinois] are not being adequately nourished, even to the point where many are arriving at school hungry.''[320] Other states, such as Georgia[321] and Louisiana,[322] also mandate participation in the SBP in public schools if a certain percentage of students is eligible for free or reduced-priced meals under a specified federal meal program. Several states require most public schools to participate in the NSLP, including Arizona,[323] Maine,[324] and North Carolina.[325]

2. Legal Mandates Concerning Nutritional Requirements

US Department of Agriculture Regulations

Participants in the NSLP and SBP must provide meals that meet federal nutritional requirements, although local school authorities or state laws decide the specific foods served and the manner in which they are prepared.[326] The federal regulations prescribed by the US Secretary of Agriculture require that school lunches meet the DGA. These guidelines state that no more than 30% of calories offered should come from total fat and less than 10% of calories offered should come from saturated fat. School lunches also must provide at least 33% of the Recommended Dietary Allowances (RDA) for protein, calcium, iron, vitamin A, vitamin C, and calories.[327] Likewise, school breakfasts must meet minimum nutritional requirements prescribed by the Secretary of Agriculture.[328] Applicable regulations apply similar standards under the DGA, although school breakfasts need only provide 25% of the RDA for protein, calcium, iron, vitamin A, vitamin C, and calories.[329] There are no specific federal standards for cholesterol, sodium, carbohydrates, fiber, or sugar contents; however, participating schools are required to reduce the level of cholesterol, moderate the use of sodium and salt, and include more dietary fiber as compared to existing menu options.[330]

Local Wellness Policies

Section 204 of the Child Nutrition and WIC Reauthorization Act of 2004 requires that each local educational agency (or school district) participating in the NSLP and/or SBP establishes a Local Wellness Policy by the beginning of the 2006-2007 school year.[331] According to the USDA, the Local Wellness Policy is important because in part it ''[r]eaches beyond USDA-funded meal programs to influence children's health'' and ''[a]cknowledges local community responsibility to support or build on government efforts.''[332] Federal law requires that the Local Wellness Policy has a minimum of five specified components, which include setting nutrition guidelines for all foods available on school grounds during the school day to promote student health and reduce childhood obesity.[333]

State Nutritional Standards

According to a 2005 report by the Trust for America's Health, a handful of states set nutritional standards for school lunches and breakfasts that are stricter than the federal requirements.[334] For example, in March 2004, the Commissioner of the Texas Department of Agriculture used her regulatory authority to develop the Texas Public School Nutrition Policy ''to promote a healthier environment in schools.''[335] Since August 1, 2004, all Texas public schools participating in federal child nutrition programs (ie, NSLP, SBP, and After School Snack Program) must comply with the Policy's terms. Under one standard, schools and other vendors may not serve food items that contain more than 28 g of fat per serving size more than twice per week. This standard applies to all foods and beverages served or made available to students in K-12 in school meals, à la carte, and as competitive foods and beverages (see below).[336] Standards issued by Child and Adult Nutrition Services, South Dakota Department of Education, set specific levels for sodium, cholesterol, and fiber to be served in school lunches and breakfasts.[337] On September 15, 2005, California Governor Arnold Schwarzenegger signed three bills[338] regulating food and beverages served in public schools that purportedly give California schools ''the strongest nutrition standards in the nation.''[339] The standards limit the amount of calories and sugar content that students consume in schools and supplement additional legislation that bans the sale of soda during school hours to high school students.[340]

3. Sale of Competitive Foods

Federal Restrictions

Competitive foods are defined in federal regulations as ''any foods sold in competition with the [NSLP and SBP] to children in food service areas during the [lunch and breakfast] periods.''[341] Federal law does not completely prohibit the sale of competitive foods in public schools. Instead, it limits their sale in certain locations at certain times by requiring state agencies and school authorities to establish rules or regulations to control their sale. This includes prohibiting the sale of foods of ''minimal nutritional value'' in the food service areas during lunch and breakfast periods. A list of categories of foods of minimal nutritional value is provided in the appendix to the regulations and includes sodas, water ices, chewing gum, hard candy, jellies and gums, marshmallow candies, fondant, licorice, spun candy, and candy-coated popcorn.[342] The sale of other competitive foods is permitted in the food service areas during lunch and breakfast periods ''if all income from the sale of such foods accrues to the benefit of the nonprofit school food service or the school or student organization approved by the school.''[343] States and school districts may impose further restrictions on the sale of, and income from, all foods sold at any time in

their schools; however, the USDA does not have the authority to regulate competitive foods beyond the food service area during meal periods.[344]

Thus, under federal law, public schools participating in the NSLP and the SBP cannot sell foods deemed to be of minimal nutritional value in the food service areas during lunch and breakfast periods, but they can sell these foods outside such areas at any time during the school day. For example, during the lunch period, students may buy soft drinks and candy in vending machines outside the cafeteria. In addition, foods not sold through the NSLP or SBP and not deemed to be of minimal nutritional value (eg, potato chips, chocolate bars, and doughnuts) may be sold in the cafeteria during meal times, provided the proceeds benefit the approved entities. They also may be sold anywhere else on the school grounds (eg, vending machines, snack bars, and school stores) at any time of the day without restriction as to the use of the proceeds.

In January 2001, USDA issued a report to Congress, *Foods Sold in Competition with USDA School Meal Programs*, concluding that ''the availability of food sold in competition with school meals jeopardizes the nutritional effectiveness of the programs and may be a contributor to the trend of unhealthy eating practices among children and subsequent health risks.''[345] Specifically, USDA found that competitive foods have diet-related health risks because federal law does not provide nutrition standards for them, may stigmatize participation in federal school meals programs, may affect the viability of federal school meal programs, and convey a mixed message to children who are taught about good nutrition and the value of healthy eating but are surrounded by unhealthy food choices. Among its recommendations, USDA called for strengthening federal law so that all foods sold anywhere on school grounds during the school day meet nutrition standards, and revenues from all competitive food sales in schools accrue solely to the benefit of the school food service.

State and Local Restrictions

Several studies have looked at the availability of competitive foods in schools, as well as state and local policies that address their sale.[346] An August 2005 GAO report found that, in school year 2003-2004, nearly 90% of schools sold competitive foods to students (ranging from nutritious items such as milk and fruit to less nutritious items such as soft drinks and candy) through a variety of channels, including vending machines, school stores, and a la carte lines in the cafeteria.[347] Often, competitive foods were sold in or near the cafeteria and during lunchtime. The GAO report also found that 28 states have made efforts to restrict the sales of competitive foods beyond federal regulations. The majority of these policies restrict some (but not all) competitive foods during school meal periods but not during the entire school day.

As an example, an Arkansas statute bans ''in-school access'' to vending machines that sell food and beverages in elementary schools.[348] Florida's State Board of Education Administrative Rules state that foods of minimal nutritional value (as defined in federal regulations) ''may be sold in secondary schools only, with the approval of the school board, one hour following the close of the last lunch period.''[349] Connecticut requires that each local and regional board of education makes available in its schools nutritious, low-fat foods and drinks (including at a minimum low-fat milk, 100% natural fruit juices, and water) whenever drinks are available for purchase in school and low-fat dairy products and fresh or dried fruit whenever food is available for purchase in school during the school day.[350] Localities such as Chicago, Los Angeles, New York City, Philadelphia, and Seattle have banned the sale of soft drinks, among other things, in school vending machines.[351]

Industry Measures

The soft drink industry has taken measures to restrict the sale of soft drinks in schools. On August 16, 2005, the American Beverage Association (ABA) Board of Directors, which represents 20 companies that make up about 85% of school vending beverage sales by bottlers, unanimously approved voluntary guidelines.[352] Under the policy, ABA recommends that the beverage industry:

- Provides only bottled water and 100% juice to elementary school students.
- Provides nutritious and/or lower calorie beverages to middle school students (such as water, 100% juice, sports drinks, no-calorie soft drinks, and low-calorie juice drinks). No full-calorie soft drinks or full-calorie juice drinks with 5% or less juice would be provided until after school hours.
- Provides a variety of beverage choices to high school students (such as bottled water, 100% juice, sports drinks, and juice drinks). No more than 50% of the vending selections would be soft drinks.[353]

On May 3, 2006, the Alliance for a Healthier Generation spearheaded an effort with beverage manufacturers to institute a self-imposed ban on the sale of sodas and other high-sugar drinks in most of the nation's public schools.[354] The ABA, PepsiCo, Coca-Cola, and Cadbury Schweppes are among the corporations that adopted the new guidelines as part of their new school beverage policy. The terms of the agreement, along with the specific guidelines, are set forth on the Alliance for a Healthier Generation Web site.[355]

Though restricting the sale of competitive foods in public schools is a positive trend that promotes the nutritional health of students and school staff, schools may face the loss of substantial revenues that are used to not only support food service operations but also

student activities. According to conservative estimates by the GAO, in 2003-2004, about 30% of all high schools raised more than $125,000 per school through competitive food sale; a similar percentage of elementary schools raised more than $5000 per school.[356] So-called ''exclusive pouring rights,'' or contracts in which the school agrees to promote one brand of soft drinks exclusively in exchange for money, ''have funneled more than $200 million in unrestricted revenue to schools,'' according to the American Academy of Pediatrics.[357]

The financial ramifications, however, have not gone unchallenged. In 2005, a study by Fox et al found that policies that support alternatives to improve school nutrition can be effective in improving the health of children and increase food sales revenue.[358] They concluded that communities should implement school-based nutrition programs and policies that address the sale of competitive foods.

4. Legal Decision-Making Authority on Nutrition Services

Federal law does not regulate who decides which nutrition services are offered in public schools, leaving that decision to the states. According to SHPPS 2006,[359] 94% of states had a person who oversees or coordinates nutrition services for schools at the state level (eg, a state food service director or director of child nutrition) and 88% of districts had a person who oversees or coordinates nutrition services at the district level (eg, a district food service director). The study also found that despite the need for highly skilled individuals to run school food service programs, in most school districts and schools, the only educational requirement for newly hired food service directors or managers was a high school diploma or passing General Educational Development (GED) tests. In addition, most districts and schools did not require professional certification.[360] With respect to competitive foods in particular, the GAO report found that no one consistently had responsibility for making decisions about all competitive foods at the school level, with decision making falling on district and school officials as well as members of the school groups selling the food.[361]

5. Restrictions on Food and Beverage Advertising to Children in Schools

In September 2000, the GAO released a report reviewing four types of commercial activities in schools: product sales (eg, pouring rights contracts), direct advertising (eg, free snack foods), indirect advertising (eg, corporate-sponsored contests and incentives such as McDonald's poster contests and Pizza Hut's Book-It program), and market research.[362] The report found that while commercial activities in schools are governed by general federal and state laws that apply to all businesses or that pertain to school finance, only 19 states have statutes or regulations that address specific commercial activities in schools. In 14 of these states, the laws are not comprehensive and regulate only some types of commercial activities. In most states, local school boards have the authority to make policy decisions about commercial activities or to delegate that authority to school district officials. Superintendents and principals often decide what commercial activities to permit in their schools. For example, Virginia law requires each school board to develop and implement a policy concerning ''commercial, promotional, and corporate partnerships and sponsorships'' in the public schools in its jurisdiction.[363] According to the preamble of the law, local school boards are given this authority ''to meet their local needs, circumstances, and standards.''[364]

In December 2005, the Institute of Medicine (IOM) published a comprehensive review of the scientific evidence concerning the influence of food marketing on diets and diet-related health of children and youth. It found that current marketing practices are putting children's long-term health at risk and offered a number of recommendations to guide the development of effective marketing and advertising strategies. The report contained recommendations geared toward a diverse audience, including schools, parents, the restaurant industry, and others.[365]

6. Zoning as a Legal Tool to Limit Student Access to Fast Food

Zoning is a potential legal tool to encourage students to make healthier food choices during school and on their way to and from school. A Chicago study found statistically significant clustering of fast-food restaurants in areas close to kindergarten, primary, and secondary schools.[366] Specifically, there were three to four times more fast-food restaurants within 1.5 km (0.93 miles) of schools than would have been expected if the restaurants had been distributed throughout the city in a way unrelated to school locations. The study also found that for one half of Chicago's schools, the nearest fast-food restaurant was a little more than a 5-minute walk.

Some localities have already taken measures to restrict how close fast-food restaurants can be to schools. For example, Detroit's zoning ordinance states that fast-food restaurants (and other food outlets as well) must have a minimum of 500 feet between the restaurant and the elementary, junior high, or high schools.[367] Arden Hills, Minnesota, has a similar provision, requiring 400 feet between a fast-food restaurant and a school.[368]

E. Mental Health and Social Services

In a CSHP model, mental health and social services is defined as services provided to improve students' mental, emotional, and social health. These services include 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.[369]

School mental health and social services are ''designed to prevent and address problems, facilitate positive learning and health behavior, and enhance healthy development.''[370] Access to these services in the school setting is important because approximately one in five children experience the signs and symptoms of a mental health problem each year.[371] For many children and adolescents, schools are often the only place that mental health services are available. Public schools are, in fact, the ''major providers of mental health services to school-aged children.''[372]

Students may need treatment for mental health conditions ranging from depression and suicidality to attention deficit/hyperactivity disorder (ADHD) and stress. Schools may also provide a number of other counseling and social services, such as counseling and treatment for eating disorders, substance abuse, tobacco use, and physical, sexual, or emotional abuse. The availability of counseling, psychological, and social services in public schools is widespread, although specific services vary considerably across states and school districts. Schools may facilitate counseling, psychological, and social services through multiple mechanisms, including on-site services by a variety of professionals employed by the school (eg, school counselors, psychologists, nurses, and social workers), delivery of services by SBHCs, and referrals to off-site health providers (with appropriate prior written consent if personal information is disclosed).

This section explores what is legally required of public schools and staff when providing counseling, psychological, and social services to students. Specifically, this section answers the following questions: Do federal, state, or local laws require public schools to provide counseling, psychological, and social services to students? What legal provisions facilitate screening for and treatment of mental health conditions in public schools? What is the role of national counseling and psychological services standards and objectives? Who is qualified to provide counseling, psychological, and social services? When may school officials refer students to counseling, psychological, and social service providers outside the school setting?

1. General Legal Requirements to Provide Counseling, Psychological, and Social Services to Students

Federal, state, and local laws and regulations may require schools to provide counseling, psychological, and social services to students.[373] Although federal law does not require these services for all students, federal law mandates that qualifying schools offer counseling, psychological, and social services to students with health conditions that adversely affect their educational performance (under IDEA)[374] or substantially limit their ability to learn (under section 504 of the Rehabilitation Act).[375] Schools in states receiving IDEA funding must provide related services as a component of a student's IEP. Related services may include psychological services, social work services, and counseling services.[376] The IDEA also requires schools to identify and assess potentially disabling conditions in children[377] (discussed in section II.C). Additionally, federal law may encourage the development of specific counseling, psychological, and social services at the state and school district levels. For instance, the Safe and Drug-Free Schools and Communities Act provides states with funding to implement plans for drug abuse and violence prevention.[378]

All states allow for the provision of counseling, psychological, and social services in school settings, but the scope and content of these services vary across states, school districts, and individual schools.[379] State laws do not typically require that all students have access to specific services at school or outline how services should be provided. Nevertheless, access to and eligibility for mental health services in schools are widespread. A recent report by SAMHSA concluded that all students were eligible to receive mental health services in 87% of schools surveyed.[380]

Special education students who meet the criteria for IDEA services, by contrast, must receive special education and related health services pursuant to an IEP. Schools must facilitate access to needed counseling, psychological, and social services for these students, although schools have some discretion regarding how services are provided. As a consequence, schools have implemented multiple approaches to provide these services ranging from in-school services provided by school staff to collaborative arrangements with community providers. Many of the community providers provide services on-site at the school.[381] Some schools provide counseling, psychological, and social services through SBHCs.[382] Some states, such as Texas, have laws that limit the ability of school staff to refer students for mental health evaluation or treatment without parental consent.[383]

States have encouraged schools to enhance access to counseling, psychological, and social services. In the past few years, some states have sought to expand through legislation the availability of mental health and social services in schools.[384] States also have legislatively created task forces to provide guidance and resources to schools related to specific concerns such as mental health, suicide, and substance abuse. In 2004, New Hampshire passed legislation requiring the development of a statewide comprehensive plan for youth suicide prevention.[385] A recent Texas bill provided for several state agencies to work collaboratively to recommend further development

of school-based mental health and substance abuse programs.[386]

The increasing availability of counseling, psychological, and social services in public schools departs from historic views taken by schools related to these services. Previously, most assessments have found that school-based mental health services were targeted at special education student populations.[387] However, SAMHSA's study reveals that as of 2003, almost all schools surveyed reported at least one staff member designated to provide mental health services; more than 80% of schools provided assessment for mental health problems, behavior management consultation, and crisis intervention; a majority of schools provided individual and group counseling and case management services.[388] Funding for these services comes from a number of sources, including federal programs (IDEA, Medicaid, and SCHIP), state programs,[389] and local school and district budgets.[390]

2. Testing and Screening for Mental Health Conditions

State laws set up a framework within which schools may conduct screening for mental health conditions among students. Screening may occur for a number of conditions, including depression, suicide, substance abuse, eating disorders, ADHD, and physical and emotional abuse. Research indicates that assessment of mental health problems or disorders (including behavioral observation, psychosocial assessment, and psychological testing) is offered in nearly 90% of schools.[391] The IDEA and related state laws require that schools screen for students who qualify for IDEA services. This includes screening for emotional and psychological impairments.[392] Some state laws and regulations explicitly provide for screening or evaluation of these conditions, while others allow local jurisdictions and schools to develop policies regarding these services. Illinois, for example, specifically authorizes screening and evaluation of students for psychological conditions.[393]

Federal and state laws limit the ability to conduct surveys or screenings for some mental, emotional, and social health conditions. The PPRA requires prior written consent of a parent (or adult student or emancipated minor) before a student can be required to complete a questionnaire funded in whole or in part by ED involving, among other sensitive topics outlined in the law, the mental or psychological problems of the student or the student's family or sex behavior or attitudes.[394] For questionnaires not funded by ED, parents must be notified of the specific or approximate dates of the survey, be provided an opportunity to inspect the questionnaire, and be provided the opportunity to opt their child out of participation. Parents must also be notified in writing prior to the evaluation of a student under the IDEA. Several states have passed laws that limit the ability of school officials to subject a student to a psychiatric evaluation without prior parental consent.[395]

3. Provision of Counseling, Psychological, and Social Services

Many schools provide treatment, counseling, or other types of services for students with mental health conditions or social services needs. For students who qualify for services under the IDEA, state laws may be very prescriptive. For example, Michigan regulations outline specific requirements for classroom size for students with cognitive or emotional impairments.[396] Eligibility for IDEA services has been recognized for children with a range of mental health conditions, including ADHD.[397] For the general student population, state laws are less directive, often allowing school districts or individual schools to determine their own policies for provision of counseling, psychological, and social services. Services authorized under law may include behavior management consultation (with teachers, students, and families), case management (monitoring and coordination of services), crisis intervention, individual counseling/therapy, group counseling/therapy, substance abuse counseling, medication for emotional or behavioral problems, and family support services (eg, child/family advocacy and counseling).[398]

Counseling Services

State laws broadly authorize schools to provide counseling services. For example, Arkansas and Illinois outline in detail the scope of counseling services that may be provided by schools.[399] Other states, such as Colorado, allow more discretion to individual school districts to determine the scope of services provided.[400] The availability of counseling services understandably differs according to grade level. Access to substance abuse counseling, for example, is more common in high schools compared to elementary or middle schools.[401] Some states also allow schools to require counseling as a prerequisite for students who have been disciplined under substance abuse policies and wish to reenroll in the school.[402]

Treatment Services

Treatment services or referrals are widely available in schools. Some states have initiated proactive measures to expand access to school mental health services. New York's School-Based Mental Health Program has led to the creation of more than 200 licensed, school-based clinics throughout the state. These clinics offer treatment services, crisis intervention, consultation, and technical assistance and training in the school setting.[403] Other states mandate that schools implement programs to detect and treat substance abuse. Louisiana requires schools to establish alcohol, drug, and substance abuse prevention programs and requires minor students identified as having a substance abuse problem to participate in the school

drug counseling program.[404] There must be at least one addictive disorders professional for every four schools in Louisiana.[405]

Recommending the use of psychotropic drugs has been a contentious issue at the state level. Several states, including Connecticut, Illinois, Texas, and Virginia, prohibit school officials from recommending that students use psychotropic drugs. These states do not preclude school officials from referring a student to external medical professionals for psychological evaluation. Texas also explicitly prohibits a school from excluding a student from school activities on the basis of a parental refusal to have the student take a psychotropic drug or be evaluated for a psychiatric condition.[406]

Other interventions may be authorized or required as well. Virginia requires school staff to notify a student's parents or the Department of Social Services if they believe that the student is at imminent risk for committing suicide.[407] The Garrett Lee Smith Memorial Act[408] recognized that youth suicide is a public health crisis linked to underlying mental health problems and authorized funding for youth suicide prevention programs including voluntary, confidential screening programs. SAMHSA awards grants to develop and implement state-sponsored early intervention and prevention strategies in schools and other educational institutions.

The ability to refer students for mental health or social services from external providers may be affected by state law. For instance, Texas prohibits referrals to outside counselors for care or treatment of a chemical dependency or an emotional or psychological condition without first obtaining parental consent.[409] Many states authorize referrals for medication management and to specialized programs or services for emotional or behavioral problems or disorders.[410]

4. Use of Identifiable Information

School counseling and psychological service records may contain sensitive personal information. When such records include identifiable health information, they are subject to the same privacy protections as other school records under FERPA, the HIPAA Privacy Rule, and other privacy requirements (discussed in section II.B.3). Some states provide additional protection for these types of records. California explicitly provides confidentiality protections for ''any information of a personal nature disclosed by [or about] a pupil twelve years of age or older in the process of receiving counseling from a school counselor.''[411] Idaho provides for a school counselor-student privilege in its state Rules of Evidence, protecting the confidentiality of these communications.[412]

There may be instances where a third party may require access to student records for advocacy purposes. In *State of Connecticut Office of Protection and Advocacy for Persons with Disabilities v Hartford Board of Education*,[413] the Connecticut Office of Protection and Advocacy for Persons with Disabilities (OPA) sued the Hartford Board of Education and the Hartford Public Schools. It sought access to directory information for students and their parents to investigate allegations of mistreatment or abuse. The school board argued that access should be denied on grounds of incompatible federal laws governing privacy and confidentiality. A number of federal laws (such as the Developmental Disabilities Assistance and Bill of Rights Act, the Protection and Advocacy of Individual Rights Act, and the Protection and Advocacy for Mentally Ill Individuals Act) govern the OPA's access to records in such circumstances. The court held that OPA was entitled to the information under these federal laws.

