

SB

4

From the office of . . . Senator John J. Cowdery

State Capitol Building, Rm #101

Juneau, AK 99801


907-465-3879 phone

907-465-2069 fax

MEMORANDUM

DATE: February 11, 2005

TO: Senator Fred Dyson

FROM: Senator John J. Cowdery 

RE: Request for Hearing, SB 4, "An Act requiring cardiopulmonary resuscitation and first aid certifications for issuance of a secondary school diploma"

I respectfully request that SB 4, "An Act requiring cardiopulmonary resuscitation and first aid certifications for issuance of a secondary school diploma" be scheduled for a hearing at your earliest convenience. I have attached the following for your information:

- 1) SB 4
- 2) Sponsor Statement
- 3) Fact Sheet
- 4) ADN Summary
- 5) Letters of Support
- 6) American Heart Association Circulation
- 7) Everyday Hero Stories
- 8) Legislative Research Reports
- 9) Fiscal Info
- 10) Grant Info
- 11) Training Centers
- 12) Support Articles
- 13) Statistics
- 14) Good Samaritan Statutes

If you have any questions please feel free to contact me personally, or my staff, Ruth Keller, at x3879. Thank you for your time and consideration.

SENATOR
JOHN J. COWDERY

Anchorage

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Senate

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Sponsor Statement

Senate Bill 4

“An Act requiring cardiopulmonary resuscitation and first aid certifications for issuance of a secondary school diploma.”

SB4 confirms the importance of basic first aid knowledge to sustain life until professional technicians arrive at the scene of an emergency situation. Upon reflection of such tragic situations as 9/11 and the more recent tsunami disaster, the necessity to be prepared is evident. Homeland security would necessitate a strategy of emergency preparedness. What better way to prepare our youth to respond in a decisive educated manner than with CPR/first aid training?

This bill is being introduced after the tragic stabbing and death of Eric Kalenka on Feb.27, 2004 at a Taco Bell drive-through in Anchorage, Alaska. Multiple stab wounds, loss of blood, and possible shock were the elements that extinguished this young man's life. Applying direct pressure to the wounds, elevating them above the heart, then applying pressure at the arterial points above the wounds, and treating for shock may have saved his life. Basic first aid and CPR training could mean the difference between life and death, making bystanders active citizens prepared to respond in a crisis.

The American Heart Association estimates that more than 95 percent of cardiac arrest victims die before reaching the hospital. If every community could achieve a 20 percent cardiac arrest survival rate, an estimated 40,000 more lives could be saved each year. This could be your mother, brother, neighbor, friend surviving because someone reacted with a life-saving technique they learned at their local high school.

While this bill requires a certification in basic first aid and cardiopulmonary resuscitation before graduation at the high school level, it does not discredit such programs as the Aniak Volunteer Fire Department's Dragon Slayers, Kotzebue High School's Emergency Trauma Technician Program, and Anchorage School

District's King Career Center ETT and EMT-1 Programs. It allows for the recognition of such completed programs to meet stated requirements. As a very diverse landmass, Alaska has locality issues that most other states don't have to deal with. This implementation would empower the young adults of our communities to make a life saving difference now and in the future.

This legislation is key to promoting a well-prepared populace, reducing morbidity and mortality for all citizens in Alaska.



Alaska State Legislature

Senate Majority Web: www.akrepublicans.org

Sponsor: Senator John Cowdery
Current Version: SB 4
Contact: Ruth Keller, 465-3879

Fact Sheet for: Senate Bill 4

Short Title: REQUIRE CPR FOR HIGH SCHOOL GRADUATION

Summary:

- Makes certification in basic first aid and cardiopulmonary resuscitation a requirement for high school graduation, and directs school districts to provide such training.

Benefits:

- Aids in sustaining the life of a victim until a professional emergency technician can respond.
- Promotes a well-prepared populace in the event of a terrorist attack or natural disaster.
- Prepares students to respond appropriately in situations they are likely to encounter in after-school jobs such as babysitting.

Background:

- SB 4 was introduced in response to last year's tragic murder of Eric Kalenka, who bled to death after being stabbed in the leg following a fender-bender in the drive-through lane of a Taco Bell. Kalenka's death could have been prevented had his companion or witnesses to the accident been trained in basic first aid.

SENATOR
JOHN J. COWDERY

Anchorage



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Background Submittal for Senate Bill 4 from ADN articles:

“The stabbing took place on Feb. 27 at the Taco Bell at 2351 East Fifth Ave. Charging documents say Kalenka and a woman were at the drive-through window around 3:15 am when Morrell drove up behind them and struck their rear bumper.”¹

“Kalenka approached Morrell about the fender-bender. Witnesses say Morrell was aggressive toward Kalenka, at one point grabbing him in the area of his chest.”²

“Then Kalenka yelled, “He’s stabbing me.” according to court records. Doucet, who was in line behind Morrell, pulled Morrell away. Kalenka returned to his Subaru, and Christine Montague, Kalenka’s close friend, later told police she could smell blood.”³

“Police found Kalenka in the Subaru.”³ “Kalenka was in his car, unresponsive.”² “The officer lifted the leg, saw heavy bleeding and “seven to eight stab wounds” and started lifesaving measures, according to court documents.”³

“Medics took Kalenka to an Anchorage hospital, where he was pronounced dead.”³

“Dr. Franc Fallico, acting chief medical examiner for the state, stated, “That blood vessel in the leg...can leak enough blood in a matter of seconds or minutes that the person dies of shock from blood loss.”¹

¹ O’Harra, Doug. “Drive-Through Dispute Turns Deadly.” *Anchorage Daily News*, 28 February 2004, Record Number: 440580102/28/04

² Brant, Tataboline. “Man is Indicted in Fatal Stabbing.” *Anchorage Daily News*, 9 March 2004, Record Number: 448971703/09/04

³ Pesznecker, Katie. “Victim’s Pals Fill Court Room.” *Anchorage Daily News*, 29 February 2004, Record Number: 441386702/29/04



**American
Red Cross
of Alaska**

alaska.redcross.org

235 E 8th Avenue, Suite 200
Anchorage, AK 99501
907. 646. 5401 voice
907. 276. 1465 fax

The Honorable John Cowdrey
State Capitol, Room 101
Juneau, AK 99801-1182

February 2, 2005

RE: Support SB 4 "An Act requiring cardiopulmonary resuscitation and first aid certifications for issuance of a secondary school diploma"

Dear Senator Cowdrey:

Last year a young man was stabbed and died. If there had been someone at the scene who had been trained in basic first aid, he might have survived.

In 2003 a high school student had seizures. His teachers restrained him while he was seizing. The force they used killed him. Had they been trained in the appropriate response to this emergency, the boy would still be alive.

You now have the opportunity to create a better-prepared, safer state. By passing SB 4, you will not only be giving high school students the skills they need to save a life, you will also be giving them the necessary knowledge that they will need in an emergency, and with certification, you will be giving them valuable job skills.

As part of the American Red Cross Adult CPR and First Aid Training, students will learn to recognize an emergency, check the scene for safety, check a victim for consciousness, call 911 and care for the conditions they find.

With passage of SB 4, we can have more stories like the four-year-old girl who fell on a pencil. Fortunately, her teacher knew not to remove the pencil because it might be stopping the bleeding. The EMS system was activated, and the girl survived.

With just a few hours of training we can prepare our children for the most common emergencies they would face and we can start them on the path to being prepared for any disaster.

I am in support of Senate Bill 4. We respectfully request this bill include language which requires the high standards that the American Red Cross or its equivalent has for their curriculums. Therefore, I encourage you to include the following "**...that each student be certified in American Red Cross basic first aid and cardiopulmonary resuscitation (CPR) or equivalent before a diploma may be issued to the student.**"

For reference, please note that the State of Alabama requires American Red Cross CPR for all students and the States of Louisiana, North Carolina and Rhode Island require both American Red Cross CPR and First Aid for all students.

Sincerely,

Joe B. Mathis, CEO
American Red Cross of Alaska
907. 646. 5414 voice
mathisjo@usa.redcross.org

Southern Region
EMERGENCY
Medical Services Council, Inc.

January 18, 2005

Senator John Cowdery
State Capitol, Room 101
Juneau, Alaska 99801-1182

Dear Senator Cowdery,

Thank you for the consideration of public comment regarding the pending legislation for Senate Bill 4. This legislation has key importance in the reduction of morbidity and mortality for all citizens in Alaska. We in emergency medical services fully support the need to deliver life-saving care with the shortest delay. This bill goes a long way to reaching that goal.

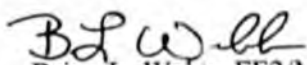
The bill as written, functionally serves the purpose above. I would like to clarify points I have made in prior correspondence to your staff. My points are as follows:

1. Your Bill's non-descript nature omits language that a specific organization's program must be used. That thought process is right on the mark, considering what resources already exist.
2. Your bill as written, allows each community the latitude to fairly work this matter out by:
 - a. ensuring local input, with local decisions.
 - b. ensuring the ability of local/regional agencies or individuals to fairly compete in this potential new market, if contracted to do so.
3. The Bill also ensures established continuity of existing programs within communities by:
 - a. providing stability (does not dismantle existing successful programs)
 - b. ensuring program is cost effective (versus new training for staff & contractors)
 - c. supporting local first aid & EMS vendors
 - d. allowing organizations and regions, with programs that exceed proposed basic requirements, the ability to substitute them for graduation requirements. Many programs already exist, and are models for the development of our future first responders. i.e.:
 - i. Aniak Volunteer Fire Department's successful Dragon Slayers program (provides ETT & EMT-1).
 - ii. Kotzebue High School's Emergency Trauma Technician in the School program.
 - iii. Anchorage School District's King Career Center provides programs for ETT and EMT-1. Of note, I am a 1976 alumni of that EMT-1 program. KCC started me in my successful 28-year EMS career.

4. We also continue to struggle with volunteer fire department recruitment statewide. If a local department may offer training that will both assist our youth with graduation requirements and promote volunteerism, then it is win-win for all.

I thank you for the time to convey my thoughts, and look forward to passage of this legislation. If I may be of any further assistance, please do not hesitate to contact me. I may be reached at SREMSC at (907) 562-6449, or via email at bwebb@sremsc.org.

Warm Regards,



Brian L. Webb, FF2/MICP

Assistant Regional EMS Training Coordinator

January 6, 2005

Janice Bates
Anchorage School District
Health Services
4600 DeBarr Road
Anchorage, AK 99519-6614

Dear Janice,

The American Heart Association (AHA) is a leader in the development and training of Emergency Cardiovascular Programs. As Alaska's Regional Manager for AHA training programs I was impressed to learn that the Anchorage School District currently supports the AHA's courses for teachers and nurses. However, I was surprised to learn that students are not required to learn a life saving skill as well. I would therefore like to seek approval for both the American Heart Association's Heartsaver CPR in Schools and CPR for Family and Friends Courses.

It has been proven that if a child learns the importance of a skill and the skill itself by the time they complete high school, they have a good chance of remembering it for the rest of their lives. Ultimately, this could save thousands of lives and empower these individuals to be able to take action in an emergency situation.

The Heartsaver CPR in Schools course teaches adult and pediatric CPR to middle- and high-school students, the warning signs of cardiac arrest, choking and stroke. Students of this course are taught the chain of survival, signs of choking in children, reducing risk of injury and sudden infant death syndrome. The CPR for Family and Friends teaches lay rescuers including school children, parents and grandparents CPR and foreign-body airway obstruction relief, as well as signs of a heart attack, cardiac arrest & stroke.

Enclosed is a booklet providing an overview of the AHA's lay responder courses. The booklet provides information on the course content, course length and the requirements for receiving a course completion card. Also enclosed, a student book for CPR in Schools for you to review--books cost only \$1 through our distributors listed on the back.

Should you require additional information about the American Heart Association's courses please feel free to contact me at 800-562-6718 extension 8667.

Sincerely,

Bobbie Stanage
Regional Manager, Alaska, Idaho/Montana Regions
Emergency Cardiovascular Care Programs
American Heart Association

March 2005

Anchorage School District POSITION STATEMENT: SB 4

W) 907-742-4322 (F) 907-742-4417
Wiget_Larry@asdk12.org

TO: SENATE HESS COMMITTEE
FROM: LARRY WIGET, DIRECTOR, GOVERNMENT RELATIONS
SUBJECT: SB 4 - AN ACT REQUIRING CPR AND FIRST AID-
CERTIFICATIONS FOR ISSUANCE OF A SECONDARY SCHOOL
DIPLOMA.

While the Anchorage School District appreciates the value of an individual having basic first aid knowledge, we do not support Senate Bill , which requires certification in basic first aid and cardiopulmonary resuscitation (CPR) before graduation at the high school level.

Our schools are focused on increasing academic achievement and the requirements of the No Child Left Behind federal legislation. Our students now must take 22.5 credits, in addition to passing the High School Graduation Qualifying Examination, in order to graduate. **Requiring certification in basic first aid and CPR would impose an unfunded mandate upon our schools that have neither the resources or the space, nor the time within the school day, in which to fulfill this mandate.**

We do not have the certified instructors who need to be recertified every two years, to meet the requirement. Furthermore, the approximately 3,500 students each year that would be required to take the required course would find that their standard first aid certificate is valid for three years, but that their adult CPR/AED certification is valid for only one year.

Certification in first aid/CPR is available from local agencies such as the American Red Cross for those individuals willing to obtain it.

The Anchorage School District opposes requiring basic first aid and CPR certification as a requirement for graduation from high school.

**MATANUSKA-SUSITNA BOROUGH SCHOOL DISTRICT**

Office of Public Information

501 N. Gulkana • Palmer, Alaska 99645

Phone: 907-746-9251 • Fax: 907-761-4076

March 11, 2005

*Senate HESS Committee
State Capitol
Juneau, AK 99801*

Dear Members of the Senate HESS Committee:

On behalf of the Mat-Su Borough School District, I would like to comment on proposed legislation to mandate CPR/First Aid as a requirement for a high school diploma (SB4). While we support the need for a citizenry that can respond in times of crisis, we feel strongly that CPR and First Aid training should be a community-based initiative rather than a school-based mandate. We are concerned the underlying cost and logistics of implementing such a mandate would detract from initiatives geared toward improving the teaching and learning of academic subjects.

It is unreasonable to assume the implementation of a Red-Cross approved CPR/First Aid Certification program in schools would be without cost. Districts would be required to set aside professional development time for teachers to be trained and certified as trainers. If such training were scheduled during the school year, it would displace important professional development specifically designed to improve classroom instruction. Any training conducted outside the 180-day school year would require funding to pay for extended contracts. Red Cross CPR/First Aid classes are typically limited to no more than 15 students for every 1 instructor. Class sizes at the high school level average between 26-35 students. Logistically and financially, this creates a problem. Presumably all costs associated with testing materials, the issuance of Red Cross certification cards, and purchase of CPR dummies and necessary cleaning materials will not be the responsibility of the American Red Cross. The necessary funding would be taken from district operation funds.

In Mat-Su Schools, Health is a required course for graduation and is typically completed by students in their ninth-grade year. Our Health curriculum is periodically reviewed by our professional curriculum council to ensure alignment to state and national standards. This curriculum includes instruction in basic first aid, prevention of hazards, and personal safety. The minimum eight-hour training required for Red Cross certification and subsequent testing would demand the dedication of several weeks of classroom instruction solely to that process (please keep in mind that most classes meet for an hour only two to three times per week). As such, students would miss out on other important aspects of the health curriculum as outlined in state and national standards, to include but not limited to:

- Identifying, evaluating, and preventing practices associated with high-risk lifestyles and the control of disease
- Facts about substance use and abuse
- Fitness and nutrition
- Human growth and development, to include emotional health and well-being
- Identifying and evaluating the roles and influences of public and private organizations which contribute to the well-being of communities (i.e. Red Cross)

- more -

"Developing Productive Citizens for an Ever-Changing World"

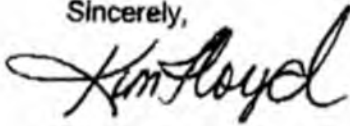
MSBSD Public Comment - SB 4 p.2

Our district currently offers EMT I & II courses as electives through our Career & Technical Education programs, along with the coursework necessary for licensing as a Certified Nursing Assistant. While we prepare students for success in these areas, we stop short of mandating testing for professional certification. This remains a personal choice for every student.

While we applaud Senator Cowdery's efforts to improve the safety of Alaska's residents, we are understandably resistant to additional unfunded mandates for schools. We believe CPR/First Aid Certification is best taught to and by community volunteers in a community forum. Further, we strongly oppose any linking of such certification as a requirement for a high school diploma.

Thank you for your consideration.

Sincerely,



Kim Floyd
Public Information Specialist/Legislative Liaison

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(*Circulation*. 2004;109:278-291.)
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AHA Scientific Statement

Response to Cardiac Arrest and Selected Life- Threatening Medical Emergencies

The Medical Emergency Response
Plan for Schools: A Statement for
Healthcare Providers, Policymakers,
School Administrators, and Community
Leaders

, Writing Group Mary Fran Hazinski, RN, MSN; David Markenson, MD, EMT-P; Steven Neish, MD; Mike Gerardi, MD; Janis Hootman, RN, PhD; Graham Nichol, MD, MPH; Howard Taras, MD; Robert Hickey, MD; Robert O'Connor, MD; Jerry Potts, PhD; Elise van der Jagt, MD, PhD; Stuart Berger, MD; Steve Schexnayder, MD; Arthur Garson, Jr, MD, MPH; Alidene Doherty, RN; Suzanne Smith

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Key Words: AHA Scientific Statements • heart arrest • pediatrics • resuscitation • defibrillation

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► **Introduction**

This document introduces a public health initiative, the Medical Emergency Response Plan for Schools. This initiative will help schools prepare to respond to life-threatening medical emergencies in the first minutes before the arrival of emergency medical services (EMS) personnel.

This statement is for healthcare providers, policymakers, school personnel, and community leaders. It summarizes essential information about life-threatening emergencies, including details about sudden cardiac arrest (SCA). This statement describes the components of an emergency response plan, the training of school personnel and students to respond to a life-threatening emergency, and the equipment required for this emergency response. Detailed information about SCA and cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) programs is provided to assist schools in prioritizing and preparing for emergencies to maximize the number of lives saved.

Life-threatening emergencies can happen in any school at any time. These emergencies can be the result of preexisting health problems, violence, unintentional injuries, natural disasters, and toxins. In recent years, stories in the lay press have documented tragic premature deaths in schools from SCA, blunt trauma to the chest, firearm injuries, asthma, head injuries, drug overdose, allergic reactions, and heatstroke. School leaders should establish an emergency response plan to deal with life-threatening medical emergencies in addition to the emergency plan for tornados or fires.

This statement has been endorsed by the following organizations: American Heart Association (AHA) Emergency Cardiovascular Care Committee, American Academy of Pediatrics, American College of Emergency Physicians, American National Red Cross, National Association of School Nurses, National Association of State EMS Directors, National Association of EMS Physicians, National Association of Emergency Medical Technicians, and the Program for School Preparedness and Planning, National Center for Disaster Preparedness, Columbia University Mailman School of Public Health. This statement was also reviewed by the Centers for Disease Control Division of School and Adolescent Health.

This statement includes all of the recommendations made in the 2001 Guidelines for Emergency Medical Care in School published by the American Academy of Pediatrics.¹ It is consistent with the position of the AHA statement on use of AEDs in children,² the National Association of School Nurses' statement on the use of AEDs in schools,³ the statement from the National Association of EMS Physicians about the use of AEDs in children,⁴ the emergency planning in athletics statement of the National Athletic Trainers' Association,⁵ and the American Lung Association Asthma Alert for Teachers.⁶

► **Background**

Magnitude of the Problem

School nurses, athletic trainers, and teachers are often required to provide emergency care during the school day and for extracurricular activities, including sports. In a survey of elementary and high school teachers in the Midwest, 18% of all teachers surveyed indicated that they personally

provided some aspect of emergency care to more than 20 students each academic year, and 17% indicated that they had responded to ≥ 1 life-threatening student emergency during their teaching career.⁷ A survey of school nurses in New Mexico documented that each year, 67% of schools activated the EMS system for a student and 37% of the schools activated the EMS system for an adult.⁸ Unfortunately, data on the type and severity of emergency calls from schools to EMS systems are limited. A review of the medical literature yielded no published reports of the national frequency and causes of life-threatening medical emergencies in schools. Information in the present statement was gathered from the medical literature, regional and statewide surveys, and registries of isolated problems.

School medical emergencies can involve students or adults. All schools have adult faculty and staff, and most schools host large numbers of adults during extracurricular activities (eg, sports events, drama productions, community meetings). As noted above, each year, more than one third of schools may have an emergency that involves an adult and requires activation of the EMS system.⁸ The data on adult life-threatening medical emergencies in schools were derived from the most frequent causes of death in adults reported by the National Center for Health Statistics⁹ and the most common causes of work-related fatalities.^{10,11}

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► **Life-Threatening Emergencies in Children and**

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Adolescents

Noncardiac Causes of Emergencies

In children and young adults, injuries cause more childhood deaths than all other diseases combined.⁹ Unless an injury involves *commotio cordis* (a sudden blow to the chest), injury deaths typically are associated with difficulty breathing or development of shock (low blood pressure) due to blood loss. In such cases, the heart often slows and then stops so that the cardiac arrest is a secondary (rather than a primary or sudden) event.¹² Victims of injuries require early activation of EMS, support of breathing, and control of hemorrhage and are unlikely to need treatment with a defibrillator.

The AHA modified the Adult Chain of Survival to emphasize the prevention of injuries and other causes of death and the need for immediate bystander CPR for children.¹² The links in the AHA Infant and Child Chain of Survival are as follows:

1. Prevention of injury and other causes of cardiac arrest
2. Early CPR
3. Early activation of the EMS system
4. Early advanced care

The Intermountain Injury Control Research Center at the University of Utah compared statewide reasons for EMS dispatch for children 5 to 18 years of age at schools with reasons for EMS dispatch for children at nonschool locations during a 3-year period (see [Table 1](#)).¹³ Injuries accounted for a greater proportion

of school-based EMS calls than other EMS calls for children; most school injuries occurred during sports activities, and 11 resulted in permanent paralysis.¹³

View this **TABLE 1. Chief Complaints^a of School Versus Nonschool EMS Dispatches, State of Utah, 1994–1996**
table:
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During the 3-year study period, the Intermountain Injury Control Research Center documented 3 chief medical complaints for school EMS dispatches for children unrelated to injury: breathing difficulty (18.4%), seizure (16%), and other illness (12.3%).¹³ These complaints are consistent with the causes of school deaths reported in the lay press: severe asthma, anaphylaxis (severe allergic reaction), choking, drug overdose, and heatstroke. These causes of arrest require recognition of the emergency and first aid, which may include administration of medications at the scene (eg, use of the victim's inhaler for severe asthma or use of an epinephrine autoinjector for anaphylaxis), cooling of heatstroke victims, opening of the airway, possible CPR (especially rescue breathing), and rapid transport to an appropriate medical facility. These treatments are time dependent. For the child to survive, the school must have a plan to ensure that trained rescuers identify the emergency and act quickly in a coordinated fashion to provide appropriate treatment within a few minutes.

