

HB

85



# FISCAL NOTE

**STATE OF ALASKA**  
**2005 LEGISLATIVE SESSION**

Fiscal Note Number: \_\_\_\_\_  
 Bill Version: HB085-EED-TLS-02-08-05  
 () Publish Date: \_\_\_\_\_

Revision Date/Time (Note if correction): \_\_\_\_\_ Dept. Affected: Education & Early Development  
 Title "An Act relating to self-administration and documen- RDU TLS  
tation of certain types of medication prescribed to a child Component Student & School Achievement  
 Sponsor Representative Meyer  
 Requester House HES Component No. 2796

**Expenditures/Revenues (Thousands of Dollars)**

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	0.0	*	*	*	*	*
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>*</b>	<b>*</b>	<b>*</b>	<b>*</b>	<b>*</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES ( )</b>						
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**FUND SOURCE (Thousands of Dollars)**

1002 Federal Receipts						
1003 GF Match						
1004 GF	0.0	*	*	*	*	*
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
<b>TOTAL</b>	<b>0.0</b>	<b>*</b>	<b>*</b>	<b>*</b>	<b>*</b>	<b>*</b>

Estimate of any current year (FY2005) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

Section 14.30.141 states that a school shall permit self-administration of medication by a pupil for asthma, anaphylaxis, or other potentially life-threatening illnesses, under specific conditions and with written authorization and certification. The Department of Education & Early Development identifies no department costs at this time.

Prepared by: Barbara Thompson, Director Phone 465-8727  
 Division Teaching & Learning Support Date/Time 2/8/05 4:24 PM  
 Approved by: Karen Rehfeld, Deputy Commissioner Date 2/8/2005  
 Agency Education & Early Development

**List of testifiers for Asthma Policy/HB 85**

**Dr. Thad Woodard, Anchorage Pediatrician – 777-1800**

**Janice Bates, The director of the Health Services Program for the Anchorage School District. – 743-4322**

**Gail White – 344-8868**

**Pat Senner, Alaska Nurses Association – 272-1255, 339-4405**

**Marge Larson, Director of Programs, American Lung Association of Alaska – Anchorage LIO**

**Dr. Mandsager, Director of Division of Public Health – At Meeting**

# **REPRESENTATIVE KEVIN MEYER**

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HOUSE DISTRICT 30

## **MEMORANDUM**

**DATE:** January 24, 2004

**TO:** Representative Peggy Wilson, Chairman  
House Health and Social Services Committee

**FROM:** Representative Kevin Meyer

**RE:** Hearing Request for House Bill 85 *Prescribed Medication for Students*

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Please schedule HB 85 *Prescribed Medication for Students* for a hearing in the House Health and Social Services Committee at your earliest convenience.

HB 85 requires schools to permit students' to self-administer medication for asthma, anaphylaxis, or other life threatening illnesses with certain provisions.

Included in this packet:

- HB 85 *Prescribed Medication for Students* v. LS-0367AG
- Sponsor Statement
- Sectional Analysis
- Asthmatic School-children's Treatment and Health Management Act of 2004
- Map of states with statutes protecting students' rights to carry and use prescribed asthma and anaphylaxis medications.
- CDC National Asthma Control Program
- List of Contacts

# REPRESENTATIVE KEVIN MEYER

HOUSE DISTRICT 30

## Sponsor Statement

### House Bill 85

**“An Act relating to self-administration and documentation of certain types of medication prescribed to a child attending school.”**

Of the 20 million Americans with asthma, 6.3 million are children under the age of 18. This chronic condition is the cause of 728,000 emergency room visits, 214,000 hospitalizations and 223 deaths annually among children.

The “Asthmatic School-children’s Treatment and Health Management Act” passed by Congress in 2004 directed the Secretary of Health and Human Services to give preference when awarding grants to states that authorize the self-administration of medication to treat students’ asthma or anaphylaxis. Thirty states have passed legislation to comply with the federal act.

House Bill 85 requires that schools permit students to self-administrate medication for asthma, anaphylaxis, or other potentially life threatening illnesses. A school must permit self-administration if:

- The school receives written authorization from a parent or legal guardian for the self-administration of the medication;
- Written certification from a pupil’s health care provider;
- Release of liability for the school and its employees or agents for injury arising from self-administration.
- An agreement to indemnify and hold harmless the school and its employees for claims arising from self-administration.

In return, schools shall provide a written notice to the pupil’s parent or guardian of the school’s absence of liability related to the self-administration of medication covered by HB 85.

Asthma and allergy related illnesses can be potentially life threatening and the current prohibition on self-administration in schools puts children at risk. HB 85 is an important step toward addressing a major risk to our children’s health.

108TH CONGRESS  
2D SESSION

**H. R. 2023**

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**AN ACT**

To give a preference regarding States that require schools to allow students to self-administer medication to treat that student's asthma or anaphylaxis, and for other purposes.

108TH CONGRESS  
2D SESSION

# H. R. 2023

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## AN ACT

To give a preference regarding States that require schools to allow students to self-administer medication to treat that student's asthma or anaphylaxis, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the "Asthmatic School-  
3 children's Treatment and Health Management Act of  
4 2004".

5 **SEC. 2. FINDINGS.**

6 The Congress finds the following:

7 (1) Asthma is a chronic condition requiring life-  
8 time, ongoing medical intervention.

9 (2) In 1980, 6,700,000 Americans had asthma.

10 (3) In 2001, 20,300,000 Americans had asth-  
11 ma; 6,300,000 children under age 18 had asthma.

12 (4) The prevalence of asthma among African-  
13 American children was 40 percent greater than  
14 among Caucasian children, and more than 26 per-  
15 cent of all asthma deaths are in the African-Amer-  
16 ican population.

17 (5) In 2000, there were 1,800,000 asthma-re-  
18 lated visits to emergency departments (more than  
19 728,000 of these involved children under 18 years of  
20 age).

21 (6) In 2000, there were 465,000 asthma-related  
22 hospitalizations (214,000 of these involved children  
23 under 18 years of age).

24 (7) In 2000, 4,487 people died from asthma,  
25 and of these 223 were children.

1           (8) According to the Centers for Disease Con-  
2           trol and Prevention, asthma is a common cause of  
3           missed school days, accounting for approximately  
4           14,000,000 missed school days annually.

5           (9) According to the New England Journal of  
6           Medicine, working parents of children with asthma  
7           lose an estimated \$1,000,000,000 a year in produc-  
8           tivity.

9           (10) At least 30 States have legislation pro-  
10          tecting the rights of children to carry and self-ad-  
11          minister asthma metered-dose inhalers, and at least  
12          18 States expand this protection to epinephrine  
13          auto-injectors.