5. Standards for Staff Providing Counseling, Psychological, and Social Services

Counseling, psychological, and social services may be provided by counselors, psychologists, social workers, nurses, and other professionals in the school setting. State laws often authorize schools to employ these professionals but do not require every school to employ specific professionals.[414] Many states have enacted education, license, and certification requirements for school counselors, psychologists, social workers, and nurses.[415] These professionals must obtain the appropriate license or certification before they are permitted to provide services in the school setting. Licensing typically is conducted by a state professional licensing board, while credentialing may be done at the state level or, in some cases, by national organizations. At least 18 states require national certification for school psychologists based upon standards set by the National Association of School Psychologists.[416] Even in states in which national certification is not required, such certification may facilitate the licensing or certification process for the professional.

States also may dictate the practice parameters or require specific training for these professionals. Arkansas requires school counselors to devote at least 75% of work time each week to providing direct counseling to students.[417] Illinois law states that ''school guidance counselors, teachers and other school personnel who work with pupils in grades 7-12 shall be trained to identify the warning signs of suicidal behavior in adolescents and teens and shall be taught various intervention techniques.''[418] In *Eisel v Board of Education of Montgomery County*,[419] the Court of Appeals of Maryland addressed the role of school counselors to inform parents of statements concerning potential suicidal tendencies of their children. Specifically, the court recognized that counselors who are on notice of a student's suicidal intent have a duty to warn his or her parent(s). Other state courts tend to evaluate a school board's policies on a case-by-case basis.[420] It is thus

essential that schools retain a ''well-defined suicide-prevention policy, combined with staff training and accessible higher officials'' to respond to situations involving potential suicidal tendencies and reduce the likelihood of being held liable for not taking appropriate measures.[421]

Several national professional organizations, including the American School Counselor Association, the National Association of School Psychologists, and the National Association of Social Workers, have developed professional codes of ethics.[422] These codes, while not legally binding on professional practice, set influential standards that significantly affect the delivery of services in the school setting.

F. Healthy and Safe School Environment

In a CSHP model, healthy and safe school environment describes the physical and aesthetic surroundings and the psychosocial climate and culture of the school. 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 physical conditions such as temperature, noise, and lighting. The psychological environment includes the physical, emotional, and social conditions that affect the well-being of students and staff.[423] ''Youth who feel connected are more likely to achieve and behave well. Schools that incorporate the characteristics of a positive school environment are more likely to improve academic achievement and staff morale, reduce disciplinary referrals and suspensions, and enhance safety.''[424] Likewise, schools can contribute to academic success by supporting safety strategies in school.[425] Legislation, regulation, and policy establish and define environmental conditions. School administrators, staff, and students are responsible for maintaining a healthy school environment.

Providing for a healthy school environment is addressed in multiple objectives of *Healthy People 2010*. For example, objective 8-20 seeks to ''[i]ncrease the proportion of the Nation's primary and secondary schools that have official school policies ensuring the safety of students and staff from environmental hazards, such as chemicals in special classrooms, poor indoor air quality, asbestos, and exposure to pesticides.''[426] Objective 27-11 encourages efforts to develop ''smoke-free and tobacco-free environments in schools, including all school facilities, property, vehicles, and school events,'' setting a target goal of 100% of schools to be smoke- and tobacco-free by 2010 from a 1994 baseline of 37%.[427] Objective 15-31 is a developmental objective addressing injury protection in school sports: ''[i]ncrease the proportion of public and private schools that require use of appropriate head, face, eye, and mouth protection for students participating in school-sponsored physical activities.'' Two other objectives address violence in schools: objective 15-38 (reduce physical fighting among adolescents)[428] and objective 15-39 (reduce weapon carrying by adolescents on school property).[429] As discussed in this section, achieving a healthy school environment involves many federal, state, and local laws, regulations, and policies covering a range of health-related areas.

1. Healthy School Environment Assessment Tools

Several assessment tools have been developed to assist school authorities in creating a healthy school environment, including three tools developed by the EPA, CDC, and the National Institute for Occupational Safety and Health (NIOSH).

EPA's software program, Healthy School Environments Assessment Tool (HealthySEAT), assists school districts with evaluating and managing their school facilities for key environmental, health, and safety issues.[430] HealthySEAT allows district-level personnel to conduct a voluntary self-assessment of their schools and to track and manage data on environmental conditions in each school in their district. EPA states that with HealthySEAT, school districts should be able to identify and correct health hazards before they result in student or staff health problems; losses in productivity and performance losses; school closures due to spills, accidents, or other preventable environmental, health, and safety issues; costly building cleanups; regulatory enforcement actions by state or federal agencies; or community concerns.[431]

NIOSH's Safety Checklist Program for Schools, based on a successful state model in New Jersey, helps school administrators, coordinators, and teachers comply with federal or state Occupational Safety and Health Administration (OSHA) regulations.[432] Its goal is to prevent injury and illness among school employees and students and to protect the environment by maintaining safe classrooms, shops, and labs in ''career-technical'' education. The tool provides numerous checklists directly related to career-technical classroom programs and courses but does not, for example, cover EPA regulations concerning asbestos abatement in schools.

Although not solely a school environment assessment tool, CDC's School Health Index (SHI) is ''a [confidential] self-assessment and planning tool that schools can use to improve their health and safety policies and programs.''[433] SHI is structured around an eight-component CSHP model. The eight self-assessment modules (in online or paper form) allow schools to assess school health and safety policies and programs. The planning tool helps schools to decide which actions can be implemented annually to improve performance in areas that received low scores in the assessment phase. CDC notes that SHI is not a research or evaluation tool nor is it meant to be used to punish school staff members.

2. School Climate

In SHPPS 2006, states and districts were asked about efforts to promote positive school climate, defined as a sense of community and welcome within the school. Positive school climate is exemplified through caring student-teacher relationships, high teacher morale, student involvement and leadership in activities and programs, and family involvement.[434] Many states (71%) and districts (77%) had policies that explicitly promoted positive school climate. In addition, 42% of states and 67% of districts had policies stating that schools will adopt prosocial codes of conduct that address such concepts as cooperation, conflict resolution, and helping others.

3. Physical School Environment

The physical environment is an important aspect of student health. ED's National Center for Education Statistics published results of a survey assessing the conditions of public schools in 1999.[435] The survey found that three fourths of public schools needed to repair, renovate, or modernize their on-site buildings to put them in good overall condition, at a cost of about $127 billion. Although most schools were in adequate or better condition, many were not. For example, 43% of the schools reported that at least one of the six environmental conditions (lighting, heating, ventilation, indoor air quality, acoustics or noise control, and physical security of buildings) was in unsatisfactory or very unsatisfactory condition. Of these schools, two thirds reported more than one unsatisfactory or very unsatisfactory environmental condition. Ventilation was most often reported (26%), followed by physical security of buildings (20%), indoor air quality (18%), acoustics or noise control (18%), heating (17%), and lighting (12%).

Several states have laws requiring school authorities to provide a healthy physical environment for students. For example, a Pennsylvania law states:

> The board of school directors of each district shall provide the necessary grounds and suitable school buildings to accommodate all the children between the ages of six and twenty-one years, in said district, who attend school. Such buildings shall be constructed, furnished, equipped, and maintained in a proper manner as herein provided. Suitable provisions shall be made for the heating (including the purchase of fuel), ventilating, adequate lighting, and sanitary conditions thereof, and for a safe supply of water, so that every pupil in any such building may have proper and healthful accommodations.[436]

Texas law requires that school buildings be located on grounds that are well drained and maintained in a sanitary condition; be properly ventilated and have an adequate supply of drinking water, an approved sewage disposal system, hand washing facilities, a heating system, and lighting facilities that conform to established standards of good public health engineering practices; and be maintained in a sanitary manner. Public school lunchrooms must comply with the state food and drug rules, and a full-time building custodian must be knowledgeable in the fundamentals of safety and school sanitation.[437]

Asbestos

In 1986, Congress passed the Asbestos Hazard Emergency Response Act[438] (AHERA) as part of the Toxic Substances Control Act.[439] According to the EPA, AHERA was ''designed to keep asbestos fiber levels low by teaching people to recognize asbestos-containing materials and actively manage them. Removing asbestos-containing material is usually not necessary unless it is severely damaged or will be disturbed by a building demolition or renovation project.''[440] AHERA and its accompanying regulations[441] require LEAs[442] to:

- Perform an original inspection and reinspection of asbestos-containing material every 3 years.
- Develop, maintain, and update an asbestos management plan and keep a copy at the school.
- Provide yearly notification to parent, teacher, and employee organizations regarding the availability of the school's asbestos management plan and any asbestos abatement actions taken or planned in the school.
- Designate a contact person to ensure that the responsibilities of the LEA are properly implemented.
- Perform periodic surveillance of known or suspected asbestos-containing building material.
- Ensure that properly accredited professionals perform inspections and response actions and prepare management plans.
- Provide custodial staff with asbestos awareness training.[443]

Two years earlier, the Asbestos School Hazard Abatement Act of 1984, as amended,[444] created a program to provide schools with expertise, technical assistance, financial resources, and other incentives to ascertain the extent of danger to the health of students and staff from asbestos materials in schools.[445] This Act further assures that no employee of any LEA will suffer any disciplinary action as a result of calling attention to potential asbestos hazards that may exist in schools.[446] It established the Asbestos Hazards Abatement Program[447] and the Asbestos Hazards Abatement Assistance Program[448] within EPA and the Asbestos Trust Fund in the Treasury of the United States.[449] Between 1984 and 1993, Congress appropriated a total of $382 million in grants and loans for this program. Since then, no money has been appropriated.

Many state laws address the problem of asbestos in schools in accordance with federal law. Alaska established the Asbestos Health Hazard Abatement

Program in the state Department of Labor and Workforce Development to coordinate state agencies' efforts to abate asbestos health hazards in schools.[450] The program applies to public schools regarding demolition, removal, encapsulation, salvage, repair, transportation, disposal, storage, and containment of asbestos products, as well as any construction, alteration, repair, maintenance, or renovation that causes asbestos fibers to become airborne.[451] Illinois' Asbestos Abatement Act[452] seeks to identify, contain, and remove asbestos materials constituting a ''significant health hazard'' and to repair or maintain asbestos material not constituting a significant health hazard in schools.[453] The law requires, among other things, that schools undertake response actions as required by the federal AHERA (and corresponding regulations) and the rules promulgated under the state Asbestos Abatement Act.[454]

Indoor Radon

In 1988, Congress amended the Toxic Substances Control Act by adding Title III—Indoor Radon Abatement ''to assist States in responding to the threat to human health posed by exposure to radon.''[455] According to Title III, the national long-term goal with respect to indoor radon levels is to make the air inside buildings ''as free of radon as the ambient air outside of buildings.''[456] Title III does not specifically require monitoring or abatement of radon but instead provides financial and technical assistance to states interested in monitoring and control. With respect to schools in particular, Title III required EPA to study the extent of radon contamination in US school buildings.[457] As part of the study, a list of regional areas with a high probability of schools with elevated levels of radon was prepared[458] and shared with Congress and the states.[459] In 1990, the EPA conducted a National School Radon Survey and estimated that 73,000 schools nationwide had a potential radon problem.[460] EPA then developed resources to ''promote accurate and meaningful radon measurements'' to assist schools in resolving their radon problems.[461]

Many states also regulate radon in schools. For example, Virginia law required that every school building be tested for radon consistent with EPA standards by July 1, 1994. School buildings and additions opened for operation after that date must also be tested. Each school must keep its radon test results, make such records available for review, and report results to the state Department of Health.[462] Connecticut required its state Department of Public Health to adopt regulations establishing acceptable radon levels in ambient air and drinking water in schools by January 1, 1991.[463]

Pesticides

The Federal Insecticide, Fungicide, and Rodenticide Act regulates pesticide use in the United States but does not specifically address the use of pesticides in schools.[464] In general, a pesticide can be sold and distributed in the United States if it is registered with the EPA, which considers, among other things, whether the pesticide causes unreasonable adverse effects on human health or the environment. Once registered, a pesticide can be used only according to its label. Pesticide labels contain provisions explaining the proper use of the product in school or other settings.[465]

Many states have enacted more stringent laws concerning pesticide use in schools. A 2002 review of state pesticide laws affecting schools found that:

- Twenty-five states require that signs be posted for applying pesticide on school grounds.
- Sixteen states require sign posting for applying pesticides inside schools.
- Twenty-one states require prior written notification to students, parents, and school personnel before pesticides are applied in schools.
- Sixteen states require or recommend that schools use an integrated pest management program (designed to eliminate unnecessary application of pesticides).
- Ten states restrict the pesticides that can be applied in schools or when they can be applied.
- Seven states restrict application of pesticides in neighborhood areas buffering a school.[466]

A recent study analyzed surveillance data from nearly 2600 people with acute illnesses associated with pesticide exposures (1998-2002) in elementary and secondary schools and child care centers.[467] The study found 7.4 cases per million children and 27.3 cases per million school employee full-time equivalents. Low-severity cases accounted for 89% of the total, followed by 275 cases of moderate severity (11%) and three cases of high severity. The most common associations with illness were for insecticides (35%), disinfectants (32%), repellents (13%), and herbicides (11%). Among the 406 cases with sufficient information on exposure source, 281 (69%) were associated with pesticide use at schools. The study concluded that pesticide use should be reduced. It recommended that schools implement integrated pest management programs, establish pesticide spray buffer zones around schools, and reduce pesticide drift from farmlands.

Lead Contamination in School Drinking Water and Other Sources

The Federal Lead Contamination Control Act of 1988 amended the Safe Drinking Water Act to control lead in drinking water and included two new code provisions concerning school drinking water.[468] The law required EPA to distribute to states a list of drinking water coolers (brands and models) that were not lead free, including those with lead-lined tanks.[469] EPA also was required to publish a guidance document and a test protocol to help schools determine the source and

degree of lead contamination in school drinking water supplies and to remedy any contamination. States were required to disseminate the guidance document, the testing protocol, and the list of drinking water coolers to local educational agencies (and others). States also were required to establish programs to assist LEAs testing for and remedying lead contamination in drinking water coolers and other sources of school lead contamination and to make the test results available to students, parents, and school personnel. The program was to include measures to reduce or eliminate lead contamination in drinking water coolers that were not lead free and that were introduced into schools within a specified time period.[470] However, in *ACORN v Edwards*, the Fifth Circuit Court of Appeals found that the section requiring states to establish such a program was an unconstitutional intrusion on state sovereignty.[471]

Many states' laws also address lead exposure in schools from drinking water and other sources. For example, California's comprehensive Lead-Safe Schools Protection Act of 1992[472] applies to public elementary schools, as well as to preschools and day care facilities located on public school property.[473] It directs the state Department of Health Services to survey a representative sample of schools to identify risk factors for lead contamination[474] from exposure to paint, soil in school play areas, tap drinking water, and other potential sources. The state department must (1) summarize the survey results and report them to the state legislature and the state Department of Education, (2) notify the school principal or school site director, school personnel, and parents of the results, (3) recommend the feasibility and need to conduct statewide lead testing and any additional action related to lead contamination in the schools, (4) develop environmental lead testing methods and standards for use by schools and contractors if appropriate, (5) evaluate the most current cost-effective technologies, and (6) work with the state Department of Education to develop voluntary guidelines for schools to minimize lead hazards in the course of school repair, maintenance programs, and abatement procedures. A school determined to have significant risk factors for lead must notify school personnel and parents and indicate to parents specific protections under the state Childhood Lead Poisoning Prevention Act of 1991.[475] The law also prohibits lead-based paint, lead plumbing and solders, and other potential sources of lead contamination used in constructing new school facilities or modernizing or renovating existing school facilities[476] and authorizes funding to implement its provisions.[477]

Unintentional Injuries

Unintentional injuries to students or staff resulting from the physical environment is a preventable public health problem in schools. SHPPS 2006 found that most states and districts have adopted some policies to prevent unintentional injuries.[478] For example, most states and districts have policies related to the inspection or maintenance of fire extinguishers; smoke detectors; halls, stairs, regular and special classrooms; athletic facilities; and playgrounds. Indoor and outdoor lighting are also addressed in many state or district policies. Nationwide, 76% of states and 95% of districts had adopted a policy requiring students to wear appropriate protective gear when engaged in classes such as wood shop or metal shop and 76% of states and 95% of districts had adopted policies requiring students to wear appropriate protective gear when engaged in lab activities for photography, chemistry, biology, or other science classes. SHPSS 2006 also found that 33% of districts had ever been sued because of an injury that occurred on school property or at an off-campus, school-sponsored event.[479] This included any claim filed with a court, regardless of the outcome, but did not include suits against individual staff members. In 2002, California amended its law known as Billy's Bill for Sun Safety (named after William S. Graham, who died at age 22 from a malignant melanoma[480]) to require every school to allow the outdoor use of sun protective clothing or sunscreen during the school day without a physician's note or prescription.[481]

School Bus Safety

Under federal law, the National Highway Traffic Safety Administration (NHTSA)[482] issues the Federal Motor Vehicle Safety Standards and Regulations (FMVSS),[483] setting minimum safety performance requirements for motor vehicles. The standards protect the public ''against unreasonable risk of crashes occurring as a result of the design, construction, or performance of motor vehicles [and] against unreasonable risk of death or injury in the event crashes do occur.''[484] Four standards pertain exclusively to school bus safety: standard no. 131 (School bus pedestrian safety devices),[485] standard no. 220 (School bus rollover protection),[486] standard no. 221 (School bus body joint strength),[487] and standard no. 222 (School bus passenger seating and crash protection).[488]

NHTSA requires that school buses weighing less than 10,000 pounds be equipped with lap or lap/shoulder belts.[489] Standard no. 213, which regulates child restraint systems in motor vehicles, sets forth the requirements of harnesses if used in school buses.[490] The standards do not require that larger school buses be equipped with seat belts or other child restraint systems.[491] NHTSA's position is that the small number of fatal crashes on school buses (since 1984, an average of 11 bus passengers have died each year) does not justify a federal mandate. Instead, NHTSA favors ''compartmentalization,'' which requires the interior of large school buses to provide protection without seat belt use. Seats are closely spaced and have high, energy-absorbing backs.[492]

States and some localities have enacted laws requiring school buses be equipped with child restraint systems and mandate their use. For example, New York law requires that large school buses manufactured after July 1, 1987, have seat belts and that children aged younger than 4 years riding on school buses sit in child restraint systems meeting FMVSS. New York school districts are required to conduct at least three school bus drills per school year that include instruction in safe entering and exiting procedures.

In addition to addressing the safety of children and adolescents using school buses, federal law requires each state to have a highway safety program approved by the Secretary of Transportation that is ''designed to reduce traffic accidents and deaths, injuries, and property damage,''[493] including a program to reduce injuries and deaths involving school bus crashes.[494]

Pedestrian Safety Near Schools

School speed zones set by states or localities protect children and adolescents using public streets in the vicinity of schools. For example, Minnesota law gives local authorities the power to establish speed limits within a school zone defined as ''that section of a street or highway which abuts the grounds of a school where children have access to the street or highway from the school property or where an established school crossing is located.'' According to state law, the speed limits are in effect ''when children are present, going to or leaving school during opening or closing hours or during school recess periods.'' State law restricts the discretion of local authorities to set the speed limit in the school zone: it cannot be lower than 15 miles per hour (mph) nor can it be more than 30 mph slower than the speed limit on the affected street or highway. Violators of the speed limit in a school zone are assessed an additional surcharge equal to the usual fine but not less than $25.[495]

Reducing speed limits in school zones is part of a larger effort to enable children to walk or ride a bicycle to school and thereby engage in physical activity to improve their health. Nineteen states have laws that impose additional sanctions on drivers who speed in school zones.[496] Section 1401 of the Federal Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users[497] requires the Secretary of Transportation to establish and implement a Safe Routes to School (SR2S) Program aimed at children in grades K-8 with three expressed health-related purposes: to enable and encourage children, including those with disabilities, to walk and bicycle to school; to make bicycling and walking to school a safer and more appealing transportation alternative, thereby encouraging a healthy and active lifestyle from an early age; and to facilitate the planning, development, and implementation of projects and activities to improve safety and reduce traffic, fuel consumption, and air pollution in the vicinity of schools.[498]

Grants are awarded to states[499] that support infrastructure-related projects (eg, improvements to sidewalks, pedestrian and bicycle crossings, and traffic diversion in the vicinity of schools) as well as noninfrastructure-related projects such as student information sessions on bicycle and pedestrian safety, health, and environment.[500] Delaware's SR2S Program[501] gives the state's Division of Highways the authority to establish bikeways ''for the use, enjoyment and participation of the public in nonmotorized bicycling.''[502] South Carolina's program designates the first Wednesday of October as ''Walk or Bicycle with Your Child to School Day'' to encourage students to walk or ride bicycles to school and identify improvements needed to promote walking or riding to school, such as sidewalks or pedestrian routes not open to motor vehicle traffic.[503]

Building Healthy, High-Performance Schools

A report published by the Environmental Law Institute (ELI), with funding from EPA, *Building Healthy, High Performance Schools: A Review of Selected State and Local Initiatives*, describes in detail initiatives of three states (California, Massachusetts, and New Jersey) and four school districts (in Minnesota, North Carolina, the District of Columbia, and Los Angeles) to build the so-called ''high-performance'' schools—''buildings that support the learning process and are healthier, more environmentally responsible, and less expensive to operate.''[504] Health, environmental, economic, and educational goals are included in the building process from the earliest planning stages to the evaluation and operation of the facility after occupancy. The Sustainable Building Industry Council has identified integrated components to help to create healthy and productive, cost efficient, and sustainable high-performance schools. These relate to acoustic, thermal, and visual comfort; superior indoor air quality; safety and security; high-performance heating, ventilation, and air-conditioning system and electric lighting; daylighting; energy efficiency; and environmentally sound materials, products, and site planning.[505] Each of the case studies presented in the ELI report discusses relevant laws, regulations, and policies (eg, state building codes, county planning and zoning ordinances, and school board resolutions) that affect the building of high-performance schools.