Because injuries are the most common life-threatening emergencies encountered in children and adolescents in or out of schools, teachers, school nurses and physicians, and athletic trainers should know the general principles of first aid (eg, how to ensure scene safety and assess responsiveness, how to use personal protective equipment when in contact with blood or other body fluids, when and how to phone the EMS system, and when it is acceptable to move a victim). In addition, first aid rescuers must be able to control bleeding, recognize

and treat shock, immobilize the spine, warm hypothermia victims, cool heatstroke victims, detect and treat hypoglycemia, support the airway, and provide CPR and use an AED when needed. These skills are taught in 1-day first aid courses that teach first aid, CPR, and AED use.

Children With Special Healthcare Needs

Children with special healthcare needs have chronic physical, developmental, behavioral, or emotional conditions and require health and related services of a type or amount not usually required by typically developing children.¹⁴⁻¹⁶ These children may need emergency care for acute, life-threatening complications that are unique to their chronic conditions (such as severe asthma or obstruction of a tracheostomy airway), or they may develop progression of underlying respiratory failure or neurological disease. However, approximately half of EMS responses to children with special healthcare needs are unrelated to the child's special needs and include traditional causes of EMS calls, such as injury.

When a child with special healthcare needs or any illness with life-threatening complications attends school, the school nurse should have access to specific medical information about the child's baseline condition, the medical plan of care, the child's current medications, and potential complications or signs of deterioration. The healthcare provider guiding the child's care should provide information to school personnel about emergency actions.

A standardized form, the Emergency Information Form, was developed by the American Academy of Pediatrics and the American College of Emergency Physicians and is available on the World Wide Web.¹⁶ In most instances, the school nurse is responsible for interpreting the Emergency Information Form and developing an individual emergency care plan that is specific to the school environment.^{17,18}

The school should have specific instructions about whom to contact for emergencies and when such contact should be made.¹⁸ If the child has a tracheostomy, everyone responsible for the child's care at school should be taught to assess airway patency, clear the airway, and provide CPR with the artificial airway. If the child has asthma, the school nurse and any teacher

responsible for the child's care should be able to recognize wheezing and signs of breathing difficulty and should know to follow the asthma action plan for the child.⁶

If the physician who cares for the child, the child's parents, and the child (as appropriate) have made a decision to limit resuscitation efforts or withhold resuscitation attempts, the physician should write a Do Not Attempt Resuscitation (DNAR) or "no-CPR" order specifically for use in the out-of-hospital setting. The child's primary caretaker, the school, and the EMS systems for the child's home and school should have copies of these orders.

SCA in Children and Adolescents

SCA is the sudden cessation of cardiac activity so that the victim becomes unresponsive, with no normal breathing and no signs of circulation. Unless the victim receives immediate CPR and other treatment to restore normal cardiac activity, he or she will die. Although the precise incidence of SCA in children is unknown, it is not a leading cause of death in children and young adults.

Response to SCA is a major focus of this statement. Although SCA is relatively uncommon in children and young adults, victims are more likely to survive SCA than prehospital traumatic cardiac arrest if they receive prompt support and treatment.

When SCA does occur in children and young adults, it may be precipitated by ventricular fibrillation (VF) or rapid ventricular tachycardia (pulseless VT). These abnormal heart rhythms in children are typically caused by inherited or congenital cardiac conditions or by acute medical problems that cause inflammation of the heart. Examples of conditions that may be familiar to school nurses, physicians, and parents include long-QT syndrome, hypertrophic cardiomyopathy, abnormal development of the coronary arteries, aortic dissection, myocarditis, and congenital aortic stenosis.¹⁹ Many of these conditions will not be detected during routine screening for school physicals or sports activities,^{20,21} so SCA may be the first sign of these problems. Vigorous exercise appears to act as a trigger for lethal arrhythmias.²¹

SCA may also result from *commotio cordis*, a blow to the chest that causes VT or VF. Each year \approx 5 to 10 cases of *commotio cordis* are reported nationwide for victims of all ages.²¹⁻²³

A statewide survey of SCA in athletes in Minnesota conducted by Maron et al^{24,25} was the basis for estimating the risk of SCA in high school athletes, which is thought to be 0.5 to 1.0 per 100 000 high school athletes (or 1 per 200 000 to 1 per 100 000) per year.^{21,25} This risk is \approx 1/100 to 1/200 of the risk reported in the adult population 35 years of age and older.²⁶ In 1999, an estimated 5 000 000 athletes competed in varsity athletics in 34 486 public and private high schools throughout the United States. Extrapolation from the Maron Minnesota data predicted \approx 25 to 50 episodes of SCA nationwide among all high school athletes per year.

The National Center for Catastrophic Sports Injury Research (NCCSIR) tracks voluntary reports of serious injuries and deaths that occur during training or competition in male and female high school and college sports.²⁷ The NCCSIR reports deaths attributable to an injury (direct injury death) and those not attributable to an injury (indirect nontraumatic death). In 2000, the NCCSIR reported 15 deaths of high school athletes nationwide: Twelve deaths were caused by SCA (indirect nontraumatic death), 2 deaths resulted from direct injury with *commotio cordis* (blow to the chest), and 1 death resulted from a brain injury.²⁸ The 14 reported cardiac deaths among 5 000 000 high school athletes are lower than the 25 to 50 fatalities predicted by the Maron Minnesota data and yield an incidence of 0.28 cardiac deaths per 100 000 high school athletes, or 1 death per 357 000 high school athletes.

Over a 10-year period from July 1983 to June 1993, the NCCSIR reported 126 nontraumatic sports deaths in high school athletes and 34 deaths in college athletes, or an average of 16 reported deaths per year nationwide.²⁹ Most of these deaths were caused by cardiovascular conditions, especially hypertrophic cardiomyopathy and congenital anomalous coronary arteries. Estimated death rates in male athletes were 5-fold higher than those in female athletes (0.747

versus 0.133 per 100 000 athletes per year; $P < 0.0001$) and 2-fold higher in male college athletes than in male high school athletes (1.45 versus 0.66 per 100 000 athletes per year; $P < 0.0001$).²⁹

The NCCSIR database includes only voluntary reports of deaths or injuries at athletic activities sanctioned and sponsored by high schools and colleges. It does not include deaths or injuries that occur during routine class hours, physical education classes, or pickup sporting activities. Despite these limitations, the NCCSIR represents the best ongoing source of data on high school athletic injuries and death.

There is little information about SCA among high school students who do not compete in athletics or about SCA among elementary school students. Although SCA has been reported in nonathletic adolescents during sedentary activities, the risk of SCA appears to be lower in high school students who do not play competitive sports than in athletes.^{21,24,30} When the limited data from EMS systems are examined,³¹ the risk of SCA in elementary school-age children appears to be much lower than that reported in high school-age students who are not athletes and substantially lower than that reported in high school athletes. Because the Maron and NCCSIR registries provide the most concrete data available, the risk of SCA of 0.5 to 1.0 per 100 000 (or 1 per 200 000 to 1 per 100 000) children and young adults is used for calculations in the present statement. This figure will likely *overestimate* the incidence of SCA, particularly in elementary school children and adolescents who do not participate in athletics.²¹

As in an adult, if a child develops SCA caused by VF or pulseless (rapid) VT, immediate bystander CPR and early defibrillation are needed. AEDs are computerized defibrillators designed for use by lay rescuers to treat SCA. The AED provides voice and visual prompts to guide the rescuer. When attached with adhesive pads to an unresponsive victim in cardiac arrest, the AED analyzes the victim's heart rhythm, determines if a shock is needed, charges to an appropriate shock dose, and prompts the rescuer to deliver a shock. The AED delivers a shock only if VF or rapid VT is present.

The US Food and Drug Administration has now cleared several AEDs for use in children younger than 8 years of age. Two of these devices have been shown to accurately identify VF and rapid VT in young children and are also accurate in identifying pediatric rhythms that do not require defibrillation.^{32,33} When used with a designated pediatric pad-cable system, these AEDs deliver an energy dose that is smaller than that delivered with adult pads. The AHA² and the National Association of EMS Physicians⁴ state that AEDs may be used with CPR for treatment of prehospital cardiac arrest (victims who are unresponsive, with no breathing and no signs of circulation) in children 1 to 8 years of age. The AHA continues to recommend the use of CPR with AEDs for treatment of cardiac arrest in children 8 years of age and older and in adults.³⁴

Life-Threatening Emergencies in Adults

Noncardiac Life-Threatening Emergencies in Adults

In developing the 2000 international guidelines for CPR and emergency cardiovascular care,¹¹ the AHA and the International Liaison Committee on Resuscitation (ILCOR) identified the leading causes of death in persons 25 to 64 years of age. The 10 leading causes of death are malignancy, heart disease, unintentional injury, suicide, stroke, diabetes, liver disease, human immunodeficiency virus (HIV), respiratory disease (bronchitis, emphysema, and asthma), and homicide. The leading causes of work-related fatalities are transportation incidents (41%); assaults and violence (20%); contacts with objects and equipment, including poisons (16%); environmental exposure (12%); falls (10%); and fires and explosions (3%).^{10,11}

Adult workplace emergencies are likely to be representative of life-threatening emergencies among adults who work in schools. Rescuers responding to these emergencies must recognize the condition, notify the EMS system when appropriate, and provide basic first aid until EMS providers arrive. First aid rescuers must know the general principles for all emergencies, such as how to ensure scene safety, how to assess responsiveness, how to use personal protective equipment when in contact with blood or other body fluids, when and how to phone the EMS system, and when it is acceptable to move a victim. In

addition, as noted above, first aid rescuers must be able to control bleeding, recognize and treat shock, immobilize spine, warm hypothermia victims, cool heatstroke victims, detect and treat hypoglycemia, support the airway, and provide CPR and use an AED when needed.

SCA in Adults

SCA is a leading cause of death for adults ≥ 35 to 40 years of age and is the most common cause of death for those >45 years of age. In the United States each year, SCA occurs with an estimated frequency of ≈ 1 per 1000 persons ≥ 35 years of age per year.³⁴⁻³⁷ These statistics can be used to estimate the risk of adult SCA for any location on the basis of the number of adults aged 35 and older typically present at that location and the number of hours they are present at that location per year (see Appendix 1). Note that the risk of SCA in adults is ≈ 100 to 200 times the estimated risk in children and adolescents and those under 35.^{21,24-}

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VF and, much less frequently, pulseless VT are the most common abnormal heart rhythms that cause SCA in adults, although they are not the only rhythms that cause cardiac arrest.³¹ VF and pulseless VT are treated with a defibrillator that delivers a shock to the heart. This shock briefly "stuns" the heart, eliminating the abnormal rhythm and allowing the heart's normal rhythm to resume.

Victims of SCA due to VF/VT can survive if bystanders and EMS providers act quickly. Bystanders must be able to recognize cardiac arrest, phone the EMS system, perform CPR, and use the AED. The AHA has depicted these rescue steps of early recognition, early access to the EMS system, early CPR, and early defibrillation as links in the Adult Chain of Survival³⁸:

1. Early recognition of the emergency and early activation of the EMS system
2. Early CPR
3. Early defibrillation
4. Early advanced life support

Studies have shown that immediate bystander CPR and defibrillation within minutes provide the best chance of survival from sudden VF cardiac arrest in adults. Survival rates of 50% to 74% have been reported when adult victims of

VF SCA collapse in front of witnesses and receive immediate bystander CPR plus defibrillation within 3 to 5 minutes of collapse. These adult survival rates have been documented in settings such as airports,³⁹ commercial airlines,^{40,41} casinos,⁴² and communities with police who are trained and equipped to respond to SCA.⁴³⁻⁴⁶

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► **Current Level of School Preparation for Medical Emergencies**

School nurses, teachers, athletic trainers, coaches, and staff are responsible for the physical well-being of a large portion of the nation's children for many hours each day. Schools now employ fewer nurses, and school nurses often rotate between schools, so some schools are without professional medical coverage for hours or days every week.⁷ Much of the responsibility for the physical care of students during a typical school day now rests with teachers, athletic trainers, coaches, and staff. In a random survey of elementary and high school parents and teachers in the Midwest, 80% of parents indicated that they assumed that teachers were adequately trained in first aid and CPR, but one third of the teachers surveyed had no training in first aid, and 40% had never completed a

course in CPR.⁷ A survey in New Mexico confirmed that few school nurses and staff had any emergency training.⁸

In a survey of all high schools in Washington State, 80% of teachers thought that CPR training was important, yet 35% of schools provide no CPR training for students.⁴⁷ When the schools were asked to identify factors that would be most likely to encourage schools to offer CPR training for students, 24% indicated that funding would be helpful, and 17% indicated that a requirement or credit for CPR training would encourage CFR training.⁴⁷

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▶ **School Medical Emergency Response Plan: Recommended Elements**

The goal of the Medical Emergency Response Plan for Schools initiative is to encourage every school to develop a program that reduces the incidence of life-threatening emergencies and maximizes the chances of intact survival from an emergency. Such a program will have the potential to save the greatest number of lives with the most efficient use of school equipment and personnel.

The authors and endorsing organizations of the present statement recommend the following core elements of a school medical emergency response plan:

1. *Effective and efficient communication throughout the school campus:* Establish a rapid communication system linking all parts of the school campus, including outdoor facilities and practice fields, to the EMS system. Establish protocols to clarify when the EMS system and other emergency contact people should be called. Determine the time required for EMS response to any location on campus and establish a method to efficiently direct EMS personnel to any location on campus. Create a list of important contact people and phone numbers with a protocol to indicate when each person should be called. Include names of experts to help with postevent support.
2. *Coordinated and practiced response plan:* Develop a response plan for all medical emergencies in consultation with the school nurse, the school or school athletic team physicians, athletic trainers, and the local EMS agency, as appropriate. EMS and emergency dispatchers (9-1-1 centers) should be made aware of the type of rescue equipment available at the school and its location. Practice the response sequence at the beginning of each school year and periodically throughout the year, and evaluate and modify it as needed.
3. *Risk reduction:* Prevent injuries through safety precautions in classrooms and on the playground. Identify students, faculty, and staff with medical conditions that place them at risk for development of life-threatening conditions, and train and equip personnel to provide the appropriate response for those conditions.
4. *Training and equipment for first aid and CPR:* Ensure that many teachers are trained as CPR and first aid instructors. Train school staff and graduating high school students in CPR. Teachers and staff trained in first aid should, at a minimum, be equipped and able to give first aid for the following life-threatening emergencies until EMS rescuers arrive:

- a. Severe breathing problems, including asthma, choking, and anaphylaxis (severe allergic reaction)
- b. Chest pain and heart attack
- c. Diabetes and low blood sugar
- d. Stroke
- e. Seizure
- f. Shock
- g. Bleeding
- h. Head and spine injury
- i. Broken bones
- j. Burns
- k. SCA
- l. Temperature-related emergencies (heatstroke and hypothermia)
- m. Poisoning

5. *Implementation of a lay rescuer AED program in schools with an established need:* If the school determines that a lay rescuer AED program is needed, school administrators and medical personnel should include the AED program in the school medical emergency response plan and practice and evaluate response to SCA using the AED. EMS and 9-1-1 centers should be notified of the specific type of AED and the exact location of the AED on the schoolgrounds. Rescuers

who are unfamiliar with the school can call 9-1-1 and receive instructions from 9-1-1 dispatchers to find and use the AED. AED programs should have the following elements:

- a. Medical/healthcare provider oversight
- b. Appropriate training of anticipated rescuers in CPR and use of the AED
- c. Coordination with the EMS system
- d. Appropriate device maintenance
- e. Ongoing quality improvement program

A medical emergency response plan must start with development of a good system of communication. It also requires development and coordination of a planned and practiced response, risk reduction, and training and equipment.

Effective and Efficient Communication

An effective emergency response plan begins with establishment of rapid, effective communication to and from every location on the school campus. This network can be built with cellular telephones, walkie-talkies, alarms, or intercom systems to establish contact with a central location that is responsible for the EMS call. Several such systems may work, as long as the EMS system can be contacted immediately and directed to the site of any emergency without delay. Critical delays will result if teachers or coaches must send a runner from a distant practice field or track to the school office, so this method of communication is not recommended. The local EMS system may be able to provide valuable input in development of the plan.

Every school district and each school should identify persons who will be authorized and trained to make decisions when health emergencies occur. The names, telephone numbers, and locations of these persons should be provided to all staff members, with a protocol indicating when each authority should be called.

All school staff should be taught when to telephone the EMS service (phone 9-1-1), when to phone other school or medical personnel, where to find the emergency equipment, how to clear crowds, and how to direct arriving EMS personnel to all sites on campus. These efforts will ensure that the entire staff is engaged in the response plan.

The lay press has reported unfortunate delays in emergency response when student calls for help are dismissed as pranks. The school must sensitize teachers, staff, and students to the gravity of reports of emergencies. Student reports of emergencies must be taken seriously, and disciplinary consequences must follow any false claims.

Coordinated and Practiced Response Plan

Plan Development

The school nurse and school or team physicians and athletic trainers should be involved in development of the medical emergency response plan. The plan should specify their participation in the emergency response and in documentation, evaluation, and postevent support of students, teachers, and staff.

The school should coordinate the plan with the local EMS agency and integrate it with the local EMS system. School administrators should invite input from both the emergency medical dispatch system and the EMS system that provides responding units to the school. The local EMS agency should be encouraged to conduct an on-site "preincident" visit to identify problems, such as restrictive passages through the school parking lot or buildings or any areas that are inaccessible to a crew in an ambulance.

Written notification protocols should list the appropriate contact people and their contact telephone numbers and should specify when parents, school district personnel, and the EMS system should be contacted. Forms should be available to document the details of an emergency event. A complete Emergency Information Form should be available for reference during emergencies involving children with special healthcare needs.

The school should give a copy of the final emergency response plan to the local EMS system and local EMS dispatcher. This plan should include the location and type of emergency equipment. The school should notify the local fire/emergency rescue agency if any faculty, staff, or students at the school are dependent on mechanical ventilation or other electrical equipment so the agency is prepared to provide support in the event of a power failure or other emergency. National crisis

plans now require schools to keep detailed floor plans and maps of the school property for use in emergencies. Much of this information can be entered into computer-aided dispatch systems at the 9-1-1 dispatch center and linked to the school's address and telephone numbers. Entering this information will permit 9-1-1 dispatchers to have immediate access to this information during the emergency call.

Plan Practice and Evaluation

Each school should practice and evaluate the response plan with participation of the school nurse, school or team physicians, athletic trainers, and the local EMS system. This plan should target a collapse-to-EMS call time of ≤ 1 minute, provision of first aid and CPR when appropriate, and a collapse-to-first shock time of < 3 minutes for SCA if an AED program is on site.³⁴

Designated rescuers should participate in unannounced practice drills on a regular basis (eg, at the beginning of every school year and repeated during the school year) to promote an efficient, organized, and timely response to life-threatening medical emergencies anywhere on the schoolgrounds. These practice drills should include real-time participation by students, staff, and faculty who feign emergency conditions or participate as members of the response or communication team. The drill should use manikins to simulate victims in cardiac arrest. The AHA has created scenario cards that may be used for these practice drills. The scenario cards are available in the AHA instructor materials.⁴⁸

Scenarios are also in the ARC first aid/CPR/AED program instructor materials.

During each practice drill, an observer should record the following:

1. *Critical time intervals:* time from development of the emergency to 9-1-1 call; time from development of the emergency to administration of first aid; time from collapse to bystander initiation of CPR (if indicated); time from collapse in cardiac arrest to delivery of first shock (if an AED program is in place); and time to arrival of EMS personnel at the victim's side.
2. *Availability and function of emergency equipment at the school.*

After each drill, review performance of each component of the plan, and revise the school emergency response plan as needed to improve performance and efficiency.

When a life-threatening medical emergency does occur at the school, administrators should hold a postevent meeting of all involved personnel. This meeting should be scheduled within a few days of the emergency and should provide the opportunity for a frank discussion of what worked, what didn't work, and how to improve the response plan. This will enable revision of the response plan to better serve the next emergency.

Postincident counseling should be available to staff and students whenever a fatal or near-fatal event occurs at the school. Most school districts have designated counseling staff to handle such needs. The school supervisor should identify resource personnel before an emergency arises and should have contact numbers for use in the event of an emergency. The local children's hospital, medical center, community mental health agency, or local EMS agency may be able to provide names of experts.

Risk Reduction

The Medical Emergency Response Plan for Schools should strengthen each link in the Chain of Survival. The first link in the AHA Infant and Child Chain of Survival is prevention of life-threatening events through education about injury prevention and identification, evaluation, and support of children at risk. Some injuries that occur on schoolgrounds result from high-risk behavior that begins at home. Schools should provide injury prevention information to children and families about the importance of age-appropriate restraint devices in automobiles, use of bicycle helmets, use of smoke detectors, and use of trigger locks and lock boxes for firearms stored at home.

Injury prevention in schools requires proper equipment maintenance and supervision of students during shop and laboratory classes, playground time, physical education classes, and team sports. Students and teachers should wear proper safety gear during shop, laboratory, and physical education classes. All

class equipment should be kept in good working order and any dangerous or flammable chemicals stored in locked cabinets.

The ground surface under swing sets, climbing bars and slides, and gymnastic equipment should be sufficiently cushioned to reduce impact and prevent injuries. All playground equipment should be constructed without sharp edges and should be properly maintained.

As noted above, the school should be aware of any children with medical conditions that may have life-threatening complications. If a student has a health problem that could be life threatening, the school nurse should develop an emergency care plan for that child. The child's teachers and the school nurse should be prepared to activate that plan when needed. The school should ask the parents to consult the child's physician to determine if the school should maintain an extra supply of medications (eg, bronchodilator administered by metered-dose inhalers with spacers for children with severe asthma) for use during emergencies or exacerbations. The school must be in compliance with state laws and regulations and school board policies for use of these medications. If appropriate, information about the child's condition should also be conveyed to the local EMS agency.

Routine medical care of many conditions, such as asthma, can modify the course of the disease and make acute exacerbations less likely. Teachers should consult the child's parents and physician to identify and eliminate factors in the classroom or school environment that may act as triggers for asthma or severe allergic reactions.⁶

Training and Equipment for First Aid and CPR

As part of the Medical Emergency Response Plan, the school nurse and physician, the athletic trainer, and several faculty members should be trained in and equipped to provide first aid and CPR. Ideally, the school should establish a goal to train every teacher in CPR and first aid and train all students in CPR. All students, faculty, and staff should know how to access the EMS system. The

school should maintain a first aid kit, and school staff must know where emergency equipment is stored.

The authors and endorsing organizations of this statement have not specified the number of teachers and staff to be trained in first aid and CPR at each school. There should be a sufficient number of trained faculty, staff, and students, however, to ensure that a trained rescuer can get the appropriate equipment and reach any area of the campus within 90 seconds of the onset of the emergency. Persons trained in CPR and first aid should therefore be carefully selected on the basis of their likely location on the school campus each day, their typical responsibilities, and their likely response interval in the event of an emergency. An office assistant may be able to respond more quickly to an emergency than a teacher who is often off campus for meetings. In a typical school, at least 2 teachers and 2 alternate rescuers will likely be required to ensure coverage for every location and every school day. The school should also evaluate the number of students and adults present on schoolgrounds during afterschool activities, and the plan should cover these time periods if needed.