14          (11) Tragic refusals of schools to permit stu-  
15          dents to carry their inhalers and auto-injectable epi-  
16          nephrine have occurred, some resulting in death and  
17          spawning litigation.

18          (12) School district medication policies must be  
19          developed with the safety of all students in mind.  
20          The immediate and correct use of asthma inhalers  
21          and auto-injectable epinephrine are necessary to  
22          avoid serious respiratory complications and improve  
23          health care outcomes.

24          (13) No school should interfere with the pa-  
25          tient-physician relationship.

1           (14) Anaphylaxis, or anaphylactic shock, is a  
2 systemic allergic reaction that can kill within min-  
3 utes. Anaphylaxis occurs in some asthma patients.  
4 According to the American Academy of Allergy,  
5 Asthma, and Immunology, people who have experi-  
6 enced symptoms of anaphylaxis previously are at  
7 risk for subsequent reactions and should carry an  
8 epinephrine auto-injector with them at all times, if  
9 prescribed.

10           (15) An increasing number of students and  
11 school staff have life-threatening allergies. Exposure  
12 to the affecting allergen can trigger anaphylaxis. An-  
13 aphyllaxis requires prompt medical intervention with  
14 an injection of epinephrine.

15 **SEC. 3. PREFERENCE FOR STATES THAT ALLOW STUDENTS**  
16 **TO SELF-ADMINISTER MEDICATION TO**  
17 **TREAT ASTHMA AND ANAPHYLAXIS.**

18 (a) AMENDMENTS.—Section 399L of the Public  
19 Health Service Act (42 U.S.C. 280g) is amended—

20           (1) by redesignating subsection (d) as sub-  
21 section (e); and

22           (2) by inserting after subsection (c) the fol-  
23 lowing:

1       “(d) PREFERENCE FOR STATES THAT ALLOW STU-  
2 DENTS TO SELF-ADMINISTER MEDICATION TO TREAT  
3 ASTHMA AND ANAPHYLAXIS.—

4           “(1) PREFERENCE.—The Secretary, in making  
5 any grant under this section or any other grant that  
6 is asthma-related (as determined by the Secretary)  
7 to a State, shall give preference to any State that  
8 satisfies the following:

9           “(A) IN GENERAL.—The State must re-  
10 quire that each public elementary school and  
11 secondary school in that State will grant to any  
12 student in the school an authorization for the  
13 self-administration of medication to treat that  
14 student’s asthma or anaphylaxis, if—

15           “(i) a health care practitioner pre-  
16 scribed the medication for use by the stu-  
17 dent during school hours and instructed  
18 the student in the correct and responsible  
19 use of the medication;

20           “(ii) the student has demonstrated to  
21 the health care practitioner (or such prac-  
22 titioner’s designee) and the school nurse (if  
23 available) the skill level necessary to use  
24 the medication and any device that is nec-

1            necessary to administer such medication as  
2            prescribed;

3            “(iii) the health care practitioner for-  
4            mulates a written treatment plan for man-  
5            aging asthma or anaphylaxis episodes of  
6            the student and for medication use by the  
7            student during school hours; and

8            “(iv) the student’s parent or guardian  
9            has completed and submitted to the school  
10           any written documentation required by the  
11           school, including the treatment plan for-  
12           mulated under clause (iii) and other docu-  
13           ments related to liability.

14           “(B) SCOPE.—An authorization granted  
15           under subparagraph (A) must allow the student  
16           involved to possess and use his or her  
17           medication—

18                    “(i) while in school;

19                    “(ii) while at a school-sponsored activ-  
20                    ity, such as a sporting event; and

21                    “(iii) in transit to or from school or  
22                    school-sponsored activities.

23                    “(C) DURATION OF AUTHORIZATION.—An  
24                    authorization granted under subparagraph  
25                    (A)—

1                   “(i) must be effective only for the  
2                   same school and school year for which it is  
3                   granted; and

4                   “(ii) must be renewed by the parent  
5                   or guardian each subsequent school year in  
6                   accordance with this subsection.

7                   “(D) BACKUP MEDICATION.—The State  
8                   must require that backup medication, if pro-  
9                   vided by a student’s parent or guardian, be  
10                  kept at a student’s school in a location to which  
11                  the student has immediate access in the event  
12                  of an asthma or anaphylaxis emergency.

13                  “(E) MAINTENANCE OF INFORMATION.—  
14                  The State must require that information de-  
15                  scribed in subparagraphs (A)(iii) and (A)(iv) be  
16                  kept on file at the student’s school in a location  
17                  easily accessible in the event of an asthma or  
18                  anaphylaxis emergency.

19                  “(2) RULE OF CONSTRUCTION.—Nothing in  
20                  this subsection creates a cause of action or in any  
21                  other way increases or diminishes the liability of any  
22                  person under any other law.

23                  “(3) DEFINITIONS.—For purposes of this sub-  
24                  section:

1           “(A) The terms ‘elementary school’ and  
2           ‘secondary school’ have the meaning given to  
3           those terms in section 9101 of the Elementary  
4           and Secondary Education Act of 1965.

5           “(B) The term ‘health care practitioner’  
6           means a person authorized under law to pre-  
7           scribe drugs subject to section 503(b) of the  
8           Federal Food, Drug, and Cosmetic Act.

9           “(C) The term ‘medication’ means a drug  
10          as that term is defined in section 201 of the  
11          Federal Food, Drug, and Cosmetic Act and in-  
12          cludes inhaled bronchodilators and auto-  
13          injectable epinephrine.

14          “(D) The term ‘self-administration’ means  
15          a student’s discretionary use of his or her pre-  
16          scribed asthma or anaphylaxis medication, pur-  
17          suant to a prescription or written direction  
18          from a health care practitioner.”.

19          (b) APPLICABILITY.—The amendments made by this  
20          section shall apply only with respect to grants made on  
21          or after the date that is 9 months after the date of the  
22          enactment of this Act.

1 **SEC. 4. SENSE OF CONGRESS COMMENDING CDC FOR ITS**  
2 **STRATEGIES FOR ADDRESSING ASTHMA**  
3 **WITHIN A COORDINATED SCHOOL HEALTH**  
4 **PROGRAM.**

5 The Congress—

- 6 (1) commends the Centers for Disease Control  
7 and Prevention for identifying and creating “Strate-  
8 gies for Addressing Asthma Within a Coordinated  
9 School Program” for schools to address asthma; and  
10 (2) encourages all schools to review these strat-  
11 egies and adopt policies that will best meet the needs  
12 of their student population.

Passed the House of Representatives October 5,  
2004.