SHPPS 2006 queried state and district respondents about Phase I Environmental Site Assessments. These assessments can include a physical survey of the property and surrounding properties to assess general land use and occupants of the area, an on-site visual inspection of the site to identify environmental concerns, an assessment of current and past uses of the property particularly if any hazardous materials were

stored or disposed of at the site, a review of owner records, and a review of local, state, and federal regulatory agency records maintained for the site. More than one half of states (59%) required Phase I Environment Site Assessments prior to the construction of a new school facility (respondents from 20% of states did not require such assessments and another 20% of states were unsure whether they were required). Among districts, 35% required Phase I Assessments, 30% did not require such assessments, and 35% had no new facilities planned.[506]

Fire Drills

Many states have enacted laws requiring schools to incorporate fire drills as part of the training pursuant to their emergency action plans. In Arkansas, for example, the state police must ensure that schools conduct one fire drill each month and keep all doors and exits unlocked during school hours.[507] In Virginia, every public school must conduct a fire drill at least once every week during the first 20 school days of each school session, and more often if necessary, to ensure its students are thoroughly familiar with the evacuation procedures in the event of a fire.[508]

4. Violence

a. Federal and State Laws Addressing School Violence

Federal law makes it a crime to possess a firearm, or knowingly or recklessly discharge a firearm[509] in a school zone, subject to some exceptions. ''It shall be unlawful for any individual knowingly to possess a firearm that has moved in or that otherwise affects interstate or foreign commerce at a place that the individual knows, or has reasonable cause to believe, is a school zone.''[510] The Act applies to public, private, and parochial schools that provide elementary or secondary education.[511] ''School zone'' means in a school, on the grounds of a school, or within 1000 feet of the school grounds.[512] Violation of the Act is a felony punishable by imprisonment of up to 5 years and/or fines.[513]

The current law addressing firearm possession and use in a school zone replaced the Gun-Free School Zones Act of 1990,[514] which the US Supreme Court ruled unconstitutional in *United States v Lopez* (1995)[515] on federalism grounds, holding that it exceeded Congress' authority to regulate commerce among the states.[516] Specifically, the Supreme Court found that the 1990 law contained ''no jurisdictional element which would ensure, through case-by-case inquiry, that the firearm possession in question affects interstate commerce.''[517] The 1990 law made it a federal crime ''for any individual knowingly to possess a firearm at a place that the individual knows, or has reasonable cause to believe, is a school zone.''[518] The 1996 version amended this language to clarify that ''It will be unlawful for any individual knowingly to possess a firearm that has moved in or that otherwise affects interstate or foreign commerce'' to address the constitutional deficiency identified in *Lopez*. The Eighth and Ninth Circuit Courts of Appeals have held that 1996 version with this additional language is constitutional.[519]

States also may supplement the protections of federal legislation addressing firearm possession and use in a school zone.[520] For example, Wisconsin makes it a class I felony[521] to knowingly possess a firearm in a school zone,[522] defined substantially as in the federal law.[523] Maine makes it a class E crime (ie, the maximum period of incarceration does not exceed 6 months) to possess a firearm on public school property or discharge it within 500 feet of school property.[524] Other states, such as California,[525] Louisiana,[526] and Ohio,[527] also feature gun-free school zone laws.

The Gun-Free Schools Act requires that each state receiving funds under NCLB[528] enacts a state law requiring LEAs to expel any student who brings a gun to school or who possesses a gun at school.[529] Expulsion must last at least 1 year. Expulsion requirements may be modified in writing on a case-by-case basis.[530] The state may also provide educational services to expelled students.[531] The law does not apply if the gun is lawfully stored inside a locked vehicle on school property or if the gun is for activities approved and authorized by the LEA, and the agency adopts safety measures to ensure student safety.[532] In addition, LEAs must establish policies requiring that a student who brings a gun to school is referred to the criminal justice or juvenile delinquency system.[533]

The ''Schoolyard Statute.'' Violence associated with the possession or sale of illegal drugs in or near schools is a serious problem in some school districts. Under the federal ''schoolyard statute,'' Congress doubles the standard penalties for first violations of federal laws prohibiting the possession, distribution, or manufacture of controlled substances (eg, cocaine and heroin) ''in or on, or within one thousand feet of'' a public school.[534] In addition, penalties are tripled for an adult who ''employs, hires, uses, persuades, induces, entices, or coerces'' a child to violate the schoolyard statute or to assist in avoiding detection or apprehension for an offense under the schoolyard statute.[535]

Federal and State Juvenile Transfer Laws. All states, the District of Columbia, and the federal government have laws that transfer children to adult criminal courts for prosecution and sentencing in specified circumstances.[536] So-called ''juvenile transfer laws'' are of three general types depending upon where the responsibility is placed for determining whether a child is tried as a juvenile in delinquent proceedings or as an adult in criminal proceedings: (1) judicial waiver (case begins in the juvenile court and the judge may, and sometimes must, transfer the case to the adult criminal

court), (2) direct file (prosecutor decides whether to initiate case in juvenile or criminal court), and (3) statutory exclusion (laws that exclude certain categories of juveniles from the jurisdiction of the juvenile court and place jurisdiction in the criminal court). In response to the shootings at Columbine High School and other school shootings, three states (Illinois, Nevada, and New York) recently changed their transfer laws; juveniles who commit violent offenses on school property are prosecuted as adults in criminal courts.[537]

''Persistently Dangerous'' School. NCLB requires that each state receiving funds under ESEA establishes and implements a statewide policy concerning safe school attendance for affected children and adolescents. Any student who attends a ''persistently dangerous'' public school (as determined by the state in consultation with a representative sample of local educational agencies), or is a victim of a violent crime (as defined by state law) on the grounds of a school that the student attends, may transfer to a safe public school within the jurisdiction of the LEA pursuant to the Unsafe School Choice Option (USCO) under NCLB.[538] ED has also issued nonregulatory guidance that highlights key aspects of USCO and provides information that may be useful to meet its requirements.[539] This includes a description of what a state's USCO policy should contain, how to identify a persistently dangerous school, and school safety and data collection, among other vital information.[540] During the 2005-2006 school year, only 36 schools from seven states were determined to be persistently dangerous.[541] These data are subject to change due to appeals.[542]

States comply with this federal mandate in various ways.[543] For example, Nevada[544] and South Carolina[545] laws specifically direct the state board of education to carry out its provisions. New Hampshire defines a ''persistently dangerous school'' as a school area in which three violent acts (eg, homicide, sexual assault, arson, robbery, and unlawful possession or sale of a firearm) have occurred during each school year for three consecutive years.[546] Schools designated as persistently dangerous must operate as a ''safe school'' for 2 years to be decertified.[547]

State-Based Protections. SHPPS 2006 found that nearly all states, districts, and schools have policies prohibiting weapon possession or use by students, many of which apply also to off-campus, school-sponsored events.[548] Most districts and schools also prohibit physical fighting, gang activities, and harassment of other students. Many states have passed laws to specifically deter bullying in schools.[549] To date, 24 states have anti-bullying statutes, and 3 states have created anti-bullying regulations.[550] These statutes typically address what constitutes ''bullying,'' its reporting, and consequences to students.[551] Some states define the term ''bullying'' broadly, some are more specific, and some leave the definition to local school districts. For example, New Hampshire's law merely states that each local school board ''shall adopt a pupil safety and violence prevention policy which addresses pupil harassment, also known as 'bullying' ... ''[552] Rhode Island's law is more specific: ''[h]arassment, intimidation or bullying means an intentional written, verbal or physical act or threat of a physical act that, under the totality of circumstances: (i) a reasonable person should know will have the effect of: physically harming a student, damaging a student's property, placing a student in reasonable fear of harm to his or her person, or placing a student in reasonable fear of damage to his or her property; or (ii) is sufficiently severe, persistent or pervasive that it creates an intimidating, threatening or abusive educational environment for a student.''[553] Most state anti-bullying laws and policies address an intention to harm, repetition of behavior, and power imbalance (eg, intimidation), although no state has included all three definition elements.[554] Although there is no uniformity among state anti-bullying laws, each state does require or encourage school districts to adopt anti-bullying policies, and most recommend that witnessed accounts of bullying behavior be reported to a school administrator.[555]

States may require or encourage school personnel to report bullying[556] or require local school authorities to develop a system in which students can anonymously report incidents of bullying.[557] Most states direct local school authorities to determine the consequences of bullying.[558] For example, Connecticut's anti-bullying law requires local school authorities to develop an anti-bullying policy that, among other things, requires notifying the parents (or guardians) of the bully and the target of the bullying.[559] The Howard County School Board in Maryland recently created an Anti-Bullying Task Force that offers training to nurses, counselors, and others in schools on how to address bullying issues.

b. Personal and Property Searches of Students to Prevent Violence in Schools

Fourth Amendment Protection Against Unreasonable Searches. The Fourth Amendment protects the right of individuals ''to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures.''[560] What constitutes an unreasonable search or seizure concerning students in public school settings was addressed in the US Supreme Court case, *New Jersey v T.L.O.* (1985).[561] In this case, the Court held that local public school officials engaged in a lawful search of students' personal possessions. Two girls in high school were caught smoking in a lavatory, violating a school rule. One of the girls admitted to smoking, but the other, a 14-year-old freshman, denied it. A school official demanded to see the freshman's purse. He found within it a pack of cigarettes and rolling papers. Suspecting illegal drugs, he continued to search the

student's purse and also found a small amount of marijuana, a pipe, and evidence of drug dealing (eg, numerous $1 bills and an index card with other students' names indicating they owed her money).

The Supreme Court initially held that the Fourth Amendment protections against unreasonable searches by federal and state governments apply to searches conducted by public school officials. This normally would require searches grounded in probable cause or with a lawfully secured warrant. However, the Court further noted that reasonableness under the Fourth Amendment depends upon the context in which the search takes place and requires a balancing of the need to search (maintaining discipline in the classroom or school grounds so that learning can take place) against the invasive nature of the search.

In striking the balance, the Supreme Court held that constitutional probable cause or warrant requirements are not always required. Instead, ''the legality of a search of a student should depend simply on the reasonableness, under all circumstances, of the search.'' To determine reasonableness, the Supreme Court established a twofold inquiry. First, was the action justified at its inception? That is, are there ''reasonable grounds for suspecting that the search will turn up evidence that the student has violated or is violating either the law or the rules of the school?'' Second, was the search, as conducted, reasonably related in scope to the circumstances justifying the interference in the first place? A search is permissible in its scope if ''the measures adopted are reasonably related to the objectives of the search and not excessively intrusive in light of the age and sex of the student and the nature of the infraction.''[562]

Locker and Desk Searches. State law and school policies determine under what circumstances a student's locker or desk can be searched to detect or deter school violence. Some states, like Minnesota, view lockers or desks as property of the school, giving school officials the authority to search them ''for any reason at any time, without notice, without student consent, and without a search warrant.''[563] Similarly, Indiana's locker search law states in part ''[a] student who uses a locker that is the property of a school corporation is presumed to have no expectation of privacy in: (1) that locker; or (2) the locker's contents.''[564] Oklahoma law provides similar justification for extensive locker searches.[565] Other states require reasonable suspicion before a search of lockers and desks is justified.[566]

Use of Metal Detectors. The use of metal detectors in schools to prevent incidents of violence is considered less intrusive on privacy interests than bodily or other types of searches and is therefore constitutionally permissible.[567] The federal Safe and Drug-Free Schools and Communities Act funds SEAs and LEAs to, among other things, ''support programs that prevent violence in and around schools.''[568] Part of the grants available to LEAs includes funding for acquiring and installing metal detectors (as well as electronic locks, surveillance cameras, and other such equipment and technology).[569] State laws in Delaware,[570] Tennessee,[571] Louisiana,[572] and Pennsylvania[573] (among others) permit the use of metal detectors in schools. South Carolina law requires all secondary public schools to have one handheld metal detector.[574]

c. Student Dress Codes to Prevent Violence in Schools

To reduce violence, gang activity, and theft, many school boards have student dress codes or policies requiring students to wear a uniform that prevents students from communicating gang-related or violent messages.[575] Oklahoma's anti-bullying statute gives each local school board the option to adopt a dress code, including school uniforms, for the students in its district.[576] Iowa's state law explains the association between the dress code and the violence:

> Gang-related apparel worn at school draws attention away from the school's learning environment and directs it toward thoughts or expressions of violence, bigotry, hate, and abuse ... [A] school district may adopt ... a dress code policy that prohibits students from wearing gang-related or other specific apparel if [it] determines that the policy is necessary for the health, safety, or positive educational environment of students and staff in the school environment or for the appropriate discipline and operation of the school.[577]

School dress codes raise complicated First Amendment issues concerning students' rights to freedom of speech and expressive conduct. First Amendment challenges are determined by federal courts on a case-by-case basis. Typically, if the policy can be linked to a school's goal of creating a safe and peaceful environment and preventing violence, it is more likely that the dress code will be upheld.[578]

d. Environmental Modifications to Prevent Violence in Schools

Environmental factors—the physical design (eg, blind spots, lighting, and number of entrances to facility) and immediate situational factors (eg, security officers and number of people using or observing a place)—can promote or deter violence in school settings. Strategies such as Crime Prevention through Environmental Design (CPTED), situational crime prevention, and defensible space seek to prevent violence and other crimes by modifying the environment.[579] CPTED refers to ''the proper design and effective use of the built environment that can lead to a reduction in the fear and incidence of crime and in improvement in the quality of life.''[580] Training is

provided by the National Institute of Crime Prevention to control criminal behavior and reduce the fear of crime. The institute works with architects, city officials, and educators across the nation to design and use the environment to decrease the opportunity for criminal behavior.[581]

Some states, school districts, and schools have relied on these strategies to reduce violence in their schools. For example, Virginia law mandates that each local school board requires its schools to conduct a school safety audit each year.[582] To help guide schools in the audit process, the Virginia Department of Education, in collaboration with school divisions, developed a School Safety Audit Protocol.[583] As part of its ''Best Practice Tips'' for building security, the protocol specifically mentions CPTED. Similarly, the Leon County (Florida) Schools' Office of Planning and Policy Development requires a CPTED review of all phases of plans for the construction of new school facilities.[584] In 2006, the US Attorney's Office for the District of Minnesota, with the support of the Minnesota Department of Education and Minnesota Department of Public Safety, released a publication entitled *School Safety: Lessons Learned*.[585] Among other things, the publication recommends that schools secure an independent school safety assessment that considers CPTED principles.

5. Substance Abuse

a. Tobacco Use

Pro-Children Act of 2001. The Pro-Children Act of 2001[586] prohibits smoking within any indoor facility that provides routine or regular K-12 education or library services to children if that facility receives any federal funding.[587] A violation may result in a civil penalty up to $1000 for each violation, an administrative compliance order, or both.[588] The Act does not preempt state or local laws that may be more restrictive.[589] For example, North Carolina requires local boards of education to adopt and enforce a written policy concerning the enforcement of the Pro-Children Act of 2001.[590] The policy must further prohibit the use of all tobacco products in enclosed school buildings during regular school hours and must include adequate notice of the policy to students and school personnel, posting of signs on the appropriate use of tobacco products, and requirements that school personnel enforce the policy. Local boards of education are expressly permitted to adopt and enforce more restrictive tobacco use policies in school buildings and facilities, on school campuses, at school-related or sponsored events, or in or on other school property.

State and Local Mandates. SHPPS 2006 found that although most states and districts had adopted policies prohibiting some tobacco use in some locations, only 38% of states and 55% of districts had adopted policies that (1) prohibited cigarette smoking and smokeless tobacco use among all students, all faculty and staff, and all school visitors in school buildings; outside on school grounds; on school buses or other vehicles used to transport students; and at off-campus, school-sponsored events and (2) prohibited cigar or pipe smoking by all students, all faculty and staff, and all school visitors.[591] Less than half of all states, but more than three fourths of all districts, had adopted policies prohibiting tobacco advertisements in school buildings, outside on school grounds, on school buses or other vehicles used to transport students, in school publications, and through sponsorship of school events and prohibiting students from wearing tobacco brand-name apparel or carrying merchandise with tobacco company names, logos, or cartoon characters on it.[592]

b. Alcohol and Illegal Drug Use

State and Local Mandates. Federal funding is available to states and LEAs under the Safe and Drug-Free Schools and Communities Act[593] to prevent the illegal use of alcohol, tobacco, and drugs in elementary and secondary schools[594] and in institutions of higher education.[595] Private schools have no equivalent source of revenue. Nevertheless, nearly all states, school districts, and schools have policies prohibiting alcohol use and illegal drug use by students according to SHPPS 2006.[596] For example, Connecticut law provides that:

> [E]ach local and regional board of education shall develop, adopt and implement policies and procedures . . . for (i) dealing with the use, sale or possession of alcohol or controlled drugs . . . by public school students on school property, including a process for coordination with, and referral of such students to, appropriate agencies and (ii) cooperating with law enforcement officials.[597]

Testing of Students for Illegal Drug Use. Schools can require students who want to participate in athletics and other competitive extracurricular activities to consent to random drug testing without violating the unreasonable search and seizure clause of the Fourth Amendment.[598] The US Supreme Court has reviewed the constitutionality of school drug testing policies on two occasions and on both occasions has found them constitutional.[599] In the most recent case, *Pottawatomie County Board of Education v Earls*,[600] the Court held that a school district policy to test students who participate in competitive extracurricular activities for drugs was ''a reasonable means of furthering the School District's important interest in preventing and deterring drug use among its schoolchildren.''[601] The policy required all secondary school students to consent to drug testing in order to participate in extracurricular activities sanctioned by the Oklahoma Secondary Schools Activities Association (eg, athletics, band, choir, and Future Homemakers of America). Students were required to take a drug test before participating in an

extracurricular activity, to submit to random drug testing while participating in that activity, and to consent to testing at any time upon reasonable suspicion. The urinalysis tests were used to detect only the presence of illegal drugs and not the presence of authorized prescription medication or medical conditions. A student who failed a drug test was required to receive drug counseling and faced various lengths of suspension from participating in competitive extracurricular activities depending on the number of times the student had failed the test.

Building on its earlier rulings, the Supreme Court in *Earls* noted that in the criminal context, the ''reasonableness'' of a search usually required a showing of probable cause and a warrant. However, ''a search unsupported by probable cause may be reasonable when special needs, beyond the normal need for law enforcement, make the warrant and probable-cause requirement impracticable.'' This so-called ''special needs'' test applies in the public school context where a warrant and probable-cause showing ''would unduly interfere with the maintenance of the swift and informal disciplinary procedures that are needed.'' To determine the constitutionality of the school district's drug testing policy, the Supreme Court considered three issues: (1) the nature of the privacy interest allegedly compromised by the drug testing, (2) the character of the intrusion imposed by the policy, and (3) the nature and immediacy of the government's concerns and the efficacy of the policy in meeting them. The Court held that the drug testing policy was constitutional because the affected students had a ''limited expectation of privacy''; the invasion of privacy was ''not significant'' (due to the method of collecting the sample that was ''minimally intrusive'' and the limited uses of the test results); and the policy was ''a reasonably effective means of addressing the School District's legitimate concerns in preventing, deterring, and detecting drug use.''[602]

Anabolic Steroids. In addition to policies addressing illegal drug use in general, some states have enacted laws to address the use of anabolic steroids by student athletes to enhance performance. Students caught using steroids may be ineligible to participate in school-sponsored athletic events[603] or extracurricular activities.[604] California law requires interscholastic high school athletes to sign a pledge not to use ''performance-enhancing substances'' illegally.[605] Virginia law authorizes the state board of education to suspend or revoke the administrative or teaching license of any person who fails to report a student who uses steroids to the school authorities. Any person whose license is suspended or revoked under this law cannot be employed in Virginia public schools for 3 years.[606] In Kansas, any person possessing anabolic steroids, intending to sell, selling, or offering to sell steroids ''in or on, or within 1,000 feet'' of school property is guilty of a felony.[607]

6. Emergencies

School emergencies include a range of events including natural disasters (eg, hurricane, tornado, earthquake, and flood), fires, chemical or hazardous material spills, bus crashes, school shootings, bomb threats, medical emergencies, and terrorism. No legal consensus exists as to what constitutes an emergency or disaster; rather, such terms are normally drafted to fit the needs of the institution, agency, or law.[608]

At the federal level, NCLB requires schools that receive Title IV funds to have a ''crisis management plan for responding to violent or traumatic incidents on school grounds.''[609] State and local educational authorities have engaged in planning processes to develop emergency preparedness plans. SHPPS 2006 found that 92% of states had adopted a policy requiring districts or schools and 84% of districts had adopted a policy requiring schools to have a comprehensive plan to address crisis preparedness, response, and recovery in the event of a natural disaster or other emergency or crisis situation.[610] Georgia law requires every public school to prepare a ''school safety plan'' to respond to a variety of emergencies, including preparedness for natural disasters, hazardous materials or radiological accidents, acts of violence, and acts of terrorism.[611] Similarly, Virginia law requires each school board to ensure that each school under its supervision develops a written ''school crisis and emergency management plan.''[612]

Federal Emergency Response and Crisis Management grants available through the Safe and Drug-Free Schools and Communities Act[613] support local educational agencies' efforts ''to improve and strengthen emergency response and crisis management plans at the district and school-building level.''[614] Plans address four phases of crisis planning (prevention/mitigation, preparedness, response, and recovery) and must include training of school personnel and students in emergency response procedures; coordination with local law enforcement, public safety, public health, and mental health agencies; and a system for communicating school emergency response policies and reunification procedures to parents/guardians. For 2005 awardees, the federal government made available an estimated $27 million.[615] ED explains the grant program through its Web site to help schools prepare and develop emergency plans.[616]

School Closure in Response to Disease Outbreaks

As concern with a potential influenza pandemic heightened in 2006-2007, federal, state, and local officials reviewed a number of ''nonpharmaceutical interventions'' or ''social distancing'' measures as potential steps that could be taken to mitigate a pandemic's impact. Among these was school closure or, more specifically, the cancellation of classes or dismissal of students, for the relatively extended periods

associated with such a pandemic. Research indicated that closing schools potentially could reduce by more than 90% the incidence rate of infection among children.[617]

A 2007 study by the Centers for Law and the Public's Health reviewed states' explicit or express legal authorities for school closure and found crosscutting patterns it considered problematic for effective, interjurisdictional use of school closure as a pandemic mitigation tool.[618] The Centers' study found that many states did not appear to have laws that expressly allowed for school closure for extended periods. Even states that appeared to authorize school closure expressly exhibited considerable heterogeneity in the relevant legal authorities. On this basis, the Centers concluded that delays in effective implementation of school closure could result from disagreements over the agencies responsible for closing schools or when schools could or should be closed legally. For example, state or local departments of education or health might not concur on the timing or legal bases for closing or reopening schools. Additional delays in school closure might also result from potential legal or other challenges to governments' decision to close schools.

Based on its findings and interpretations, the Centers recommended that emergency management, health, and education officials and their legal counsel specifically assess the express legal routes for closing schools in their jurisdictions and attempt to resolve any identified issues that might impede effective implementation of school closure as a social distancing measure.