Training in First Aid and Universal Precautions

All school nurses, physicians, athletic trainers, and several faculty and staff should be trained and equipped to provide first aid because immediate first aid can prevent a life-threatening problem from becoming a fatal one. Potential rescuers must be able to recognize and provide initial treatment for breathing emergencies such as choking, severe asthma, or severe allergic reaction; injury emergencies such as burns, shock, head or spinal cord injury, or bleeding; neurological emergencies such as seizures and stroke; temperature-related emergencies such as heatstroke and hypothermia; and poisoning. Certified athletic trainers are educated to care for student athletes with sports-related injuries and emergencies.⁵ Coaches should be trained to provide CPR (with an AED if indicated) and first aid for common and life-threatening sports-related emergencies.⁴⁹

Every school should comply with precautions to minimize the risk of blood-borne pathogens. In some states, public schools must comply with the Occupational

Safety and Health Administration (OSHA) standards with regard to blood-borne pathogens.

Several courses have been developed in recent years to provide training in first aid, including precautions to minimize risk of blood-borne pathogens. The AHA and ARC have developed first aid courses to teach these essential assessment, knowledge, and first aid skills to workplace rescuers.⁵⁰ The University of Connecticut College of Continuing Studies developed the School Nurse Emergency Medical Services for Children (SNEMS-C) Program.⁵¹ The National Standards for Athletic Coaches provide information needed by coaches to deal with sports-related injuries.⁴⁹ Visual aids such as first aid posters can be displayed in conspicuous places to remind faculty, staff, and students of critical first aid and CPR skills.

Training In CPR

CPR training is important for several reasons. First, rapid bystander CPR, particularly provision of rescue breathing, may prevent breathing problems and other emergencies from progressing to cardiac arrest. Second, CPR has been shown to improve the chance of survival in adults and children with cardiac arrest. In one recent study of children who required CPR in the out-of-hospital setting, \approx 1 child was resuscitated by bystander CPR alone for every 7 children who required CPR by EMS personnel.^{52,53} Immediate bystander CPR for adults with SCA can double survival.⁴⁰

Because bystander CPR is so critical in improving survival from SCA, the AHA recommends that all high school students be trained in CPR. To facilitate this training, the AHA and ARC developed school CPR courses with course materials tailored for teaching children in a classroom setting.⁵⁴ The Maternal and Child Health Bureau has also developed a course to teach CPR in schools.⁵⁵ Such training should increase the likelihood of immediate initiation of bystander CPR for victims of SCA and should contribute to improved survival rates. CPR training may also have less quantifiable benefits. For example, CPR training implies an underlying commitment to fellow citizens and may encourage and model a willingness to provide assistance to victims of medical emergencies.

Equipment

Equipment is an important part of any medical emergency response plan, beginning with a first aid kit and CPR barrier devices and may include an AED. First aid and CPR-AED equipment should be carefully selected on the basis of the types of emergencies likely to develop at the school. For example, if football, gymnastics, or diving events take place on campus, a backboard with restraints should be available to immobilize an athlete with suspected spine injury. Epinephrine can be lifesaving for victims with anaphylaxis (severe allergic reaction), such as that resulting from a bee sting, a severe food allergy, or latex allergy. Some states and EMS systems encourage the use of epinephrine autoinjectors for emergency treatment of severe allergic reactions. If state and EMS regulations allow, these autoinjectors can be included in the school's emergency equipment, and staff should be trained in their use. A physician's prescription is required to purchase autoinjectors. To check state regulations about epinephrine autoinjectors, contact the AHA at 1-888-277-5463.

A physician may determine that other medications, such as bronchodilators (medicines that open narrowed airways) administered by metered-dose inhalers with spacers, oxygen, and glucose or glucagon (a rapid-acting hormone for treatment of severe low blood sugar), should be kept at the school for at-risk students or staff. In this case, the student's family or a member of the school staff is responsible for providing the medication. A school nurse must be regularly available to give medications or delegate administration of medications if allowed by local law and school district policy.

School personnel first aid training includes recognition of low blood sugar (hypoglycemia) and administration of a source of rapid-acting sugar. The parent of the diabetic child is responsible for providing the school with such foods as fruit juice, packets of sugar, or a (nondiet) soft drink to be administered by trained staff if the child shows signs of hypoglycemia.

Any equipment is useless unless it is readily accessible in an emergency and rescuers are appropriately trained to use it. First aid and resuscitation equipment should be placed in a central, highly visible, and accessible location near a

telephone, and all school faculty, staff, and students should know where the equipment is stored. If the school is large, it may be necessary to keep duplicate equipment in several areas. Because injuries are most likely to occur during athletic activities, the athletic facilities should be considered high-priority areas for placement of equipment such as the first aid kit and spine backboards.

General emergency equipment should not be placed in a locked office or cabinet because this might delay emergency care. Unfortunately, accessibility will provide opportunities for theft or vandalism of equipment. This problem has been solved in many schools and public places such as airports by the use of mounted cabinets with audible alarms that sound when the cabinet door is opened. These cabinets cost ≈\$250 to \$500.

If medications such as epinephrine autoinjectors, bronchodilators, and glucagon are included in the school medical emergency response plan or a child's emergency care plan, these items should be kept in a location that is readily available to trained rescuers and the school nurse but not accessible by students and the general public. If a student has a healthcare problem that may require the use of emergency medications, the school nurse must develop a plan to make the medication available to the child when needed.

EMS and 9-1-1 centers must know in advance where emergency equipment is kept on school property. This can prevent failure to use available equipment (such as an AED) because responders are unaware of the existence or location of the equipment. If the 9-1-1 center knows where emergency equipment is located on the school grounds, the dispatcher can tell the rescuer where to find the equipment and can instruct rescuers in the use of the equipment before the arrival of EMS personnel.

Implementation of a Lay Rescuer AED Program in Schools With a Documented Need

To determine the need for an AED program at any location, the ECC Guidelines 2000³⁴ recommend consideration of lay rescuer AED program implementation in locations with at least one of the following characteristics:

1. The frequency of cardiac arrest events is such that there is a reasonable probability of AED use within 5 years of rescuer training and AED placement. This probability is calculated on the basis of 1 cardiac arrest known to have occurred at the site within the last 5 years, or the probability can be estimated on the basis of population demographics (see Appendix 1); **or**
2. There are children attending school or adults working at the school who are thought to be at high risk for SCA (eg, children with conditions such as congenital heart disease and a history of abnormal heart rhythms, children with long-QT syndrome, children with cardiomyopathy, adults or children who have had heart transplants, adults with a history of heart disease; etc); **or**
3. An EMS call-to-shock interval of <5 minutes *cannot* be reliably achieved with conventional EMS services **and** a collapse-to-shock interval of <5 minutes *can* be reliably achieved (in >90% of cases) by training and equipping laypersons to function as first responders by recognizing cardiac arrest, phoning 9-1-1 (or other appropriate emergency response number), starting CPR, and attaching/operating an AED.

When funds are limited, but there is a desire to establish some AED school programs, priority should be given to establishing programs in large schools, schools used for community gatherings, schools at the greatest distance from EMS response, and schools attended by the largest number of adolescents and adults (eg, high schools and trade schools).

The 5 components of an AED program are

1. Medical/healthcare provider oversight
2. Appropriate training of anticipated rescuers in CPR and use of the AED
3. Coordination with the EMS system
4. Appropriate device maintenance
5. An ongoing quality improvement program to monitor training and evaluate response with each use of the device

If an AED program is established at the school, the AED should be placed in a central location that is accessible at all times and ideally no more than a 1- to 1 1/2-minute walk from any location. The device should be secure and located near a telephone (eg, near the school office, library, or gymnasium) so that a rescuer can activate the EMS system and get the AED at the same time. The EMS system should be notified of the establishment of the AED program, and the emergency medical dispatcher should know the specific type of AED at the

school and where it is located. Several staff members should be trained in both CPR and use of the AED.

Recent federal legislation provides guidance for AED programs in schools. HR 389-PL 108-41 enabled the creation of an information clearinghouse with funds from the AED program in the Public Health Security and Bioterrorism Response Act (PL 107-188). The new law allows creation of a national resource center to provide schools with information and technical guidance to set up AED programs, giving schools access to the appropriate training, fundraising techniques, and other logistics required to make such programs successful. The national resource center is modeled after Project ADAM (Automatic Defibrillators in Adam's Memory), a joint venture between the Children's Hospital of Wisconsin and David Ellis, a friend of the project's namesake, Adam Lemel, who collapsed and died during a high school basketball game. Senate Bill 231 is a companion measure. For information about the clearinghouse, visit <http://healthlink.mcw.edu/article/962141848.html>. For information about establishing an AED program, call the AHA (1-877-242-4277), or visit the AHA website at <http://www.americanheart.org/cpr>.

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► **Potential Costs of Proposed School Emergency Response Plans**

The goal of a school emergency response plan is to ensure an organized, efficient, and effective response to life-threatening emergencies. Although the response plan is designed for all life-threatening emergencies, an estimation of program cost per life saved can be made by using the example of the cost per survival of a high school victim of SCA in a school with a medical emergency response plan that includes a lay rescuer AED program. This example will enable calculation using the costs of all potential elements described in this statement: the costs of training 4 teachers to serve as first aid, CPR, and AED rescuers and instructors every 2 years; training half of the student body in CPR and use of an AED every year; establishment of a lay rescuer AED program; and all first aid, CPR, and AED equipment needed.

Estimation of Costs per School

In 1999 there were 13 369 163 high school students in the United States. These students were enrolled in 23 825 public schools and 10 661 private schools, or a total of 34 486 high schools, with an average of 390 students per school. For this example, an estimated annual incidence of SCA of 0.5 to 1.0 in 100 000 high school students was used.²⁵ This predicts that there may be \approx 133 to 266 SCAs in high school students nationwide per year, or 1 event per 259 to 547 schools. Note that this number of cardiac arrests has not been reported, but it is used as a starting number that likely overestimates the number of cardiac arrests in high school students.

The program costs per life saved are estimated by calculating the cost of all equipment plus the cost of training at each school and then multiplying the result by the number of schools required to save 1 life annually. Costs are depreciated over the anticipated lifespan at an annual rate of 3%.⁵⁶

The following assumptions are made to estimate the annual costs of the program (Table 2).

- If students in the high school receive formal CPR training during their freshman and junior years, \approx 200 students per school (freshman class size tends to be larger than subsequent years) will be trained each year in an average high school.

- At each school, 2 teachers and 2 alternate teachers are trained as first aid plus CPR and AED rescuers and instructors (total of 4 instructors). The provider plus instructor training requires 2 days. The calculated costs include funds for hiring 4 substitute teachers during training. If the teachers are trained on professional development days, substitute teachers will not be required, and the money allocated for substitute teachers is not needed.
- The school medical emergency response plan is developed as part of school faculty (salaried) responsibilities, so no additional costs are incurred for development of the plan, practice drills, and evaluation.
- The healthcare provider who coordinates the medical emergency response plan does so on a voluntary basis.
- The school establishes an AED program and purchases an AED that has been cleared by the US Food and Drug Administration for use in children and documented to be accurate in children. In addition, the school purchases several adhesive AED pads for adults and children plus an equipment pack, at a total cost of ≈\$2500 amortized over 8 years. Note that if the school does not establish an AED program, the \$2500 cost may be subtracted from the costs listed in [Table 2](#).
- The average school purchases 8 manikins, 8 AED trainers, and 2 CPR instructor toolkits. The manikins and trainers are replaced every 6 years, and the instructor toolkits are replaced every 5 years when the AHA revises its resuscitation guidelines and training materials.
- The school purchases and equips a first aid kit (see Appendix 2) with a Mylar blanket, dressings, 2 epinephrine autoinjectors, and bronchodilator inhalers with spacers. The \$300 estimated total cost of the kit is amortized over 10 years (\$30 per year). The medications and some supplies are replaced annually at an estimated annual cost of \$120 (total of \$150 per year). The parents are responsible for the purchase of prescription medications that are routinely used by students at the school.
- The school provides CPR student manuals, CPR cards (credentials), and barrier devices for each student trained and will train half of all students (average of 200 manuals and cards per school) every year.
- The school purchases 2 copies of a CPR reference text for the students each year.
- All training materials are available for use in practice drills. As a result, the practice drills are conducted without additional costs.

View this **TABLE 2. Approximate Annual Costs* per School for School Medical Emergency Response Plan With Student CPR and AED Education and a Lay Rescuer AED Program**
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Estimation of Costs per Life Saved

To determine the potential cost per life saved (premature death prevented), an incidence of SCA of 0.5 to 1.0 in 100 000 high school students per year was used, or 1 episode of SCA annually for every 259 to 547 schools. A successful program should have a goal of saving at least half of the potential victims of SCA (50% survival to hospital discharge),^{57,58} or 1 life saved every year for every 518 to 1094 schools. Because each school must invest \approx \$3065 per year, this would result in a cost per life saved of \$1 587 670 to \$3 353 110 (\$3065 annual cost per school x 518 to 1094 schools per life saved). Note that the actual cost per life saved is probably higher than this number because the predicted risk of SCA reported was for athletes, and that number is probably higher than the actual risk of SCA for all high school students. If fewer students experience cardiac arrest than the number predicted, there will be fewer potential lives saved and a higher cost per life saved. These figures should be reevaluated when more data are available.

These numbers provide only the cost of life saved at the school and do not include the EMS costs or costs of hospital care, implantable defibrillator insertion, or rehabilitative care for the victim. They do not include subsequent lost wages for parents of the victim, the victim, and other family members. These calculations do not consider life-years saved or potential contributions to society by a surviving victim. A child survivor of SCA may live a long life. If the victim of SCA survives neurologically intact and lives for 50 years after the event, then the cost per life-year saved may be very low.⁵⁹

These calculations do not account for the effect on overall public health that would result from training all high school students in the United States to perform CPR. Benefits to society from training a large number of adolescents in CPR cannot be accurately quantified. These calculations also neglect the potential benefit of a school AED program that results in resuscitation of an adult coach or spectator. School insurance pools have recognized the benefits and risk

reduction of having trained personnel and equipment available for life-threatening situations.⁵⁰

A challenge to estimating the cost-effectiveness of this program is the lack of published data on the effectiveness of first aid and CPR training and the use of AEDs in schools. This analysis predicts a 50% survival rate from SCA using published models from adult victims.^{57,58} When school emergency response plans are enacted, it will be important to collect data about activation of the plans and outcomes and revise these cost estimates as needed.

An international multicenter trial of lay rescuer AED programs, funded by the AHA, AED manufacturers, and the National Heart, Lung and Blood Institute (NHLBI), is evaluating the effectiveness and cost of lay rescuer AED programs. The trial is a prospective, multicenter, randomized clinical study testing whether volunteer, nonmedical responders can improve survival from out-of-hospital cardiac arrest by using AEDs. The study has just concluded data collection at 24 field centers in ≈1000 community units (eg, apartment or office buildings, gated communities, sports facilities, senior centers, shopping malls, etc) in the United States and Canada. The primary end point is the number of out-of-hospital cardiac arrest victims who survive to hospital discharge. Secondary end points include neurological status, health-related quality of life, cost, and cost-effectiveness. Data collection for this trial was completed in September 2003, and the results should be published shortly.⁶¹

School Data Collection

More information is needed about the frequency of life-threatening emergencies, including SCA in schools. Schools must collect or provide reports of emergencies. These reports will have maximum impact if collected and verified using the model of Mason and colleagues.^{75,28} Only through the gathering of reliable data can we begin to accurately determine the frequency of life-threatening emergencies and plan the best interventions to save lives.

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► **Legislative Mandates and Funding for School Medical Emergency Response Plan**

Legislative efforts to save the lives of children who develop life-threatening emergencies at schools should support an approach that is most likely to save the greatest number of lives. A planned program should be required, as should appropriate training and equipment.

Unfunded legislative mandates, particularly those that address the purchase of equipment rather than programs of planned response, will limit effectiveness and place a substantial burden on school budgets. Many school budgets are already stretched to provide basic education, achieve student test score goals, and meet the needs of a wide range of students, including those with special healthcare and learning needs. Unfunded mandates for emergency care in schools are likely to be met with minimal effort that does not include the development of planned and practiced responses and the training and retraining that are most likely to save lives. Policymakers must work with schools to ensure that long-term solutions are enacted to be sure that programs are sustained indefinitely. Local and state policymakers should support an immediate response to life-threatening medical emergencies with the following priorities for policy and appropriations:

1. Establishing an efficient and effective campus-wide communication system for each school
2. Developing a coordinated and practiced medical emergency response plan with the school nurses, physicians, athletic trainers, and the EMS system, with appropriate evaluation and quality improvement
3. Reducing the risk of life-threatening emergencies by identifying students at risk and ensuring that each has an individual emergency care plan and by reducing the risk of injury and disease triggers at the school
4. Training and equipping teachers, staff, and students to provide CPR and first aid
5. Establishing an AED program in those schools with a documented need

Note that some schools throughout the United States have implemented some components of the medical emergency response plans without the use of public funds. Fundraising for such activities can take many different approaches, including sponsorship by local organizations (eg, Rotary Club, Parent-Teacher Association) and student activities (eg, car washes, bake sales). Such programs do not ensure predictable coverage for the greatest number of students, however.

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► **Conclusions**

On any given day, as much as 20% of the combined US adult and child population can be found in schools. Life-threatening emergencies in schools are relatively uncommon, but when they do occur, they require a planned, practiced,

and efficient response with provision of first aid and possible CPR and use of an AED. To maximize survival from a life-threatening emergency, schools must develop a medical emergency response plan designed to provide appropriate therapy within the first minutes of the emergency. The medical emergency response plan includes (1) creation of an effective and efficient campus-wide communication system; (2) coordination, practice, and evaluation of a response plan with the school nurse and physician, athletic trainer, and local EMS agency; (3) risk reduction; (4) training in and equipment for CPR and first aid for the school nurse, athletic trainers, and teachers and CPR training for students; and (5) in schools with a documented need, establishment of an AED program.

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► **Appendix 1**

Sample Calculations to Estimate Risk of SCA in Adult and Young Populations

Use of Person-Hours to Estimate Risk of SCA

Calculating Risk in a School

Person-hours are calculated by multiplying the number of persons gathered in one place by the number of hours they will spend at the same site in a given year. On the basis of limited epidemiological data, the incidence of SCA in high school athletes has been estimated at 0.5 to 1.0 SCA per 100 000 athletes per year, and that figure has been extrapolated to apply to the young population

under 35 years of age per year. That translates to 0.5 to 1.0 possible episode of SCA per 876 million *young* person-hours (100 000 young persons x 24 h/d x 365 d/y = 876 million young person-hours), compared with 1 SCA per 8.76 million *adult* person-hours based on adult risk.

To provide a rough estimate of the risk of a child's SCA in a school, calculate the number of hours that students spend in a given school per year, including all sports events and conferences. In a school of 4000 students who attend school 10 hours per day, 5 days per week, 40 weeks per year, the result is 8 million young person-hours at that school per year (4000 young persons x 10 h/d x 5 d/wk x 40 wk/y = 8 million young person-hours per year). If no other students or adults gather at that school, 1 SCA is predicted in a child or adolescent attending that school every 100 to 200 years. This calculation is likely to overestimate the number of cardiac arrests per year because it is based on risk in high school athletes; risk will likely be lower in nonathletes and elementary school children. Note that the number of hours that adults spend at the school should also be calculated to consider the risk of an adult SCA (see calculation formulas in [Table 3](#), below).

View this table: TABLE 3. Calculation Formulas
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View this table: **TABLE 4. Sample First Aid Kit**
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► **Footnotes**

The American Heart Association makes every effort to avoid any actual or potential conflicts of interest that may arise as a result of an outside relationship or a personal, professional, or business interest of a member of the writing panel. Specifically, all members of the writing group are required to complete and submit a Disclosure Questionnaire showing all such relationships that might be perceived as real or potential conflicts of interest.

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1. American Academy of Pediatrics. Guidelines for emergency medical care in school. Committee on School Health. *Pediatrics*. 2001; 107: 435-436. [[Abstract/Free Full Text](#)]
2. Samson RA, Berg RA, Bingham R, et al. Use of automated external defibrillators for children: an update. An advisory statement from the Pediatric Advanced Life

Support Task Force, International Liaison Committee on Resuscitation. *Circulation*. 2003; 107: 3250-3255. [\[Free Full Text\]](#)

3. National Association of School Nurses. Position statement: the use of automatic external defibrillators in the school setting. Available at: <http://www.nasn.org/positions/autoexterdefib.htm>. Accessed October 31, 2003.
4. Markenson DS, Domeier RM. The use of automated external defibrillators in children. National Association of EMS Physicians Pediatric Task Force and Standards and Clinical Practices Committee. *Prehosp Emerg Care*. 2003; 7: 258-264. [\[Medline\]](#)
5. Andersen J, Courson RW, Kleiner DM, et al. National Athletic Trainers' Association position statement: emergency planning in athletics. *J Athl Train*. 2002; 37: 99-104. [\[Medline\]](#)
6. American Lung Association. Asthma Alert for Teachers. Available at: http://www.lungusa.org/school/asthma_alert.html. Accessed August 21, 2003.
7. Gagliardi M, Neighbors M, Spears C, et al. Emergencies in the school setting: are public school teachers adequately trained to respond? *Prehosp Disaster Med*. 1994; 9: 222-225. [\[Medline\]](#)
8. Sapien RE, Allen A. Emergency preparation in schools: a snapshot of a rural state. *Pediatr Emerg Care*. 2001; 17: 329-333. [\[CrossRef\]](#) [\[Medline\]](#)
9. Minino AM, Smith BL. Deaths: preliminary data for 2000. In: National Vital Statistics Reports. Hyattsville, Md: National Center for Health Statistics; 2001: 1-40. DDHHS Publication Number (PHS) 2001-1120.
10. National Safety Council. 1999 Injury Facts. Itasca, Ill: National Safety Council; 1999.
11. The American Heart Association in collaboration with the International Liaison Committee on Resuscitation. Part 5: new guidelines for first aid. In: Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care.

Circulation. 2000; 102(suppl 8): I-77-I-85.