Attest:

*Clerk.*

# LEGAL SERVICES

# COPY

DIVISION OF LEGAL AND RESEARCH SERVICES  
LEGISLATIVE AFFAIRS AGENCY  
STATE OF ALASKA

(907) 465-3867 or 465-2450  
FAX (907) 465-2029  
Mail Stop 3101


State Capitol  
Juneau, Alaska 99801-1182  
Deliveries to: 129 6th St., Rm. 329

## MEMORANDUM

January 24, 2005

**SUBJECT:** HB 85 (Work Order No. 24-LS0367\G)

**TO:** Representative Kevin Meyer  
Attn: Mike Pawlowski

**FROM:** Jean M. Mischel  
Legislative Counsel 

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

**Section 1.** Requires public elementary and secondary schools to allow the self administration by a student of medications needed to treat asthma, anaphylaxis and other potentially life-threatening illness if certain conditions are met. Imposes annual documentation, indemnification, and release requirements on the parent or guardian of a student who wishes to self-administer medication while at school.

JMM:jad  
05-047.jad

# National Asthma Control Program: Improving Quality of Life and Reducing Costs 2003

CDC-Funded Asthma Activities by State and Type of Funding



*"Much of what is known about controlling asthma is not being applied. This is the challenge that we have taken on. CDC is supporting asthma data tracking, interventions, and partnerships nationwide in order to bridge this gap and to help people with asthma live symptom-free."*

*Julie Louise Gerberding, MD, MPH  
Director, Centers for Disease Control and Prevention*

## Asthma Control: Improving Quality of Life and Reducing Costs

Despite evidence that asthma death rates are leveling off and asthma hospitalization rates are declining, asthma's impact on health, quality of life, and the economy remain substantial. Rates of severe asthma continue to disproportionately affect poor, minority, inner-city populations. For example, African Americans visit emergency departments, are hospitalized, and die due to asthma at rates three times higher than rates for white Americans.

The initial onset of asthma cannot yet be prevented or cured. However, asthma can be controlled, and people who have asthma still can lead quality, productive lives. Asthma can be controlled by following a medical management plan and by avoiding contact with environmental "triggers." These environmental triggers include cockroaches, dust mites, furry pets, mold, tobacco smoke, and certain chemicals.

### Asthma's Impact on the U.S. Population

#### *In 2001, an estimated*

- 31.3 million people had been diagnosed with asthma during their lifetime
- 20.3 million people currently were diagnosed with asthma
- 12 million people experienced an asthma attack in the previous year

#### *In 2000, asthma accounted for*

- 10.4 million outpatient visits
- 1.8 million emergency department visits
- 465,000 hospitalizations
- 4,487 deaths

*Source: CDC National Center for Health Statistics*  
<http://www.cdc.gov/nchs/products/pubs/pubd/hestats/asthma/asthma.htm>

## CDC's National Asthma Control Program

CDC created the National Asthma Control Program in 1999. The program supports the goals and objectives of *Healthy People 2010* for asthma and is based on the following three public health principles:

- **Tracking:** collecting and analyzing data on an ongoing basis to understand the "who, what, and where" of asthma
- **Interventions:** ensuring that scientific information is translated into public health practices and programs to reduce the burden of asthma
- **Partnerships:** ensuring that all stakeholders have the opportunity to be involved in developing, implementing, and evaluating local asthma control programs

**The goals of the program are to reduce the number of deaths, hospitalizations, emergency department visits, school or work days missed, and limitations on activity due to asthma.**

With appropriations of \$35.2 million in fiscal year 2002, CDC funded 11 asthma tracking projects, 48 asthma interventions, and 33 asthma partnership projects under its National Asthma Control Program

for activities to be conducted in 2003. CDC also funded six urban school districts, one state education agency, and six national nongovernment organizations to support and address asthma control within a coordinated school health program.

### Major Data Collection Systems

CDC supports a number of major asthma data collection efforts, including (1) collection of state-level adult asthma prevalence rates for detailed subgroups in 50 states, 3 territories (Puerto Rico, Guam, and the Virgin Islands), and Washington, D.C., through the Behavioral Risk Factor Surveillance System Survey; (2) collection of data on days of restricted activity, days in bed, days of work or school lost, physician visits, and hospitalizations due to asthma through the National Health Interview Survey; and (3) collection of in-depth state and local asthma data through development and testing of a National Asthma Survey module in Alabama, California, Illinois, New York, and Texas. See the "Data" section at <http://www.cdc.gov/asthma> for more information.

## Asthma Control Program Highlights

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### Tracking

#### **Enhanced surveillance of asthma deaths.**

To understand the circumstances surrounding asthma deaths and determine whether these deaths were preventable, CDC is funding state health departments in California and Michigan to develop, implement, and evaluate a rapid asthma death notification and investigation system.

**Population-based models to establish surveillance for asthma incidence in defined geographic areas.** To better estimate asthma rates, CDC is funding the Kaiser Foundation Research Institute (Portland, Oregon) and the Miami-Dade County Health Department (Miami, Florida) to develop models for identifying new asthma cases.

### Interventions

#### **Controlling asthma in American cities.**

To decrease asthma-related morbidity, CDC is funding grantees in seven urban communities (New York City, Philadelphia, Chicago, Richmond, Oakland, St. Louis, and Minneapolis/St. Paul) to use innovative collaborative approaches to improve overall asthma management among urban children up to 18 years of age.

**Enabling the nation's schools to prevent asthma attacks and absences.** CDC will fund six urban school districts and one state education agency in 2003 to develop or implement exemplary local education agency policies and programs to reduce asthma episodes and related absences. CDC also is funding six national nongovernment organizations (American Lung Association, Asthma and Allergy Foundation of America, STAKBRIGHT Foundation, National Association of School Nurses, American Academy of Pediatrics, and American Association of School Administrators) to support and address asthma control within a coordinated school health program. For updates on school-related asthma activities, go to <http://www.cdc.gov/healthyyouth/healthtopics/asthma>.

**Inner-city asthma intervention.** CDC is funding 23 sites in 15 states (Alabama, Arizona, California, Florida, Illinois, Massachusetts, Minnesota, Missouri, Mississippi, North Carolina, New Jersey, New York, Ohio, Oregon, and Texas) to provide inner-city families

with asthma education and individualized asthma control plans.

#### **Replication and implementation of scientifically proven asthma interventions.**

CDC is funding grantees to implement the following two scientifically evaluated asthma interventions shown to decrease acute care visits, decrease hospitalizations, and increase compliance with asthma care plans: the Asthma and Allergy Foundation of America's "Asthma Care Training for Kids" (ACT), grantees in Illinois [two sites], New York, Pennsylvania, Texas, and Washington) and the American Lung Association's "Open Airways for Schools" (OAS), grantees in California [two sites], Colorado, Illinois, New Jersey [two sites], and New York). The goals for ACT are to increase asthma control compliance behaviors and to decrease emergency department visits and number of days spent in the hospital. The goals for OAS are to improve school performance and self-management behaviors and to decrease the number of asthma episodes.