School Design and Construction

School facilities range in size from one-room schoolhouses in rural areas to city schools that contain 5000 students or more. Schools buildings tend to be used for long periods; some schools designed and constructed in the early 1900s are still in use.

Modern design principles recognize that schools should be built to protect against natural hazards and ensure occupant health, safety, and security. Traditionally, US building codes used the prescription approach. Prescriptive-based codes are quantitative and typically rely on fixed values such as allowable area and height, wind and earthquake loads, and fire-resistance ratings. This approach provides an ''acceptable level of risk'' and is considered to produce the minimum standards necessary for public health, safety, and general welfare. Prescriptive codes also contain provisions known as ''alternative methods and materials'' or ''equivalencies,'' which permit the use of methods, materials, and equipment not prescribed in the code if approved by a code official. In contrast, performance-based designing provides more systematic ways to review alternative design options. The Federal Emergency Management Agency recommends augmenting the traditional prescriptive approach with performance-based design to protect schools and their occupants against all natural hazards (''extreme phenomena'' related to earth, water, wind, and fire).[619] SHPPS 2006 found that only 13% of school districts had a policy to include green design when building new schools or renovating existing buildings (eg, use of energy-efficient lighting and electrical systems, preservation of green space or protection of the existing landscape, and use of alternative transportation, including public transportation, walking, or biking).[620]

Schools as Shelters

States often designate schools as potential shelters in the event of an emergency. For example, Illinois' School Code requires that schools' buildings be made available ''for use as civil defense shelters for all persons.''[621] A Florida law allows schools to be used as shelters in the event of a hurricane.[622] California schools' comprehensive safety plans must include a procedure for allowing ''a public agency, including the American Red Cross to use school buildings, grounds, and equipment for mass care and welfare shelters during disasters or other emergencies affecting the public health and welfare.''[623] Vermont not only allows schools to be designated as emergency shelters but also requires certain schools to be constructed for this use.[624]

7. Background Screening for School Staff

All states require background checks for school employees, although there is variability among state laws and local policies.[625] More than 16,000 school boards around the country have policies that ''differ from board to board and school to school.''[626] Some states may require a state police check. Other states require a Federal Bureau of Investigation check. Some states require both checks. Still, some officials caution that schools should take additional steps to protect their students. The National School Safety and Security Services observed, ''schools typically perform the bare minimum, one-time criminal history checks for teachers and school employees. Red flags in the employment history of new applicants often go undiscovered, and crimes committed by school staff during the term of their employment can easily go undetected.''[627] It recommends (1) criminal history checks that cover the widest available databases, (2) more detailed background checks that look into employment history, past work performance, educational credential verification, or other detailed personal histories, (3) periodic criminal history checks during the course of employment, (4) policies that require school employees to report any arrests for crimes to their district employer within 24 hours, and (5) training for staff and students to ensure timely reporting of any threats or incidents to school officials and police.[628]

G. Health Promotion for Staff

In a CSHP model, health promotion for staff is defined as opportunities for school staff to improve their health status through activities such as health assessments, health education, and health-related fitness activities. These opportunities encourage 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 coordinated health program. This personal commitment often transfers into greater commitment to the health of students and creates positive role modeling. Health promotion activities have improved productivity, decreased absenteeism, and reduced health insurance costs.[629] The importance of a healthier workforce is recognized by two *Healthy People 2010* objectives. One seeks to increase the proportion of worksites that offer a comprehensive employee health promotion program to their employees;[630] the other seeks to increase the proportion of employees who participate in employer-sponsored health promotion activities.[631] Many schools provide employees with health promotion opportunities.

School staff may qualify for health services as local government employees. However, laws do not usually require health services to be offered to school employees. Instead, health services and health promotion initiatives for school staff typically are provided on a voluntary basis at the discretion of the school district or individual school. Health-related laws and policies for school staff may be organized into four distinct categories:

- those that impose health requirements on staff and that may authorize testing or screening for health conditions;
- those that authorize health promotion initiatives for school staff;
- those that facilitate health promotion in the workplace; or
- those that regulate the school environment and guard against negative health outcomes for school staff.

This section explores these categories of laws and how they affect health promotion for school staff by examining issues such as the legal requirements for public schools to provide, protect, or facilitate health promotion services to staff.

1. Testing, Screening, or Examinations of Staff for Health Conditions

Prehiring Health-Related Screenings

State laws often apply prerequisites for hiring school employees. These provisions have been enacted for the same reasons as similar prerequisites that apply to students—lawmakers are hoping to reduce the likelihood of contagious diseases or other health risk factors being introduced into the school system. Consequently, multiple states require staff to undergo physical examinations, or screening for TB or illegal drug use, as a condition of employment. Staff in certain positions, such as teachers or bus drivers, may have additional or different screening requirements. SHPPS 2006 revealed that 20% of states and 28% of districts required a physical health examination and 26% of states and 43% of districts required TB screening prior to employment.[632] New Jersey allows local boards of education to require employees to undergo a physical examination as a condition of hiring.[633] California law requires that all school staff successfully submit to a TB examination within 60 days before commencing employment.[634] Prospective employees with religious objections to this test may be excused but subsequently may be excluded from service if it is believed that they have active TB.[635] Screening for illegal drug use is much less common.[636]

Ongoing Health-Related Screening

Many states also require school staff to submit to ongoing health-related screening at periodic intervals.[637] A staff member's continuing employment may depend on successfully passing illegal drug and active TB screening requirements. In California, for example, school staff must undergo subsequent TB examinations at least once every 4 years.[638] As with preemployment screening, staff found to have active TB may be excluded from service until they are determined to be free of active TB.[639] New Jersey allows school district boards to engage in individual psychiatric or physical examinations of any employee, whenever, in the judgment of the board, an employee shows evidence of deviation from normal physical or mental health.[640] Other types of screening may be offered to school staff as preventive health care services (see subsection G.2 below).

2. Health Promotion Activities Authorized or Available for Public School Staff

Wellness Programs

Many states have enacted employee wellness initiatives. For example, the California Task Force on Youth and Workplace Wellness promotes fitness and health in schools and workplaces and produces resources for citizens, schools, and companies on worksite wellness.[641] Colorado has a similar initiative that encourages workplaces to develop a working environment and culture that support and enhance personal accountability for health and well-being, including healthy eating choices, a tobacco-free lifestyle, and regular physical activity. Texas obliges its Local School Health Advisory Councils to consider school employee wellness among other factors related to school health policies.[642] A common feature of these wellness programs is that employers are not required, but rather encouraged, to implement them.

Employee Assistance Programs

EAPs provide a variety of services to school employees to help them address problems that may affect their ability to work effectively, efficiently, and safely. Typically, EAPs cover a range of prevention, health, and wellness activities and may allow for referrals to outside professionals for assistance with substance abuse, mental health, and other health problems (as well as nonhealth problems, such as legal and financial issues). EAPs may be provided by the employer or through a union. State laws may require or authorize the availability of EAPs to government employees. Massachusetts requires school districts to provide EAPs to teachers enrolled in the state teacher retirement system.[643] Kansas, by contrast, merely authorizes school districts to contract for and fund EAP services for school employees and their dependents.[644] More frequently, however, EAPs are available to school staff through school district policies or as a component of a broader health benefits package.

Health Insurance Benefits

The availability of health insurance to school employees varies across the country. Some states demand that school districts provide health insurance options to school employees. Texas law requires each school district to provide group health insurance coverage to school employees for medical, surgical, or diagnostic procedures for illness or injury (but not necessarily including experimental procedures).[645] Texas school districts may establish health care plans for employees and their dependents.[646] Other states establish a more coordinated health insurance plan for school employees. Georgia authorizes its Board of Community Health to set up health insurance plans for public school teachers.[647] Mississippi coordinates health insurance for school district employees at the state level through the Mississippi State and School Employees Health Insurance Plan.[648] California is currently studying the feasibility of creating a single statewide health care pool that would cover all public school employees.[649]

HIPAA also may affect the availability of health insurance for school employees. HIPAA generally provides portability for health insurance coverage from one plan to another if there is no lapse in coverage between plans. However, local governmental entities that are self-insured, including many school districts, may opt out of this portability guarantee, leaving their employees potentially unable to obtain sufficient health insurance coverage.[650]

Routine Screening for Chronic Health Conditions

Routine screening for chronic health conditions such as diabetes, high blood pressure, and elevated cholesterol levels provides staff with important information about their own health. These preventive screening services are rarely required by law, but many school districts voluntarily provide and fund these services.[651]

3. Occupational Safety Protections

Federal, state, and local laws and policies promoting safe and healthy school environments benefit both students and staff. Many provide protective standards for the use of dangerous environmental hazards such as lead paint, asbestos, mercury and chemical spills, radon exposure, and other injury risks on school premises. School staff benefit from all the school health environmental protections put into place to protect the health of students (discussed in section III.F). In addition, assessment tools developed to create healthy and safe schools, such as EPA's HealthySEAT,[652] the CDC's SHI,[653] and the NIOSH Safety Checklist,[654] guide school staff in maintaining safe classrooms, shops, and labs; preventing injury and illness in school employees; and complying with relevant federal or state safety regulations.

Workplace health and safety standards guarantee additional protection to public school staff based upon their status as workers and local government employees. The federal Occupational Safety and Health Act of 1970 and related regulations do not apply to state and local government employees.[655] Therefore, state occupational safety and health (OSH) regulations typically govern workplace safety standards for school employees. Many states have implemented labor relations and OSH laws that reflect the analogous federal standards.[656] Twenty-two states and territories have implemented OSH plans approved by the federal government that apply to both public and private sector employees.[657] Four additional states and territories have enacted federally approved OSH plans for public sector employees only.[658] State plans in all these jurisdictions cover public school employees.[659]

Michigan, Minnesota, and Utah, for example, explicitly apply their state OSH standards to political subdivisions including school districts.[660] In Michigan, each school district is required to ''[f]urnish to each employee, employment and a place of employment which is free from recognized hazards that are causing, or are likely to cause, death or serious physical harm to the employee'' through a variety of means outlined in administrative regulations.[661] Michigan, like some other states with federally approved OSH plans, incorporates the federal standards directly into its state program.[662] Minnesota and Utah instead outline detailed OSH requirements analogous to the federal protections.[663] Maine does not have an OSH plan approved by the federal government, but it does authorize the state Bureau of Labor Standards to monitor OSH compliance with the standards set out by the OSHA.[664] The director of the bureau may inspect the workplace of any employer, including school districts,

for threats to health, follow-up on employee complaints, and offer injunctive and other relief for violations.[665] According to a 2000 Department of Labor audit, Alabama and Delaware have no recognizable OSH programs for state or local government employees.[666]

Beyond OSH regulations, states may impose additional specific requirements on schools intended to protect staff from potentially hazardous conditions. These may include tobacco bans on school property, additional safety requirements, and other related regulations. Michigan requires protective measures, such as industrial-quality eye protection, to be in place for school courses that expose pupils and teachers to dangerous materials.[667]

H. Family and Community Involvement

In a CSHP model, family and community involvement is defined as an integrated school, parent, and community approach for enhancing the health and well-being of students. School health advisory councils, coalitions, and broadly based constituencies for school health can build support for school health program efforts. Schools actively solicit parent involvement and engage community resources and services to respond more effectively to the health-related needs of students.[668]

With encouragement and authorization from state lawmakers and policymakers, schools have increasingly entered into partnerships with families, community groups, individuals, and others to create an integrated approach for enhancing and improving school health. These partnerships are ''designed to maximize resources and expertise in addressing the healthy development of children, youth, and their families.''[669] As a consequence, school health services are more frequently provided through collaborative arrangements with community providers, building on the capacity, insights, and expertise of external experts. A recent study found that more than one half of the schools surveyed reported ''formal arrangements with one or more community-based organizations or individual providers for student mental health services.''[670] Schools that open their doors to support community health and learning needs build strong community support for school programs. Moreover, the establishment of school health advisory councils, coalitions, and broadly based constituencies for school health can build support for school health program efforts, garner the expertise of community members, and even increase the resources available for school health initiatives and services. This section explores the legal basis for family and community involvement in school health.

1. Legal Requirements to Facilitate Family/Community Involvement in Health

The direct participation of families and communities in school health decision making and policymaking is authorized under federal and state laws, as described below. Community participation in school health may be explicitly authorized under state laws providing for the creation of school health councils or establishing coalitions that have the right, or the opportunity, to participate in school health policy decisions (discussed in section III.H.3 and section III.H.4). Family members, particularly parents and guardians, may have the right to participate in decisions related to the provision of health services to their children or dependents (discussed in section III.C.4). Likewise, family members may be permitted to dictate whether their children are exposed to certain health education materials (discussed in section III.A.2).

2. Involvement at the Individual Student Level

Federal and state laws grant rights to parents and guardians to participate in decisions related to their children's health. Because most students are minors and lack the legal capacity to consent to medical care, laws demand that parental consent be obtained before the delivery of health services, except in emergency situations, where the life or health of the student is at stake.[671] In the context of special education, IDEA provides parents with the right to participate extensively in decisions related to their child. Parental consent is required in most circumstances to allow school officials to conduct initial evaluations to determine if the child has a disability, to proceed with the development of an IEP, and to provide special education services to the child.[672] Parents are key participants in the team that develops the child's IEP.[673] Parents also have procedural process rights under IDEA to examine records, to participate in meetings regarding the evaluation and educational placement of the child, to appeal decisions, and to obtain an independent educational evaluation of the child.[674]

IDEA is silent as to who must bear the burden of persuasion in an administrative hearing that challenges an IEP. In 2005, the US Supreme Court ruled in *Schaffer v Weast*[675] that the burden of persuasion rests with the party seeking relief (ie, the school board or the disabled child). In *Schaffer*, the parents of a disabled child challenged the recommended IEP. The Court rejected the notion that every IEP is invalid until the school district demonstrates that it is not. In practice, the majority of hearing requests concerning whether an IEP is appropriate come from parents rather than schools. Therefore, if parents are dissatisfied with an IEP, they must demonstrate that it does not satisfy the statutory requirements.

In *Irving Ind. Sch. Dist. v Tatro*,[676] parents of 8-year-old Amber Tatro sued state school officials to require the school district to provide their daughter with clean intermittent catheterization (CIC). They argued that CIC was a ''health-related'' service under the IDEA and that refusal to provide the service constituted a

violation of §504 of the Rehabilitation Act. The Supreme Court held that the IDEA imposed an obligation to provide special education and related services as a condition for the state's receipt of funds. Since the IDEA is an entitlement program, this obligation would arguably place the school district in a position to justify that the education and services it provides satisfy the statutory requirements. As Justice Ginsburg observed, the school district is in a better position to demonstrate that it has fulfilled its statutory obligation than the disabled student's parents are to show that the school district has failed to do so. A school's access to information, control over individuals involved with the child's education, and educational expertise were all cited as examples of its advantage in demonstrating compliance with statutory requirements. Still, *Schaffer*'s holding is controlling, and the burden of persuasion rests with the party seeking relief.

3. Involvement in School Policy Through School Health Councils

School health councils are important participants in the development of school health policies and programs. These councils (or similar groups with varying titles) bring together district school officials and community participants with varying backgrounds to discuss and advise school health policies and programs.[677] SHPPS 2006 found that 86% of states had a school health council that was formally charged with coordinating state-level school health activities. Nationwide, 73% of districts had one or more school health councils at the district level that offered guidance on the development of policies or coordinated activities on health topics.[678] A number of states, such as Texas, mandate that school systems create school health councils. In Texas, the council provides input related to school health services, counseling and guidance services, a safe and healthy school environment, school employee wellness, and health education curriculum. It must be consulted before the district makes changes to health education curricula. Texas' school health advisory councils are required to include parents, teachers, school administrators, students, health care professionals, the clergy, law enforcement, the business community, senior citizens, and nonprofit health organizations.[679]

Florida mandates a prominent role for its local school health advisory committees in the development of school health services programs.[680] Mississippi requires the creation of local health education councils ''to make recommendations regarding a comprehensive health education curriculum'' but does not elaborate on the constitution of the councils.[681] Maryland has created a state-level school health council to assist local officials to create local school health councils.[682]

Other states allow, but do not require, the creation of school health councils. For instance, Pennsylvania charges school district administrative officers with promoting the formation of advisory school health councils.[683] Colorado permits school districts to ''establish a comprehensive health education advisory council.''[684]

The development and creation of SBHCs provide increasing opportunities to augment community involvement in school health policies, service development, and evaluation. In Texas, for example, state legislation authorizing the creation of SBHCs provides for the creation of local health education and health advisory councils to advise schools on the establishment of SBHCs and to ensure that ''local community values are reflected in the operation of each center and the provision of health education.''[685] These health education and health advisory councils must include a variety of school and community participants, including teachers, school administrators, licensed health care professionals, the clergy, law enforcement, the business community, senior citizens, and students.[686] Schools also are encouraged to work with their local public health agencies and existing local providers in the development of SBHCs.[687] Arizona has a statewide School-Based Health Care Council that coordinates the state's SBHCs. Participants in the council include government officials, school officials, health care professionals, and representatives of nonprofit organizations.[688] Maryland has established a statewide School-Based Health Center Policy Advisory Council, with 25 members drawn from a geographically diverse group of government, school, and health experts throughout the state.[689] The purpose of the council is to develop, sustain, and promote high-quality SBHCs in Maryland.[690]

4. Coalitions

Other types of coalitions also may participate in school health program policies and planning. Parent Teacher Associations[691] and other community groups may be consulted in relation to school health decisions in some jurisdictions. These collaborative initiatives are often established by local policy rather than law. Similarly, much family and community involvement in school health activities such as nutrition, health education, health services, and physical education occurs permissively and is not required by law.[692]

IV. CONCLUSIONS

Protecting the health and safety of children and adolescents in schools is an important part of any comprehensive education and public health plan. Laws and policies can provide education and public health leaders with valuable tools to promote programs and strategies that foster an environment where children and adolescents can thrive and learn. To date, no one has systematically identified the full range of relevant legal authorities pertinent to schools that may help shape the health of children and adolescents. This report attempts to fill that gap by facilitating

educators and public health professionals access to information on laws and policies concerning the health of children and adolescents in schools. It is intended to help practitioners and policymakers in education and public health at the federal, state, and local levels enhance their knowledge of relevant laws and policies.

The CDC recognizes that ''schools by themselves cannot—and should not be expected to—solve the nation's most serious health and social problems.''[693] Yet through a CSHP, schools can ''provide a critical facility in which many agencies might work together to maintain the well-being of young people.''[694] Thus, the framework for this legal review is based on a CSHP model featuring the following components: health education, physical education, health services, nutrition services, mental health and social services, healthy and safe school environment, health promotion for staff, and family and community involvement.

As discussed throughout this report, the nation's public schools are regulated through a multitude of federal, state, and local governmental entities. And, as in many areas of public health, laws and policies are important tools for improving health outcomes of children and adolescents in schools. Though subject to limits, laws underlie virtually all programs, interventions, initiatives, and efforts undertaken by government and the private sector to craft healthy schools. Thus, an appreciation for the complexity of the legal environment in which schools operate is beneficial. This report provides a review of the many federal and state laws and policies that influence the health of children and adolescents in schools.

Many legal and policy themes emerge from this review, including the following:

- *Integration of public health and education services.* Multiple examples in law and policy documented in this report demonstrate the close ties between public health and education services in many jurisdictions. School authorities are routinely asked to assist in public health programs; public health officials are expected to protect the health of children in school environments. These respective requirements can lead to legal complications in some cases (eg, sharing identifiable health data in education records pursuant to FERPA and the HIPAA Privacy Rule). However, they can also lead to tremendous opportunities for accomplishing significant improvements in child and adolescent health.
- *Division of responsibilities.* Despite many examples of attempts to integrate public health and education services through law and policy, there remains considerable division of responsibilities among many governmental and private sector entities for the health of children and adolescents in schools. In many cases, these divisions are furthered by laws or policies that assign to one entity (eg, the state public health authority or the local superintendent of schools) the primary task of accomplishing stated health goals. Assigning responsibility to one entity without a concomitant duty to work closely with other entities or persons, however, can lead to difficulties. When laws fail to reflect the need for accountability coupled with collaboration, improvements in child and adolescent health may not be fully realized. Laws at every level of government should attempt to specifically incorporate requirements for collaboration across multiple sectors. In support of local educational agencies' efforts to develop enhanced emergency response and crisis management plans, the federal Safe and Drug-Free Schools and Communities Act, for example, requires that plans address coordination with local law enforcement, public safety, public health, and mental health agencies.
- *National primacy.* Federal laws and policies governing student health may take primacy over state and local laws; however, in the absence of federal laws or policies, opportunities exist for the development of state or local laws and policies that promote child health and academic achievement. In many ways, federal laws defer to state and local governmental discretion. For example, federal grant programs like the PEP are implemented through state or local laws that distribute resources consistent with state and local priorities. In this way, national health objectives can support efforts to protect and enhance students' health.
- *State and local innovation.* State and local officials demonstrate in multiple ways their creativity in shaping legal and policy tools for better student health. Many state and local laws apply to areas of child and adolescent health in schools where federal laws or programs may not apply. Thus, for example, although the federal government does not attempt to regulate the placement of fast-food outlets near local schools, Detroit has ordained that no such restaurants be located within 500 feet of an elementary school. Protecting children and adolescents from skin cancer is an important priority in California; this led the state to pass its sun safety bill requiring every school to allow the outdoor use of sun protective clothing or sunscreen during school without a physician's note or prescription. Vermont features a legal provision requiring the construction of schools that can be used as emergency shelters. These and other examples demonstrate the capacity of state and local public health and education leaders to improve child and adolescent health through innovative laws focused on school populations or environments.

As illustrated through these legal themes, education and public health officials, their legal counsel, and partners from other relevant agencies (eg, environment, zoning, food safety, mental health, justice,

and law enforcement agencies) can benefit from a greater understanding of the contribution laws and policies can make to improve health for children and adolescents in the school setting. Legal and policy tools may help refine schools' roles in *protecting* the health of children and adolescents in school environments, *motivating* them to choose healthy behaviors through policies that encourage improved health and safety, and *safeguarding* them from multifarious health threats.

REFERENCES*

*Due to the unique nature of this monograph, journal requirements for reference format were waived.

[1] CDC, *Healthy Youth! Coordinated School Health Program*, *available at* http://www.cdc.gov/HealthyYouth/CSHP/(last visited October 30, 2007).

[2] Diane D. Allensworth and Lloyd J. Kolbe, *The Comprehensive School Health Program: Exploring and Expanded Concept*, 57(10) J SCH HEALTH 409 (1987).