12. The American Heart Association in collaboration with the International Liaison Committee on Resuscitation. Part 9: pediatric basic life support. In: Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. Circulation. 2000; 102(suppl 8): I-253-I-290.
13. Knight S, Vernon DD, Fines RJ, et al. Prehospital emergency care for children at school and nonschool locations. *Pediatrics*. 1999; 103: e81.[[Abstract/Free Full Text](#)]
14. Newacheck PW, Strickland B, Shonkoff JP, et al. An epidemiologic profile of children with special health care needs. *Pediatrics*. 1998; 102 (1 pt 1): 117-123.[[Abstract/Free Full Text](#)]
15. McPherson M, Arango P, Fox H, et al. A new definition of children with special health care needs. *Pediatrics*. 1998; 102 (1 pt 1): 137-140.[[Free Full Text](#)]
16. Emergency preparedness for children with special health care needs. Committee on Pediatric Emergency Medicine, American Academy of Pediatrics. *Pediatrics*. 1999;104:e53. Available at: <http://pediatrics.aappublications.org/cgi/content/full/104/4/e53>. Accessed November 26, 2003.
17. Spaite DW, Conroy C, Tibbits M, et al. Use of emergency medical services by children with special health care needs. *Prehosp Emerg Care*. 2000; 4: 19-23.[[Medline](#)]
18. Schultz-Grant LD, Young-Cureton V, Kataoka-Yahiro M. Advance directives and do not resuscitate orders: nurses' knowledge and the level of practice in school settings. *J Sch Nurs*. 1998; 14: 4-10, 12-13.
19. Liberthson RR. Sudden death from cardiac causes in children and young adults. *N Engl J Med*. 1996; 334: 1039-1044.[[Free Full Text](#)]
20. Maron BJ, Thompson PD, Puffer JC, et al. Cardiovascular preparticipation screening of competitive athletes: addendum. An addendum to a statement for health professionals from the Sudden Death Committee (Council on Clinical

Cardiology) and the Congenital Cardiac Defects Committee (Council on Cardiovascular Disease in the Young), American Heart Association. *Circulation*. 1998; 97: 2294.[\[Free Full Text\]](#)

21. Maron BJ. Sudden death in young athletes. *N Engl J Med*. 2003; 349: 1064-1075.[\[Free Full Text\]](#)
22. Maron BJ, Poliac LC, Kaplan JA, et al. Blunt impact to the chest leading to sudden death from cardiac arrest during sports activities. *N Engl J Med*. 1995; 333: 337-342.[\[Abstract/Free Full Text\]](#)
23. Maron BJ, Gohman TE, Kyle SB, et al. Clinical profile and spectrum of commotio cordis. *JAMA*. 2002; 287: 1142-1146.[\[Abstract/Free Full Text\]](#)
24. Maron B, Shirani J, Poliac LC, et al. Sudden death in young competitive athletes: clinical, demographic, and pathological profiles. *JAMA*. 1996; 276: 199-204.[\[Abstract\]](#)
25. Maron BJ, Gohman TE, Aeppli D. Prevalence of sudden cardiac death during competitive sports activities in Minnesota high school athletes. *J Am Coll Cardiol*. 1998; 32: 1881-1884.[\[CrossRef\]](#)[\[Medline\]](#)
26. Myerburg RJ, Mitrani R, Interian A, et al. Identification of risk of cardiac arrest and sudden death in athletes. In: Wang PJ, ed. *Sudden Cardiac Death in the Athlete*. Armonk, NY: Futura Publishing Co; 1998: 25-56.
27. Mueller PO, Costo RC. NCCSIR Eighteenth Annual Report (National Center for Catastrophic Sports Injury Research). Chapel Hill, NC: National Center for Catastrophic Sports Injury Research; 2000.
28. Luckstead EF, Patel DR. Catastrophic pediatric sports injuries. *Pediatr Clin North Am*. 2002; 49: 581-591.[\[Medline\]](#)
29. Van Camp SP, Bloor CM, Mueller FO, et al. Nontraumatic sports death in high school and college athletes. *Med Sci Sports Exerc*. 1995; 27: 641-647.[\[Medline\]](#)

30. Corrado D, Basso C, Rizzoli G, et al. Does sport activity enhance the risk of sudden death in adolescents and young adults? A prospective population-based study. *Circulation*. 2001; 104 (suppl II): II-346. Abstract.
31. Appleton GO, Cummins RO, Larson MP, et al. CPR and the single rescuer: at what age should you 'call first' rather than 'call fast'? *Ann Emerg Med*. 1995; 25: 492-494.[\[Medline\]](#)
32. Atkinson E, Mikysa B, Conway JA, et al. Specificity and sensitivity of automated external defibrillator rhythm analysis in infants and children. *Ann Emerg Med*. 2003; 42: 185-196.[\[CrossRef\]](#)[\[Medline\]](#)
33. Cecchin F, Jorgenson DB, Berul CI, et al. Is arrhythmia detection by automatic external defibrillator accurate for children? Sensitivity and specificity of an automatic external defibrillator algorithm in 696 pediatric arrhythmias. *Circulation*. 2001; 103: 2483-2488.[\[Abstract/Free Full Text\]](#)
34. The American Heart Association in collaboration with the International Liaison Committee on Resuscitation. Part 4: the automated external defibrillator: key link in the chain of survival. In: Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Circulation*. 2000; 102(suppl 8): I-60-I-76.
35. Kannel WB, Wilson PW, D'Agostino RB, et al. Sudden coronary death in women. *Am Heart J*. 1998; 136: 205-212.[\[Medline\]](#)
36. de Vreede-Swagemakers JJ, Gorgels AP, Dubois-Arbouw WI, et al. Out-of-hospital cardiac arrest in the 1990's: a population-based study in the Maastricht area on incidence, characteristics and survival. *J Am Coll Cardiol*. 1997; 30: 1500-1505.[\[CrossRef\]](#)[\[Medline\]](#)
37. Kuisina M, Maatta T. Out-of-hospital cardiac arrests in Helsinki: Utstein style reporting. *Heart*. 1996; 76: 18-23.[\[Abstract\]](#)
38. Cummins RO, Ornato JP, Thies WH, et al. Improving survival from sudden cardiac arrest: the 'chain of survival' concept. A statement for health professionals from the Advanced Cardiac Life Support Subcommittee and the Emergency Cardiac Care Committee, American Heart Association. *Circulation*.

1991; 83: 1832-1847.[\[Medline\]](#)

39. Caffrey SL, Willoughby PJ, Pepe PE, et al. Public use of automated external defibrillators. *N Engl J Med.* 2002; 347: 1242-1247.[\[Abstract/Free Full Text\]](#)
40. Robertson RM. Sudden death from cardiac arrest—improving the odds. *N Engl J Med.* 2000; 343: 1259-1260.[\[Free Full Text\]](#)
41. Page RL, Joglar JA, Kowal RC, et al. Use of automated external defibrillators by a U.S. airline. *N Engl J Med.* 2000; 343: 1210-1216.[\[Abstract/Free Full Text\]](#)
42. Valenzuela TD, Roe DJ, Nichol G, et al. Outcomes of rapid defibrillation by security officers after cardiac arrest in casinos. *N Engl J Med.* 2000; 343: 1206-1209.[\[Abstract/Free Full Text\]](#)
43. White RD, Asplin BR, Bugliosi TF, et al. High discharge survival rate after out-of-hospital ventricular fibrillation with rapid defibrillation by police and paramedics. *Ann Emerg Med.* 1996; 28: 480-485.[\[Medline\]](#)
44. White RD, Hankins DG, Bugliosi TF. Seven years' experience with early defibrillation by police and paramedics in an emergency medical services system. *Resuscitation.* 1998; 39: 145-151.[\[CrossRef\]](#)[\[Medline\]](#)
45. White RD, Hankins DG, Atkinson EJ. Patient outcomes following defibrillation with a low energy biphasic truncated exponential waveform in out-of-hospital cardiac arrest. *Resuscitation.* 2001; 49: 9-14.[\[CrossRef\]](#)[\[Medline\]](#)
46. Bunch Tj, White RD, Gersh BJ, et al. Long-term outcomes of out-of-hospital cardiac arrest after successful early defibrillation. *N Engl J Med.* 2003; 348: 2626-2633.[\[Abstract/Free Full Text\]](#)
47. Reder S, Quan L. Cardiopulmonary resuscitation training in Washington state public high schools. *Resuscitation.* 2003; 56: 283-288.[\[CrossRef\]](#)[\[Medline\]](#)

48. Stapleton ER, Aufderheide T, Hazinski MF. Instructor's Manual: Basic Life Support. Dallas, Tex: American Heart Association; 2001.
49. National Association for Sport and Physical Education. National Standards for Athletic Coaches. Dubuque, Iowa: National Association for Sport and Physical Education; 1995.
50. Chameides L, Aufderheide T, Berlin P, et al. Heartsaver First Aid With CPR and AED. Dallas, Tex: American Heart Association; 2002.
51. School Nurse Emergency Medical Services for Children (SNEMS-C) Program. Available at: <http://www.continuingstudies.uconn.edu> Accessed October 31, 2003.
52. Hickey RW, Cohen DM, Strausbaugh S, et al. Pediatric patients requiring CPR in the prehospital setting. *Ann Emerg Med.* 1995; 25: 495-501. [[Medline](#)]
53. Sirbaugh PE, Pepe PE, Shook JE, et al. A prospective, population-based study of the demographics, epidemiology, management, and outcome of out-of-hospital pediatric cardiopulmonary arrest. *Ann Emerg Med.* 1999; 33: 174-184. Erratum in: *Ann Emerg Med.* 1999;33:358. [[Medline](#)]
54. Stapleton ER, Aufderheide T, Hazinski MF. Heartsaver CPR in the Schools. Dallas, Tex: American Heart Association; 2001.
55. Maternal and Child Health Bureau. Basic Emergency Lifesaving Skills (BELLS): A Framework for Teaching Emergency Lifesaving Skills to Children and Adolescents. Newton, Mass: Children's Safety Network, Education Development Center, Inc; 1999.
56. Gold MR, Siegel JE, Russell LB, et al. Appendix A: Summary Recommendations. In: Gold MR, ed. Cost-Effectiveness in Health and Medicine. New York, NY: Oxford University Press; 1996: 425.
57. Nichol G, Hallstrom AP, Kerber R, et al. American Heart Association report on the second public access defibrillation conference, April 17-19, 1997.

Circulation. 1998; 97: 1309-1314.[\[Free Full Text\]](#)

58. Nichol G, Hallstrom AP, Ornato JP, et al. Potential cost-effectiveness of public access defibrillation in the United States. *Circulation*. 1998; 97: 1315-1320.[\[Abstract/Free Full Text\]](#)
59. Tengs TO. Dying Too Soon: How Cost-Effectiveness Analysis Can Save Lives. Dallas, Tex: National Center for Policy Analysis; 1997.
60. Portable Heart Defibrillators: Medical/Health Loss Control Bulletin #43a. Buriem, Wash; Washington School Risk Management Pool; 2002.
61. Ornato JP, McBurnie MA, Nichol G, et al. The Public Access Defibrillation (PAD) trial: study design and rationale. Public Access Defibrillation Trial Investigators. *Resuscitation*. 2003; 56: 135-147.[\[CrossRef\]](#)[\[Medline\]](#)

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Everyday Heroes

Beyond the Swimming Pool: High School Student Prepared to Help Thanks to Red Cross Training
Written by Kristine Ripley

Seventeen-year-old Mary Isely was working at the Astro Movie Theatre, in Clemson, South Carolina, when she sprung into action with the skills she learned as part of her American Red Cross lifeguard training. For the last four years, Mary had renewed her American Red Cross CPR certification in order to continue to lifeguard. One fall night she was able to apply this knowledge beyond the swimming pool.

As Mary helped moviegoers with popcorn and soft drinks, a woman frantically rushed into the theatre lobby yelling for people to call 911. A baby in the parking lot was having trouble breathing. Mary hesitated for a moment but knew she could help. She raced out to the baby. Mary determined that the 8-month-old baby girl had a blocked airway. She later described to *The Greenville News* how the infant looked. "Her face was beet red and there was tears coming out of her eyes but there was no sound."

Mary flashed back to her Red Cross training. She held the baby as she was taught. She then provided about four cycles of back blows and chest thrusts just like she had recently practiced on a manikin. Mary was so relieved to hear the baby cry. This meant the baby was able to breathe once again. Emergency Medical Services arrived, verified the infant was all right, and Mary returned to work.

Mary Isely has been awarded the American Red Cross Certificate of Merit for her heroic actions. This is the highest award given by the American Red Cross to individuals who save or sustain a life using skills they learned in an American Red Cross Health and Safety Course. The President of the United States signs the certificate.

Everyday Heroes

A Teenager is Prepared to Save the Life of His Next Door Neighbor

Written by Kristine Ripley

Seventeen-year-old L.C. Mixon was in his room watching television. His neighbor, Cookie Henderson, rushed into his apartment screaming she needed help. She found her 22-month-old son, Ricky Henderson, face down in the blow-up baby pool and he was unconscious in her apartment. L.C. said his "heart dropped."

Ricky had been playing in his wading pool when Ricky's mother turned away for about 30 seconds to help her two-year-old daughter who had fallen off an inner tube into the water. Ms. Henderson turned back around and found Ricky face down in the pool and not moving. She brought him inside, called 9-1-1 and dropped the phone in the middle of the conversation to run next door for help.

L.C. had been trained in American Red Cross CPR in his health class at Granite Hills High School in Apple Valley, California just the year before. L.C. immediately went over to the Henderson's apartment and found the infant lying motionless on the floor. L.C. determined Ricky was not breathing but had a pulse. He provided rescue breaths for about two minutes at which point the victim began to cough and vomit. L.C. then rolled Ricky onto his side. He told Ms. Henderson to keep talking to her son as he went outside to direct the paramedics. Ricky was air transported to the hospital and recovered fully. After the save, L.C. went and thanked his American Red Cross CPR instructor. The teenager believes his neighbor would have died if he had not received the training. He thought that in an emergency he would not remember what he was taught—but he did. He remembered his instructor telling the students to remain calm and to remember the manikin they worked on in class.

For his heroic efforts, L.C. has been awarded the American Red Cross Certificate of Merit. This is the highest award given by the American Red Cross to individuals who save or sustain a life using skills they learned in an American Red Cross Health and Safety Course. The President of the United States signs the certificate.

More Everyday Heroes Stories

GIRLS BREATHE LIFE INTO DAD



Nine-year-old Tori Martin enjoys the life she saved, her proud father, Leonard "Joe" Martin Jr. of Arnaudville.

Photo by Freddie Herpin

Skill and quick thinking saves Arnaudville man's life

By William Johnson
wjohnson@dailyworld.com

Proud of what she had learned, 9-year-old Tori Martin wanted to practice CPR on her father ... just for fun. A little busy at the time, Leonard "Joe" Martin Jr., said no.

Two weeks later, Tori would get the chance to perform CPR on her father, though this time it wasn't practice.

Tori and her 14-year-old sister Michelle used their newly-acquired skill to save their father's life after he had

passed out and stopped breathing inside their Arnaudville home. With maturity and patience beyond their years, Tori and Michelle, still groggy from having to wake up at 2 a.m., immediately went into action — Michelle doing the chest work and Tori breathing air into her father's lungs.

"Thank God they were there," said a grateful mother and wife, Pauline Martin. "I'm so proud of them."

Pauline Martin said that

night her husband wasn't feeling well. She decided he needed to go to the emergency room, so she woke up her two daughters to get them ready.

"He was coming out of the bathroom. He was real, real pale," she remembers. "Then he collapsed on the bed. I was in a state of shock. I didn't know what to do."

She turned to her daughters for help.

Tori had just learned how to do CPR thanks to her Arnaudville Elementary phys-

"Thank God they were there. I'm so proud of them."

Pauline Martin

Wife of Leonard and mother of Tori and Michelle

ical education teacher, Edie LeBlanc. Her big sister didn't have the same training but knew what to do thanks to TV.

"She watches ER and CSI and I watched Order," Tori said.

Tori said she and her sister performed CPR for about three minutes, though it

See Daughters Page 5A

Daughters

Continued from Page 1A

seemed like an hour according to their mother.

"Then he finally came back alive," Tori said, smiling.

An ambulance eventually arrived and rushed Martin to Doctors' Hospital in Opelousas, where he would spend the next two days in intensive care undergoing tests.

"He's back home now. He's doing fine," Pauline Martin said.

Leonard Martin Sr., who lives next door to his son and grandchildren, is recommending his granddaughters for the Young Hero's Lifesaving Award, which is given out by the VFW, where he is a member.

Dr. Mohamed Khan with the Cardiovascular Institute of the

South said they deserve it. He is a big believer in bystander CPR.

"I'm proud of these young girls for being such heroes. They showed real strength, fortitude and courage in helping their father," Khan said.

He said CPR needs to be started within four to seven minutes after a heart attack, long before an ambulance can arrive, are the most critical.

"Bystander CPR is probably the most important link in the chain of survival," Khan said.

He said CPR needs to be started within four to seven minutes after an attack to prevent brain damage. If it isn't started within 10 minutes, the chance of death is greatly increased.

"Even a 12-year-old can compress the chest enough to provide 30 percent of blood flow. That is adequate to prevent brain death and provide time for

CPR class

To register for free CPR classes, call (877) 288-0011.

the ambulance to get there," Khan said. "Maybe the example of these two young girls will encourage other students and families members to learn CPR. They too could become someone's hero."

For anyone who wants to learn this lifesaving skill, Dr. Khan will sponsor the second annual "Keep the Beat" free CPR training class Feb. 26 at Opelousas Catholic School.

"We trained 275 people last year. I hope we will have a huge turnout this year," Khan said. To register for the free class call (877) 288-0011.

LEGISLATIVE RESEARCH REPORT

SEPTEMBER 15, 2004



REPORT NUMBER 05.005

STATE REQUIREMENTS FOR CPR TRAINING IN SCHOOLS

PREPARED FOR REPRESENTATIVE KEVIN MEYER

BY CHUCK BURNHAM, LEGISLATIVE ANALYST

You asked about cardiopulmonary resuscitation (CPR) training in schools. Specifically, you wanted to know which states require school districts to provide students CPR training as part of the curriculum.

Our research found only one state, Texas, that requires school districts to provide CPR training to students.¹ Texas House Bill 821, 2001, provided that students be trained in CPR at least once at the ninth grade level or above only if sufficient funding and resources are available to the district (Tex. Ed. Code § 29.903(b)). At least one other state, New York, has considered bills requiring CPR training for students.² We include, as Attachment A, Texas HB 821 (2001) and New York State Assembly Bill 9595-A (2004).

While state laws mandating CPR training for students are not common, a number of school districts, in conjunction with the American Heart Association (AHA) and local advocates, provide training to students. Through its "Heart Saver CPR in Schools" program, the AHA provides school districts with materials, information, and assistance in developing CPR and automated external defibrillation training programs. It is the goal of the AHA to have implemented the Heart Saver program in ten percent of high schools by 2005. We include, as Attachment B, a copy of the American Heart Association's, "Heart Saver CPR in Schools: How-To Guide."

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

¹ Suzanne Smith, American Heart Association Advocacy Consultant, (214) 706-1404, indicated that Louisiana had statutory language requiring CPR training for students, but that the law was not enforced. Our research of Louisiana statute, however, found no such law on record.

² As you may know, a number of states require CPR training for teachers and school staff. In addition, some states require that school districts offer classes at schools, but do not mandate student training as part of the curriculum.

Attachment A

Texas House Bill 821, 2001
New York State Assembly Bill 9595-A, 2004

Office of House Bill Analysis H.B. 821
by: Giddings
Public Education
7/10/2001
Enrolled

BACKGROUND AND PURPOSE

The American Heart Association estimates that each day more than 95 percent of Americans who suffer sudden cardiac arrest die before reaching the hospital. Additionally, at least 50,000 lives could be saved each year if the national sudden cardiac arrest survival rate could be increased from five percent to 20 percent or higher. One course of action that might increase survival rates is the chain of survival, a four-step process of providing treatment to victims of sudden cardiac arrest which includes administering cardiopulmonary resuscitation (CPR). More lives could potentially be saved if more people were skilled in CPR. House Bill 821 requires each school district in Texas to provide CPR instruction to its students to the extent that donations from the Texas Education Agency and other donations are available.

RULEMAKING AUTHORITY

It is the opinion of the Office of House Bill Analysis that rulemaking authority is expressly delegated to the commissioner of education in SECTION 1 (Section 7.025, Education Code) and SECTION 2 (Section 29.903, Education Code) of this bill.

ANALYSIS

House Bill 821 amends the Education Code to require each school district to provide to CPR instruction to students to the extent that donations from the Texas Education Agency (TEA) and other donations, including equipment, are available to the district for that purpose. The bill authorizes TEA to accept donations, including equipment, for use in providing CPR instruction to students and requires TEA to distribute the donations to districts that provide the instruction. TEA is authorized to use a portion of the donations to pay administrative expenses related to the donations. H.B. 821 authorizes the commissioner of education to adopt rules as necessary to implement the provisions of this bill.

EFFECTIVE DATE

June 14, 2001.

New York State
ASSEMBLY
Sheldon Silver - Speaker

Monday, September 13, 2004

Bill Text - A09595

[Back](#) | [New York State Bill Search](#) | [Assembly Home](#)

[See Bill Summary](#)

STATE OF NEW YORK

9595--A

IN ASSEMBLY

January 29, 2004

Introduced by M. of A. WEISENBERG, BENJAMIN, GREENE, LAVELLE, ORTIZ --
Multi-Sponsored by -- M. of A. BOYLAND, CAHILL, CLARK, COLTON, DINOW-
ITZ, GRANNIS, GRODENCHIK, HOOPER, JACOBS, LAFAYETTE, LOPEZ, MAYERSOHN,
NOLAN, PHEFFER, ROBINSON, SCARBOROUGH, SIDIKMAN, SWEENEY, WRIGHT --
read once and referred to the Committee on Education -- committee
discharged, bill amended, ordered reprinted as amended and recommitted
to said committee

AN ACT to amend the education law, in relation to the instruction of
cardiopulmonary resuscitation and the use of automated external defi-
brillators in high schools

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEM-
BLY, DO ENACT AS FOLLOWS:

- 1 Section 1. Section 904-c of the education law, as added by chapter 269
2 of the laws of 1999, is amended to read as follows:
3 S 904-c. Cardiopulmonary resuscitation instruction. 1. Instructions
4 regarding cardiopulmonary resuscitation (may) MUST be (offered for
5 voluntary admission) INCLUDED as a part of the health education curric-
6 ulum in all senior high schools. In addition to the requirement that all
7 teachers of health education shall be certified to teach health, persons
8 instructing pupils in cardiopulmonary resuscitation shall possess valid
9 certification by an agency offering such certification in the perform-
10 ance of cardiopulmonary resuscitation and in its instruction.
11 2. The commissioner may prescribe regulations governing such health
12 education courses which shall include instruction in cardiopulmonary
13 resuscitation. Such regulations shall in no event prescribe a course of
14 study in cardiopulmonary resuscitation which sets forth standards for
15 instruction of a lesser quality than the requirements of the programs
16 adopted by the American Heart Association or the American Red Cross.
17 3. School authorities (that choose to offer such course) shall
18 provide, OR MAKE THE REQUIRED ARRANGEMENTS FOR, the needed facilities,
19 time and place for the instruction set forth herein and shall provide,
20 OR MAKE THE REQUIRED ARRANGEMENTS FOR, learning aids and curriculum
21 resource materials to support such course of study.

EXPLANATION--Matter in *ITALICS* (underscored) is new; matter in brackets
() is old law to be omitted.