### Partnerships

**Addressing asthma from a public health perspective.** CDC is funding state health departments in Colorado, Connecticut, Georgia, Hawaii, Idaho, Indiana, Iowa, Maine, Maryland, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, Oklahoma, Rhode Island, Texas, Utah, Virginia, Vermont, Washington, West Virginia, Wisconsin, and Washington, D.C., to develop asthma control plans that include disease tracking, intervention, and occupational components. CDC also is funding California, Illinois, Michigan, Minnesota, New York, and Oregon to implement the states' comprehensive asthma control plans.

**National asthma health education enhancement program.** CDC is funding the Allergy and Asthma Network/Mothers of Asthmatics, American Lung Association, and Asthma and Allergy Foundation of America to conduct activities related to asthma education. These activities range from identifying effective educational programs for adults that can be adapted for nationwide use to educating children with asthma and their families and caregivers.

### Examples of CDC's National Asthma Control Partners

- Allergy and Asthma Network/Mothers of Asthmatics
- American Academy of Allergy, Asthma & Immunology
- American Academy of Pediatrics
- American Association of School Administrators
- American Lung Association
- Asthma and Allergy Foundation of America
- National Association of School Nurses
- National Education Association
- National Heart, Lung, and Blood Institute
- National Institute of Allergy & Infectious Diseases
- STARBRIGHT Foundation
- U.S. Environmental Protection Agency

## State Activity Highlights



### California

With support from CDC, the California Department of Health Services has worked with leading asthma organizations, agencies, and public interest groups throughout the state to develop an integrated plan (*The Strategic Plan for Asthma in California*) to address the asthma epidemic in California. A diverse advisory committee, consisting of California asthma professionals, coalitions, local public health agencies, educational agencies and schools, and health-care plans, is guiding the plan's implementation in the state. Major components of the strategic plan include epidemiology and evaluation, public education, asthma treatment and management, secondary prevention of asthma, and policy. California will support and expand its asthma partnerships and provide technical assistance to local coalitions and public health departments in monitoring and reducing the asthma burden.



### New York

In collaboration with several community health centers and after-school programs, the Bronx Lebanon Hospital Center is implementing two asthma interventions for children aged 8 to 12 who have persistent asthma problems. Through the Asthma Care Training for Kids (ACT) intervention, children and their families will be taught asthma-management skills that can help reduce the frequency and severity of asthma episodes. Through the Open Airways for School (OAS) intervention, children will be taught to detect warning signs of and identify environmental factors that can trigger an attack. The program has been shown to significantly increase asthma management skills, reduce symptoms of asthma, and improve academic performance. In 2003, 160 children and their parents are expected to complete the ACT program and 160 children are expected to complete the OAS program.

## Future Directions

With continued and increased funding, CDC will (1) work with state and local health departments and other partners to improve asthma tracking, (2) identify and develop population-based and individual solutions for controlling asthma, (3) help more partner

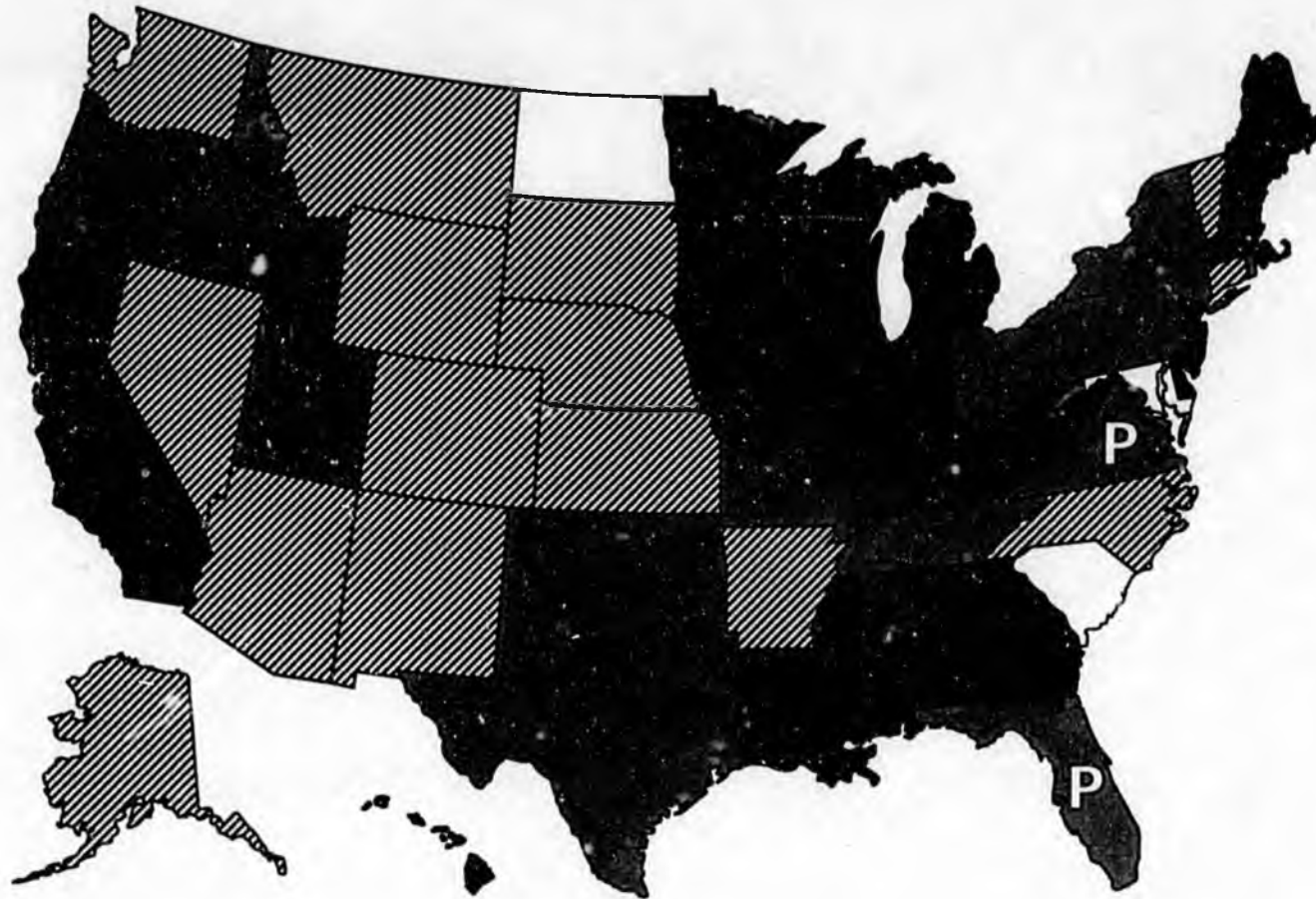
organizations implement and evaluate programs to reduce the incidence and severity of asthma, and (4) build capacity of educational agencies and national nongovernment organizations to address asthma in schools.