[3] JAMES F. BOGDEN, HOW SCHOOLS WORK AND HOW TO WORK WITH SCHOOLS, NATIONAL ASSOC. OF STATE BDS. OF EDUC. (2003); *see also* CDC DASH webpage, *available at* http://www.cdc.gov/HealthyYouth/CSHP/index.htm (last visited October 19, 2007).

[4] CDC, *supra* note 1.

[5] Lloyd J. Kolbe et al., *Overview and Summary Findings: School Health Policies and Programs Study 2000*, 71(7) J SCH HEALTH 253 (2001); *see also* Laura Kann et al., *Health Education: Results from the School Health Policies and Programs Study 2006*, 77(8) J SCH HEALTH 408(2007).

[6] *Id.*

[7] 20 U.S.C. § 1232a.

[8] Allensworth and Kolbe, *supra* note 2.

[9] BOGDEN, *supra* note 3; *see also* CDC DASH, *supra* note 3.

[10] U.S. DEP'T OF EDUC. NAT'L CTR. FOR EDUC. STATISTICS, DIGEST OF EDUC. STATISTICS, 2004 CHAPTER 2. ELEMENTARY AND SECONDARY EDUCATION, *available at* http://nces.ed.gov/programs/digest/d04/ch_2.asp#3 (last visited October 1, 2006).

[11] U.S. DEP'T OF EDUC. NAT'L CTR. FOR EDUC. STATISTICS, DIGEST OF EDUC. STATISTICS, 2004, Table 3 (NCES 2006-005, 2005), *available at* http://nces.ed.gov/fastfacts/display.asp?id=65 (last visited October 3, 2006) (calculations based on 2003 data).

[12] U.S. DEP'T OF EDUC., *supra* note 11, at 1-2.

[13] *See, e.g.*, N.C. CONST. art. I, § 15; *see also id*. at art. IX, § 2(1).

[14] San Antonio Independent Sch. Dist. v. Rodriguez, 41 U.S. 1, 35 (1973). Similarly, the Supreme Court has refused to interpret the constitution as implicitly protecting the right to education. *See id*.

[15] *See* KERN ALEXANDER & M. DAVID ALEXANDER, AMERICAN PUBLIC SCHOOL LAW. 63-64 (5TH ED. 2001).

[16] NELDA H. CAMBRON-MCCABE, ET AL., PUBLIC SCHOOL LAW: TEACHERS' AND STUDENTS' RIGHTS. 2 (5TH ED. 2004) (citing Tinker v. Des Moines Indep. Sch. Dist., 393 U.S. 503, 507(1969)).

[17] U.S. CONST. art. I, § 8, cl. 3.

[18] *Id*. at art. I, § 8, cl. 1.

[19] *See* ALEXANDER & ALEXANDER, *supra* note 15, at 69-70.

[20] *See generally*, United States v. Lopez, 514 U.S. 549 (1995).

[21] *See* ALEXANDER & ALEXANDER, *supra* note 15, 66 (2001).

[22] P.L. 107-110.

[23] 20 U.S.C.S. § 6301.

[24] *Id*. at § 6311; *see also* Lori Meyer, *Accountability and Funding: a Guide to Key Provisions in the New Federal Law*, INSIDE SCH LAW 304 (Summer 2002), *available at* https://secure.nsba.org/site/docs/8900/8882.pdf (last visited October 19, 2007).

[25] 20 U.S.C.S. § 6311.

[26] *Id*. at § 6316; *see* Meyer, *supra* note 24.

[27] 20 U.S.C.A. § 6316(b)(1)(E)(1).

[28] 20 U.S.C.S. § 6302.

[29] MICHAEL IMBER & TYLL VAN GEEL, EDUCATION LAW 105 (3RD ED. 2004).

[30] *Id.*

[31] *See id*. at 106.

[32] 20 U.S.C.S. § 3402(2).

[33] U.S. DEP'T OF EDUC., GRANTS & CONTRACTS webpage, *available at* http://www.ed.gov/fund/landing.jhtml (last visited January 2, 2007).

[34] 20 U.S.C.S. §3402(1); *see also* U.S. DEP'T OF EDUC., MISSION, *available at* http://www.ed.gov/about/overview/mission/mission.html (last visited October 1, 2006).

[35] *See* CDC, HEALTHY YOUTH: AN INVESTMENT IN OUR NATION'S FUTURE, 2007, *available at* http://www.cdc.gov/HealthyYouth/about/healthyyouth.htm (last visited October 30, 2007).

[36] *See generally* U.S. ENV'T PROTECTION AGENCY, HEALTHY SCHOOLS ENVIRONMENTAL ASSESSMENT TOOL, BASIC INFORMATION, *available at* http://www.epa.gov/schools/healthyseat/basicinformation.htm (last visited October 3, 2006).

[37] *Id.*

[38] ALEXANDER & ALEXANDER, *supra* note 15, at 90.

[39] MARK G. YUDOF, ET AL., EDUCATIONAL POLICY AND THE LAW 13 (2002).

[40] *Id; see also* Pierce v. Society of Sisters, 268 U.S. 510 (1925).

[41] CAMBRON-MCCABE, *supra* note 16, at 2.

[42] *See* ALEXANDER & ALEXANDER, *supra* note 15, at 241.

[43] *Id*. at 243.

[44] CAMBRON-MCCABE, *supra* note 16, at 2.

[45] *See id*. at 2; *see also* Board of Educ. of Aberdeen-Huntington Local Sch. Dist. v. State Bd. of Educ., 116 Ohio App. 515, 189 N.E.2d 81 (1962).

[46] Child Welfare Soc. of Flint v. Kennedy Sch. Dist., 220 Mich. 290, 89 N.W. 1002 (1922).

[47] CAMBRON-MCCABE, *supra* note 16, at 3-4.

[48] *Id.*

[49] U.S. DEP'T OF EDUC. NAT'L CTR. FOR EDUC. STATISTICS, OVERVIEW OF PUBLIC ELEMENTARY AND SECONDARY SCHOOLS AND DISTRICTS: SCHOOL YEAR 2001-02, Table 2 (2003), *available at* http://nces.ed.gov/pubs2003/2003411.pdf (last visited October 1, 2006).

[50] CAMBRON-MCCABE, *supra* note 16, at 5.

[51] Goodman v. School Dist. No. 1, 32 F.2d 586 (8thCir. 1929).

[52] Hallett v. Post Printing & Publishing Co., 68 Colo. 573, 192 P. 658 (1920).

[53] CAMBRON-MCCABE, *supra* note 16, at 27.

[54] Lemon v. Kurtzman, 403 U.S. 602 (1971).

[55] ALEXANDER & ALEXANDER, *supra* note 15, at 161-62; *see also* Board of Educ. of Kiryas Joel Village Sch. Dist. v. Grumet, 512 U.S. 687 (1994).

[56] Engel v. Vitale, 370 U.S. 421 (1962); Abington Sch. Dist. v. Schempp, 374 U.S. 203(1963).

[57] Newdow v. United States Congress, 328 F.3d 466 (9thCir. 2003), *rev'd on other grounds sub nom*., Elk Grove Unified Sch. Dist. v. Newdow, 542 U.S. 1 (2004).

[58] 20 U.S.C.S. § 7904.

[59] Urofsky v. Gilmore, 216 F.3d 401 (4thCir. 2000).

[60] CAMBRON-MCCABE, *supra* note 16, at 81. *See also* State *ex rel*. Andrews v. Webber, 108 Ind. 31, 8 N.E.708 (1886).

[61] ALEXANDER & ALEXANDER, *supra* note 15, at 348-49 (citing Meyer v. Nebraska, 262 U.S. 390 (1923)).

[62] Troxel v. Granville, 530 U.S. 57, 65 (2000).

[63] *Meyer*, *supra* note 61, at 401.

[64] *Pierce*, *supra* note 40, at 510, 534-35.

[65] Brown v. Hot, Sexy and Safer Productions, Inc., 68 F.3d 525, 533-34 (1st Cir. 1995) (citations and internal quotation marks omitted), *cert. denied*, 516 U.S. 1159 (1996).

[66] Fields v. Palmdale Sch. District, 427 F.3d 1197 (9th Cir. 2005).

[67] Goss v. Lopez, 419 U.S. 565 (1975).

[68] Epperson v. Arkansas, 393 U.S. 97 (1968).

[69] Edwards v. Aguillard, 482 U.S. 578 (1987).

[70] Kitzmiller v. Dover Area Sch. Dist., 400 F. Supp 2d 707 (M.D. Pa. 2005).

[71] Hazelwood v. Kuhlmeier, 484 U.S. 260 (1988).

[72] YUDOF, *supra* note 39, at 253 (citing American Association of University Professors, *The 1915 Declaration of Principles*, *in* L. JOIGLIN, ED, ACADEMIC FREEDOM AND TENURE (1969)); *see also* Bradley v. Pittsburgh Bd. of Educ., 910 F.2d 172 (3rd Cir. 1990).
[73] YUDOF, *supra* note 39; *see also* ALEXANDER & ALEXANDER, *supra* note 15, at 276; Clark v. Holmes, 474 F.2d 928, 931 (7th Cir. 1972), *cert denied*, 411 U.S. 972 (1973).
[74] YUDOF, *supra* note 39, at 253 (quoting Board of Educ. v. Pico, 457 U.S. 853, 864 (1982).
[75] *Clark*, *supra* note 73; Ahern v. Board of the Sch. Dist. of Grand Island, 327 F. Supp. 1391 (D. Neb. 1971).
[76] *See Bradley*, *supra* note 72, at 1176.
[77] *Clark*, *supra* note 73.
[78] 20 U.S.C.S. § 1232g.
[79] P.L. 104-191.
[80] 20 U.S.C.S. § 1232h.
[81] *Id*. at § 1232g(b)(1).
[82] CDC, *HIPAA Privacy Rule and Public Health: Guidance from the Centers for Disease Control and the Department of Health and Human Services*, 52 MMWR 1 (Supp. 2003); *see also* James G. Hodge, Jr., *Health Information Privacy and Public Health*, 31 J.L. MED. & ETHICS 663, 663 (2004); Lawrence O. Gostin, *Health Information Privacy*, 80 CORNELL L. REV. 451(1995).
[83] 45 C.F.R. § 160.103.
[84] Abigail English, *The HIPAA Privacy Rule and FERPA: How Do They Work in SBHCs*. Center for Adolescent Health and the Law, *available at* http://www.nasbhc.org/TAT/Newsletter/HIPAA_Privacy_Rule_and_FERPA.htm (last visited October 1, 2006).
[85] 20 U.S.C.S. § 1232h(c)(1).
[86] U.S. CONST. amend. XIV, § 1.
[87] Brown v. Board of Educ. of Topeka, 347 U.S. 483 (1954).
[88] 20 U.S.C.S. § 1681 *et seq*.
[89] *Id*. at § 1681(a).
[90] U.S. DEP'T OF EDUC., SECRETARY OF EDUCATION's COMMISSION ON OPPORTUNITY IN ATHLETICS. OPEN TO ALL: TITLE IX AT THIRTY (2003), *available at* http://www.ed.gov/about/bdscomm/list/athletics/title9report.pdf (last visited October 1, 2006).
[91] U.S. DEP'T OF EDUC. NAT'L CTR. FOR EDUC. STATISTICS, THE CONDITION OF EDUCATION 2005, NCES 2005-094 at 2, *available at* http://nces.ed.gov/pubs2005/2005094.pdf (last visited October 3, 2006).
[92] NATIONAL DISSEMINATION CTR. FOR CHILDREN WITH DISABILITIES, WHO ARE CHILDREN IN SPECIAL EDUCATION? 3 (June 2003), *available at* http://www.nichcy.org/pubs/research/rb2.pdf (accessed October 1, 2006).
[93] 29 U.S.C.S. § 794.
[94] *Id*. at § 794(a).
[95] Marsha Moses, et al., *Section 504 of the Rehabilitation Act: Determining Eligibility and Implications for School Districts*, 21 J. SCHOOL NURSING 48, 49 n. 1 (2005).
[96] *Id*. at 49.
[97] 42 U.S.C.S. §§ 12101 *et seq*.
[98] *Id*. at § 12131.
[99] 34 C.F.R. § 104.12.
[100] 29 U.S.C.S. § 706(8); 34 C.F.R. § 104.3(j)(1).
[101] Moses, *supra* note 95, at 49.
[102] *Id.*
[103] 34 C.F.R. § 104.3(j)(2)(ii).
[104] 29 C.F.R. § 1630.2(j)(1).
[105] P.L. 94-142.
[106] Lauren Lambert, *Discrimination and Developmental Delays: A Failing Grade in the Public Schools*, 34 S.W.U.L. REV. 551, 562 (2005).
[107] 20 U.S.C.S. §§ 1400-1491.
[108] *Id*. at § 1400(d)(1)(A).
[109] *Id*. at § 3417.
[110] Moses, *supra* note 95, at 49.
[111] 20 U.S.C.S. § 1401(3)(A)(i).
[112] JOSEPH R. BOYLE AND MARY K. WEISHAAR, SPECIAL EDUCATION LAW WITH CASES 3 (2000).
[113] *Id; see also* 34 C.F.R. § 300.111(a)(1)(i).
[114] NIKKI L. MURDICK, ET AL., SPECIAL EDUCATION LAW 23 (2nd ed. 2006).
[115] 20 U.S.C.S. § 1414(b)(3)(A)(i).
[116] *Id*. at § 1414(b)(3)(A)(iii), (iv); *See* MURDICK, *supra* note 114, at 23.
[117] 20 U.S.C.S. § 1414; Lambert, *supra* note 106, at 563.
[118] MURDICK, *supra* note 114, at 25.
[119] 20 U.S.C.S. § 1414(d)(1)(B).
[120] *Id*. at § 1414(d)(3)(A), (B).
[121] MURDICK, *supra* note 114, at 24.
[122] 20 U.S.C.S. § 1412(a)(5).
[123] MURDICK, *supra* note 114, at 14.
[124] *Id*. at 24.
[125] Bonnie Strickland, et al., *Access to the Medical Home: Results of the National Survey of Children with Special Health Care Needs*, 113(5) PEDIATRICS 1495 (2004).
[126] *Id.*
[127] LAUDAN Y. LOPREST ET AL., SERVING CHILDREN WITH DISABILITIES: A SYSTEMATIC LOOK AT THE PROGRAMS 107 (1996).
[128] Irving Independent Sch. Dist. v. Tatro, 468 U.S. 883 (1984).
[129] ALEXANDER & ALEXANDER, *supra* note 15, at 340.
[130] *Id*. at 342.
[131] State *ex rel*. Burpee v. Burton, 45 Wis. 150, 30 Am. Rep. 706 (1898).
[132] Richardson v. Braham, 125 Neb. 142, 249 N.W. 557 (1933).
[133] Kuhl v. Perri, 706 A.2d 1328 (R.I. 1998).
[134] CAMBRON-MCCABE, *supra* note 16, at 486.
[135] *Id*. at 487.
[136] *Id.*
[137] Tony Plohetski, *5 Teens Charged in Taped Assault*, *available at* http://www.bridges4kids.org/articles/1-03/AS1-16-03.html (last visited October 1, 2006).
[138] Simms v. School Dist. No. 1, Multnomak Cty., 508 P. 2d 236 (Or. Ct. App. 1973); Frame v. Comeaux, 735 So. 2d 753 (La. Ct. App. 1999).
[139] CAMBRON-MCCABE, *supra* note 16, at 488.
[140] *Id*. at 489.
[141] Gerks v. Deathe, 832 F. Supp. 1450 (W.D. Okla. 1993).
[142] M.H. by and through Callahan v. State, 385 N.W.2d 533, 539 (Iowa 1986).
[143] Collins v. Union Cty. Jail, 291 N.J. Super. 318, 677 A.2d 285 (Law Div. 1995), *aff'd*, 291 N.J. Super. 169, 677 A.2d 210 (App. Div. 1996), *judgment rev'd*, 150 N.J. 407, 696 A.2d 625 (1997).
[144] Davison *ex rel*. Sims v. Santa Barbara High Sch. Dist., 48 F. Supp. 2d 1255 (C.D. Cal. 1998).
[145] Moon v. Condere Corp., 690 So. 2d 1191, 1195 (Miss. 1997).
[146] Stevens v. Tillman, 855 F.2d 394 (CA 7 1988).
[147] ALASKA STATS. § 90.50.250; GA. CODE § 50-21-23.
[148] COLO. REV. STATS. ANN. § 24-10-106; TEX. CIV. PRAC. & REM. CODE § 101.021.
[149] WASH. REV. CODE § 4.92.090.
[150] Columbus Independent Sch. Dist. v. Five Oaks Achievement Ctr., 162 S.W.3d 812 (Tex. App. Houston.14.Dist.2005); Harper v. Patterson, 606 S.E.2d 887 (Ga. App. 2004).
[151] Allensworth and Kolbe, *supra* note 2.
[152] The CSHP model is consistent with the CDC's description of a school as a ''critical facility in which many agencies might work together to maintain the well-being of young people.'' For more information, *see* CDC, *supra* note 1.
[153] *Id*.
[154] DHHS, HEALTHY PEOPLE 2010. *About Healthy People*, *available at* http://www.healthypeople.gov/About/(last visited October 1, 2006).
[155] *Id*. at Objective 7-2.

[156] Kann, *supra* note 5.
[157] *Id*. at 419.
[158] IOWA CODE § 256.11, 5.j.
[159] *Id*. at § 256.11, 6.
[160] Kann, *supra* note 5, at 417.
[161] 20 U.S.C.S. § 7906.
[162] *Id*. at § 7861(c)(9)(C).
[163] Leebaert v. Harrington, 332 F.3d 134 (2nd Cir. 2003).
[164] *Brown*, *supra* note 65, at 533-34.
[165] W. VA. CODE § 18-2-9(b).
[166] *Id*. at § 18-2-9(c).
[167] N.J. STAT. ANN. § 18A:35-4.20.
[168] *Id*. at 4.21.
[169] *Id*. at 4.7.
[170] CAL. EDUC. CODE §§ 51930-51939.
[171] *Id*. at § 51938.
[172] *Id*. at § 51937.
[173] ARIZ. REV. STAT. ANN. § 15-716.
[174] NEV. REV. STAT. ANN. § 389.065.
[175] UTAH CODE ANN. § 53A-13-101.
[176] Kann, *supra* note 5, at 414.
[177] 20 U.S.C.S. § 1232h(c)(1)(C).
[178] *Id*. at § 1232h(b)(2) &(3). The law also lists six other areas where student participation cannot be compelled. *Id*. at § 1232h(b)(1)(4-8).
[179] ALASKA STAT. § 14.03.110; UTAH CODE ANN. § 53A:13-302; N. J. STAT. ANN. § 18a:36-34.
[180] COLO. REV. STAT. ANN. § 22-1-123; IND. CODE ANN. § 20-30-5-17; NEV. REV. STAT. § 392.029.
[181] 42 U.S.C.S. § 1788(c)(1).
[182] *Id*. at § 1788(b).
[183] *Id*. at § 1788(a) (emphasis added).
[184] *Id*. at § 1788(g)(2).
[185] *Id*. at § 710(b)(1).
[186] *Id*. at § 710(b)(2).
[187] Rebecca A. Maynard, et al., *First-Year Impacts of Four Title V, Section 510 Abstinence Education Programs*. (June 2005), *available at* http://aspe.hhs.gov/hsp/05/abstinence (last visited October 19, 2007).
[188] U.S. GEN. ACCT. OFF., ABSTINENCE EDUCATION 2-3 (2006), *available at* http://www.gao.gov/new.items/d0787.pdf (last visited October 19, 2007).
[189] The term ''local educational agency'' refers to ''a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary schools or secondary schools in a city, county, township, school district, or other political subdivision of a State, or of or for a combination of school districts or counties that is recognized in a State as an administrative agency for its public elementary schools or secondary schools.'' 20 U.S.C.S. § 7801(26)(A).
[190] *Id*. at § 7102.
[191] *Id*. at § 7139(a).
[192] *Id*. at § 7161(2).
[193] *Id*. at § 7114(a).
[194] *Id*. at § 7115(b)(2)(A)(iii) & (iv).
[195] *Id*. at § 7162.
[196] *Id*. at § 7163.
[197] Drug-Free Schools and Campuses Regulations, 34 C.F.R. Part 86.
[198] NCLB § 4114(d)(7)(e).
[199] Kann, *supra* note 5, at 419.
[200] LA ADMIN CODE, tit.28, pt. LIX, §§ 505, 507, 509, 511, 513, and 515; *see also* Kann, *supra* note 5, at 421.
[201] Joint Committee on National Health Education Standards, *National Health Education Standards: Achieving Health Literacy* (1995). The Joint Committee included representatives from the American Association for Health Education, American School Health Association, Society for State Directors of Health, Physical Education, and Recreation, and the School Health Education and Services Section of the American Public Health Association (B.J. Smith, Executive Director, American Association for Health Education; written communication; December 2005). (American Cancer Society, Dec. 2005-Ap. 2006).
[202] American Assn for Health Educ. *National Health Education Standards*, *available at* http://www.aahperd.org/AAHE/template.cfm?template=natl_health_education_standards.html (last visited October 1, 2006).
[203] Kann, *supra* note 5, at 414 (SHPPS 2006 also looked at other ways states and districts assisted with teaching health education such as the percentage of states and districts providing lesson plans or learning activities for health education and plans for how to assess or evaluate students taking health education classes).
[204] S.C. CODE ANN. § 59-32-5 *et. seq*.
[205] *Id*. at § 59-32-80.
[206] Missouri Dep't of Elementary and Secondary Educ., Division of Sch Improvement, *HIV Prevention Education Program: Frequently Asked Questions about HIV Prevention Education Requirements in Missouri's Public Schools*, *available at* http://dese.mo.gov/divimprove/curriculum/hiveducation/faqs.html (last visited October 1, 2006).
[207] Kann, *supra* note 5.
[208] *Id*. at 417.
[209] CDC, *supra* note 1.
[210] DHHS, *supra* note 154, at *Understanding and Improving Health*, Online Table of Contents, 22. Physical Activity and Fitness, *available at* http://www.healthypeople.gov/document/tableofcontents.htm (last visited October 1, 2006).
[211] Sarah M. Lee, et al., *Physical Education and Activity: Results from the School Health Policies and Programs Study 2006*, 77(8) J SCH HEALTH 435, 440 (2007).
[212] FLA. REV. STAT. § 1003.43(1)(j).
[213] Lee, *supra* note 211, at 452.
[214] *Id*. at 440.
[215] ALM GL ch. 71, § 3.
[216] Lee, *supra* note 211.
[217] *Id*. at 444.
[218] 20 U.S.C.S. § 1681 *et seq*.
[219] 34 C.F.R. § 106.41.
[220] *Id*. at § 106.41(c)(2), (7) & (8).
[221] *Id*. at § 106.41(c)(1).
[222] U.S. DEP'T OF EDUC., OFFICE FOR CIVIL RIGHTS, CLARIFICATION OF INTERCOLLEGIATE ATHLETICS POLICY GUIDANCE: THE THREE-PART TEST (Jan. 16, 1996), *available at* http://www.ed.gov/about/offices/list/ocr/docs/clarific.html (last visited October 1, 2006).
[223] 20 U.S.C.S. § 7261 (a), (e), (b), and b(b)(4).
[224] DHHS, THE PRESIDENT'S COUNCIL ON PHYSICAL FITNESS AND SPORTS, *available at* http://www.fitness.gov/ (last visited October 1, 2006).
[225] National Association for Sport & Physical Education. *Welcome to NASPE*, *available at* http://www.aahperd.org/naspe/template.cfm?template=about-welcome.html (last visited October 1, 2006).
[226] *Id.*
[227] *Id.*
[228] Lee, *supra* note 211, at 446.
[229] LA. ADMIN. CODE, tit.28, pt. LIX, §§ 505, 507, 509, 511, 513, and 515.
[230] Lee, *supra* note 211, at 443.
[231] *Id.*
[232] 2005 S.C.H.B. 3499, 2005 S.C.R. 129, Section 59-10-10(A); *see also* South Carolina Department of Education website explaining the requirements of the Student Health and Fitness Act of 2005, a synopsis of which is *available at* http://ed.sc.gov/agency/offices/cso/pe/documents/Tablef1.doc (last visited October 3, 2006).
[233] 2005 S.C.H.B. 3499, 2005 S.C.R. 129, Section 59-10-10(A).
[234] Lee, *supra* note 211.
[235] 70 OKLA. STAT. § 11-103.9a.