LBD16113-02-4

Attachment B

American Heart Association, "Hearsaver CPR in Schools: How-To Guide,"
available online through www.americanheart.org

American Heart
Association



Fighting Heart Disease and Stroke

Heartsaver CPR

in Schools

How-To Guide



CPR in Schools

Introduction

The Heartsaver CPR in Schools program can significantly increase the number of lay bystanders who recognize the signs of an emergency, know when to phone 911, and know how to perform cardiopulmonary resuscitation (CPR). The more bystanders who phone 911 when an emergency develops and know how to perform CPR, the more likely it is that victims of sudden cardiac arrest will receive immediate CPR, early defibrillation and advanced life support. These interventions have been proven to significantly reduce disability and death from heart attack and sudden cardiac arrest.

By educating lay bystanders, the Heartsaver CPR in Schools program can also reduce disability from stroke. A prompt call to 911 will shorten the time for a stroke victim's arrival in a hospital emergency room. There the victim may be eligible for treatment with new clot-busting drugs, which can substantially reduce the permanent disability caused by stroke.

This guide provides a framework to help school systems and/or individual schools implement the Heartsaver CPR in Schools program. The actual implementation structure will vary among communities, depending on the key players involved (e.g., school contacts, training center coordinators/instructors and community contacts) in the implementation process. Heartsaver CPR in Schools is a complex program to implement and requires the collaboration of individuals from various disciplines. This *Heartsaver CPR in Schools: How-To Guide* is designed to answer most questions about getting started, who the key players are, and the nature of their roles.

Heartsaver CPR in Schools is based on the latest scientific evidence and has been successfully piloted and field-tested. The curriculum and course materials are designed specifically for high school students.



Started

This section provides a course description, the different teaching models, course options, course materials and equipment requirements. Each school will select a training model and the course option best suited to its requirements, funding and available time.

Course Description

The Heartsaver CPR in Schools course is designed to teach students CPR skills in the classroom setting.

The course is about 4 to 5 hours long, depending on the sections covered. It is designed to be taught over multiple class periods of about 40 minutes each.

Following is an outline of course topics:

- The chain of survival and warning signs of heart attack, cardiac arrest, stroke and choking
- The importance of calling 911
- Techniques of adult and pediatric CPR (the ABCs)
 - **A**irway: Open the airway
 - **B**reathing: Check for breathing and provide rescue breaths if needed
 - **C**irculation: Check for signs of circulation and begin chest compressions and cycles of compressions and ventilations if needed
 - Relief of choking
- Child safety and injury prevention
- Optional: Review of automated external defibrillation (AED)
- Optional: Infant CPR and relief of infant choking

Training Models

Schools may use any of several Heartsaver CPR in Schools training models to teach CPR. The three basic models currently in use are the training center

model, the teacher/instructor model, and the peer-to-peer teaching model. Each of the training models, the cost factors associated with each, and strategies for reducing costs are described below.

*Training Center Model**

- The Training Center (TC) provides schools with instructors and equipment to train students in CPR.
 - Usually training takes place during a 1-day mass training event, in which one or multiple grades are trained.
- The TC provides schools with instructors and equipment to train students in CPR during scheduled class time (e.g., health or physical education class).
 - The course is taught over a few weeks during a number of class periods.
- In both examples the TC provides course completion cards.

Strategies related to the TC model:

If the TC provides the schools with instructors and equipment at no cost, the only expense the school has is training materials. In some cases the TC may provide the equipment but charge for the instructor's time. These issues should be addressed during the meeting between the school decisionmaker and the TC representative. This model can also be used if a TC cannot adopt a school, but outside funding is available to cover training costs.

* Training centers are community organizations that provide American Heart Association courses to the public. American Heart Association training centers are typically hospitals, EMS and fire departments, private ambulance companies, community colleges and universities. A number of school districts in the United States are American Heart Association training centers.

Option 2: Heartsaver CPR Certification Adult Only

This Heartsaver CPR Course covers everything except infant CPR and choking. (Note: All participants should review the child section of the pediatric video and practice child skills even if they need to use an adult manikin.)

Option 3: Heartsaver CPR Certification Including AED Overview

This Heartsaver CPR course includes an overview of AEDs. Students will not receive AED certification for this course; instead they will only receive a Heartsaver CPR Course Completion Card. Students who want to take an AED course can do so if the school offers the complete course, or they can take it at a local training center.

Option 4: Heartsaver CPR in Schools Course Participation (No Examination)

In some cases, because of time constraints or financial limitations, a teacher may conduct a review of the course and not cover all the material. In this case students will receive a certificate of participation rather than a Heartsaver CPR Course Completion Card. Completion of a written examination is not required in this situation.

Scenario Cards, Performance Criteria and Exam Information

Heartsaver CPR Scenario Cards — BLS Instructor's Manual (Part 3, Appendix C).

Heartsaver CPR Skill Practice Sheet — BLS Instructor's Manual (Part 3, Appendix A, 3-7 through 3-16 — BLS Performance Criteria).

Heartsaver CPR Exam — The exam will be provided by the sponsoring training center.

Heartsaver CPR Course Completion Cards — Provided by the sponsoring training center.

Instructor Course Description

Basic Life Support Instructor Course

The current requirements to teach the AHA Heartsaver CPR in Schools course are the same as teaching any AHA Basic Life Support (BLS) course. The potential instructor of a Heartsaver CPR in Schools course must take the standard 2-day BLS Instructor Course. This course covers these topics:

- The American Heart Association training network
- BLS science
- Strategies for teaching CPR
- Watch-then-practice videos
- Scenario practice
- Principles of written examinations
- BLS course options
- Principles of remedial instruction
- Provider course administration
- Maintenance and decontamination of manikins
- Instructor candidate presentations
- Instructor written examination

The prerequisite for entry into the BLS Instructor Course is a valid American Heart Association BLS Healthcare Provider Card or the Red Cross equivalent.

Note: The American Heart Association's Emergency Cardiovascular Care (ECC) Committee is developing ways to streamline the current BLS Instructor Course specifically to meet the needs of instructors of lay rescuers. The new course will be for instructors who will not be teaching healthcare providers or who already have a professional education background. This may affect the requirements listed above.

Session 5: Infant Skills (Optional — 40 minutes)

Infant Watch-Then-Practice Video Instruction	40 minutes
<i>Infant Skills</i>	
Mouth-to-mouth-and-nose	8 minutes
Signs of circulation, chest compressions	8 minutes
1-rescuer CPR	8 minutes
FBAO responsive	8 minutes
Review infant/child CPR	8 minutes

Session 6: Review Adult, Child and (Optional) Infant Skills (40 minutes)

Review of Adult, Child and (Optional) Infant CPR	40 minutes
Adult 1-rescuer CPR	6 minutes
Adult FBAO responsive	6 minutes
Child 1-rescuer CPR	6 minutes
Child FBAO responsive	6 minutes
Infant 1-rescuer CPR	6 Minutes
Infant FBAO responsive	6 minutes
Questions and discussion	4 minutes

Session 7: Written Examination and Skills Evaluation (40 minutes)

Adult, Child and (Optional) Infant CPR Evaluation	40 minutes
Group A: skills evaluation	
Group B: written evaluation and course evaluation	
(Half of the class completes the written examination/course evaluation while half of the class takes the practical evaluation. The groups switch in the next session.)	

Session 8: Written Examination and Skills Evaluation (40 minutes)

Adult, Child and (Optional) Infant CPR Evaluation	40 minutes
Group A: written evaluation and course evaluation	
Group B: skills evaluation	
(Half of the class completes the written examination/course evaluation while half of the class takes the practical evaluation.)	

Total course time range:	4 to 5 hours
---------------------------------	---------------------

supplemental material for teaching the course. These overheads cover the anatomy and functions of the heart, signs and signals of cardiac arrest and stroke, techniques of adult and pediatric CPR (ABCs), and child safety and injury prevention.

Manikins

The recommended ratio of manikins to students is 1 manikin to 4 students. For example, a class of 32 students requires 8 manikins for skills practice and 1 more manikin for the instructor to use during demonstrations.

Training manikins are designed to simulate a victim of cardiac arrest. Manikins used for CPR training should be realistic. The manikin airway should open and close, the chest should rise and fall as ventilations are given, and the chest must have proper landmarks to ensure accurate hand position for chest compressions. The more realistic the manikin, the better prepared the student will be for a real-life situation. The manikin should be specifically designed for practicing the skills required to perform CPR and relief of choking.

Before skills practice, make sure that students remove chewing gum and lipstick. Use manikin face shields, which provide three benefits: (1) they serve as an extra barrier between the student and manikin, (2) they help keep manikin faces cleaner, and (3) they give students an opportunity to learn how to use a barrier device.

Sanitation requirements for manikins vary. Some require that airways be changed after each use by a student or at the end of each CPR class. Each student is issued a removable manikin face that is either theirs to keep or to clean at the end of each class and then reuse. Alternatively, the manikin face is not removed but is wiped down with an appropriate bleach or alcohol solution between each student use.

Barrier Devices

The Heartsaver CPR in Schools course contains information about using barrier devices. The American Heart Association recommends that each student receive a manikin barrier device for skills practice and a barrier device to keep for use in an emergency.

Space Requirements

The course is designed to be taught in the classroom setting. There must be sufficient floor space for students to work in groups of three to four in a circle, with the manikin in the middle.

Optional Training Equipment: Automated External Defibrillator (AED) Trainer

AED trainers are designed to safely simulate an actual AED and are used to train individuals to use AEDs.

Where To Buy Training Materials

Heartsaver CPR in Schools training materials can be purchased through the following distributors or local American Heart Association training centers:

Channing L. Bete

800-611-6083
200 State Road
South Deerfield, MA 01373

Laerdal Medical Corporation

888-LMC-4AHA
167 Myers Corners Road
PO Box 1840
Wappingers Falls, NY 12590

WorldPoint ECC

888-322-8350
151 S Pfingsten Road, Suite E
Deerfield, IL 60015

CPR in Schools Programs

Finding funding for new programs is often the hardest part of implementation. This section gives information about costs and possible funding sources.

Implementation Budget

The greatest expense for implementing a Heartsaver CPR in Schools program is in the first year. Costs include training teachers to be instructors, using substitute teachers during training, and purchasing manikins, accessories, training materials and course cards. This initial outlay varies depending on the size of the school and the number of students trained at the same time. The ongoing cost per year is calculated by multiplying the cost of training materials by the number of students being trained.

Successful CPR programs in schools where CPR training is integrated into the curriculum have taken

years to develop. Allow at least a few years to incorporate a Heartsaver CPR program into the school curriculum. We recommend that an implementation budget be based on a 3-year period. Below is a sample implementation budget for a school training 200 students per year for 3 years. The total estimated cost of \$5,475 also includes instructor training, use of substitute teachers, re-certification after 2 years, and training equipment and materials. The Heartsaver CPR in Schools Budget Worksheet can be modified to determine the implementation cost for training a specific number of teachers and students and purchasing equipment for one or multiple schools.

Implementation Cost	Cost	Quantity	1st Yr	2nd Yr	3rd Yr	3-Year Total
Instructor Training						
Teacher training*	\$250 x	2 (# teachers)	\$500		\$500	\$1,000
Substitute teachers	\$175 x	2 (# teachers)	\$350		\$350	\$700
Training Equipment						
Manikins**	\$1,400	manikins	\$1,400			\$1,400
Miscellaneous accessories***	\$1.25 x	200 (# students)	\$250	\$250	\$250	\$750
Training Materials						
Instructor toolkit	\$100 x	2 (# teachers)	\$200			\$200
Student manual	\$1 x	200 (# students)	\$200	\$200	\$200	\$600
Heartsaver CPR card	\$1 x	200 (# students)	\$200	\$200	\$200	\$600
Set of Heartsaver CPR texts****	\$7.50 x	30 (class size)	\$225			\$225
			\$3,325	\$650	\$1,500	\$5,475

*Cost varies by region. **This is an estimated cost and will vary depending on brand purchased. ***Airways, faces, manikin face shields. ****It is recommended that a classroom set of Heartsaver CPR textbooks be purchased as reference materials.

Sponsorship Opportunities and Costs

The implementation cost is within dollar amounts that can be reasonably solicited from local businesses, corporations or fraternal/civic organizations. Schools can also look to internal school organizations, such as the PTA or PTO, for funding. Schools can seek funding through grants,² too.

¹CPR in Schools Budget Worksheet

²Sample funding proposals templates

Asked Questions

What is Heartsaver CPR in Schools?

Heartsaver CPR in Schools is a new American Heart Association CPR course to teach high school students CPR skills. The approximately 4–5 hour course can be taught over multiple class periods of 40 minutes. The primary audience is 9th and 10th grade students. The American Heart Association's goal is to implement Heartsaver CPR in Schools in 10 percent of public and private high schools by 2005 and to train more than 1 million students in CPR.

Why is Heartsaver CPR in Schools so important?

Decades of medical research show that a certain sequence of events must occur to give victims of cardiac arrest, heart attack or stroke the best chances of survival. This chain of survival includes early access (calling 911), early CPR, early defibrillation and early advanced life support (paramedics). Most cardiac arrests occur suddenly, with little warning. Many occur at home and are witnessed by family members who are unprepared to respond. CPR training prepares family members to deal with a cardiac arrest emergency and creates a teachable moment for heart-health education. Targeting youth for CPR training allows its early introduction as a life skill.

Who will implement Heartsaver CPR in Schools?

Implementing this program requires collaboration among teachers, administrators, community training centers, and organizations such as the American Heart Association. Heartsaver CPR in Schools can be

incorporated into a school's health, science and/or physical education curriculum, making it a challenging program to implement.

What are the benefits of teaching students CPR?

- Teaches students what to do if a parent suffers a cardiac arrest, heart attack or stroke.
- Teaches students what to do if a sibling is involved in a drowning emergency, or a schoolmate chokes or suffers a breathing emergency.
- Teaches CPR as a life skill and provides a certificate.
- Teaches responsibility, builds self-esteem, saves lives.
- Builds partnerships among community groups, elected officials, the health sector and school boards.

Who teaches the Heartsaver CPR in Schools course to students?

Schools can choose from various training models to teach their students Heartsaver CPR in Schools. Three basic models now used are Teacher/Instructor, Training Center (TC) and Peer Teaching Model.

Teacher/Instructor Model

- Teachers are trained as American Heart Association Basic Life Support (BLS) instructors by a Training Center.
- Teachers then incorporate the Heartsaver CPR in Schools course into their class curriculum.
- Training Center provides course-completion cards once a teacher presents names of students who have successfully completed the course skill performance and exam.

LEGISLATIVE RESEARCH REPORT

SEPTEMBER 29, 2004



REPORT NUMBER 05.019

FIRST AID TRAINING IN SCHOOLS

PREPARED FOR REPRESENTATIVE KEVIN MEYER

BY CHUCK BURNHAM, LEGISLATIVE ANALYST

You asked about mandatory first aid training in schools. Specifically, you wanted to know which states have laws requiring school districts to provide first aid training to students

At least six states have legal provisions for first aid instruction in schools.¹ Laws in three of these states—Illinois, Oklahoma, and Pennsylvania—provide that first aid training "may be" included in schools, but do not require first aid training for all students. Law in another state—Massachusetts—requires training in the administration of first aid, but allows local school committees to exclude such training with a simple majority vote. We found just two states—Connecticut and North Carolina—that require by law first aid training for all students.²

The statewide curriculum published by the North Carolina Department of Education calls for fourth grade students to receive training in performing the Heimlich maneuver for choking victims. In grade five, students are trained in providing basic first aid for common minor injuries. The Connecticut Department of Education's school health and safety program calls for increasingly complex first aid training as students progress through grade levels K-12.³

While state mandated curricula is not common—local decisions and local control are generally considered appropriate—the U.S. Department of Education and the American Red Cross have expressed interest in expanding first aid training in schools part of the U.S. government's overall emergency preparedness strategy. In May, 2003, those organizations jointly sponsored a pilot

¹ Jeanne Kaufmann, Policy Specialist with the National Conference of State Legislatures, performed a search of all fifty states' education laws for required first aid programs. Ms. Kaufmann, whose findings are included in this report, can be reached by telephone at (303) 364-7700.

² We include, as Attachment A, copies of Connecticut General Statute §10-16b and North Carolina General Statute §115-81(e1).

³ The North Carolina "Healthful Living Education" curriculum guide can be found online at <http://sbepolicy.dpi.state.nc.us/>. The Connecticut "Health and Safety Education Curriculum Guide" is available at www.state.ct.us/sde/dti/curriculum/frhth.pdf.

program certifying teachers in Montgomery County, Maryland, schools in basic first aid. The teachers, in turn, taught students a two hour first aid course designed by the American Red Cross. The program's developers intended that it eventually be implemented in school districts nationwide. Bill Modzeleski, Associate Deputy Under Secretary, U.S. Department of Education, Office of Safe and Drug Free Schools, however, states that the pilot program has not yet been expanded and there currently are no plans to do so.⁴

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

⁴ Mr. Modzeleski can be reached by email at Bill.Modzeleski@ed.gov

Attachment A

Connecticut General Statute §10-16b
North Carolina General Statute §115-81(e1)

**Connecticut
Sec. 10-16b.**

Prescribed courses of study. (a) In the public schools the program of instruction offered shall include at least the following subject matter, as taught by legally qualified teachers, the arts; career education; consumer education; health and safety, including, but not limited to, human growth and development, nutrition, first aid, disease prevention, community and consumer health, physical, mental and emotional health, including youth suicide prevention, substance abuse prevention, safety, which may include the dangers of gang membership, and accident prevention; language arts, including reading, writing, grammar, speaking and spelling; mathematics; physical education; science; social studies, including, but not limited to, citizenship, economics, geography, government and history; and in addition, on at least the secondary level, one or more foreign languages and vocational education. For purposes of this subsection, language arts may include American sign language or signed English, provided such subject matter is taught by a qualified instructor under the supervision of a teacher who holds a certificate issued by the State Board of Education.

(b) If a local or regional board of education requires its pupils to take a course in a foreign language, the parent or guardian of a pupil identified as deaf or hearing impaired may request in writing that such pupil be exempted from such requirement and, if such a request is made, such pupil shall be exempt from such requirement.

(c) Each local and regional board of education shall on September 1, 1982, and annually thereafter at such time and in such manner as the Commissioner of Education shall request, attest to the State Board of Education that such local or regional board of education offers at least the program of instruction required pursuant to this section, and that such program of instruction is planned, ongoing and systematic.

(d) The State Board of Education shall make available curriculum materials and such other materials as may assist local and regional boards of education in developing instructional programs pursuant to this section. The State Board of Education, within available appropriations and utilizing available resource materials, shall assist and encourage local and regional boards of education to include: (1) Holocaust education and awareness; (2) the historical events surrounding the Great Famine in Ireland; (3) African-American history; (4) Puerto Rican history; (5) Native American history; (6) personal financial management; and (7) topics approved by the state board upon the request of local or regional boards of education as part of the program of instruction offered pursuant to subsection (a) of this section.

(P.A. 78-218, S. 11; 78-303, S. 85, 136; P.A. 79-128, S. 13, 36; P.A. 80-166, S. 2; P.A. 89-133, S. 1, 2; 89-185, S. 1, 2; P.A. 93-416, S. 6, 10; P.A. 95-101, S. 1; P.A. 97-45, S. 1; 97-61, S. 1.)
History: P.A. 78-303 allowed substitution of commissioner of education for secretary of state board of education in accordance with P.A. 77-614, S. 302, effective January 1, 1979; P.A. 79-128 replaced specific subject listings with more general subject matter areas and added Subsecs. (b) and (c); P.A. 80-166 changed initial date in Subsec. (b) from "in 1981" to "on September 1, 1982"; P.A. 89-133 in Subsec. (a) added provision that language arts may include certain sign languages, added new Subsec. (b) providing an exemption from foreign language requirements for deaf or hearing impaired pupils and relettered Subsecs. (b) and (c) as Subsecs. (c) and (d); P.A. 89-185 in Subsec. (a) added the subjects which health and safety education shall include but not be limited to; P.A. 93-416 amended Subsec. (a) to provide that "safety" may include the dangers of gang membership, effective June 29, 1993; P.A. 95-101 added provision concerning Holocaust education and awareness in Subsec. (d); P.A. 97-45 amended Subsec. (d) to add provision concerning the Great Famine in Ireland; P.A. 97-61 amended Subsec. (d) to expand the list of topics for programs of instruction to include African-American History, Puerto-Rican History, Native American History, personal financial management and topics approved by the State Board of Education at the request of local or regional boards of education.

See Sec. 10-19 re courses concerning effects of alcohol, nicotine or tobacco and drugs.

See Sec. 10-221a re high school graduation requirements.

See Sec. 29-7n(a) re definition of "gang".

Cited. 187 C. 187, 190. Cited. 195 C. 24, 26, 27, 29, 31, 34, 35, 38. Cited. 238 C. 1.

Subsec. (a):

Cited. 195 C. 24, 33, 41, 42.
Cited. 44 CA 179.

North Carolina
115C-81. Basic Education Program.

(e1) School Health Education Program to Be Developed and Administered.

(1) A comprehensive school health education program shall be developed and taught to pupils of the public schools of this State from kindergarten through ninth grade. This program includes age-appropriate instruction in the following subject areas, regardless of whether this instruction is described as, or incorporated into a description of, "family life education", "family health education", "health education", "family living", "health", "healthful living curriculum", or "self-esteem":

- a. Mental and emotional health;
- b. Drug and alcohol abuse prevention;
- c. Nutrition;
- d. Dental health;
- e. Environmental health;
- f. Family living;
- g. Consumer health;
- h. Disease control;
- i. Growth and development;
- j. First aid and emergency care, including the teaching of cardiopulmonary resuscitation (CPR) and the Heimlich maneuver by using hands-on training with mannequins so that students become proficient in order to pass a test approved by the American Heart Association, or American Red Cross;
- k. Preventing sexually transmitted diseases, including Acquired Immune Deficiency Syndrome (AIDS) virus infection, and other communicable diseases;
- l. Abstinence until marriage education; and
- m. Bicycle safety.

Ruth Keller

From: Chuck Burnham
Sent: Friday, February 18, 2005 3:49 PM
To: Ruth Keller
Subject: FW: Legislative research: CPR/first aid training in Alaska schools

Hi Ruth - I'm forwarding an email containing costs estimates from the Red Cross of Alaska. It appears the "Full Service Option" is fairly straight forward; schools would pay the Red Cross, which would supply all training and materials. It is not clear to me if travel expenses for instructors is included in these prices, but I was not sure if you wanted that cost to be considered. If so, let me know.

The "Authorized Provided Option" is a bit more complex as there are a number of variables to consider. The prices quoted do not take into account replacement costs for materials, travel costs for training instructors, or staff/instructor wages during classes. Again, I'm uncertain which of these "other" aspects you want to include in your per student cost estimate.

From my perspective, these figures do not appear to capture all of the expenses that would likely be associated with either option. Nonetheless, they are the best information I have found thus far.

Let me know if you have further questions or need additional information. Alternatively, if confidentiality is not an issue, you can directly contact Shad Engkilterra, who provided the cost figures below. He has been very helpful and has indicated his willingness to offer any further assistance we need.