For more information or additional copies of this document, please contact  
Centers for Disease Control and Prevention  
National Center for Environmental Health, MS F52  
4770 Buford Hwy, Atlanta, GA 30341  
1-888-232-6789; EHHEinq@cdc.gov; <http://www.cdc.gov/asthma>



Allergy & Asthma Network  
Mothers of Asthmatics

## State Statutes Protecting Student Rights to Carry and Use Prescribed Asthma and Anaphylaxis Medications



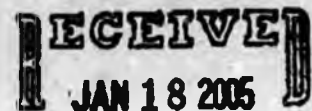
### Color Key:

- States that protect student rights to possess and self-administer prescribed lifesaving asthma and anaphylaxis medications.
- ▨ States that protect student rights to possess and self-administer prescribed lifesaving asthma medications.
- P States that protect student rights to possess and self-administer prescribed lifesaving asthma medications and have pending legislation also allowing anaphylaxis medications.
- States that have pending legislation.
- ▩ States that do not have statutes protecting student rights to possess and self-administer prescribed lifesaving asthma and/or anaphylaxis medications.

Updates at 800.878.4403

[breatherville.org](http://breatherville.org)

**American Academy of Pediatrics**  
DEDICATED TO THE HEALTH OF ALL CHILDREN®



BY:.....

**Alaska Chapter****Chapter President**

Thomas J Porter, MD, FAAP  
3900 Mathews Drive  
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January 13, 2005

**Chapter Vice-President**

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Janice T Tower  
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Dear sir or madam:

The Alaska Chapter of the American Academy of Pediatrics wishes to provide support to the Alaska Asthma Coalition's efforts to encourage Alaska legislation this year allowing elementary and secondary school students to self administer medication for asthma or anaphylaxis under specified conditions.

The ability for students to use safe and effective medication for these conditions in school, as they do out of school, has been a recommendation for years of the American Academy of Pediatrics (Committee on School Health, Guidelines for the Administration of Medication in School Pediatrics; 112 (3): 697-699, September, 2003) and the American Academy of Allergy, Asthma, and Immunology (Policy Statement, Anaphylaxis in schools and other child-care settings, *Journal of Allergy and Clinical Immunology*; 102 (2): 173-176, August, 1998). Now with financial encouragement of the federal government through the Asthmatic Schoolchildren's Treatment and Health Management Act of 2004, which provides preference for certain grants to states with this legislation, the time has come in Alaska for action. Furthermore 35 states already have these laws in place. ---

Warm regards,

Thomas J. Porter, MD, FAAP  
President  
American Academy of Pediatrics, Alaska Chapter



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## Asthma Inhalers in Schools: Rights of Students with Asthma to a Free Appropriate Education

| Sherry Everett Jones, PhD, JD, MPH, and Lani Wheeler, MD

Students who possess and self-administer their asthma medications can prevent or reduce the severity of asthma episodes. In many states, laws or policies allow students to possess and self-administer asthma medications at school.

In the absence of a state or local law or policy allowing public school students to possess inhalers and self-medicate to treat asthma, 3

federal statutes may require public schools to permit the carrying of such medications by students: the Individuals With Disabilities Education Act, Section 504 of the Rehabilitation Act of 1973, and Title II of the Americans with Disabilities Act. Local policies and procedures can be based on these federal laws to ensure that students with asthma can take their medicines as needed.

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**MORE THAN 6 MILLION AMERICAN** children aged younger than 18 years have asthma, making it one of the most common chronic diseases among children.<sup>1</sup> In 2001, more than 4 million children younger than 18 years had an asthma episode

in the previous year (a rate of 57/1000), suggesting that many young people with asthma may not have their asthma under control.<sup>1</sup> As many as an estimated 1.4% of all American children experience some level of limitation owing to asthma, such as an inability (or limited ability) to engage in school or play activities.<sup>2</sup> Young people with asthma miss an estimated



14 million days of school each year because of the disease,<sup>3</sup> and some children's school performance consequently suffers.<sup>4</sup>

Provided parents or guardians and a health care provider, preferably with input from the child's school and especially the school nurse, deem it appropriate for a student to self-medicate and have granted authorization, it is beneficial to students with asthma to have unobstructed access to their medication before, during, and after school.<sup>5,6</sup> Students who self-administer their asthma medications can prevent or reduce the severity of asthma episodes.<sup>7</sup> However, some schools perhaps as part of a drug use prevention program or in hopes of minimizing liability claims, do not allow students to carry their inhalers in school.<sup>8,9</sup> In 2000, students were allowed to self-medicate with prescription inhalers in 68% of all schools nationwide (79% of middle/junior and senior high schools).<sup>10</sup>

Restrictions on students carrying their inhalers may preclude the immediate use of medication at the onset of symptoms. For example, the room in which the medication is kept may be too far from the student's classroom or playing field, some students may believe it is too disruptive to go to another part of the school building to take their medication,<sup>11</sup> and many students are embarrassed about needing to take medications.<sup>12</sup> Restrictions on the use of inhalers may ultimately compromise medication adherence, increase the risk of a full-blown asthma episode, and cause unnecessary suffering, emergency

treatment, and asthma-related school absences.<sup>2,8,13</sup>

In 2000, approximately 223 children aged 0 through 17 years died as a result of asthma (a rate of 0.3/100 000).<sup>1</sup> Furthermore, asthma results in substantial increased use of the health care system. In 2000, children aged 0 through 17 years had an estimated 4.6 million asthma-related outpatient visits to doctors' offices and hospital outpatient departments (a rate of 649/10 000), approximately 728 000 asthma-related emergency department visits (a rate of 104/10 000), and approximately 21 000 asthma-related hospitalizations (a rate of 30/10 000).<sup>1</sup> Asthma-related missed school days among children aged 5 through 17 years resulted in an estimated cost of \$726.1 million in caretakers' time lost from work.<sup>14</sup>

By knowing the rights of students with asthma, school administrators, educators, physicians, and other health care providers can help ensure that students have appropriate access to medications. This article explores state laws and policies that allow students to carry and self-administer asthma inhalers in school and federal statutes that may, under certain circumstances, require schools to allow students to do so.