[236] DHHS, *supra* note 224.
[237] 70 OKLA. STAT. § 11-103.9a, B.
[238] *Id*. at § 11-103.9a, D.
[239] Lee, *supra* note 211, at 443.
[240] *Id*. at 446.
[241] CDC, *supra* note 1.
[242] 20 U.S.C.S. § 1232g; 34 C.F.R. Part 99 (2005); *see also* Section III.C (5) (access to information).
[243] 20 U.S.C.S. §§ 1400-1491.
[244] Pub. L. No. 101-336, 104 Stat. 337 (1990) (codified as amended at 42 U.S.C. §§ 12101-12213).
[245] 20 U.S.C.S. § 794.
[246] *Id*. at §1400 (d) (1) (A).
[247] *Id*. at § 1401 (26) (A); *see also* 34 C.F.R. §300.24 (2005).
[248] Cedar Rapids Comm. Sch. Dist. v. Garret, 526 U.S. 66 (1999); *see also Irving*, *supra* note 128.
[249] *See e.g*., 23 Ill. Adm. Code § 226. 310; NY CLS Educ. § 4402.
[250] Nancy D. Brener, et al., *Health Services: Results from the School Health Policies and Programs Study 2006*, 77(8) J SCH HEALTH 464-485 (2007).
[251] Florida School Health Services Act, FLA. STAT. § 381.0056.
[252] BARRY R. FURROW, ET AL., HEALTH LAW 59 (West Group, 2000).
[253] The National Council of State Legislatures has information on nurse ratios in twelve states (AL, AR, CT, DE, LA, MA, MN, NJ, PA, RI, TN, WV), *available at* http://www.ncsl.org/programs/health/nursestudent.htm (last visited October 1, 2006). *See also* 24 P.S. §14-1402 (2005) (requiring a 1:1500 ratio in PA).
[254] DHHS, *supra* note 154, at Objective 7-4.
[255] U.S. GEN. ACCT. OFF., HEALTH: SCHOOL BASED HEALTH CENTERS CAN EXPAND ACCESS TO CHILDREN, GAO-HEHS 95-35 (1994).
[256] Texas and Massachusetts provide grants to schools that opt to create SBHCs. TEX. EDUC. CODE § 38.063; ALM GL ch. 69, § 1L (2005) (grants for school health services). As of 2002, there were nearly 1,500 SBHCs in 45 states. Center for Health and Health Care in Schools, *2002 State Survey of School Based Health Care Initiatives* (2003). NCSL also has resources on SBHCs, *available at* http://www.ncsl.org/programs/health/sbhc.htm http://www.ncsl.org/programs/health/sbhc2001.htm (last visited October 1, 2006).
[257] James G. Hodge, Jr. and Lawrence O. Gostin, *School Vaccination Requirements: Historical, Social, and Legal Perspectives*, 90 KY L.J. 831, 869-73 (summarizing state vaccination laws and requirements); Ross D. Silverman, *No More Kidding Around: Restructuring Non-Medical Childhood Immunization Exemptions to Ensure Public Health Protection*, 12 ANNALS HEALTH L. 277, 282-83 (2003) (discussing state school immunization laws). *Contra* McCarthy v. Boozman, 212 F. Supp. 2d 945 (W.D. AR, 2002) (upholding an Arkansas state law requiring all children to be immunized for certain diseases and to present certification acknowledging immunization prior to being admitted to school, but invalidating a religious exemption for those who believed in the tenets of a ''recognized church or religious denomination.'' Arkansas's religious exemption was unconstitutional because it only applied to members of recognized churches).
[258] *See* Hodge and Gostin, *supra* note 257, at 859-75 (discussing in depth United States case law regarding religious exemptions to vaccination requirements). Three seminal U.S. Supreme Court cases have determined the parameters of governmental power to compel immunization over a religious objection or otherwise protect the welfare or health of a child in contravention of a parent's religious beliefs: *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (finding that the government was authorized to compel vaccination for the public good); *Zucht v. King*, 260 U.S. 174 (1922) (upholding a government mandate for vaccination as a prerequisite for public school attendance); and *Prince v. Massachusetts*, 321 U.S. 158 (1944) (the right to free exercise of religion does not permit the exposure of the community or one's children to harm from disease).
[259] McKinney-Vento Homeless Education Assistance Improvements Act of 2001, 42 U.S.C.S. 11431 *et seq*.
[260] VA. CODE ANN. § 22.1-270 (requiring physical examination prior to school admission in Virginia, but providing for a religious exemption from this requirement); 24 P.S. § 14-1402 (same in Pennsylvania); NY CLS PUB HEALTH § 2164 (same in New York); 105 CMR 200.001 *et seq*. (same in Massachusetts).
[261] TEX. EDUC. CODE § 38.003.
[262] VA. CODE ANN. § 22.1-273.1 (requiring annual scoliosis testing from grades 5 to 10).
[263] *Id*. at §22.1-273 (requiring sight and hearing testing at intervals to be determined).
[264] A.C.A. § 20-7-135(c)(3).
[265] *Id*. at 20-7-135(c)(4).
[266] TEX. CODE ANN. § 49-6-1401(a)(2).
[267] N.Y. CLS EDUC. § 3208-a.
[268] Vernonia Sch. Dist. 47j v. Acton, 515 U.S. 646 (1995) (upholding a school drug testing policy and finding that students were not entitled to full Fourth Amendment protections where the state's interest in preventing drug addiction among students was compelling and student athletes had a decreased expectation of privacy); *see also* Board of Educ. v. Earls, 536 U.S. 822 (2002).
[269] CAL. EDUC. CODE §§ 49403, 49426; CAL. HEALTH & SAFETY CODE § 120380.
[270] Kenney v. Gurley, 208 Ala. 623, 95 So. 34 (1923); Nutt v. Board of Educ. of City of Goodland, Sherman Cty., 128 Kan. 507, 278 P. 1065 (1929); Bright v. Beard, 132 Minn. 375, 157 N.W. 501 (1916).
[271] 34 C.F.R. 104.37 (2005).
[272] American Academy of Pediatrics, *Guidelines for the Administration of Medication in School*, 92 PEDIATRICS 499 (1993), *available at* http://aappolicy.aappublications.org/cgi/content/full/pediatrics; 112/3/697 (last visited October 1, 2006).
[273] MASS. GEN. LAWS ch. 71 § 54B; 105 MASS. CODE REGS. 210. 001 *et seq*. (2005).
[274] 42 U.S.C.S. § 280g.
[275] Maine P.L. 531 (2004 session).
[276] Sherry Everett Jones and Lani Wheeler, *Asthma Inhalers in Schools: Rights of Students with Asthma to a Free Appropriate Education*, 94 AM J PUBLIC HEALTH 1106 (2004).
[277] *Id*.
[278] *Id*. (*citing* U.S.DEP'T OF EDUC., OFFICE OF SAFE AND DRUG-FREE SCHOOLS, SAFE AND DRUG-FREE SCHOOLS AND COMMUNITIES ACT STATE GRANTS: GUIDANCE FOR STATE AND LOCAL IMPLEMENTATION OF PROGRAMS (2004), *available at* http://www.ed.gov/programs/dvpformula/guidance.doc (last visited October 1, 2006)).
[279] CAL. EDUC. CODE § 49423.
[280] 657 IOWA ADMIN. CODE § 10.16(1); 244 CMR 3.05.
[281] MONT. CODE ANN. § 20-5-412; N.C. GEN. STAT. § 115C-12(31).
[282] CAL. EDUC. CODE § 49414; HRS § 302A-1164.
[283] A.C.A. § 6-18-703.
[284] FLA. STAT. § 1002.20.
[285] LA. REV. STAT. ANN. § 40:1098.3.
[286] 2004 Cal. AG LEXIS 37; 87 Op. Atty Gen. Cal. 168 (November 29, 2004). Minors may consent to particularly sensitive medical services under California law, including care related to the prevention or treatment of pregnancy; treatment of an infectious, contagious, or communicable disease; diagnosis or treatment of drug-related or alcohol-related problems; mental health treatment, counseling, or residential shelter services; and HIV testing. *See* CAL. FAM. CODE §§ 6920-6929.
[287] CAL. EDUC. CODE §§ 49403, 49426.
[288] ABIGAIL ENGLISH AND KIRSTEN E KENNEY, STATE MINOR CONSENT LAWS: A SUMMARY. (2d ed. 2003), *available at*

http://www.cahl.org/publications.htm (last visited October 1, 2006).

[289] 20 U.S.C.S. § 1232g; 34 C.F.R. Part 99 (2005).

[290] 45 C.F.R. §160.103 (2005).

[291] JILL MOORE AND AMY WALL, APPLICABILITY OF HIPAA TO HEALTH INFORMATION IN SCHOOLS (Chapel Hill, NC: UNC Institute of Government, 2003), *available at* http://www.medicalprivacy.unc.edu/pdfs/schools.pdf (last visited October 1, 2006).

[292] ALM GL ch. 71, § 34E; TEX. EDUC. CODE § 38.0095.

[293] 20 U.S.C.S. § 1232g (d).

[294] TEX. EDUC. CODE § 38.009 (2005).

[295] N.H. REV. STAT. ANN. § 200:35(2005).

[296] N.Y. CLS EDUC. § 3209-a (2005).

[297] TEX. EDUC. CODE § 38.004 (2005).

[298] U.S. GEN. ACCT. OFF., MEDICAID IN SCHOOLS: POOR OVERSIGHT AND IMPROPER PAYMENTS COMPROMISE POTENTIAL BENEFIT, GAO/T-HEHS/OSI-00-87 (2000).

[299] Connie Garcia, *A Medicaid Reimbursement Program in Colorado Schools*, 71 J SCH HEALTH 80 (2001).

[300] U.S. GEN. ACCT. OFF., COORDINATION BETWEEN MEDICAID AND IDEA, GAO/HEHS-00-20 (1999).

[301] National Council of State Legislatures, *Medicaid Funding for Special Education*, *available at* http://www.ncsl.org/programs/educ/PubsMedicaid.htm (last visited October 1, 2006).

[302] FLA. STAT. § 381.0057.

[303] TEX. EDUC. CODE §§ 38.062, 38.063.

[304] LAUDON Y. ARON, ET AL., SERVING CHILDREN WITH DISABILITIES: A SYSTEMATIC LOOK AT THE PROGRAMS (University Press of America: 1996).

[305] Position Statement of the National Assembly on School-Based Health Care, *available at* www.nasbhc.org/APP/Medicaid_SCHIP_postion.pdf (last visited October 1, 2006).

[306] Forum Brief, *Financing Out-of-School Time and Community School Initiatives*, American Youth Policy Forum, February 18, 2000, *available at* http://www.aypf.org/forumbriefs/2000/fb021800.htm (last visited October 1, 2006).

[307] CDC, *supra* note 1.

[308] DHHS, *supra* note 154, at 1-2.

[309] 42 U.S.C.S. §§1751 *et seq*.; s*ee also* 42 C.F.R. § 210 (federal regulations governing the National School Lunch Program). The National School Lunch Program was created by the National School Lunch Act in 1946. USDA, Food and Nutrition Service, *National School Lunch Program Fact Sheet, available at* http://www.fns.usda.gov/cnd/Lunch/AboutLunch/NSLPFactSheet.pdf (last visited October 1, 2006).

[310] 42 U.S.C.S. §1771 *et seq*; *see also* 7 C.F.R. § 220. The Act establishing the School Breakfast Program is known as the Child Nutrition Act of 1966. The Child Nutrition Act also established the Special Milk Program, another voluntary federal program that reimburses public schools of high school grade or under (and other institutions) that do not participate in other federal child nutrition meal service programs with limited exceptions for the milk that they serve. 42 U.S.C.S. § 1772; 7 C.F.R. Part 215; USDA, Food and Nutrition Service, *Special Milk Program*, *available at* http://www.fns.usda.gov/cnd/milk (last visited October 1, 2006).

[311] 7 C.F.R. §§ 210.3 (National School Lunch Program), 220.3 (School Breakfast Program). At the federal level, the Food and Nutrition Service at the USDA administers the programs. At the state level, the programs are usually administered by state educational agencies and operated through agreements with local school food authorities.

[312] The federal regulations distinguish between the National School Lunch Program and the Commodity School Program. As defined in the regulations, the Commodity School Program includes schools that received donated food assistance in lieu of general cash assistance (with limited exceptions), while under the National School Lunch Program, schools may receive both general and special cash assistance and donated food assistance. 7 C.F.R. § 210.2 (Definitions). For the purposes of this Report, ''National School Lunch Program'' includes the Commodity School Program.

[313] 42 U.S.C.S. § 1766a.

[314] Economic Research Service, USDA, Briefing Room, *Child Nutrition Programs: National School Lunch Program*, *available at* http://www.ers.usda.gov/Briefing/ChildNutrition/lunch.htm (last visited October 1, 2006).

[315] 42 U.S.C.S. § 1773; USDA, Food and Nutrition Service, *School Breakfast Program, available at* http://www.fns.usda.gov/cnd/breakfast/ (last visited October 1, 2006).

[316] 42 U.S.C.S. § 1758.

[317] Economic Research Service, *supra* note 314.

[318] 105 ILL. COMP. STAT. §§ 126/1, 126/5, 126/10, 126/15, and 126/1.

[319] *Id*. at §§ 126/15(a).

[320] *Id*. at §§ 126/5.

[321] GA. CODE ANN. § 20-2-66(a).

[322] LA. REV. STAT. ANN. § 17:192(B).

[323] ARIZ. REV. STAT. § 15-242(B).

[324] 20 ME. REV. STAT. ANN. § 6602(1) & (2).

[325] NC GEN STAT. ANN. § 115C-264(a).

[326] USDA, *supra* note 309. The Healthy Meals for Healthy Americans Act of 1994 (P.L. 103-448) amended the Child Nutrition Act of 1966 (which includes the School Breakfast Program) and the National School Lunch Act to require that schools serve lunches and breakfasts that ''are consistent with the goals of the most recent Dietary Guidelines for Americans.'' *See* 42 U.S.C.S. §1758(f)(1)(A); P.L. 103-448. In 1995, federal regulations governing the nutrition standards for the National School Lunch and School Breakfast Programs were amended so that school lunches and breakfasts would comply with the recommendations of the Dietary Guidelines for Americans, and that school meals must meet specific minimum standards for key nutrients and calories, as part of the USDA School Meals Initiative for Healthy Children (SMI). *See* 60 C.F.R. § 31188. In 1996, National School Lunch Act was further amended to require that school lunches provide ''1/3 of the daily recommended dietary allowance established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences'' and school breakfasts to provide ''1/4 of the daily recommended allowances.'' *See* 42 U.S.C.S. § 1758(f)(1)(B); P.L. 104-193.

[327] 7 C.F.R. § 210.10; USDA, *supra* note 309.

[328] 42 U.S.C.S. §§ 1773(e), 1779(a).

[329] 7 C.F.R. § 220.8.

[330] USDA, FOODS SOLD IN COMPETITION WITH USDA SCHOOL MEAL PROGRAMS (2001), *available at* http://www.fns.usda.gov/cnd/Lunch/CompetitiveFoods/report_congress.htm (last visited October 1, 2006).

[331] The Child Nutrition and WIC Reauthorization Act of 2004 (P.L. 108-265, § 204) (enacted June 20, 2004); 42 U.S.C.S. § 1751 (History; Ancillary Laws and Directives).

[332] USDA, Food and Nutrition Service, Healthy Schools, *Local Wellness: Frequently Asked Questions, available at* http://www.fns.usda.gov/tn/Healthy/wellnesspolicy_faq.html (last visited October 1, 2006).

[333] The Child Nutrition and WIC Reauthorization Act of 2004, § 204(a)(2).

[334] Trust for America's Health, *F as in Fat: How Obesity Policies are Failing in America*, Washington, D.C. (2005), *available at* http://healthyamericans.org (last visited October 1, 2006).

[335] Tex. Dept. of Agric., *Texas Public School Nutrition Policy*, *available at* http://www.squaremeals.org/vgn/tda/files/2348/2538_Texas%20Public%20School%20Nutrition%20Policy.pdf (last visited October 1, 2006).

[336] *Id*. at §§ III(B)(1)(a), IV(B)(1)(a); V(B)(1)(a).

[337] Based on the weekly average of the nutrient content of school lunches, South Dakota public schools limit sodium to 1300 mg

and cholesterol to 100 mg, and require a minimum of 3.8 mg of fiber for K-3rd grade and 5.9 mg of fiber for grades 4th-12th, or 4.3 mg of fiber for grades K-6th and 6.5 mg of fiber for grades 7th-12th. Based on the weekly average of the nutrient content of school breakfasts, public schools in South Dakota limit sodium to 800 mg and cholesterol to 75 mg, and require a minimum of 4.5 mg of fiber for all grades. Personal communication with representative at the Child & Adult Nutrition Services, South Dakota Department of Education (November 1, 2005); Trust for America's Health, *supra* note 334.

[338] CA SB 985, amending § 49431.5 of the CAL. EDUC. CODE (modifies the list of beverages that can be sold to elementary, middle or junior high school students and restricts the sale of beverages to high school students at specified times to certain specified beverages); CA SB 12, amending §§ 49430, 49431, 49433.9, and 49434 of, and adding § 49431.2 to the CAL. EDUC. CODE (among other things places sugar and fat content and calorie restrictions on certain foods items sold); CA SB 281, adding new Article 11.5, §§ 49565 - 49565.8, to Chapter 9 of Part 27 of the CAL. EDUC. CODE (establishes the California Fresh Start Pilot Program to provide fresh fruits and vegetables to public school students).

[339] Office of the Governor of California, Press Release, *Governor Schwarzenegger Signs Landmark Legislation to Combat Childhood Obesity* (Sept. 15, 2005), *available at* http://gov.ca.gov/index.php?/press-release/1424/ (last visited October 1, 2006).

[340] Lynda Gledhill, *Governor signs bills to trim obesity in schools*, SAN FRANCISCO CHRONICLE @ A1 (Sept. 16, 2005).

[341] 7 C.F.R. §§ 210.11(a)(1) (National School Lunch Program); 220.2(c-1) (School Breakfast Program).

[342] *Id*. at § 210 App. B; *id*. at § 220 App. B (these sections define each of the listed foods of minimal nutritional value).

[343] *Id*. at §§ 210.11, 220.12. This language is apparently derived from § 1779 of the Child Nutrition Act, which states that the federal regulations cannot prohibit the sale of competitive foods approved by the Secretary of Agriculture in food service facilities or areas during the time meals are served under the SBP or NSLP ''if the proceeds from the sales of such foods will inure to the benefit of the schools or of organizations of students approved by the schools.'' 42 U.S.C.S. § 1779(b).

[344] 7 C.F.R. §§ 210.11, 220.12. Federal regulations in effect from 1980-1983 prohibited the sale of foods of minimal nutritional value on school grounds from the beginning of the school day until the last meal period. The regulations were struck down in *National Soft Drink Ass'n v. Block*, 721 F.2d 1348 (D.C. Cir. 1983), which held that the U.S. Department of Agriculture could only regulate the sale of competitive foods in food service areas during meal periods. Subsequently, the federal regulations were amended in accordance with this ruling. U.S. GOV. ACCT. OFF., SCHOOL MEAL PROGRAMS: COMPETITIVE FOODS ARE WIDELY AVAILABLE AND GENERATE SUBSTANTIAL REVENUES FOR SCHOOLS, GAO-05-563 (Washington, D.C.; U.S. General Accountability Office, August 2005), *available at* http://www.gao.gov/new.items/d05563.pdf (accessed October 1, 2006).

[345] USDA, *supra* note 330.

[346] CDC. *Competitive foods and beverages available for purchase in secondary schools—selected sites, United States, 2004*. 54(37) MMWR 917-921 (2005); Trust for America's Health, *supra* note 334; U.S. GOV. ACCT. OFF., SCHOOL MEAL PROGRAMS: COMPETITIVE FOODS ARE AVAILABLE IN MANY SCHOOLS; ACTIONS TAKEN TO RESTRICT THEM DIFFER BY STATE AND LOCALITY, GAO Report-04-673 (Washington, D.C. 2002); Terrence P. O'Toole et al., *Nutrition Services and Foods and Beverages School: Results from the School Health Policies and Programs Study 2006*, 77(8) J SCH HEALTH 500-21(2007).

[347] U.S. GOV'T ACCT. OFF., *supra* note 344.

[348] ARK. STAT. ANN. § 20-7-135.

[349] FLA DEP'T OF EDUC., STATE BD. OF EDUC., ADMIN. RULE 6-7.042, *available at* http://www.myfloridaeducation.com/rules/6a-7.htm#6A-7.042 (accessed October 1, 2006). *See also* Trust for America's Health, *supra* note 334.

[350] CONN. GEN. STAT. § 10-221p.

[351] Trust for America's Health, *supra* note 334.