Have a great holiday weekend -

Chuck Burnham, Legislative Analyst
Legislative Research Services
State Capitol
Juneau, AK 99801
907-465-3991
907-465-3908 (fax)
chuck.burnham@legis.state.ak.us

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From: Engkilterra, Shad [mailto:EngkilterraS@usa.redcross.org]
Sent: Friday, February 18, 2005 3:36 PM
To: Chuck Burnham
Cc: Smith, Michael (Anchorage)
Subject: RE: Legislative research: CPR/first aid training in Alaska schools

Hey Chuck,

2/22/2005

This is the Full Service Option.

For us to send an instructor out to teach the students, it will cost \$25 for the Adult CPR (4 hours 30 minutes), \$35 for the Adult CPR with First Aid (5 hours 30 minutes), and \$47 for the Adult, Infant and Child CPR with First Aid (8 hours and 30 minutes) - per student. We would need to charge more if the class needed to be done in more than 2 days. (We could split the class over two days; more than that would involve more costs to us.) We would supply everything needed for the class except for space.

The Authorized Provider option:

Initial Training for the instructor will cost \$110 if they can take it at a Red Cross office. This is what it cost us and includes the initial CPR and First Aid certification as well as the Instructor Training. The total number of hours involved is about 40 for the training.

To do the actual training, teachers will need to either purchase or rent supplies.

To purchase:

25 Actar manikins cost \$1650 and would be good for one class of 25 students.

The video that contains Adult CPR and First Aid costs \$78

The video that contains Infant and Child CPR costs \$48

The skills cards that are normally given to every student, we would allow to be libaried. The discounted rate is \$5.68 each and there are three skills cards - Adult CPR, Infant and Child CPR, First Aid.

First Aid Training Packs cost \$1.80 and every student in the class would need one. They can be reused.

Lungs for the Actars cost 50 cents.

Administration fees would be \$3 per student.

The participant's manual is \$1.28 per student.

To rent:

We can also rent the manikins and videos at \$5 per day per manikin/video.

So if the schools go with the purchase program, we are looking at about \$5 per student (Participant's Manual, Admin fee, lung, wear and tear on manikins and video) after the initial start-up costs. Some of the schools already have an instructor on site, which would eliminate the training aspect for them.

I know Mike Patterson is looking into getting a grant to train his teachers in CPR.

If you have any questions, please contact me.

Shad Engkilterra, RPCV
Health and Safety Manager
American Red Cross of Alaska.
(907)646-5405

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: SB004-EED-TLS-03-04-C
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: EED
 Title An Act requiring cardiopulmonary RDU Teaching & Learning Support
resuscitation and first aid for a secondary school diploma Component Student & School Achievement
 Sponsor Sen. Cowdery, Sen. Ellis
 Requester _____ 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						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2005) cost: 0.0
 Check 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)
 This bill requires each school district to require that each student be certified in basic first aid and cardiopulmonary resuscitation before a diploma may be issued to the student. Costs for school districts to implement this requirement are unknown at this time.

Prepared by: Barbara Thompson, Director Phone 907-465-8727
 Division Teaching & Learning Support Date/Time 3/4/05 2:50 PM
 Approved by: Karen J. Rehfeld, Deputy Commissioner Date 03/04/2005
 Agency Education & Early Development

Ruth Keller

From: Becky Metcalf [Becky_Metcalf@ak-prepared.com]
Sent: Monday, January 31, 2005 8:19 AM
To: Ruth Keller
Subject: Re: Senate Bill 4

Ruth,

I am the project manager for homeland security grants received by the state. These grants are to provide funding for planning, equipment, training, exercises, and program management and administration for emergency prevention, preparedness and response personnel. The only way I can see to possibly fund this program is through the Citizen Corps Program which trains volunteers. We deal directly with local governments so any school that may want to try to take advantage of this will need to coordinate their request with their local government. Currently, 31 local governments are eligible to apply for Homeland Security Grant Program funding. For more information on Citizen Corps in Alaska go to http://www.ak-prepared.com/serc/citizen_corps.htm

Becky

Alaska State Emergency Response Commission

Alaska Citizen Corps
Home?National Citizen Corps



ALASKA OVERVIEW

Five county tribal Councils, serving 169,143 (58% of total state population)

CITIZEN CORPS COUNCILS

Counties

- Anchorage Citizen Corps Council
- Kenai Peninsula Borough Citizen Corps Council
- Matanuska-Susitna Borough Citizen Corps

Tribal

- Kobuk Citizen Corps Council
- Shungnak Citizen Corps Council

FUNDING

FY04

- \$307,000
- Citizen Corps funding through DHS/ODP

FY03

- \$165,817
- CERT funding through FEMA, no FY03 appropriations for Citizen Corps

ALASKA STATE CITIZEN CORPS COUN

The all-hazards State Emergency Response Commission (SERC) as the Alaska State Citizen Corps Council. On January 30, 2003 SERC established the Citizen Corps Subcommittee to develop a implement a statewide strategy for assisting the establishment a operation of local Citizen Corps Councils.

The national Citizen Corps initiative presents unique opportunities Alaskan communities. Because many of Alaska's communities are isolated, techniques and skills learned through Citizen Corps programs may have greater and more frequent application in Alaska than in other states.

Though other states may focus upon training volunteers for emergency roles in community disasters, Alaska State Citizen Corps program structured around skills and standards for response to common emergencies. Alaska is committed to building partnerships and is the Alaska Emergency Language Resource Bank as a partner as of April 2004.

COMMUNITY HIGHLIGHTS

The Anchorage Citizen Corps Council has identified the five following goals for growth, development and sustainability: 1) bring together appropriate leaders to a Citizen Corps Council, 2) develop and implement a plan for the community to citizens in community preparedness and family safety through the popular and cases, nationally recognized programs of AWARE (Anchorage Watchful Alert Emergencies) Academy, AWARE Schools, Think AHEAD, and AWARE with C conduct public education and outreach for Citizen Corps charter programs and response and preparedness plans, 4) develop and implement Citizen Corps programs offering training and volunteer opportunities to support first responders, disaster groups, and community safety efforts, and 5) coordinate Citizen Corps activities Department of Homeland Security funded programs and initiatives.

FY02

- \$35,272 Citizen Corps funding through FEMA
- \$149,906 CERT funding through FEMA

STATE POC

Michelle Heun
Emergency Management Specialist
PO Box 5750
Fort Richardson AK 99505
(907) 428-7089
Michelle.Heun@ak-prepared.com

The Kenai Peninsula Borough is comprised of the Kenai Peninsula Inlet and a large unpopulated area northeast of the Alaska Peninsula approximately the same size as Massachusetts, Vermont and New Hampshire combined. A fairly well developed road system connects major towns of Seward, Homer, Soldotna, Kenai, and Anchorage. The Kenai Peninsula Borough experiences disaster events regularly. In 2000, there have been three federally declared disasters within the borough: one in 2002 due to avalanches, one in 2002 due to floods, 2003 due to winds. The area is also susceptible to wildfires, volcanic eruptions, earthquakes, and tsunamis. Given the rural nature of the Borough, the limited and from most of its communities, a limited response capability, and its extensive natural disasters, the Borough initiated a Community Emergency Response Team program in 2003. Prior to the implementation of CERT the Borough had, through education and outreach, encouraged the self-sufficiency of its residents during emergencies. With the implementation of CERT, community groups have developed limited response capability to supplement public safety responders during emergencies. The CERT program in the Kenai Peninsula is becoming increasingly popular. The knowledge and skills acquired during their training gives residents confidence, they work together with the Neighborhood Watch program to provide a community security and the resources to stand on their own until help arrives.

CHARTER PARTNERS IN ALASKA



CERT

- 2 Active Community Emergency Response Teams listed on the CERT directory
- City and Borough of Juneau; Juneau Police Department, and Capital Fire and Rescue
- Kenai Peninsula Borough



VIPS

- 3 Volunteers in Police Service programs

Kobuk is located on the right bank of the Kobuk River, about seven miles north of Shungnak and 128 air miles northeast of Kotzebue. A federally recognized tribe in the Native Village of Kobuk. It is an Inupiat Eskimo village practicing a traditional subsistence lifestyle. The Village/City of Kobuk became a Citizen Corps Council charter partner in March 2004 and jointly signed a Memorandum of Understanding with the Village/City of Shungnak to commit to working together. Both communities are committed to further developing the Search and Rescue volunteer squads already in place as well as the other Citizen Corps charter programs.

The Matanuska Susitna Borough is comprised of the lush farmlands of the Matanuska and Susitna Valleys approximately 42 miles northeast of Anchorage. Formation of the Borough Council provides leadership for program initiatives and is a natural outgrowth of the Borough's Local Emergency Planning Committee (LEPC). Both Neighborhood Watch and CERT have been instituted in Borough communities over the past two years and as they spread about the programs, the need for these programs becomes more and more apparent. The population in the Borough is growing steadily bringing with it a demand for a fabric of their community. Both Neighborhood Watch and CERT are of enduring value to the residents and institutions. They have a partnership with the Palmer Job Corps Center that extends the reach of the program into each Alaskan village and town representing students who chose CERT training as part of their curriculum.

As of May 2004

ALASKA STATE CITIZEN CORPS COUNCIL

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COMMUNITY HIGHLIGHTS

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conduct public education and outreach for Citizen Corps charter programs and other public response and preparedness plans, 4) develop and implement Citizen Corps programs offering training and volunteer opportunities to support first responders, disaster relief groups, and community safety efforts, and 5) coordinate Citizen Corps activities with other Department of Homeland Security funded programs and initiatives.

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As of May 2004

State of Alaska
Division of Homeland Security & Emergency Management

Fiscal Year 2005
Homeland Security
Grant Program

Jurisdiction Program Guidelines & Application Kit

Disclaimer

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I. STATE GUIDELINES AND OVERVIEW

I. STATE GUIDELINES AND OVERVIEW

A. State Guidelines and Overview

The US Department of Homeland Security, Office for Domestic Preparedness, has awarded the Alaska Division of Homeland Security and Emergency Management (DHS&EM) \$14,879,381 for the FY2005 Homeland Security Grant Program (HSGP). The 2005 Homeland Security Grant Program now integrates 6 separate grant programs:

- State Homeland Security Program – SHSP \$9,368,591
- Law Enforcement Terrorism Prevention Program – LETPP \$3,406,760
- Citizen Corps Program – CCP \$ 118,934
- Emergency Management Performance Grants – EMPG \$1,529,911
 - Operational Grant to State for Emergency Management:
Sub-Grantees Pre-Identified – Ongoing Sub-Grants
- Metropolitan Medical Response System – MMRS (pass-thru) \$ 455,184
 - New to DHS&EM: Sub-Grantees
Anchorage and Southeast Alaska (Juneau)
- Urban Areas Security Initiative – UASI (not applicable in Alaska) \$ -0-

The purpose of the HSGP is to fund first responders and support state and local resources necessary to prevent, respond and recover from acts of terrorism and other disasters, providing vital funding to ensure the safety and security of our homeland.

The 2005 HSGP grant for the 3 bundled specific homeland security programs: SHSP, LETPP, and CCP, totals \$12,894,285. This is 66% of the 2004 HSGP grant amount \$19,465,000 for these same 3 programs. Grant guidance from the US Dept. of Homeland Security recommends that security and preparedness officials at all levels should leverage all available funding and resources from multiple sources, including the private sector, wherever possible. That same grant guidance stipulates that Subgrantees must include an integrated approach to engaging citizens in preparedness, training, exercises, and volunteer support for emergency responders through Citizen Corps Councils, and are encouraged to fully leverage HSGP resources to accomplish this goal. All citizen education, communication, training, and participation activities funded with any source of HSGP funds must be coordinated with Citizen Corps Councils where they exist, and advance the Citizen Corps mission.

DHS&EM is now soliciting applications for the FY 2005 State Homeland Security Program (SHSP) for which \$7,494,873 is available for sub-grant awards, and the Law Enforcement Terrorism Prevention Program (LETPP) for which \$2,725,408 is available for sub-grant awards. SHSP and LETPP are integrated and shall be submitted in a single application, with separate narratives and budgets. Grants shall be used to fund projects relating to planning, equipment, training, and exercises for emergency prevention, preparedness, and response personnel. Grants can also be used to fund their program management and administration. SHSP provides funds to enhance the capability of state and local units of government to prevent, deter, respond to, and recover from incidents of terrorism involving the use of CBRNE weapons and cyber attacks, and to enhance regional preparedness efforts. LETPP provides funds to law enforcement to enhance

capabilities to detect, deter, disrupt, and prevent acts of terrorism, for activities involving information sharing to prevent attacks, target hardening to reduce vulnerability, threat recognition, intervention activities, and interoperable communications. **Applications are due by 5:00 pm Thursday March 3, 2005.**

The State Homeland Security Strategy serves as the guidepost for all grant programs in HSGP. The State Homeland Security Strategy (SHSS) is being updated to revise jurisdictional priorities based upon threat and needs analysis to include critical infrastructure protection analysis. The Strategy maintains its all-hazards approach, and cooperation and coordination of resources with multi-agencies and groups.

The grant guidance and application for the Citizen Corps Program is separately attached to this packet for your information. Because the HSGP grant guidance inter-relates the SHSP, LETPP, and CCP programs to support one another, the State recommends that you develop your applications with this overview in mind. On the next page is a table listing the Local Emergency Planning Committees, established Citizen Corps Councils, and Community Emergency Response Teams that have also received the CCP application packet and are eligible to apply for the Citizen Corps Program.

LEPC - 20	Current Citizen Corps Councils - 5	CERT - 11
Aleutians & Pribilof Island		Sand Point
Bristol Bay Borough		Bristol Bay Borough
		Dillingham
Capital City		Juneau
Copper River Basin		
Delta/Greely		
Fairbanks Area		Fairbanks North Star Borough
Greater Ketchikan Area		
Kenai Peninsula Borough	Kenai Peninsula Borough	Kenai Peninsula Borough
Kodiak Island Borough		
Matanuska-Susitna Borough	Matanuska-Susitna Borough	Matanuska-Susitna Borough
Municipality of Anchorage	Municipality of Anchorage	Municipality of Anchorage
Nome		Nome
Northern Southeast		
North Slope Borough		North Slope Borough
Northwest Arctic Borough	Kobuk, Shungnak	
Petersburg/Wrangell		
Sitka		
Southern Southeast		
Valdez		
		Whittier

B. Specific Grant Information

Unallowable Costs and Activities

- Construction and Renovation
- Hiring of sworn Public Safety officers or to supplant public safety positions and responsibilities
- Supplanting any expense already budgeted
- Transfer of funds between any programs (SHSP, LETPP, CCP, etc.)
- Indirect Costs
- Drawdown of Funds prior to expenditure
 - Reimbursement Advances with strict guidelines can be requested from DHS&EM

Performance Period

March 28, 2005(est) Through March 31, 2007

Eligible Applicants

- 30 Jurisdictions Identified in State Homeland Security Strategy
 - Borough's Required to Submit Coordinated/Prioritized Applications of all their jurisdictions
 - Grant Awards can be written directly to Jurisdictions within Boroughs upon request

Management and Administration costs (M&A) – New for 2005

- For SHSP, LETPP, CCP – up to 2.5% of Sub-award
- Not allowed for contracts/allocation to nonprofit organizations
- Local jurisdiction must state whether they want to apply for 2.5% M&A costs as part of their total allocation in their cover application. If applied for, applicants will be asked to provide a budget detail for the 2.5% of their overall allocation when DHS&EM processes their award.

LETPP Code Orange Alert

- Local jurisdictions may use up to 25% of their LETPP Awards to support operational costs incurred with increased security at critical infrastructure sites if an Orange Alert is declared at the National (DHS) level.
- Sub-recipients can request a budget amendment to adjust pre-awarded categories (i.e. eliminating an equipment purchase so funds can support a security response).
- If necessary, funds may be redirected for operational purposes at the State's discretion.
- **There is no allowance for Code Orange alert at the State level for Alaska.**

Training

- No longer required to request ODP approval for personnel to attend non-ODP courses that fall within the ODP mission to prevent, respond to, and recover from acts of

terrorism involving CBRNE weapons. **This policy applies to all unexpended training funds from previous years' grants.**

- Training applications are still required to be coordinated through the DHS&EM Training officer.
- Hazardous materials courses – see specific Training Cost Guidance
- Search and Rescue training – see specific Training Cost Guidance
- Special Weapons and Tactics (SWAT) training - see specific Training Cost Guidance
- Medical Trauma training courses – see specific Training Cost
- SHSP sub-grantees are required to support the Citizen Corps mission of which training is a central component, including Community Emergency Response Team (CERT) training.

Exercise

- US DHS is preparing several tools to assist jurisdictions in their preparedness work. First is a risk based target levels of capability for prevention, preparedness, response, and recovery for major events. Next a list of 15 National Planning Scenarios with a Universal Task List and finally a Target Capabilities List. These should be available in early spring 2005 and will be incorporated into the Alaska Homeland Security Exercise and Evaluation Program and distributed to jurisdictions.
- Citizen participation must be coordinated with existing Citizen Corps Councils to include back filling non-professional tasks for first responders deployed on exercise, administrative and logistical assistance with exercise implementation, and providing simulated victims, press and members of the public.
- SHSP sub-grantees are required to support the Citizen Corps mission of which participating in exercises is a central component, to include CERT participation.

Top State Priorities for the FY2005 HSGP:

1. Promote training and exercise activities in WMD incident prevention, mitigation, and response for emergency responders, including ICS and NIMS
2. Procure interoperable communications equipment to enhance multi-discipline response to CBRNE event
3. Ensure compatibility of State and jurisdictional all-hazard Emergency Operations Plans, including annual plan updates
4. Increase by two (2), the number of Citizen Corps Councils to a total of five (5), and include Citizen Corps volunteers in training and exercise activities.

Top State Priorities out of the FY2005 HSGP National Initiatives:

1. The State and all Homeland Security Grant Program (HSGP) Sub-Grantees are required to ensure implementation of the National Incident Management System (NIMS). Initial adoption of NIMS is required by FY06, implementing the first phase of FY05 requirements. To receive funding in FY06, local jurisdictions must certify in their FY06 grant applications that they have met the FY05 NIMS requirements. These requirements are listed on pp. 38-39 of this grant guidance. By FY07, federal preparedness assistance will be conditioned upon full compliance with NIMS. For further NIMS information you can go to www.fema.gov/nims
2. The State of Alaska will work to implement 24/7 Tactical Interoperable Communications, deployable and fully operational within an hour of an incident, and ensure sufficient

personnel are trained as Communications Unit Leaders as defined within NIMS, to support equipment deployment.

3. State and Local jurisdictions shall develop and establish an all-discipline, all-hazards single, comprehensive framework and plan for the management of domestic incidents. This plan shall be modeled after the National Response Plan (NRP) with coordinating structures, protocols and processes essential for ensuring a national comprehensive approach to domestic incident management. Implementation of the NRP will occur in 3 phases over a one-year period.
4. State Homeland Security Program (SHSP) Sub-Grantees are required to work with State and existing local Citizen Corps Councils in promoting public awareness and citizen participation. SHSP projects shall integrate citizen/volunteer resources and participation in implementation of Emergency Operations Plans (EOPs), engaging public awareness, promoting educational outreach, providing opportunities for citizen participation in training and exercises, and developing or expanding the activities of Citizen Corps Councils and Citizen Corps programs. These programs are:
 - Community Emergency Response Team – CERT
 - Volunteers in Police Service – VIPS
 - Medical Reserve Corps – MRC
 - Fire Corps
 - Neighborhood Watch

Application Submission Checklist and Review Criteria:

- To be eligible, projects must support the State and/or National priorities listed above.
- Jurisdiction Criteria: Yes or No response--Does the Jurisdiction have:
 - An Emergency Operations Plan (EOP)?
 - An established Citizen Corps Council?
- Application Comprehensiveness based on the following:
 - A. Narrative
 - Describe the following in your narrative:
 - Progress in implementing the schedule established in the State Homeland Security Exercise and Evaluation Program (HSEEP)
 - Staffing/resource levels for project administration and oversight
 - Alignment with state priorities and national initiatives
 - Coordination with other projects/programs, leverage of funds
 - Funds monitoring and tracking system(s) for grant program
 - Inter/multi-agency support, MOAs or MOUs
 - Public involvement, efforts to educate the public and encourage citizen/volunteer participation through existing Citizen Corps
 - Efforts to achieve NIMS implementation
 - Sustainability of Projects
 - Cost/Benefit analysis of the project (consequences if the project was not funded)
 - List specifically the following:
 - Project Scope of Work
 - Project timeline and milestones

- Local priorities Goals & Objectives
- Emergency responder training needs

B. Project Budget Detail:

- Planning, Training, Exercises, Equipment, M&A
 - Consistent with Narrative
-
- Additional Applicant Issues to be Reviewed by Multi Interagency Review Committee:
 - History of Project Completion
 - History of on-time or delinquent narrative/fiscal reports
 - Timeliness and Appropriate Justification for Project Milestone Adjustments
 - Management capability and capacity; longevity vs. turnover
 - Prior Audit Findings

Application Deadline

March 3, 2005

II. ELIGIBLE APPLICANTS

II. ELIGIBLE APPLICANTS AND FUNDING AVAILABILITY

A. Eligible Applicants

With 2005 funding, the state focus is shifting from first response to prevention and deterrence. Funding is open to all jurisdictions that completed the State Homeland Security and Assessment on-line assessment in the fall of 2004 and that are included in the State Homeland Security Strategy (SHSS). Jurisdictional priority is being revised to reflect threat and needs analysis. A revised SHSS will be provided to all eligible jurisdictions. Eligible jurisdictions may apply for one or both programs (SHSP and LETPP).

A single, coordinated application for each program will be accepted from the jurisdictions listed on Table 1.

Table 1. Eligible Jurisdictions

Aleutians East Borough	City of Valdez
Bristol Bay Borough	City of Whittier
City & Borough of Juneau	City of Wrangell
City and Borough of Sitka	Denali Borough
City of Bethel	Fairbanks North Star Borough
City of Cordova	Haines Borough
City of Craig	Kenai Peninsula Borough
City of Delta Junction/Deltana	Ketchikan Gateway Borough
City of Dillingham	Kodiak Island Borough
City of Galena	Mat-Su Borough
City of Nenana	Metlakatla Indian Community
City of Nome	Municipality of Anchorage
City of Petersburg	North Slope Borough
City of Skagway	Northwest Arctic Borough
City of Unalaska	Yakutat Borough

- Grants will not be awarded until an application has been reviewed and eligible items are submitted for allocation decisions by an interagency, multi-discipline committee. Submitting an application is no guarantee of funding.

Ruth Keller

From: Ruth Keller
Sent: Friday, February 11, 2005 12:21 PM
To: Ruth Keller
Subject: Rural AED Program

[CHEMS Home](#)[State of Alaska](#)[H&SS](#)[CHEMS Internet](#)[Site Map](#)**CHEMS**Section of Community Health &
Emergency Medical Services**CHEMS UNITS**[Certificate of Need
& Behavioral Health](#)[Emergency Medical
Services](#)[Injury Surveillance
& Prevention](#)[Primary Care
& Rural Health](#)**Rural AED Grants**

Revised 03/04/2004

Office Staff contact:
Doreen Risley, EMSC Coordinator
Telephone: (907) 465-8633
Email: doreen_risley@health.state.ak.us

A Proposal Review Committee (PEC) met on October 19, 2004 to review the AED applications that were submitted in March 2004 by organizations and community partnerships. The committee selected the following organizations/partnerships to receive AEDs and trainers. The communities below will receive **least** one AED and one trainer.