### STATE LAWS AND POLICIES ALLOWING INHALERS

As of April 2004, 38 states allow self-medication among students at school. Twenty-three states (Alabama,<sup>15</sup> Delaware,<sup>16</sup> Florida,<sup>17</sup> Georgia,<sup>18</sup> Illinois,<sup>19</sup>

Kentucky,<sup>20</sup> Maine,<sup>21</sup> Massachusetts,<sup>22</sup> Michigan,<sup>23</sup> Minnesota,<sup>24</sup> Mississippi,<sup>25</sup> Missouri,<sup>26</sup> New Hampshire,<sup>27</sup> New Jersey,<sup>28</sup> New York,<sup>29</sup> Ohio,<sup>30</sup> Oklahoma,<sup>31</sup> Rhode Island,<sup>32</sup> Tennessee,<sup>33</sup> Texas,<sup>34</sup> Utah,<sup>35</sup> Virginia,<sup>36</sup> and Wisconsin<sup>37</sup>) have enacted legislation specifically to allow students with asthma to possess and self-administer inhaled asthma medications while at school.

These laws require parental consent and permission from a physician or other health care provider. Also, the School Health Policies and Programs Study 2000 found that an additional 10 states (Kansas, Louisiana, Maryland, Nebraska, New Mexico, North Dakota, South Carolina, South Dakota, Vermont, and Washington) have adopted policies allowing students to self-medicate at school with prescription inhalers.<sup>38</sup> Five other states (California,<sup>39</sup> Connecticut,<sup>40</sup> Indiana,<sup>41</sup> Iowa,<sup>42</sup> and Oregon<sup>43</sup>) have laws broadly providing for the self-administration of medications. Because state laws are often changing, interested readers can access the National Conference of State Legislatures Web site to monitor legislative action related to asthma, including self-medication laws (<http://www.ncsl.org/programs/esnr/asthmamain.htm>).

### ASTHMA AS A DISABILITY: FEDERAL STATUTES

In the absence of a state or local law or policy allowing students to possess inhalers and self-medicate, health care providers and parents might be able to

use 1 of 3 federal statutes that, under certain circumstances, will provide the legal justification requiring schools to allow students with asthma to do so. Those laws are the Individuals With Disabilities Education Act (IDEA), Section 504 of the Rehabilitation Act of 1973 (Section 504), and Title II of the Americans With Disabilities Act (Title II of ADA).

### INDIVIDUALS WITH DISABILITIES EDUCATION ACT

The purpose of IDEA is to partially fund states to develop special education programs "to ensure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for employment and independent living."<sup>44</sup>

IDEA applies only to children who meet the definition of a *child with a disability*, that is, a child with "mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance (hereinafter referred to as emotional disturbance), orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities; and who, by reason thereof, needs special education and related services" (*italic added*).<sup>45</sup>

The implementing regulations further define *other health impairment* as "having limited strength, vitality or alertness, in-



cluding a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that—(i) *Is due to chronic or acute health problems such as asthma . . .*; and (ii) *Adversely affects a child's educational performance (italic added).*<sup>46</sup>

To be classified as disabled under IDEA, a child with asthma must fall under the *other health impairment* category and require special education because of the asthma or have some other disabling condition under IDEA and require special education because of that disability. In either case, modifications must be made for that student that are determined necessary by the child's individual education program team and allow the student to receive a "free appropriate public education" (defined as education and related services provided at the public's expense, which meet the standards of the state educational agency, include an appropriate preschool, elementary, or secondary school education in the state involved, and are consistent with the student's individual education plan<sup>17</sup>), including "related services" designed to meet the child's unique needs.<sup>44,48-50</sup> Such related services might include allowing a student to carry an asthma inhaler.

### SECTION 504 OF THE REHABILITATION ACT OF 1973

The purpose of Section 504 is to eliminate discrimination on the basis of a disability: "No otherwise qualified individual with a

disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. . . ."<sup>51</sup>

Under this law, *disability* is more broadly defined than under IDEA and, consequently, covers a large number of youths with disabilities who attend federally funded programs not covered under IDEA. The federal regulations promulgated under Section 504 define a disabled person as one who "(i) has a physical or mental impairment which substantially limits one or more major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment."<sup>52</sup> The term *physical impairment* encompasses respiratory disorders or conditions. *Major life activities* refers to functions such as caring for oneself, breathing, and learning.<sup>52</sup> Section 504 is broader than IDEA because it applies to not only the education program, but also to other nonacademic and extracurricular activities.<sup>53,54</sup>

As with IDEA, the regulations promulgated under Section 504 require school districts to provide a "free appropriate public education" to children with disabilities.<sup>55</sup> In the context of Section 504, this requirement means that "the provision of regular or special education and related aids and services . . . designed to meet individual educational needs of handicapped persons [must be as adequate as those designed to meet] the needs of

nonhandicapped persons. . . ."<sup>56</sup> Of note, some case law is in conflict with the Section 504 regulations requiring a free appropriate education. Some courts, including the US Supreme Court, have held that Section 504 does not impose an obligation for a free appropriate public education despite federal regulations to the contrary.<sup>57</sup> What this conflict means for future lawsuits is unclear. In accordance with the language of Section 504, courts consistently hold, however, that Section 504 requires that schools make reasonable accommodations to allow disabled students to gain equal access to educational opportunities provided at that school.<sup>57</sup>

### TITLE II OF THE AMERICANS WITH DISABILITIES ACT

ADA extends Section 504 to public accommodations in the private sector and state and local public agencies that do not receive federal funding (the discussion of which is beyond the scope of this article).<sup>58</sup> In the context of disabled students attending public schools, Section 504 and Title II of ADA are similar. Title II of ADA prohibits any public entity (e.g., public schools) from discriminating on the basis of a disability.<sup>59,60</sup> Congress intended Title II of ADA and its implementing regulations to be consistent with Section 504,<sup>54,61-63</sup> although the federal regulations and the US Department of Education, Office for Civil Rights have interpreted Section 504 more broadly than Title II of ADA.<sup>57</sup> Under both

Section 504 and Title II of ADA, recipients of federal funds and public entities must address the disability-related needs of disabled students so they can participate in services or programs to the extent necessary to avoid discrimination.<sup>54</sup> The definition of *disability* under Title II of ADA is identical to that of Section 504. Under the regulations of Title II of ADA, a school must "make reasonable modifications in policies."<sup>54</sup> A school that refuses to administer medication because of a student's disability would be in violation of Title II of ADA.<sup>48</sup>