[352] American Beverage Association, *Beverage Industry Announces New School Vending Policy: Plan Calls for Lower-Calories and/or Nutritious Beverages in Schools and New Limits on Soft Drinks*, Press Release, August 16, 2005, *available at* http://www.ameribev.org/pressroom/2005_vending.asp (last visited October 1, 2006).

[353] American Beverage Association. *Beverage Industry School Vending Policy, available at* http://www.ameribev.org/schools/vending_policy.asp (last visited October 1, 2006).

[354] Liz F. Kay, *Flunking the Fizz; Move follows threat of suit as epidemic of obesity grows*, BALTIMORE SUN @ 1A (May 4, 2006).

[355] Alliance for a Healthier Generation, *School Beverage Guidelines Progress Report, available at* http://www.healthiergeneration.org/engine/renderpage.asp?pid=s017&search_term=school%20beverage%20guidelines (last visited October 1, 2006).

[356] U.S. GOV'T ACCT. OFF, *supra* note 344.

[357] American Academy of Pediatrics, Policy Statement, *Soft Drinks in schools*. 113(1) PEDIATRICS 152 (2004).

[358] S. Fox, A. Meinen, M. Pesik, M. Landis, & P.L. Remington, *Competitive Food Initiatives in Schools and Overweight in Children: A Review of the Evidence*, 104(5) WISCONSIN MED. J. 38 (2005).

[359] O'Toole, *supra* note 346.

[360] *Id*. at 507.

[361] CITY OF DETROIT, OFFICIAL ZONING ORDINANCE §§ 92.0379A(j), B(j) & C(j), 94.0379D(i), *available at* http://www.municode.com/resources/code_list.asp?stateID=22 (last visited October 1, 2006); *see also* Julie S. Mair, Matthew Pierce, and Stephen P. Teret, *The Use of Zoning to Restrict Fast Food Outlets: A Potential Strategy to Combat Obesity* (2005), *available at* http://www.publichealthlaw.net/Research/Affprojects.htm#Zoning (last visited October 1, 2007).

[362] U.S. GEN. ACCT. OFF., PUBLIC EDUCATION. COMMERCIAL ACTIVITIES IN SCHOOLS, GAO/HEHS-00-156 (Sept. 2000). *Available at* http://www.gao.gov/archive/2000/he00156.pdf (last visited October 1, 2006).

[363] VA. CODE ANN. § 22.1-89.4.

[364] *Id*. at § 22.1-89.4 (Historical and Statutory Notes).

[365] IOM, *Food Marketing to Children and Youth: Threat or Opportunity?* (Released December 6, 2005), *available at* http://iom.edu/?id=34888 (last visited October 1, 2006).

[366] S. Bryn Austin, et al., *Clustering of Fast-food Restaurants Around Schools: A Novel Application of Spatial Statistics to the Study of Food Environments*, 95(9) AM J PUBLIC HEALTH 1575 (2005).

[367] CITY OF DETROIT, *supra* note 361.

[368] Arden Hills, Minnesota Zoning Ordinance § 6(D)(a), *available at* http://www.ci.arden-hills.mn.us/index.asp?Type=B_LIST&SEC=%7B4FDEE185-D223-47C4-BEFC-790771DEB6F2%7D (last visited October 1, 2006).

[369] CDC, *supra* note 1.

[370] BOGDEN, *supra* note 3, at 9.

[371] DHHS, MENTAL HEALTH: REPORT OF THE SURGEON GENERAL, Chapter 6 (1999).

[372] U.S. SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., SCHOOL MENTAL HEALTH SERVICES IN THE UNITED STATES, 2002-2003 (2005).

[373] *No Child Left Behind: A Desktop Reference* 117 (Office of the Undersecretary, September 2002) *available at* http://www.ed.gov/admins/lead/account/nclbreference/reference.pdf (last visited October 1, 2006) (providing that ''In addition to school counselors, school social workers, and school psychologists, the law now allows other qualified psychologists and child and adolescent psychiatrists to receive payment from program funds.'').

[374] 20 U.S.C.S. §§ 1400-1491.

[375] *Id*. at § 794.

[376] *Id*. at § 1401 (26) (A); 34 C.F.R. § 300.24 (2005).
[377] 20 U.S.C.S. § 1412 (a) (3).
[378] Safe and Drug-Free Schools and Communities Act, *id*. at §§ 7111-7116.
[379] Nancy D. Brener, et al., *Mental Health and Social Services: Results from the School Health Policies and Programs Study 2006*, 77(8) J SCH HEALTH 486 (2007).
[380] U.S. SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 372.
[381] *Id*. at 27.
[382] Brener, *supra* note 379; *see also* Mayris P. Webber, et al., *Do School-Based Health Centers Make a Difference?*, 157 ARCHIVES OF PEDIATRICS AND ADOLESCENT MED, 125 (2003); BONNIE KAUL NASTASI, ET AL., AMERICAN PSYCHOLOGICAL ASSOCIATION, SCHOOL-BASED MENTAL HEALTH SERVICES: CREATING COMPREHENSIVE AND CULTURALLY SPECIFIC PROGRAMS (2004).
[383] TEX. EDUC. CODE §§ 38.053, 38.057.
[384] Iowa House File 2162, Expanding Mental Health Screenings (a bill allowing the Department of Education to expand the availability and public awareness of services for mental health problems by making voluntary mental health screenings available to youth for the purpose of early identification of mental illness) (pending 2006); MINN. STAT. § 256.995 (authorizing school-based services for at-risk youth including mental health and substance abuse services).
[385] N.H.H.B. 1397 (Chapter 34). *See also* Arkansas Youth Suicide Prevention Act, ARK.CODE ANN. § 20-77-1605.
[386] TEX. S.B. 491.
[387] Brener, *supra* note 379.
[388] U.S. SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 372.
[389] States provide funding for counseling, psychological, and social services in a variety of ways. Funds may be provided through direct grants to schools tied to specific mental or social health initiatives. CONN. GEN. STAT. § 10-76u (establishing school-based primary mental health programs, a grant program for the purpose of providing funds to local and regional boards of education for the establishment of school-based programs for the detection and prevention of emotional, behavioral and learning problems in public school). Funding may also be disbursed by state or local departments of health. *See* HRS § 302A-442 (designating the department of health responsibility to fund related services of school health, mental health, psychological, and medical services for evaluation or diagnostic purposes for children who need these services and who attend public school in the State).
[390] Brener, *supra* note 379.
[391] U.S. SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 372.
[392] N.C. GEN. STAT. § 115C-108; MICH. ADMIN. CODE. r. 340.1700 *et seq*.
[393] 105 ILL. COMP. STAT. 5/14-1.09.1.
[394] 20 U.S.C.S. § 1232h(b)(2) & (3). The law also lists six other areas where student participation cannot be compelled. *Id*. at § 1232h(b)(1), (4) to (8).
[395] TEX. EDUC. CODE § 38.016.
[396] MICH. ADMIN. CODE. r. 340.1700 *et seq*.
[397] Donna J. Underwood and Sandra Kopels, *Complaint Filed against Schools by Parents of Children with AD/HD: Implications for School Social Work Practice*, 26 CHILDREN & SCH 221 (2004).
[398] U.S. SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 372.
[399] ARK. CODE ANN. § 6-18-1005; 105 ILL. COMP. STAT. 5/10-22.24b.
[400] C.R.S. 22-33-204.
[401] Yvonne M. Terry-McElrath, et al., *Substance Abuse Counseling Services in Secondary Schools: A National Study of Schools and Students*, 1999-2003, 75 J SCH HEALTH 334 (2005).
[402] ALA. CODE ANN. § 16-1-24.1 (d).
[403] New York School-Based Mental Health Program. *Available at* http://www.omh.state.ny.us/omhweb/Childservice/school_clinics.htm (last visited October 1, 2006).
[404] LA. REV. STAT. ANN. § 17:404.
[405] *Id*. at § 17:403.
[406] TEX. EDUC. CODE § 38.016.
[407] VA. CODE ANN. § 22.1-272.1. Maryland has also implement a youth suicide prevention program. MD. CODE ANN. EDUC. § 7-500 *et seq*.
[408] P.L.108-355.
[409] TEX. EDUC. CODE § 38.010.
[410] U.S. SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 372, at 20-21.
[411] CAL. EDUC. CODE § 49602. Exceptions to this confidentiality may exist for purposes of referring the pupil to another health care provider, to avert a threat to health, to report child abuse or neglect, to investigate a crime, and when a waiver of confidentiality has been granted.
[412] IDAHO RULES OF EVIDENCE, § 516. North Dakota has enacted a similar provision protecting the confidentiality of information shared between students and school counselors. N.D. CENT. CODE § 31-01-06.1.
[413] 2006 U.S. LEXIS 23469 (2nd Cir. 2006).
[414] CAL. EDUC. CODE § 44266 (outlining criteria for service credentials for school counseling, school psychology, child welfare and attendance services, and school social work); MICH. COMP. LAWS SERV. § 380.1251 (authorizing school psychologists).
[415] CAL. BUS. & PROF. CODE § 4986.20 (educational psychologist); FLA. STAT. § 490.001 *et seq*. (school psychologist); 105 ILL. COMP. STAT. 5/10-22.24a (school counselor); 225 ILL. COMP. STAT. 15/10 (school psychologist); MCLS § 333.18214 (school psychologist); 20-A M.R.S. § 13022 (school psychological service providers).
[416] W. VA. CODE § 18-5-18b. *See also* National Association of School Psychologists, National School Psychology License and Registration Online Resource List, *available at* http://www.nasponline.org/certification/state_info_list.html (last visited October 1, 2006).
[417] ARK. CODE ANN. § 6-18-1005 (b).
[418] 105 ILL. COMP. STAT. 5/34-18.7.
[419] Eisel v. Board of Educ. of Montgomery Cty., 597 A.2d 447 (Md. 1991).
[420] Cindy S. Cafaro, *Student Suicides and School System Liability*, SCH LAW BULLETIN 18 (Spring/Summer 2000).
[421] *Id*. at 26.
[422] American School Counselor Association, Ethical Standards for School Counselors, *available at* http://www.schoolcounselor.org/content.asp?contented=173 (last visited October 1, 2006); National Association of School Psychologists, Professional Conduct Manual Principles for Professional Ethics Guidelines for the Provision of School Psychological Services, *available at* http://www.nasponline.org/pdf/ProfessionalCond.pdf (last visited October 1, 2006); National Association of Social Workers, NASW Standards for School Social Work Services, *available at* http://www.naswdc.org/practice/standards/NASW_SSWS.pdf (last visited October 1, 2006).
[423] AMERICAN ACADEMY OF PEDIATRICS COMMITTEE ON SCHOOL HEALTH, CHAPTER 11, THE SCHOOL ENVIRONMENT: IN SCHOOL HEALTH POLICY & PRACTICE (6th ed. 2004); *see also* IOM, SCHOOLS & HEALTH: OUR NATION'S INVESTMENT 65 (1997); CDC, *School Health Guidelines to Prevent Unintentional Injuries and Violence*, 50 MMWR 1, 15 (2001); CDC, *supra* note 1.
[424] AMERICAN ACADEMY OF PEDIATRICS, *supra* note 423, at 231.
[425] CDC, *School Health Guidelines, supra* note 423.
[426] DHHS, *supra* note 154, at Objective 8-20.
[427] *Id*. at Objective 27-11.
[428] *Id*. at Objective 15-38.

[429] *Id*. at Objective 15-39, Objective 15-31.
[430] EPA. HEALTHY SCHOOL ENVIRONMENTS ASSESSMENT TOOL. BASIC INFORMATION, *available at* http://www.epa.gov/schools/healthyseat/basicinformation.htm (last visited October 1, 2006).
[431] *Id.*
[432] CDC National Institute for Occupational Safety and Health. *NIOSH Safety Checklist Program for Schools*, *available at* http://www.cdc.gov/niosh/docs/2004-101/default.html (last visited October 1, 2006).
[433] CDC. SCHOOL HEALTH INDEX: A SELF-ASSESSMENT AND PLANNING GUIDE (2005), *available at* http://www.cdc.gov/HealthyYouth/SHI (last visited February 20, 2007).
[434] Sherry Everett Jones, et al., *Healthy and Safe School Environment, Part I: Results from the School Health Policies and Programs Study 2006*, 77(8) J SCH HEALTH 522, 532 (2007).
[435] Laurie Lewis, et al., *Conditions of America's Public School Facilities: 1999*, U.S. Dep't of Educ., National Center for Education Statistics, NCES 2000-032 (2000).
[436] 24 P.S. § 7-701.
[437] TEX. HEALTH & SAFETY CODE § 341.065; *see also* 105 ILL. COMP. STAT. § 5/2-3.25.
[438] 15 U.S.C.S. §§ 2641-56.
[439] Toxic Substances Control Act, Pub. L. No. 94-496, 90 Stat. 2003 (1976) (codified at 15 U.S.C.S. §§ 2601-2692).
[440] EPA, ASBESTOS AND SCHOOLS, *available at* http://www.epa.gov/asbestos/pubs/asbestos_in_schools.html#2 (last visited October 1, 2006).
[441] 40 C.F.R. § 763(E).
[442] 20 U.S.C.S. § 7801(26).
[443] Arnold W. Reitze, Jr. and Sherly-Lynn Carof, *The Legal Control of Indoor Air Pollution*, 25 BOSTON COLLEGE ENV'T AFF L. REV. 247 (1998); *see also* 15 U.S.C.S. §§ 2643, 2644; 40 C.F.R. § 763(E).
[444] 20 U.S.C.S. §§ 4011-22.
[445] Linda-Jo Schierow, *The Toxic Substances Control Act: A Summary of the Act and Its Major Requirements*, CRS Report for Congress, FL31905, *available at* http://ncseonline.org/NLE/CRSreports/04dec/RL31905.pdf (last visited October 19, 2007).
[446] 20 U.S.C.S. § 4011.
[447] *Id*. at § 4012.
[448] *Id*. at § 4014.
[449] *Id*. at § 4022.
[450] ALASKA STAT. §§ 18.31.010-.050.
[451] *Id*. at § 18.31.010.
[452] 105 ILL. COMP. STAT §§ 105/1-16.
[453] *Id*. at § 105/2.
[454] *Id*. at § 105/4.
[455] Title III—Indoor Radon Abatement, Pub. L. No. 100-551, 102 Stat. 2755 (1988) (codified at 15 U.S.C.S. §§ 2661-2671).
[456] 15 U.S.C.S. § 2661.
[457] *Id*. at § 2667(a)(1).
[458] *Id*. at § 2667(a)(2).
[459] *Id*. at § 2667(a)(5)(6).
[460] EPA, REDUCING RADON IN SCHOOLS: A TEAM APPROACH, EPA 402-R-04-008 (April 1994).
[461] *Id.*
[462] VA. CODE ANN. § 22.1-138(B).
[463] CONN. GEN. STAT. ANN. § 19a-37b.
[464] 7 U.S.C.S. §§ 136 *et seq*.; U.S. GEN. ACCT. OFF., PESTICIDES: USE, EFFECTS, AND ALTERNATIVES TO PESTICIDES IN SCHOOLS, GAO/RCED-00-17 (1999), *available at* http://www.gao.gov/new.items/rc00017.pdf (last visited October 1, 2006).
[465] *Id.*
[466] Kagen Owens and Jay Feldman. *The Schooling of State Pesticide Laws - 2002 Update: A Review of State Pesticide Laws Regarding Schools* (Beyond Pesticides/National Coalition Against the Misuse of Pesticides, 2002), *available at* http://www.beyondpesticides.org/schools/publications/School_report_update_2002.pdf (last visited October 1, 2006).
[467] Walter A. Alarcon, et al., *Acute Illnesses Associated with Pesticide Exposure at Schools*, 294 J AMER MED ASS'N 455 (2005).
[468] Lead Contamination Control Act of 1988, 100 Pub. L. No. 572; 102 Stat. 2884 (1988) (codified 42 U.S.C.S. §§ 300j-24 & 300j-25). The Safe Drinking Water Act Amendments of 1996, 104 Pub. L. No. 182; 110 Stat. 1613(1996), among other things, made technical change to the section headings to the federal laws concerning school drinking water. 42 U.S.C.S. §§ 300j-24 & 300j-25.
[469] 42 U.S.C.S. § 300j-24(a)-(d); § 300j-23(a).
[470] *Id*. at § 300j-24(d).
[471] Association of Community Orgs. for Reform Now v. Edwards, 81 F.3d 1387 (5th Cir. 1996).
[472] CAL. EDUC. CODE §§ 32240-32245.
[473] *Id*. at § 32241(b) & (c).
[474] *Id*. at § 32241(a)-(g).
[475] *Id*. at § 32243(a). The Childhood Lead Poisoning Prevent Act is found at CAL HEALTH & SAF CODE §§ 105275 *et seq*.
[476] CAL. EDUC. CODE § 32244.
[477] *Id*. at § 32245.
[478] Everett Jones, *supra* note 434, at 528.
[479] *Id.*
[480] ''The Billy Foundation'' webpage, *available at* http://www.bfmelanoma.com (last visited October 1, 2006).
[481] CAL. EDUC. CODE § 35183.5.
[482] 49 C.F.R. §1.50.
[483] U.S. DEP'T OF TRANS. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN. QUICK REFERENCE GUIDE TO FEDERAL MOTOR VEHICLE SAFETY STANDARDS AND REGULATIONS. DOT HS 908 878 (Revised March 2004), *available at* http://www.nhtsa.gov/cars/rules/standards/FMVSS-Regs/index.htm (last visited October 1, 2006).
[484] *Id.*
[485] 49 C.F.R. § 571.131.
[486] *Id*. at 220.
[487] *Id*. at 221.
[488] *Id*. at 222.
[489] U.S. Nat'l Highway Traffic Safety Admin. *School Bus Safety Program, Seatbelts on School Buses, available at* http://www.nhtsa.dot.gov/portal/site/nhtsa/menuitem.e712547f8daccabbbf30811060008a0c/ (last visited October 1, 2006); *see* 49 C.F.R. § 571.208 (Standard No. 225; child restraint anchorage systems) and 49 C.F.R. § 571.225 (Standard No. 225; child restraint anchorage systems).
[490] 49 C.F.R. § 571.213(S5.3.1(b) & S5.6.1.11).
[491] Anne Albers, *Should There Be Laws Mandating Seatbelts in All School Buses? PRO*, 26(1) THE AMERICAN J. OF MATERNAL/CHILD NURSING 8 (2001); Dawn Garzon, *Should There Be Laws Mandating Seatbelts in All School Buses? CON*, 26(1) THE AMERICAN J OF MATERNAL/CHILD NURSING 9 (2001).
[492] U.S. Nat'l Highway Traffic Safety Admin., *supra* note 489; *see* 49 C.F.R. § 571.222 (Standard No. 222; school bus passenger seating and crash protection).
[493] 23 U.S.C.S. § 402(a). Federal regulations also govern ''school bus operations.'' *See* 49 C.R.F. §§ 605.1–605.21.
[494] 23 U.S.C.S. § 402(a)(5).
[495] MINN. STAT. ANN. § 169.14(Subd. 5a), (c), (d).
[496] Governor's Highway Safety Association. *Sanctions for Exceeding the Speed Limit in Either a Construction or School Zone*, *available at* http://www.ghsa.org/html/stateinfo/laws/sanctions_laws.html (last visited October 1, 2006).
[497] Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users, 109 Pub. L. 59, 119 Stat. 1144 (2005) (*see* notes to 23 U.S.C.S. § 402).
[498] 23 U.S.C.S. § 1404(b).
[499] *Id*. at § 1404(e).
[500] *Id*. at § 1404(f).
[501] DEL. CODE. ANN. tit. 17 §§ 1001-06; §§ 1021-22.
[502] *Id*. at § 1001.