The number of AEDs and trainers each group will receive is based on the price of the units. The bid is ongoing and should be completed by early 2005, after which time we will have a better idea of the cost per unit. If you have any questions contact Doreen Risley at 907-465-8633.

Aniak Fire Rescue
Bristol Bay Borough
Chugachmiut
Craig EMS
Dillingham Volunteer Fire Department and Rescue
Fairbanks North Star Borough
CATG Community Health Aide Program
Hoonah EMS
Hyder Community Association
Capital City Fire/Rescue
Kenai Peninsula EMS
Ketchikan, North Tongass Service Area
Kodiak Island Borough
Lake Louise

Matanuska-Susitna Borough
McGrath Volunteer Fire Department
Mosquito Lake
Nondalton Clinic
Sitka Fire Department
Tanana Chiefs Conference
Valdez Fire Department
Wrangell Fire Department
Yukon Kuskokwim Health Corporation

Automated external defibrillators (AEDs) are an essential tool in the treatment of out-of-hospital cardiac arrest. Over the years, the devices have become safer, more reliable and more maintainable. The new technologies used in these devices make them suitable for use by anyone who has had basic training in their use.

AEDs are most effective when implemented as part of an overall strategy which considers each link "Chain of Survival:"

- Early access to the emergency medical system (EMS and 9-1-1 system)
- Early cardiopulmonary resuscitation (CPR)
- Early defibrillation when indicated
- Early advanced emergency treatment

In 1998 legislation was passed that redefined the use of an automated external defibrillator as a basic support skill and provided, through the Good Samaritan Law, some immunity from civil liability to properly trained personnel who use AEDs in a resuscitation attempt and who activate the EMS system. The statute is available below.

Files of interest (click to download):

- Civil Liability for use of an AED (AS 09.65.087)
- Civil Liability for Emergency Aid (AS 09.65.090)
- Regulations for Approving AED Training Programs (7 AAC 26.585)
- Public Health Improvement Act (Includes Cardiac Arrest Survival Act)
- Answers to Frequently Asked Questions about the AEDs in Alaska

Approved Training Programs

In Alaska's Good Samaritan Law (AS 09.65.090) "properly trained" to use an AED means "that the person has completed an automated external defibrillator training course from the American Heart Association, American Red Cross, or another automated external defibrillator training course approved by the Department of Health and Social Services."

The following programs have been approved by the Department of Health and Social Services in accordance with 7 AAC 26.585:

- BLS for Health Care Providers-**American Heart Association**
- CPR for the Professional Rescuer-**American Red Cross**
- The CPR component of **Medic First Aid-Advanced**
- Basic Life Support for Professionals (BLSPRO)-**EMP America**
- CPR for the Professional Rescuer-**American Safety & Health Institute**
- **Respond Systems AED/CPR**

To request approval of an AED Training program the applicant must submit a written report that provides evidence of meeting the requirements set forth in 7 AAC 26.585. Requests are sent to:

Department of Health and Social Services
Division of Public Health
Section of Community Health and Emergency Medical Services
P. O. Box 110616
Juneau, AK 99811-0616

AED Placement

The Section of Community Health and EMS is interested in knowing the locations of AEDs so it can implement the goals of the Rural AED Grant Program effectively. Agencies receiving AEDs under the AED Grant are required to inform us of the placement or relocation of AEDs purchased under the grant. We greatly appreciate being informed of the placement or relocation of AEDs purchased with other funds. Notification is voluntary and provides us with important information. The Section of Community Health and EMS has developed a simple form that can be completed and faxed to the Section at 465-4101. As an alternative, agencies can simply complete the on-line AED Registration form that will send the information directly to CHEMS staff.

It is important for emergency medical dispatchers to know the locations of AEDs so they can direct them to the device when emergency medical services personnel are en route. The Section will fax copies of the form to the appropriate Regional EMS Office, Emergency Medical Dispatch center, and the nearest emergency medical services agency.

Model AED Placement Notification.pdf
Online AED Registration Form

AED Usage Form

This form should be completed any time an AED funded under the Rural AED Program is used in a resuscitation or resuscitation attempt. Pressing the "send" button will e-mail the contents of the form to three members of the Section of Community Health and EMS working on the Rural AED Project. It is not sent to anyone else.

A staff member of the Section of Community Health and EMS will contact you and others to obtain detailed information on the use of the device and the patient's outcome.

AED Usage Form

2002 Rural AED Act Grant Program

In the first year of the Rural AED Grant Program, the Section of Community Health and EMS was awarded \$237,000 which was used to purchase and distribute over 150 AEDs throughout Alaska. Look below for a list of agencies which received automated external defibrillators.


2003 Rural AED Act Grant Program

The Section of Community Health and EMS was awarded \$265,168 by the Department of Health and Social Services, Health Resources and Services Administration for continued implementation of the Rural Automated External Defibrillator Program. This is the first year of a three year grant. It is likely that we will receive a similar amount for years two and three if the federal program is funded and we fulfill our responsibilities in year one. Look below to see a list of agencies which received automated external defibrillators.


2004 Rural AED Grant Program Continuation

The Section of Community Health and EMS submitted its application for funding on April 8, 2004. Applications will be reviewed in the summer with notifications made in the early fall.

Important Documents

.doc  Sample Letter of Commitment (A letter of commitment is defined in the grant guidance as "A document submitted by a community partnership that delineates the role, responsibilities and resources committed to the project by that member.")

 Memorandum of Agreement (MOA evidencing acceptance of basic responsibilities for AED program)

.doc  Model AED placement Notification (Form that can be used to notify EMS program of AED placement)

 List of 2002 Recipients of AEDs (A list of AEDs that were distributed)

 List of 2003 Recipients of AEDs (A list of AEDs that were distributed)

Rural AED List Server

The Section of Community Health and Emergency Medical Services has developed an internet list to facilitate communications regarding this important issue

Join the Alaska Rural AED List Server

TOP

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[Certificate of Need & Behavioral Health](#) | [Emergency Medical Services](#) | [Injury Surveillance & Prevention](#)
[Primary Care & Rural Health](#) | [Webmaster](#) | [News](#) | [Contact Information](#)
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Ruth Keller

From: Owens, Shelley [Shelley_Owens@health.state.ak.us]
Sent: Friday, February 04, 2005 5:01 PM
To: Ruth Keller
Cc: Choromanski Hull-Jilly, Deborah
Subject: SB 4 - related programs

Hi Ruth,

The two programs we learned of in doing research on SB 4 are the "First There, First Care - Bystander Care for the Injured". The curriculum and training materials are provided at no cost by the National Highway Traffic Safety Administration (NHTSA). The web link to the materials can be found at http://www.nhtsa.dot.gov/people/injury/ems/FirstThere_Bystander/ This is a one-hour program. It has been implemented in rural schools in California. The contact person in California is Lois Williams at the State EMS Authority, (916) 322-4336, ext. 424.

The second program, called Basic Emergency Lifesaving Skills in Schools, is provided by the the Center for Emergency Health and Safety for Schools. The Center has selected Alaska for the next phase of the program and is seeking funding from 3 federal agencies to continue the Initiative, which is operational or in development in 7 states and targeted for 20 more. The website is www.cehss.org/initiatives.htm

I think the programs provide a curriculum and training materials for teachers but may not provide funding beyond that.

Shelley

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Shelley K. Owens
Health Program Manager
Section of Community Health & EMS
P.O. Box 110010
Juneau, AK 99811-0010
phone 465-3024
fax 465-4101
website www.chems.alaska.gov

2/11/2005

First There, First Care - BYSTANDER CARE FOR THE INJURED



First There First Care

Bystander Care for the Injured

*download pdf version

Have you witnessed a car crash and not known what to do or how to help? You are not alone. Many people want to help crash victims but have reservations about knowing exactly how to help. Ordinary people who are trained to use simple actions can save lives.

The challenge is to overcome fears of "not doing it right" and the attitude of "not wanting to get involved."

The First There, First Care campaign is designed to inform the public, build awareness and empower people to take action.

The First There, First Care bystander care for the injured campaign was developed by the National Highway Traffic Safety Administration (NHTSA), the Health Resources and Service Administration (HRSA) and the American Trauma Society (ATS). The campaign goal is to give motorists information, training and confidence to provide life-saving bystander care at the scene of a crash, increasing the chance of survival for crash victims.

Whether you're a concerned citizen or a medical professional, you could be the first link in introducing the First There, First Care campaign to your community.

First There, First Care Campaign Why?

Car crashes place a tragic burden on our communities. During 2000 alone, over 41,000 people lost their lives in motor vehicle crashes and another 3.2 million

were injured. About one third of all fatal crashes were single vehicle rural crashes.

While time is a critical factor in any crash, it is especially critical in rural areas. National statistics show that rural areas have far higher rates of fatal crashes per mile driven than urban areas. The average time between a car crash and the call for help is about twice as long in rural areas and, due to the greater distances that the ambulance must travel, it takes nearly twice as long for help to arrive.

In many cases, the life of the crash victim could be saved if a passing motorist would stop, call for help and deliver very basic emergency care. Many crash deaths are the result of blocked breathing passages and/or blood loss - both of which can easily be treated by trained bystanders.

What You Can Do to Get Started

Step One: Start the Community Awareness Program

Using this brochure, begin raising your community's awareness of the need to stop and help victims of car crashes.

Step Two: Identify Medical Professionals to Deliver the Hands-on Training

Training by a medical professional is a crucial step in preparing citizens to become active bystanders. It teaches people the basic skills needed to perform the actions of bystander care, and training instills confidence to act quickly and responsibly when faced with an emergency situation. Visit your local hospital, fire department, doctor's office, or school nurse's office, and discuss the community benefits of the First There, First Care campaign. Identify medical professionals who would be interested in serving as First There, First Care trainers. Let them know they will need to take a one hour self-paced CD-ROM lesson to prepare themselves for the training. You can help them obtain the CD-ROM by contacting the offices listed on this brochure.

First There, First Care Campaign Materials

If you are a medical professional (e.g., physician, nurse, paramedic) and would like to teach First There, First Care, you need:

First There, First Care Instructor Preparation Package (item # 3P0116)

This kit contains all the materials necessary to complete a one hour, self-paced lesson which prepares medical professionals for teaching **First There, First Care** to motorists. The package includes the **First There, First Care** for the injured awareness kit, the **First There, First Care** train-the-trainer CD-ROM, and the **First There, First Care** training video.

If you are a medical professional who has completed **First There, First Care** instructor preparation, and need materials to conduct **First There, First Care**

training, please request:

First There, First Care Student Materials

(English kit - item # 3P0124)

(Spanish kit - item # 3P0125)

This kit contains all the necessary materials for students participating in a **First There, First Care** training class. It includes one **First There, First Care** poster, 30 copies of the **First There, First Care -Action Guide to Roadside Care**, - 30 copies of the **First There, First Care Emergency Action Card**, and 2 rolls of **First There, First Care** stickers.

If you are a highway safety advocate, you need:

First There, First Care Bystander Care for the Injured Awareness kit.

(Item # 3P0093)

This kit contains materials for a traffic safety advocate who is interested in bringing **First There, First Care** to their community. It contains the **First There, First Care Resource Guide and Fact Sheet**, and samples of the **First There, First Care -Action Guide to Roadside Care, Emergency Action Card and Poster**, in English and Spanish.

To obtain materials, contact the National Highway Traffic Safety Administration or your state Emergency Medical Services office. All materials are FREE.

U.S. Department of Transportation
National Highway Traffic Safety Administration
EMS Division
400 7th St. SW, NTI-123
Washington, DC 20590
Fax (301) 386-2194

For more information on the **First There, First Care** campaign,
contact:

U.S. Department of Transportation
National Highway Traffic Safety Administration
EMS Division
400 7th St. SW, NTI-123
Washington, DC 20590
(202) 366-5440

DOT HS 809 292
Revised April 2003

Center for Emergency Health and Safety for Schools

Multi-Hazards in Schools

The course will provide participants with the basic information and tools needed to develop effective plans for the wide array of potential emergencies, disaster and hazardous situations that schools may face. Participants completing the course will be able to explain the importance of effective planning to others and lead individuals in their schools and community through the process of developing an effective multi-hazard program.

Special consideration will be given to those local teams that consist of at least 4-5 representatives, including school administrators, principals, school nurses, teachers, support and janitorial staff, risk managers, facility managers, or counselors, and representatives from emergency management, law enforcement, fire service, local public health department, hospital, and pre-hospital providers of all levels.

Participants who complete the course will be eligible for either 1 or 2 undergraduate or graduate credits through the University of Wisconsin La Crosse, Department of Health Education and Health Promotion. CEU's have been applied for through the National Registry of EMT's.

[View Past Participants](#)

BELSS (Basic Emergency Lifesaving Skills in Schools)

The BELSS Initiative is designed to increase the number of school-aged youth who are competent in emergency health skills by training instructors and providing curriculums to promote the development of these skills. Emergency health is the spectrum of knowledge, attitudes, and skills necessary to prevent, prepare for, and respond to serious, unexpected situations that require immediate action. Emergency health encompasses injury prevention, safety, first aid, CPR, AED, emergency preparedness, and coordinated school health

programs. More importantly, it represents the interaction and integration of these components. BELSS is the first comprehensive model of emergency health in schools.

Trainings will be held in various locations throughout Wisconsin, Minnesota, North Dakota and South Dakota. The workshops are intended for school nurses, health teachers, physical education teachers, elementary teachers, health service directors, safety/security directors, social workers, EMS personnel, and ALL those responsible for teaching emergency health skills to school district youth and staff. Participants who attend the workshops will receive valuable certifications, curriculum, and resources for implementing safety education in their schools.

.....

SERT (School Emergency Response Team)
INFORMATION COMING SOON!!!

.....

Responding to Emergencies and Disasters with
Youth
(READY) Initiatives

Coming to Wisconsin, July 18-22, 2005 will be the READY initiative! We're excited to announce this excellent opportunity to prepare youth to prevent, prepare for and respond to serious, unexpected situations that require immediate action. The READY initiative will incorporate knowledge and skills related to injury prevention, safety, first aid, CPR, AED, emergency preparedness, terrorism, school security, crime prevention, and disasters. Teens participating in the READY initiative will develop citizenship with the support and involvement from family, school staff and administration, and community members by participating in activities related to volunteerism, leadership, advocacy, and youth development. They will also gain insight on how to establish citizen corps councils and partnerships within their schools and communities (i.e. neighborhood watch, outreach training, service learning, volunteerism, etc.).

This initiative is comprised of two phases. The first phase includes the development and revision of curriculum for the Wisconsin National Guard Counterdrug Program. It offers education and prevention activities such as the Ropes Courses, which provide youth in fifth, seventh, and ninth grades with positive experiences that allow them to make better choices and experience success. The Ropes Course last year reached 20,000 students through both the outdoor low ropes course and the mobile low ropes course programs. They will include the following skills: building trust, making positive health and safety choices, and experiencing true team building. These underlying skills will be enhanced with the development of the Leadership Reaction Courses and the curriculum expansion that will include risk reduction and prevention related to alcohol and drug use, as well as safety, injury prevention, and emergency preparedness. This expansion in curricula will help Wisconsin teens be prepared to respond in emergency situations in their school or community. It should also be noted that this year, the Wisconsin National Guard Low Ropes Course received the *Secretary of Defense Community Drug Awareness Award* for excellence in youth alcohol and drug prevention and education.

The second phase of the initiative involves integrating the ROPES course into a five-day camp experience for teens. The READY camp is comprised of skills in emergency health, safety and citizen corps and is designed to increase the number of school-aged youth who are prepared and ready to respond in emergency health situations

to help make schools and communities safer. Instructors will include community emergency responders such as law enforcement, firefighters, EMS providers and emergency healthcare professionals. Another objective of the READY camp is to promote the youth to enter health and public safety careers.

This emergency health and safety leadership initiative aligns with the No Child Left Behind Act due to the focus placed on a comprehensive safe school plan that includes policies, security procedures, prevention activities, and crisis response procedures (Title IV Part A – Safe and Drug Free Schools). It also aligns well with the Title V Part A - Innovative Programs section of No Child Left Behind by providing: (1) programs for CPR training in schools for students, teachers, and other staff; (2) training for school safety programs; (3) service-learning activities; and (4) involvement and communication opportunities with families, schools and community members.

PROGRAM GOALS

1. Create partnerships that expand awareness of emergency health and safety skills and knowledge.
2. Provide a variety of opportunities for Wisconsin youth to enhance their risk reduction awareness and emergency health and safety skills and knowledge.
3. Collaborate with organizations and groups already impacting risk reduction and emergency health and safety education of Wisconsin citizens.

Alaska Region Training Centers 2004-2005

<p>Alaska Native Medical Center <i>Contact: Casie Williams</i> 4315 Diplomacy Drive Anchorage, AK 99508</p>	<p>BLS, ACLS & PALS Ph: 907-729-2936 Fax: 907-729-2938 cwilliams@anmc.org</p>	<p>Ketchikan General Hospital <i>Contact: Val'ee Gray</i> 3100 Tongass Avenue Ketchikan, AK 99901</p>	<p>BLS, ACLS & PALS Ph: 907-225-5171 x7425 Fax: 907-228-8324 VGray@peacehealth.org</p>
<p>Alaska Regional Hospital <i>Contact: Gene Wiseman</i> 2801 DeBarr Rd. Anchorage, AK 99508</p>	<p>BLS, ACLS & PALS Ph: 907-264-1277 Fax: 907-264-2064 Eugene.wiseman@hcahealthcare.com</p>	<p>North Slope Borough Fire Dept <i>Contact: Jack Smith</i> Box 69 Barrow, AK 99723</p>	<p>BLS Ph: 907-852-0246 Fax: 907-852-8734 jack.smith@north-slope.org</p>
<p>Anchorage Fire Dept., Municipality of Anchorage BLS, ACLS & PALS <i>Contact: Patricia Vincent</i> 1140 Airport Heights Road Anchorage, AK 99508</p>	<p>Ph: 907-267-5069 Fax: 907-279-2106 VincentPA@muni.org</p>	<p>Norton Sound Health Corp <i>Contact: Terry Calandrelli</i> P.O. Box 966 Nome, AK 99762</p>	<p>BLS, ACLS & PALS Ph: 907-443-3306 Fax: 907-443-3731 calandrelli@nshcorp.org</p>
<p>Bayside Fire Department <i>Contact: Bob Himes</i> 4606 E. Rezanof Dr. Kodiak, AK 99615</p>	<p>BLS, ACLS & PALS Ph: 907-486-4536 Fax: 907-486-3025 bayside_fire_dept@hotmail.com</p>	<p>Providence Health System AK <i>Contact: Laurie Edge or Carol Bagley</i> P.O. Box 196604 Anchorage, AK 99519</p>	<p>BLS, ACLS & PALS Ph: 907-261-3011 Fax: 907-261-4911 ledge@provak.org</p>
<p>Central Peninsula Hospital <i>Contact: Susan Shoemaker</i> 250 Hospital Place Soldotna, AK 99669</p>	<p>BLS, ACLS & PALS Ph: 907-714-4775 Fax: 907-714-4647 staffdev@cpgh.org</p>	<p>Southeast Region EMS Council <i>Contact: Crystal Chartrand</i> P.O. Box 259 Sitka, AK 99835</p>	<p>BLS, ACLS & PALS Ph: 907-747-8005 Fax: 907-717-1406 astrn@serems.org</p>
<p>Immediate Care <i>Contact: Betty Anne Scheeler</i> 6311 DeBarr Road Ste. L Anchorage, AK 99508</p>	<p>BLS Ph: 907-336-3365 Fax: 907-336-3397 scheelerba@immediatecareak.com</p>	<p>Southern Region EMS Council <i>Contact: Nancy Patterson</i> 6130 Tuttle Place Anchorage, AK 99507</p>	<p>BLS, ACLS & PALS Ph: 907-562-6449 Fax: 907-562-9893 npatterson@sremsc.org</p>
<p>Interior Region EMS <i>Contact: Dave Rockney</i> 3522 Industrial Avenue Fairbanks, AK 99701</p>	<p>BLS, ACLS & PALS Ph: 907-456-3978 Fax: 907-456-3970 drockney@iremsc.org</p>	<p>Trans Care Medical <i>Contact: Kevin Wright</i> 521 West 41st Ave Anchorage, AK 99503</p>	<p>BLS, ACLS & PALS Ph: 907-562-3534 Fax: 907-563-8557 kevin.l.wright@worldnet.att.net</p>

Southern Region EMS Services

Ambulance Services

Adak Volunteer FD
Alaska Professional Volunteers
Anchor Point Volunteer FD
Big Lake EMS
Butte EMS
Chugiak Volunteer FD
Cold Bay EMS
Cooper Landing EMS
Copper Center EMS
Cordova Volunteer FD
Dillingham Volunteer FD
Elmendorf/Ft Richardson EMS
Girdwood EMS
Glennallen EMS
Homer Volunteer FD
Hope/Sunrise EMS
Houston EMS
Kachemak EMS
Kenai FD
Kenny Lake EMS
King Cove EMS
King Salmon EMS
Kodiak Area FD
Kodiak Launch Complex
Kullis 176th Medical Squadron
Municipality of Anchorage FD
Naknek EMS
Nikiski FD
Ninilchik EMS
Palmer EMS
Port Graham EMS
Saint Paul EMS
Sand Point EMS
Seacorp Industries
Seldovia Volunteer FD
Seward Volunteer EMS

Soldotna/Sterling EMS
Sutton EMS
South Naknek EMS
Talkeetna EMS
Transcare Medical Services
Trapper Creek Amb.
Unalaska Volunteer EMS
Valdez FD
Wasilla EMS
Whittier Volunteer EMS
Willow Amb.
WellSafe Industries

Koliganek EMS
Lake Creek/Skwenta EMS
Lake Louise EMS
Levelock EMS
Manokotak EMS
Moose Pass EMS
Nanwalek EMS
Nelson Lagoon EMS
New Stuyahok EMS
Nondalton EMS
Old Harbor EMS
Pedro Bay EMS
Perryville EMS
Pilot Point EMS
Platinum EMS
Port Alsworth EMS
Port Heiden EMS
Port Lions EMS
Saint George EMS
Tatitlek EMS
Togiak EMS
Twin Hills EMS
Tyonek Volunteer EMS
Whittier Tunnel EMS

First Responders

Chitka EMS
Akutan EMS
Aleknagik EMS
Alyeska Ski Patrol
Atka City EMS
Bear Creek Fire & Rescue
Bayside FD
Chenega Bay FD
Chignik Bay EMS
Chignik Lagoon EMS
Chignik Lake Rescue Squad
Chiniak EMS
Chitina EMS
Clarks Point EMS
Egegik EMS
Ekwok EMS
False Pass EMS
Gakona EMS
Glacier View EMS
Goodnews Bay EMS
Iglugig EMS
Iliamna/Newhalen EMS
Kokhanok EMS

Air Medical

AK ANG 210th Air Rescue
Alaska Regional Lifeflight
LifeGuard Alaska
Bristol Bay Area HC



These patient transport vehicles for Port Lions and Nanwalek are a small part of the equipment the Code Blue project has made possible in rural areas.