### HOW THESE FEDERAL STATUTES HAVE BEEN APPLIED

A clear demarcation indicating at what point a child's asthma rises to the level of a disabling condition is not available. Presumably, when a child's asthma significantly interferes with breathing, the child would be considered to have a disability.<sup>58</sup> Parents and the child's health care provider, along with teachers, the school nurse, and other school officials, are in the best position to evaluate the effect a child's asthma has on a child's health and academic performance. Gelfman and Schwab recommend that health professionals document the following: "(1) how the disability interferes with 1 or more life functions [e.g., breathing, learning]; (2) how the disability affects the student's functioning (e.g., energy level, exercise needs, medication effects, etc); and (3) what individualized



supports or accommodations in school the student requires in order to access an appropriate education.<sup>54(p.337)</sup>

When a child's asthma is disabling to the extent that the child needs "special education and related services,"<sup>55,46</sup> under IDEA a school is obligated to offer that student sufficient specialized services (e.g., allowing a student to carry an asthma inhaler) so that the student may benefit from his or her education.<sup>50,64</sup> During 2000–2001, the US Department of Education estimated that 292 000 children aged 3 to 21 years were served under IDEA as a result of a disability categorized as "other health impairment."<sup>65</sup> The US Supreme Court, in *Cedar Rapids Community School District v Garret F.*, established that under IDEA, those services may go as far as providing a full-time, one-on-one nurse or health assistant.<sup>66</sup> If a student has no other disability and the student's asthma does not affect his or her educational performance, IDEA does not apply.<sup>67</sup> However, students who need access to an asthma inhaler because their asthma places a substantial limitation on major life activities (i.e., the child is disabled because of his or her medical condition) but do not need special education remain qualified under Section 504 and Title II of ADA<sup>68,69</sup> and may avoid being labeled as children who need special education.

To succeed in a Section 504 or Title II of ADA claim alleging that an accommodation was not granted, the claimant must show that the accommodation was de-

nied because of the student's disability (i.e., was discriminatory).<sup>54,70,71</sup> In *East Helena (MT) Elementary School District # 9*, the school district refused to either administer or ensure that the student took asthma medication prescribed and filled by a naturopathic physician.<sup>70</sup> Instead, the school offered to allow a family member to administer the child's medication. In refusing to administer the medication, the school district was following a state law that prohibited the administration of medication unless the prescription was filled by a pharmacist. In that case, the court upheld the policy because the refusal applied to all students regardless of disability status.

Similarly, in *DeBord v Board of Education of the Ferguson-Honssant School District*<sup>54</sup> and *Davis v Francis Howell School District*,<sup>71</sup> schools refused to administer a prescription medication (methylphenidate [Ritalin] for attention deficit hyperactivity disorder) because the doses exceeded that recommended by the *Physicians' Desk Reference*. Both school districts had policies prohibiting schools from administering such prescriptions, although both were willing to let a parent or designee come to the school to administer the medication. The schools argued that the policies were to protect students' health and minimize potential liability. Courts in both cases found that because the school policies were neutral and applied to all students regardless of disability status, no discrimination had taken place. *DeBord, Davis, and East Helena* are examples of situ-

ations in which the claimant could not show that the school district's refusal to accommodate the child was based solely on a disability; therefore, no violations of Section 504 or Title II of ADA were found.<sup>54,70,71</sup>

Although some school policies that forbid staff to administer medications to students have been upheld by courts if uniformly applied, it is unlikely that a "no medications" policy (i.e., a policy that denies the administration of any and all medications at school) applied to all students would stand up in court because those policies have the effect of denying children with disabilities the free appropriate public education to which they are entitled under IDEA and perhaps Section 504, or reasonable accommodations under Section 504 and Title II of ADA.<sup>57,72,73</sup> A free appropriate public education must be specifically designed to meet the unique needs of the child,<sup>74</sup> and consequently, related services, including medications, must accompany that design.<sup>55,56,66</sup> Likewise, under Section 504, health services provided as part of related services must be individually evaluated and prescribed.<sup>58</sup>

#### INDIVIDUAL EDUCATION PROGRAMS

Under IDEA, a "child with a disability" must be provided with an appropriate individualized educational program (IEP).<sup>49,75</sup> Federal regulations promulgated under Section 504 indicate that schools may use IEPs or other plans as a means of meeting free appropriate public education re-

quirements included in those regulations<sup>55</sup> (whether Section 504 includes such requirements is less clear<sup>57</sup>). An IEP is a written statement designed to identify a child's educational needs and other programs and related services the child requires to progress in the general curriculum.<sup>49</sup> IEPs are developed by an IEP team that typically includes the disabled child's parents, regular and special education teachers, and other representatives from the local education agency who are best suited to assist the child in meeting his or her educational needs.<sup>49</sup> A school nurse may be part of the IEP team when school health services (e.g., administration of medications) are necessary.<sup>76</sup> This team, created specifically for each individual child, ensures that all aspects of the child's educational and related services needs are tailored to that child. This team, along with consultation from the child's health care provider, is best equipped to determine on a case-by-case basis whether self-medication using asthma inhalers is appropriate.

For students with asthma, an *asthma management plan* (Table 1) is an appropriate part of an IEP.<sup>5</sup> Health care providers give instructions on how best to manage the child's asthma during the school day. For a student with asthma, it is helpful if part of the IEP (or 504 plan or individual health service plan or asthma management plan) includes specific information about where, when, and how each asthma medication is to be taken, including when medication possession



**TABLE 1—Elements of Typical Asthma Management Plan**

- Student's asthma history
- Student's asthma symptoms
- How to contact student's health care provider and parent or guardian
- Signatures of physician and parent or guardian permitting use of medications in school
- List of factors that make student's asthma worse
- Student's best peak flow reading (if student uses peak flow monitoring)
- List of student's asthma medications
- Student's treatment plan, including actions school personnel can take to help handle asthma episodes

Source: NIH Publication 95-3651.<sup>5</sup>

and self-administration provisions are appropriate.

It is best if asthma management plans are on file in the school office or health services office and available to teachers and coaches. From a legal perspective, it is recommended that the asthma management plan include parental permission for the plan to be shared with relevant school personnel to avoid possible violations of the Family Education Rights and Privacy Act of 1974 (FERPA), which prohibits the unauthorized disclosure of confidential information in education records (including school health records in most cases).<sup>77,78</sup> However, under FERPA education records may be released to school officials without written consent of students' parents, including to teachers within the educational institution or local education agency, who have a "legitimate educational interest."<sup>79</sup> Under FERPA, it is important to note a narrow emergency exception whereby a school may disclose personally identifiable information to appropriate parties in connection with an emergency

if knowledge of the information is necessary to protect the health or safety of the student.<sup>77,80</sup>

### OVERCOMING POTENTIAL DISADVANTAGES

Although many advantages to self-medication exist, families and schools need to recognize some theoretically possible disadvantages of students' being responsible for carrying and administering their own medication. These disadvantages can be minimized, however. First, students may unintentionally leave their inhalers at home or misplace their inhalers at school. One possible solution is to keep a spare inhaler in a school nurse's office or health room.