[503] S.C. CODE ANN. § 59-17-150(C).
[504] Tobie Bernstein and Zachary Lamb, *Building Healthy, High Performance Schools: A Review of Selected State and Local Initiatives* (Washington, D.C., Environmental Law Institute, 2003), *available at* http://www.cdc.gov/niosh/docs/2004-101/default.html (last visited October 19, 2007).
[505] Deane Evans, *High-Performance School Buildings: Resource and Strategy Guide*, (2nd ed., Washington, DC, Sustainable Building Industry Council), *available at* http://www.sbicouncil.org/PDFs/HPSB_sample.pdf (last visited October 1, 2006).
[506] Sherry Everett Jones, et al., *Healthy and Safe School Environment, Part II: Results from the School Health Policies and Programs Study 2006*, 77(8) J SCH HEALTH 544, 550 (2007).
[507] ARK. CODE. ANN. § 12-13-109.
[508] VA. CODE ANN. § 22.1-137.
[509] 18 U.S.C.S. § 922(q)(2) and (3).
[510] *Id*. at § 922(q)(2)(A). The law does not apply, for example, to the possession of a firearm ''on private property not part of school grounds'' (*id*. at § 922(q)(2)(B)(i)) and ''by an individual for use in a program approved by a school in the school zone'' (*id*. at § 922(q)(2)(B)(iv)).
[511] *Id*. at § 921(a)(26).
[512] *Id*. at § 921(a)(25).
[513] *Id*. at §§ 924(a)(1)(B) & (a)(4).
[514] Crime Control Act of 1990, 101 Pub. L. 647, Title XVII, § 1702, 104 Stat. 4789, 4844 (1990).
[515] United States v. Lopez, 514 U.S. 549 (1995).
[516] U.S. CONST., art. I, § 8, cl. 3.
[517] *Lopez*, *supra* note 515, at 561.
[518] *Id*. at 549.
[519] United States v. Danks, 221 F.3d 1037 (8th Cir. 1999); *see also* United States v. Dorsey, 418 F.3d 1038 (9th Cir. 2005).
[520] 18 U.S.C.S. § 922(q)(4).
[521] WIS. STAT. § 939.50(3)(i).
[522] *Id*. at § 948.605(2). Like the federal law the Wisconsin statute has enumerated exceptions and also makes it illegal to discharge a gun in a school zone.
[523] *Id*. at § 948.605(1)(c).
[524] ME. REV. STAT. ANN. tit. 20 § 6552; *see also id*. at tit. 17 § 1252(2)(E).
[525] CAL. PEN. CODE § 626.9.
[526] LA. REV. STAT. ANN. § 14:95.2.
[527] OHIO REV. CODE. ANN. § 2923.161.
[528] 20 U.S.C.S. §§ 6301 *et seq*.
[529] *Id*. at § 7151(b)(1).
[530] *Id*.
[531] *Id*. at § 7151(b)(2).
[532] *Id*. at § 7151(g).
[533] *Id*. at § 7151(h)(1).
[534] 21 U.S.C.S. § 860(a).
[535] *Id*. at § 860(c).
[536] For a detailed description and analysis of state juvenile transfer laws *see* P. Griffin. *Trying and Sentencing Juveniles as Adults: An Analysis of State Transfer and Blended Sentencing Laws*. Pittsburgh, PA: National Center for Juvenile Justice; October 2003, *available at* http://ncjj.servehttp.com/NCJJWebsite/pdf/transferbulletin.pdf (last visited October 1, 2006); the National Center for Juvenile Justice's website for state profiles and national overviews of trying juveniles as adults, *available at* http://www.ncjj.org/stateprofiles/overviews/overviewtransfer.asp?overview=overviewtransfer.asp (last visited October 1, 2006).
[537] National Ctr for Juvenile Justice, Nat'l Overviews. *How Have State Laws Governing Criminal Prosecution of Juveniles Changed in Recent Years?, available at* http://www.ncjj.org/stateprofiles/overviews/transfer9.asp (last visited October 1, 2006).
[538] 20 U.S.C.S. § 7912(a).
[539] U.S. DEP'T OF EDUC., UNSAFE SCHOOL CHOICE OPTION, NON-REGULATORY GUIDANCE, *available at*: http://www.ed.gov/policy/elsec/guid/unsafeschoolchoice.pdf (last visited October 1, 2006).
[540] *Id*.
[541] U.S. DEP'T OF EDUC., UNSAFE SCHOOL CHOICE OPTION. PRESENTATION TO THE SAFE AND DRUG-FREE SCHOOLS ADVISORY COMMITTEE (October 23, 2006), *available at* http://www.ed/gov/about/bdcomm/list/sdfscac/present10-06.html (last visited March 27, 2007).
[542] Personal Communication. U.S. Dep't of Educ. official. March 31, 2007.
[543] The Education Commission of the States released a report last updated in September 2004 describing and analyzing the state response to the federal school choice requirement concerning persistently dangerous schools. *See* G. Zradicka, *Persistently Dangerous School Criteria*. Education Commission of the States (September 2004), *available at* http://www.ecs.org/clearinghouse/52/98/5298.pdf (last visited October 3, 2006).
[544] NEV. REV. STAT. ANN. § 392.017.
[545] S.C. CODE ANN. § 59-63-333.
[546] N.H. REV. STAT. ANN. §§ 193-G:1(I) & (II).
[547] *Id*. at § 193-G:3.
[548] Everett Jones, *supra* note 434, at 527.
[549] *See* Susan Hanley Kosse and Robert H. Wright, *How Best to Confront the Bully: Should Title IX or Anti-Bullying Statutes be the Answer?*, 12 DUKE J. GENDER L. & POL'Y 53 (2005), *citing* ARK. CODE ANN. 6-18-514; COLO. REV. STAT. § 22-32-109.1; COLO. REV. STAT. § 10-222d; GA. CODE ANN. § 20-2-145; LA. REV. STAT. ANN. § 17:416.13; N.H. REV. STAT. ANN. § 193-F:3; N.J. STAT. ANN. § 18A:37-15; 708 OKLA. STAT. ANN. tit. 24 § 100.4; OR. REV. STAT. § 339.356; R.I. GEN. LAWS § 16-21-26; WASH. REV. CODE § 28A:300.285; W. VA. CODE § 18-2C-3 *et seq*. For states with laws intended to create a safer learning environment for students, but not addressing bullying specifically, *see* CAL. EDUC. CODE § 32282; 105 ILL. COMP. STAT. § 5/10-20.14; M.N.A. § 1A.03(2); MISS. CODE ANN. § 37-11-54; NEV. REV. STAT. § 388.139; VT. STAT. ANN. tit. 16 § 165.
[550] Michael B. Greene. *State Bullying Laws with Definitions* (updated August 2006). YCS Center for the Prevention of Violence (Personal Correspondence dated September 5, 2006).
[551] CO REV. STAT. ANN. § 22-32-109.1(2)(a)(X).
[552] N.H. REV. STAT. ANN. § 193-F:3(I)(a).
[553] R.I. GEN. LAWS § 16-21-26(a)(2).
[554] Michael B. Greene and Randy Ross. *The Nature, Scope, and Utility of Formal Laws and Regulations that Prohibit School-based Bullying and Harassment. Persistently Safe Schools 2005: The National Conference of the Hamilton Fish Institute on School and Community Violence* 92 (2005).
[555] *Id*. at 94.
[556] ARK. CODE ANN. § 6-18-514(b)(4).
[557] CONN. GEN. STAT. § 10-222d.
[558] Tawanda W. Johnson, *Bullies could face expulsion*, BALTIMORE EXAMINER @ A4 (May 13, 2006).
[559] CONN. GEN. STAT. § 10-222d(7).
[560] U.S. CONST., amend. IV; *see American Civil Liberties Union of New Jersey. Students' Rights Handbook, Second Edition*. Newark, NJ: American Civil Liberties Union of New Jersey; 2005, *available at* http://www.aclu-nj.org/downloads/StudntsRightHandbk.pdf (last visited October 1, 2006).
[561] New Jersey v. T.L.O., 469 U.S. 325 (1985).
[562] *Id*. at 342.
[563] MINN. REV. STAT. ANN. § 121A.72(Subdivision 1).
[564] IND. REV. CODE ANN. § 20-33-8-32(b); *see also* MICH. COMP. LAWS SERV. § 380.1306(1).
[565] 70 OKL. ST. § 24-102.
[566] ACLU, *supra* note 560.
[567] *Id*.
[568] 20 U.S.C.S. § 7102.
[569] *Id*. at § 7115(b)(2)(E)(ii).

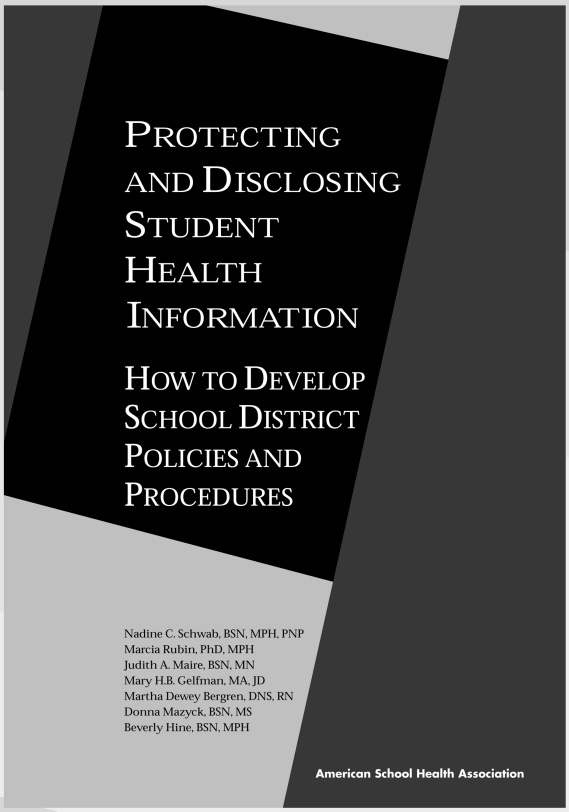
[570] DEL. CODE ANN. tit. 14 § 4119.
[571] TENN. CODE ANN. § 49-6-4207.
[572] LA. REV. STAT. § 17:81(J).
[573] 24 PENN. STAT. ANN. § 13-1302-A.
[574] S.C. CODE ANN. § 59-66-30.
[575] *See e.g.* Sherry Everett Jones, *supra* note 434.
[576] 70 OKL. STAT. § 24-100.4(C). *See also* LA. REV. STAT. tit. 21 § 17: 416.7; MO. REV. STAT. § 167.029; OH. REV. STAT. ANN. § 3313. 665.
[577] IOWA CODE § 279.58. *See also* N.J. STAT. § 18A:11-9 (New Jersey law prohibiting gang-related apparel).
[578] Bragg v. Swanson, 371 F.Supp. 2d 814 (W.D. W.Va. 2005); Chalifoux v. New Caney Inde. Sch. Dist., 976 F. Supp. 659 (S.D.Tex. 1997); Griggs v. Fort Wayne Sch., 359 F. Supp. 2d (N.D. Ind. 2005); Long v. Board of Educ., 121 F.Supp. 2d 621 (W.D.Ky 2000), *aff'd* 21 Fed. App. 252, 160 Ed. Law Rep. 392 (6th Cir. 2001).
[579] For more discussion on modifying the environment to prevent violence and on the above-mentioned strategies and others *see* Julie S. Mair and Michael Mair, *Violence Prevention and Control Through Environmental Modifications*, 24 ANN. REV. PUB. HEALTH 209 (2003). With respect to school settings *see* National Clearinghouse for Educational Facilities. *CPTED for Schools: Crime Prevention Through Environmental Design*, *available at* http://www.edfacilities.org/rl/cpted.cfm (last visited October 1, 2006).
[580] National Clearinghouse for Educational Facilities, *supra* note 579.
[581] *Id.*
[582] VA. CODE ANN. § 22.1-279.8. A ''school safety audit'' is defined as: a written assessment of the safety conditions in each public school to (i) identify and, if necessary, develop solutions for physical safety concerns, including building security issues and (ii) identify and evaluate any patterns of student safety concerns occurring on school property or at school-sponsored events. Solutions and responses shall include recommendations for structural adjustments, changes in school safety procedures, and revisions to the school board's standards for student conduct. *Id*. at § 22.1-279.8(A).
[583] Virginia Department of Education. *School Safety Audit Protocol*, *available at* http://www.pen.k12.va.us/VDOE/Instruction/schoolsafety/safetyaudit.pdf (last visited October 1, 2006).
[584] Leon County Schools, Planning & Policy Development. *Policy No. 5.09: Planning, Maintaining and Improving Facilities*, Section (9), *available at* http://www.planning.leon.k12.fl.us/Policies/509.htm (last visited October 1, 2006).
[585] U.S. Attorney's Office, District of Minnesota. *School Safety: Lessons Learned*. Winter, 2006, *available at* http://children.state.mn.us/mde/mdecontrib/groups/safehealthy/documents/report/008931.pdf (last visited October 1, 2006).
[586] 20 U.S.C.S. §§ 7181-7184. This Act replaces the Pro-Children Act of 1994, *id*. at §§ 6081 through 6084.
[587] *Id*. at § 7182 and § 7183. *See* U.S. Dep't of Educ. *Guidance Concerning State and Local Responsibilities Under the Pro-Children Act of 2001*, *available at* http://www.ed.gov/policy/elsec/guid/prochildact01.doc (last visited October 1, 2006).
[588] 20 U.S.C.S. § 7183(e).
[589] *Id*. at § 7184.
[590] N.C. GEN. STAT. § 115C-407.
[591] Everett Jones, *supra* note 434, at 529.
[592] *Id.*
[593] 20 U.S.C.S. § 7101 *et seq*.
[594] *Id*. at § 7102.
[595] *Id*. at § 7011i(a) (''Notwithstanding any other provision of law, no institution of higher education shall be eligible to receive funds or any other form of financial assistance under any Federal program, including participation in any federally funded or guaranteed student loan program, unless the institution certifies to the Secretary that the institution has adopted and has implemented a program to prevent the use of illicit drugs and the abuse of alcohol by students and employees. . .).
[596] Everett Jones, *supra* note 434, at 529.
[597] CONN. GEN. STAT. § 10-221(d).
[598] ''The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures. . .'' U.S. CONST. amend. IV.
[599] Board of Educ. v. Earls, 536 U.S. 822 (2002); Vernonia Sch. Dist. v. Acton, 515 U.S. 646 (1995).
[600] Earls, *supra* note 599.
[601] *Id*. at 838.
[602] *Id*. at 837.
[603] VA. CODE ANN. § 22.1-276.3; WASH. REV. CODE § 69.41.340.
[604] R.R.S. Neb. § 79-296.
[605] CAL. EDUC CODE § 49033.
[606] VA. CODE ANN. § 22.1-292.2.
[607] KAN. STAT. ANN. § 65-4163.
[608] U.S. DEP'T OF EDUC., THE OFFICE OF SAFE AND DRUG-FREE SCHOOL. PRACTICAL INFORMATION ON CRISIS PLANNING: A GUIDE FOR SCHOOLS AND COMMUNITIES (Washington, DC, 2003), *available at* http://www.ed.gov/admins/lead/safety/emergencyplan/crisisplanning.pdf (last visited October 1, 2006).
[609] N.C.L.B. § 4114(d)(7)(D).
[610] Everett Jones, *supra* note 434, at 529.
[611] GA. CODE ANN. § 20-2-1185(a).
[612] VA. CODE ANN. § 22.1-279.8(D).
[613] Safe and Drug-Free Schools Programs, Final Priority and Other Application Requirements. 70 Fed. Reg. 35652-35655 (June 21, 2005).
[614] *Id*. at 35653.
[615] Office of Safe and Drug-Free Schools Programs; Overview Information, Emergency Response and Crisis Management Grant Program; Notice Inviting Applications for New Awards for Fiscal Year (FY) 2005. *Id*. at 35649-35652.
[616] U.S. DEP'T OF EDUC., OFFICE OF SAFE AND DRUG-FREE SCHOOLS, EMERGENCY PLANNING, *available at* http://www.ed.gov/admins/lead/safety/emergencyplan/index.html (last visited October 1, 2006).
[617] CDC, INTERIM PRE-PANDEMIC PLANNING GUIDANCE: COMMUNITY STRATEGY FOR PANDEMIC INFLUENZA MITIGATION IN THE UNITED STATES (February 2007).
[618] CENTERS FOR LAW AND THE PUBLIC'S HEALTH: A COLLABORATIVE AT JOHNS HOPKINS AND GEORGETOWN UNIVERSITIES, DRAFT LEGAL PREPAREDNESS FOR SCHOOL CLOSURES IN RESPONSE TO PANDEMIC INFLUENZA OR OTHER EMERGENCIES: A REVIEW AND REPORT FOR THE CDC (October 2, 2007).
[619] DHS FEMA. DESIGN GUIDE FOR IMPROVING SCHOOL SAFETY IN EARTHQUAKES, FLOODS, AND HIGH WINDS (Washington, D.C., 2004, FEMA 424).
[620] Everett Jones, *supra* note 506, at 550.
[621] 105 ILL. COMP. STAT. ANN. § 5/10-22.35.
[622] FLA. STAT. § 252.385.
[623] CAL. EDUC. CODE § 32282(a)(2)(B)(ii).
[624] VT. STAT. ANN. tit. 16 § 3453a.
[625] Anne Bridgman, *Safe Hiring*, 192(12) AMERICAN SCH BD J. 1 (2005).
[626] *Id.*
[627] Kenneth S. Trump, *School Employee & School Teacher Background Checks: Schools Can Do More to Prevent and Detect Sexual Predators in Schools*, *available at* http://www.schoolsecurity.org/resources/teacher_background_checks.html (last visited October 1, 2006).
[628] *Id.*
[629] CDC, *supra* note 1.
[630] DHHS, *supra* note 154, at Objective 7-5.
[631] *Id*. at Objective 7-6.
[632] Danice K. Eaton, et al. *Faculty and Staff Health Promotion: Results from the School Health Policies and Programs Study 2006*, 77(8) J SCH HEALTH 557, 561 (2007).
[633] N.J. STAT. § 18A:16-2.

[634] CAL. EDUC. CODE § 49406 (a).
[635] *Id*. at § 49406 (g).
[636] Eaton, *supra* note 632, at 561.
[637] *Id.*
[638] CAL. EDUC. CODE § 49406(b).
[639] *Id*. at § 49406(c).
[640] N.J. STAT. § 18A:16-2.
[641] 2001 CAL. STATS., Resolution Chap. #111.
[642] TEX. EDUC. CODE § 28.004.
[643] ALM GL ch. 32, § 5B.
[644] KAN. STAT. ANN. § 72-5398.
[645] TEX. EDUC. CODE § 22.004.
[646] *Id*. at § 22.005.
[647] GA. CODE ANN. § 20-2-880 *et seq*.
[648] MISS. CODE ANN. § 25-15-3.
[649] CAL. GOV. CODE § 22849.
[650] Rick Casey, *Kidney stones and the $78K loophole*, HOUSTON CHRONICLE, @ A24, Aug. 13, 2003.
[651] Eaton, *supra* note 632, at 567.
[652] EPA, *supra* note 430.
[653] CDC, *supra* note 1.
[654] CDC NIOSH, *supra* note 432.
[655] Occupational Health and Safety Act of 1970, 29 U.S.C.S. § 651 *et seq*. States and their political subdivisions are not considered to be employers under the Act. *Id*. at § 652(5); 29 C.F.R. § 1975.5 (2005).
[656] OSHA encourages states to develop their own occupational safety and health standards. 29 U.S.C.S. § 667. The federal regulations detail the requirements for approval of state OSHA standards that are enforced in place of the federal regime. 29 C.F.R. § 1952-1956(2005).
[657] The jurisdictions with federal certification for their state OSH plans are: Alaska, Arizona, California, Hawaii, Indiana, Iowa, Kentucky, Maryland, Michigan, Minnesota, Nevada, New Mexico, North Carolina, Oregon, Puerto Rico, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, and Wyoming. Additional information about these states may be found at http://www.osha.gov/fso/osp/faq.html#oshaprogram (last visited on October 1, 2006).
[658] The jurisdictions are Connecticut, New Jersey, New York, and the Virgin Islands. 29 C.F.R. § 1956.
[659] 29 U.S.C.S. § 667; 29 C.F.R. § 1952-1956.
[660] Michigan Occupational Safety and Health Act, MICH. COMP. LAWS SERV. § 408.1006; Minnesota Occupational Safety and Health Act of 1973, MINN. STAT. § 182.651; Utah Occupational Safety and Health Act, UTAH CODE ANN. § 34A-6-103.
[661] MICH. COMP. LAWS SERV. § 408.1011.
[662] *Id*. at § 408.1014.
[663] MINN. REV. STAT. ANN. § 182.655; UTAH CODE ANN. § 34A-6-202.
[664] ME. REV. STAT. tit. 26 § 42.
[665] ME. REV. STAT. tit. 26 §§ 44, 50.
[666] U.S. DEP'T OF LABOR, OFFICE OF INSPECTOR GEN., OFFICE OF AUDIT EVALUATING THE STATUS OF OCCUPATIONAL SAFETY AND HEALTH COVERAGE OF STATE AND LOCAL GOVERNMENT WORKERS IN FEDERAL OSHA STATES, Report Number: 05-00-001-10-001 (February 9, 2000).
[667] MICH. COMP. LAWS SERV. § 380.1288.
[668] CDC, *supra* note 1.
[669] BOGDEN, *supra* note 3, at 9.
[670] U.S. SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *supra* note 372, at 27.
[671] Parents have the right to make educational and health decisions on behalf of their minor children. Courts have stripped parents of this right if their decisions clearly endanger the life or health of the child. Application of Pres. and Directors of Georgetown College, 331 F.2d 1000 (App. DC 1964).
[672] 20 U.S.C.S. § 1414 (a).
[673] *Id*. at § 1414 (d).
[674] *Id*. at § 1415.
[675] 126 S. Ct. 528 (2005).
[676] Irving, *supra* note 128.
[677] Nancy D. Brener, et al., *The Relationship Between School Health Councils and School Health Policies and Programs in US Schools*, 74 J SCH HEALTH 130 (2004).
[678] Everett Jones, *supra* note 434, at 525-26.
[679] TEX. EDUC. CODE § 28.004.
[680] FLA. REV. STAT. § 381.0056.
[681] MISS. CODE ANN. § 37-13-135.
[682] MD. CODE REGS. 13A.05.05.13.
[683] 28 PA. STAT. ANN. § 23.31.
[684] COL. REV. STAT. § 22-25-106.
[685] TEX. EDUC. CODE § 38.058(a).
[686] *Id*. at § 38.058(b).
[687] *Id*. at §§ 38.059, 38.060.
[688] Arizona School-Based Health Care Council, *available at* http://www.azschoolhealthcouncil.org/ (last visited October 1, 2006).
[689] MD. EDUC. CODE ANN. § 7-4A-03.
[690] *Id*. at § 7-4A-05.
[691] The National Parent-Teacher Association provides policy guidance on the interaction between parents and schools, *available at* http://www.pta.org/homepage.html (last visited October 1, 2006).
[692] Nancy L. Brener, et al., *Family and Community Involvement in Schools: Results from the School Health Policies and Programs Study 2000*, 71 J SCH HEALTH 340 (2001) (examining school interaction with families related to the implementation of school health activities).
[693] CDC, *supra* note 1.
[694] *Id.*


You work hard to keep your students safe from bullies and drugs.
But what about chemicals?
Mismanaged chemicals expose students and staff to unnecessary dangers.
Learn about the Schools Chemical Cleanout Campaign at **www.epa.gov/SC3**.
UNITED STATES ENVIRONMENTAL PROTECTION AGENCY

Protecting Student Health Information

Publication of the American School Health Association



72 pages / 2005 / American School Health Association

This book was developed in collaboration with representatives from 20 national health and education organizations.

This must-have handbook provides practical guidance to help school district personnel navigate the myriad and sometimes conflicting legal considerations connected to managing student health information. Not just for nurses, this valuable resource will assist all school officials in developing and implementing policies and administrative procedures that will enable them to confidently protect, use and handle sensitive information appropriately within the scope of their responsibilities. This book gives particular attention to balancing the requirements of the Health Insurance Portability and Accountability Act (HIPAA) with other applicable federal and state laws.

Sections in this volume include:

Introduction – describes various types of student health information and the issues surrounding appropriate and inappropriate use of that information

Legal Framework – discusses the importance of understanding and balancing the various laws that pertain to student health information

Fundamentals for Developing Policies and Procedures – includes the essential foundations, ethical and legal principles, and additional values influencing professional practice

Standards – identifies 8 building blocks of effective policies and procedures, the rationale and critical elements for each standard, and sample language

Glossary – defines 49 key terms

Appendix – lists additional resources

Index – facilitates quick reference

ASHA American School Health Association

Please send me ____ copies of *Protecting and Disclosing Student Health Information* at $18.95 (ASHA member) or $24.95 (Non-member).

Orders under $60, add $6.50 shipping/handling.
Orders over $60, add 10% to total for shipping/handling

Shipping Address

Name _____

Address _____

City _____

State _____ Zip _____

Payment Information

❑ Check Enclosed (Make checks payable to ASHA.)
Ohio residents add 6.5% sales tax.

❑ VISA / MasterCard

Card Number _____

Exp. Date _____

Signature _____

Contact ASHA for bulk discount rates.

Return this form to: ASHA Publications, 7263 State Route 43 / P.O. Box 708, Kent, OH 44240; 330/678-1601 (phone); 330/678-4526 (fax); www.ashaweb.org