Second, self-medication may make it more difficult for the school to keep medication records. Such documentation ensures that medication adherence can be communicated to parents and children's health care providers; documentation might be required as part of an IEP or Section 504 plan or might be recommended by school boards as a way to

monitor the health and safety of students. To solve this problem, schools could require that students report each inhaler use to a school nurse or record each medication use in a diary.

Third, students may not be well educated about when to take their medications,<sup>80,81</sup> may be embarrassed to take their medications in front of peers,<sup>8</sup> or may lack the maturity to use their medications appropriately (e.g., most elementary school students). Health care providers and parents are primarily responsible for teaching children about administering asthma medications and determining on a case-by-case basis whether the student has reached a level of maturity necessary for self-medication. School-based programs can supplement student education by helping students with asthma understand their disease and the importance of asthma self-management<sup>82,85</sup> as well as destigmatize the need for using asthma inhalers during the school day.<sup>63</sup>

### CONCLUSION

Not all students with asthma have their asthma under good control.<sup>14</sup> Patient education and medical management about the proper use of asthma medication are crucial to preventing asthma morbidity and mortality.<sup>86,87</sup> For optimal asthma management, it is important that students with asthma not be denied appropriate access to their medications in school.<sup>5,6,11,88,89</sup> Many states have laws or policies that allow students to self-medicate with

asthma inhalers at school (there is no evidence on whether state laws or policies are more effective to ensure immediate access for students in schools). In addition, 3 federal laws require schools to accommodate students whose asthma qualifies as a disability under IDEA, Section 504, or Title II of ADA. Such accommodations may include allowing students to carry their asthma inhalers so they can self-medicate as indicated in their asthma management plan. Of note, the US Department of Education, Office of Safe and Drug-Free Schools has issued guidance clarifying 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]."<sup>90</sup>

Although these laws and policies are important, they cannot provide an individualized answer to asthma management. Ideally, parents or guardians, the child's health care provider, and school personnel, including the school nurse, will work together as a team to determine the best way to manage a student's asthma in school. Table 2 outlines some factors that should be considered in determining the appropriateness of self-carrying and self-administering inhalers in school. For example, whether a child with asthma should be permitted to self-medicate ought to be determined on a case-by-case basis, based on a child's abilities and interest and maturity and the situation at the school. When that team deems the child skilled and mature enough, the student with



**TABLE 2—Elements to Consider When Determining Appropriateness of Self-Carrying and Self-Administering of Inhaler Medication in Schools**

**Student factors**

- Asthma severity and morbidity (hospitalizations, emergency department visits, severe episodes, types of triggers)
- Student's asthma knowledge, attitude, skills, and behavior (awareness of asthma signs and symptoms, desire to self carry inhaler, willingness to self administer and report use of inhaler, understanding of importance of not sharing inhaler with other students, correct peak flow and inhaler technique)
- History of asthma episodes at school
- Adherence to school rules regarding medication administration
- Inhaler self-carrying experience in other settings (child care, camp, after-school care, at friends' homes)

**Family factors**

- Desire of parents/guardians for student to self-carry and self-administer medications with an inhaler
- Collaboration of parents/guardians with school team; permission for physician and school to share information

**School factors**

- Health staff availability (whether or not there are full-time school nurses or health assistants)
- School size (whether or not there is quick and easy access to health room)
- Ability to reduce student's triggers at school
- Proximity and availability of inhalers from local emergency medical services

**Health care provider factors**

- Completion of physician's or other health care provider's written asthma management plan and all required forms
- Student's education by physician or other health care provider about asthma generally, controlling asthma, and proper use of inhalers, spacers, and peak flow meters
- Assessment by physician or other health care provider of student's technique for inhaler, spacer, and peak flow meter use

asthma should be allowed to keep asthma inhalers in his or her possession<sup>11,88</sup> to reduce the chances of a full-blown asthma episode, asthma-related school absences, and the need for emergency medical care.<sup>88,89</sup> Some students may not want or need to carry their inhalers, for example, when the school building is very small and health staff are available during all school hours. Each student needs individual as-

essment as part of the implementation of that student's personal asthma management plan.

In some circumstances, parents may need assistance from the child's physician or other health care provider in advocating for the student to gain the right to self-carry an asthma inhaler. By knowing the rights of students with asthma, physicians and other health care providers can help ensure that students

have appropriate access to medications at school. An informed health care provider can bring to the attention of school administrators and educators, as well as parents, the legal requirements of schools with students with asthma, and the benefits of self-administration and adequate control of asthma (e.g., improved health and fewer school absences). For example, health care providers can obtain parental permission to send a written asthma management plan to schools including specific guidance about the student's skill and maturity regarding self-administering the asthma inhaler. They can personally contact the principal if there is reluctance to permit self-carrying of inhalers. Students are more likely to be able to control their asthma when school personnel, parents or guardians, and health care providers know about disability laws and about appropriate asthma management. ■

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**Contributors**

S Everett Jones collected, analyzed, and synthesized the literature and wrote the article. L Wheeler assisted in synthesizing the literature and contributed to the writing of the article.

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Fax transmittal sheet

To Leg Legal  
Fax # 465-2029  
From: Kathy Hope Erickson for Representative Peggy Wilson  
Re: HB 85, Prescribed medication for students

Date February 16, 2005  
1 page

Comments: HESS Committee has passed HB 85 out of Committee, and has made these two amendments:

① Page 1 line 8: DELETE ", or other potentially life-threatening illness"; and  
Page 1, line 13-14: DELETE ", or other potentially life-threatening illness"  
(and any corresponding grammatical and punctuation corrections);  
and

② Page 2, beginning on line 3: REPLACE (C) with: the student has demonstrated to the health care provider the skill level necessary to use the medication and any device that is necessary to administer such medication as prescribed;

ADD: (D) the health care practitioner formulates a written treatment plan for managing asthma or anaphylaxis episodes of the student and for medication use by the student during school hours; and  
(E) the student's parent or guardian has completed and submitted to the school any written documentation required by the school, including the treatment plan formulated under subsection (D) and other documentation (\*related to liability).

Wording for this amendment is from HR 2023. If you would like a copy of this legislation, please give me a call.

I am also requesting a final of CSHB 85 (HESS). Thank you for everything.

\* Representative McGuire trailed off and had a sort of a question mark at this phrase, possibly because liability is covered in section (C). I have left a copy of this request with Rep. McGuire's staff, and expect to hear from her before 10 a.m. on her intention. Please let me know if I should do something else???

Thanks much.