Uwe Kalenka Statement

I want to address two subjects today:

1. A young, bright man that graduated from the Anchorage school district and is no longer with us.
2. Terrorism.

Let me begin with the young man. He attended school in Anchorage from kindergarten through 12th grade. His name was Eric. He was murdered on February 27, 2004. He was my son. I want to thank his 4th grade teacher for inspiring him. He thought the world of her. He was an honor student at Hanshew Middle School. However, at Service High things started to deteriorate. While at Service he took badminton 3 times for credit. I objected vehemently to this. I was told badminton was part of the health and physical education program. So was sex education. He was taught well in that subject.

However, through all his schooling from math through French and German one thing he was not taught was how to survive. He was taught how to put a condom on but not how to put a tourniquet on. I looked through the curriculum and was unable to find anything addressing first aid. If Eric had been taught first aid he could have saved his own life. The fatal wound was behind the knee.

I wonder how many of our students have lost their lives needlessly because we failed to teach them first aid? I need to add that Eric died less than a mile from the fire station and less than a mile from the hospital he was born in. He called the police before the assault occurred, but they were no help. My point is that our public safety organizations are reactive forces which, in reality, many times cannot protect us. This makes it all the more necessary for students to learn how to protect themselves.

That brings me to my next subject, terrorism. Recently there was a major bombing in Spain which claimed over 200 lives. I wonder how many lives were needlessly lost because people did not know first aid. I wonder how many people needlessly bled to death. I wonder what would have happened and how many of us would needlessly die if this would happen here.

But it does not have to be terrorism. How about if we have a natural disaster? I do not believe that our emergency organizations can adequately respond and protect us. Therefore, I believe that all students should be trained in first aid and CPR so they can help themselves and each other in case of need. I urge you to include first aid in the health curriculum and make it a requirement for graduation.

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February 22, 2005
Fairbanks, AK

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Article Published: Tuesday, February 22, 2005

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Schools weigh first aid training

By AMANDA BOHMAN

Staff Writer

Heart attack sufferers, near-drowning victims or diners who find a bone lodged in their throat might want a Ryan Middle School eighth-grader nearby during the crisis.

By the end of the school year, all eighth-graders will be certified through the American Heart Association to perform CPR, administer abdominal thrusts--formerly known as the Heimlich Maneuver--and use an automated external defibrillator.

Ryan health teacher Stefani Brown is among a handful of teachers in the Fairbanks North Star Borough School District who offer first aid and CPR certification. A bill in the Legislature would make the certification a high school graduation requirement.

Through Brown, eighth-graders paid a fee of \$8 for the certification. Half of the students completed the instruction on Monday, and the other half is slated to take the weeklong course in April.

"With so much in the curriculum, generally, this just gets breezed over," Brown said. "The younger they start, the more confidence they'll have in a crisis situation."

At West Valley High School, about 20 sophomores, juniors and seniors completed a CPR and first aid certification course recently.

Dawn LaFleur, a health and physical education teacher, offered the training to students in her health leadership class, an elective. A grant through Interior Region Emergency Medical Services Council paid for the training, she said.

"It's just part of a good basic life skill that my students can use," LaFleur said. "Some of them want to be camp counselors. Some of them want to be lifeguards and some of them work in day-cares."

Only a few states and school districts nationwide have CPR and first aid certification as a high school graduation requirement, according to an aide to Sen. John Cowdery, the Anchorage Republican who wants to make CPR and first aid certification a graduation requirement in Alaska.

Cowdery's Senate Bill 4 is in response to last year's death of Eric Kalenka, 27, of Anchorage, who was stabbed in a Taco Bell drive-through after getting into a light with a motorist who rear-ended him.

According to the bill, basic first aid-- such as applying pressure to the wound and

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Arts by Gordon

elevating it above the man's heart—might have saved Kalenka's life.

Since its introduction Jan. 11, the bill has generated little discussion. It was referred to two legislative committees, neither of which has held a hearing.

The Fairbanks North Star Borough District Board of Education has yet to weigh in.

It's unclear from the bill how much adding the certification would cost and who would pay.

Royce Chapman, vice president of the school board, likes the idea, he said, but he's not sure it's practical.

"I think everybody should know CPR," Chapman said. "But when we're trying to make sure that our students make the standards in reading, writing and math, it's hard to justify taking time away from these subjects to teach something else, as worthwhile as it may be."

Hull and Freeman said they think CPR and first aid certification should be widely available.

"It only took a week," Hull said. "Anybody can do it, and I think they should."

Reporter Amanda Bohman can be reached at abohman@newsminer.com or 459-7544.

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Never Too Young to Learn

This Heartsaver CPR in Schools Program Exceeds Expectations

The adults in the Mississippi classroom were pleasant but a bit skeptical toward the group of teens: "You're mighty young to be taking this class, aren't you?" Then they learned that the eighth-graders were the instructors.

Sgt. Gary Davis was assigned as a liaison in Old Towne Middle School in Ridgeland, Mississippi, to present a positive view of the police force to the students. That was why Police Chief Charles Newell and Principal Ken Aeton created the in-school position and selected him to fill it. But Sgt. Davis had much more in mind.

"EMS has always been my love," says Davis, who is also a paramedic. "I wanted to do more for the kids than just be a friendly presence in the school. I decided that I would teach these kids how to perform CPR. Then I thought, no, that's not enough. I'm going to teach them to be CPR instructors."

Getting Started

The Ridgeland community of 25,000 offered money for the pilot program. A group called "Students Uniting Crime" raised money for materials. The school band donated funds for course books. The PTA buys shirts and lunches for the students who qualify for the program. Says Sgt. Davis: "These students aren't selected by me or their parents or the head of the PTA. They self-select. And it's not easy; I had 65 who signed up in the last group; 40 made it to the first level of commitment; 10 showed up for the pre-test; 6 actually graduated. I expect 100% as their score on the tests and to skills—and they deliver. That's more than the AHA requires, but I must ensure that they are prepared beyond question. We got a lot of skepticism until people see them in action—and then they're in awe. 'How did you do it?' they ask me. I didn't do it. They wanted to."

Positive Response

Ken Aeton, retired principal of Old Towne, says: "This program has been great for our kids and great for our community. Parents and kids have responded very positively."

Davis' first graduates in February 2000 were Archana Ravikumar, Kimberly Dickard, Eric Ochar, Mallori Racking, Teri Crawford, and Mary Landen-Downs. Instructor Archana Ravikumar, now 15, says: "The hardest part was getting other people to accept us at our young age. But if you put your heart into it, you can get anything accomplished."

Chain of Survival Award

Sgt. Gary Davis and the Old Towne Middle School CPR in Schools Program were recipients of the 2001 Chain of Survival Award, presented to the individual or group that has gone above and beyond the call of duty in promoting the Chain of Survival in the community. Although pleased at the recognition, instructor Kimberly Dickard, 15, says: "This has affected my life far beyond any awards."

Sgt. Davis' "bazillion" teaches CPR to their peers and teachers in the Ridgeland school system and the neighboring middle school. They also teach paramedics and nursing students in the community college. In addition to having trained more than 1,000 people, they've had three documented saves. The weekend after the first training session, a student came to the aid of a man who had shot a nail through his leg. A student choking on food had the obstruction released by a teacher who had been trained by one of Sgt. Davis' students. One of the 8th-grade learners saved his own brother when the little boy was knocked over while holding a marble in his mouth.

Given their documented success, these well-trained teens are winning acceptance as bona-fide instructors, despite their youth. But Sgt. Davis isn't stopping there; when he introduces AEDs in his community speeches, the demonstrator is his daughter Stephanie. She's eight.

Sgt. Gary Davis can be reached at garydavis@oldtowne.net.



Photo courtesy of Sgt. Gary Davis.

arrest can be reversed if it's treated within a few minutes with an electric shock to the heart to restore a normal heartbeat. This process is called defibrillation. A victim's chances of survival are reduced by 7 to 10 percent with every minute that passes without defibrillation. Few attempts at resuscitation succeed after 10 minutes.

How many people survive cardiac arrest?

No statistics are available for the exact number of cardiac arrests that occur each year. It's estimated that more than 95 percent of cardiac arrest victims die before reaching the hospital. In cities where defibrillation is provided within 5 to 7 minutes, the survival rate from sudden cardiac arrest is as high as 49 percent.

What can be done to increase the survival rate?

Early CPR and rapid defibrillation combined with early advanced care can result in high long-term survival rates for witnessed cardiac arrest. For instance, in June 1999, automated external defibrillators (AEDs) were mounted 1 minute apart in plain view at Chicago's O'Hare and Midway airports. In the first 10 months, 14 cardiac arrests occurred, with 12 of the 14 victims in ventricular fibrillation. Nine of the 14 victims (64 percent) were revived with an AED and had no brain damage.

If bystander CPR was initiated more consistently, if AEDs were more widely available, and if every community could achieve a 20 percent cardiac arrest survival rate, an estimated 40,000 more lives could be saved each year. Death from sudden cardiac arrest is not inevitable. If more people react quickly by calling 9-1-1 and performing CPR, more lives can be saved.

Related AHA publications:

- [Heart and Stroke Facts](#)
- [Heart Disease and Stroke Statistics Update](#)
- [Heart Attack and Stroke: Signals and Actions](#) (also in Spanish)

Detailed Research

AHA Scientific Statement: Improving Survival From Sudden Cardiac Arrest: The "Chain of Survival" Concept, #71-0003
Circulation. 1991;83:1832-1847

Sec. 09.65.090. Civil liability for emergency aid.

(a) A person at a hospital or any other location who renders emergency care or emergency counseling to an injured, ill, or emotionally distraught person who reasonably appears to the person rendering the aid to be in immediate need of emergency aid in order to avoid serious harm or death is not liable for civil damages as a result of an act or omission in rendering emergency aid.

(b) A member of an organization that exists for the purpose of providing emergency services is not liable for civil damages for injury to a person that results from an act or omission in providing first aid, search, rescue, or other emergency services to the person, regardless of whether the member is under a preexisting duty to render assistance, if the member provided the service while acting as a volunteer member of the organization; in this subsection, "volunteer" means a person who is paid not more than \$10 a day and a total of not more than \$500 a year, not including ski lift tickets and reimbursement for expenses actually incurred, for providing emergency services.

(c) The immunity provided under (b) of this section does not apply to civil damages that result from providing or attempting to provide any of the following advanced life support techniques unless the person who provided them was authorized by law to provide them:

- (1) manual electric cardiac defibrillation;
- (2) administration of antiarrhythmic agents;
- (3) intravenous therapy;
- (4) intramuscular therapy; or
- (5) use of endotracheal intubation devices.

(d) This section does not preclude liability for civil damages as a result of gross negligence or reckless or intentional misconduct.

(e) *[Repealed, Sec. 2 ch 92 SLA 2003].*

(f) *[Repealed, Sec. 2 ch 92 SLA 2003].*

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(b) A person, organization, or government agency may not represent itself as an emergency medical service or ambulance service certified by the state unless the person, organization, or government agency is certified as an emergency medical service under AS 18.08.082.

(c) A person may not provide, offer, or advertise to provide advanced life support services outside a hospital unless authorized by law.

(d) A person, organization, or government agency that provides, offers, or advertises to provide an emergency medical service may not provide advanced life support services unless authorized under AS 18.08.082.

(e) A hospital, clinic, or other entity may not represent itself as being a trauma center unless it is certified under AS 18.08.082 as meeting the criteria established for a trauma center.

(f) A person, organization, or government agency may not offer or conduct a training course that is represented as a course for mobile intensive care paramedics unless the person, organization, or agency is certified under AS 18.08.082 to offer or conduct that course. (§ 2 ch 78 SLA 1978; am §§ 15, 16 ch 36 SLA 1993)

Sec. 18.08.086. Immunity from liability. (a) A person certified under AS 18.08.082 who administers emergency medical services to an injured or sick person, a person or public agency that employs, sponsors, directs, or controls the activities of persons certified under AS 18.08.082 who administer emergency medical services to an injured or sick person, or a health care professional or emergency medical dispatcher acting within the scope of the person's certification who directs or advises a person to administer emergency medical services to an injured or sick person is not liable for civil damages as a result of an act or omission in administering those services or giving that advice or those directions if the administering, advising, and directing are done in good faith and the injured or sick person reasonably seems to be in immediate danger of serious harm or death. This subsection does not preclude liability for civil damages that are the proximate result of gross negligence or intentional misconduct, nor preclude imposition of liability on a person or public agency that employs, sponsors, directs, or controls the activities of persons certified under AS 18.08.082 if the act or omission is a proximate result of a breach of duty to act created under this chapter. For the purposes of this subsection, "gross negligence" means reckless, wilful, or wanton misconduct.

(b) A physician who in good faith arranges for, requests, recommends, or initiates the transfer of a patient from a hospital to another hospital is not liable for civil damages as a result of arranging, requesting, recommending, or initiating the transfer if

(1) in the exercise of that degree of knowledge or skill possessed, or that degree of care ordinarily exercised by physicians practicing the same specialty in the same or similar communities to that in which the physician is practicing, the physician determines that treatment of the patient's medical condition is beyond the capability of the transferring hospital or the medical community in which the hospital is located;

(2) the physician has confirmed that the receiving facility is more capable of treating the patient; and

(3) the physician has secured a prior agreement from the receiving facility to accept and render the necessary treatment to the patient.

(c) A registered nurse or licensed practical nurse who escorts a patient in a means of conveyance not equipped as an ambulance is not liable for civil damages as a result of an act or omission in administering patient care services, if done in good faith and if the life of the injured or sick person is in danger. This subsection does not preclude liability for civil damages that are the result of gross negligence or intentional misconduct.

(d) A person certified as an emergency medical technician instructor, a person or entity certified to conduct a training course for mobile intensive care paramedics, and a person who employs or contracts with a certified emergency medical technician instructor or

with a person or entity certified to conduct a training course for mobile intensive care paramedics is not liable for civil damages as a result of a negligent act or omission during a training course that injures the person or property of a person participating in the training course. (§ 2 ch 78 SLA 1978; am § 2 ch 122 SLA 1986; am §§ 17, 18 ch 36 SLA 1993)

Cross references. — For liability for services rendered by a physician-trained mobile intensive care paramedic, see AS 08.64.366.

For civil liability for emergency aid, see AS 9.65.090.

Collateral references. — Hospital's liability as to diagnosis and care of patients brought to emergency ward. 72 ALR2d 396

Application of rule of strict liability in tort to person or entity rendering medical services. 100 ALR3d 1205.

Liability for injury or death allegedly caused by activities of hospital "rescue team". 64 ALR4th 1200.

Liability of operator of ambulance service for personal injuries to person being transported. 68 ALR4th 14.

Sec. 18.08.087. Disclosure of medical records. When requested for the purpose of evaluating the performance of an emergency medical technician, mobile intensive care paramedic, or physician who provided emergency medical care or other assistance to a sick or injured person, a licensed physician, advanced nurse practitioner, or physician assistant may disclose to an emergency medical technician, a mobile intensive care paramedic, or physician the medical or hospital records of a sick or injured person to whom the paramedic, technician, or physician is providing or has rendered emergency medical care or assistance. However, the disclosing physician, nurse practitioner, or physician assistant shall limit disclosure under this section to the records that are considered necessary by the discloser for evaluation of the paramedic's, technician's, or physician's performance in providing the emergency medical care or assistance. A mobile intensive care paramedic, emergency medical care technician, or physician to whom confidential records are disclosed under this section may not further disclose the information to a person not entitled to receive that information under this section or another law. (§ 19 ch 36 SLA 1993)

Sec. 18.08.088. Penalty. A person who violates a provision of this chapter is guilty of a misdemeanor and upon conviction is punishable by a fine of not more than \$1,000, or by imprisonment for not more than 90 days, or by both. Each violation is a separate offense. (§ 2 ch 78 SLA 1978)

Sec. 18.08.089. Authority to pronounce death. (a) A mobile intensive care paramedic or physician assistant registered or licensed under AS 08.64.107 or an emergency medical technician certified under this chapter may make a determination and pronouncement of death of a person under the following circumstances:

- (1) the paramedic or emergency medical technician is an active member of an emergency medical service certified under this chapter;
- (2) neither a physician licensed under AS 08.64 nor a physician exempt from licensure under AS 08.64 is immediately available for consultation by radio or telephone communications;
- (3) the paramedic, physician assistant, or emergency medical technician has determined, based on acceptable medical standards, that the person has sustained irreversible cessation of circulatory and respiratory functions.

(b) A mobile intensive care paramedic, physician assistant, or emergency medical technician who has determined and pronounced death under this section shall document the clinical criteria for the determination and pronouncement on the person's emergency medical service report form and notify the appropriate medical director or collaborative physician as soon as communication can be established. The paramedic, physician assistant, or emergency medical technician shall provide to the person who signs the death certificate the

Senate Bill 4

HESS Hearing

March 14, 2005

(from Sen. Cowdery)

Alaska's 20th Legislature passed a law requiring a pupil passing a competency examination in the areas of reading, English, mathematics, science, and social science for a secondary school diploma.

- Graduation Mandate – SB 4

Rural Areas

- Homeland Security Grant Program
 - Alaska State Citizen Corps Council – trains volunteers to come in to teach
 - Eligible Jurisdictions

Aleutians East Borough	City of Valdez
Bristol Bay Borough	City of Whittier
City & Borough of Juneau	City of Wrangell
City & Borough of Sitka	Denali Borough
City of Bethel	Fairbanks North Star Borough
City of Cordova	Haines Borough
City of Craig	Kenai Peninsula Borough
City of Delta Junction/ Deltana	Ketchikan Gateway Borough
City of Dillingham	Kodiak Island Borough
City of Galena	Mat-Su Borough
City of Nenana	Metlakatla Indian Community
City of Nome	Municipality of Anchorage
City of Petersburg	North Slope Borough
City of Skagway	Northwest Arctic Borough
City of Unalaska	Yakutat Borough
- AHA AK Region Training Centers
 - 7 Training Centers in Anchorage
 - 1 Training Center in Kodiak
 - 1 Training Center in Soldotna
 - 1 Training Center in Fairbanks
 - 1 Training Center in Ketchikan
 - 1 Training Center in Barrow
 - 1 Training Center in Nome
 - 1 Training Center in Sitka
- Southern Region EMS Services
 - 48 Ambulance Services Statewide
 - 47 First Responders
 - 4 Air Medical

is from this set of recommendations that the current state content and performance standards were developed.

In 1997, under the *Quality Schools Initiative*, the legislature passed a law requiring Alaska high school students to pass an exit exam before receiving a high school diploma. This exam is designed to test students skills in the areas of reading, writing and mathematics according to the state performance standards. The exam itself was assigned by a commercial test publisher contracted by the State and overseen by a number of committees appointed by the State Board of Education. There is currently a debate in the legislature as to when the exit exam should be incorporated into the system. Currently the State Department of Education web site states that the exam will be required for the graduating class of 2004.

The education system in Alaska is currently in the process of re-examining itself. The sentiment around Alaska, as well as the Nation, is that the system has failed our students in the past and that reform is necessary. The State has implemented a number of wide sweeping measures to raise the standards of education. The system is going through growing pains related to these reforms. Are these changes increasing the education level in all of our students? Will the new testing methods reflect the level of education our students possess? Are these testing methods accurate and fair to all students within the system? The long and short-term effects of the education reforms are in need of further study.

Sources & Links

Alaska Comprehensive Improvement Plan
www.eed.state.ak.us/AlaskaGoals2000master.pdf

A Nation at Risk
www.ed.gov/pubs/NatAtRisk/index.html

Goals 2000 Educate America Act
www.ed.gov/legislation/GOALS2000/TheAct/intro.html

Improving America's Schools Act
www.ed.gov/legislation/ESEA/toc.html

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HOUSE BILL NO. 146

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Introduced: 2/18/97

Referred: Health, Education and Social Services

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to competency testing requirements for secondary students; and
2 providing for an effective date."

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * Section 1. AS 14.03 is amended by adding a new section to read:

5 **Sec. 14.03.075. Secondary pupil competency testing.** (a) A pupil may not
6 be issued a secondary school diploma unless the pupil passes a competency
7 examination in the areas of reading, English, mathematics, science and social science.
8 The department shall determine the form and contents of the examination and shall
9 score completed examinations. A pupil who fails to pass the examination required
10 under this subsection and who is no longer in attendance shall receive a certificate of
11 attendance from the school district indicating the years of attendance and that the pupil
12 has not passed a competency examination or received a diploma.

13 (b) A pupil who fails the examination required under this section may be
14 reexamined. A reexamination may not be offered more often than once every three

- 1 months and must occur within three years after the date the pupil is no longer in
2 attendance. A pupil who passes the reexamination and who meets any other
3 graduation requirements shall receive a diploma from the school district
4 * Sec. 2. This Act takes effect July 1, 1997.

Ruth Keller

From: Brian Webb [bwebb@sremsc.org]
Sent: Wednesday, March 09, 2005 3:40 PM
To: Ruth Keller
Subject: FW: Additional Input to SB4

It will be hard to nail down exact costs for each area. A rough ballpark is that an instructor should expect to be paid around \$15.00 per hour of classroom instruction, plus associated manikin and supplies costs if the school does not own manikins. Individual cards are around \$5.00 per student.

There are first aid/CPR instructors at most volunteer fire departments throughout the state in town & villages. Most Village health Aids could also fill the role as instructor (understanding that they, like many one-person shows, are overworked, but are the most likely to interface medically with their fellow villagers), especially if they can be compensated for their time.

Brian

-----Original Message-----

From: Brian Webb [mailto:bwebb@sremsc.org]
Sent: Wednesday, March 09, 2005 3:29 PM
To: 'ruth_keller@legis.stat.ak.us'
Subject: Additional Input

Hi Ruth, here is what I talked to you about today:

Location	Course	Starts	Ends	Instructor
Kotzebue H.S.	Emergency Trauma Tech (ETT)	01/05/05	05/20/05	Pardue
Hooper Bay H.S.	Emergency Trauma Tech (ETT)	01/11/05	04/28/05	Funk
Sitka H.S.	Emergency Trauma Tech (ETT)	01/17/05	05/26/05	Reilly
King Caree Center	Emergency Trauma Tech (ETT)	01/18/05	05/10/05	Loken
Nenana H.S.	Emergency Trauma Tech (ETT)	01/31/05	05/18/05	Mensch
King Career Center	Emergency Trauma Tech (ETT)	01/31/05	06/02/05	Loken
Burchell H.S. (Wasilla)	Emergency Medical Technician (EMT-1)	01/07/05	04/24/05	Estelle
Mt. Edgacumbe H.S.	Emergency medical Technician (EMT-1)	01/10/05	05/10/05	Raschick
King Career Center	Emergency Medical Technician (EMT-1)	01/31/05	04/28/05	Loken
King Career Center	Emergency Medical Technician (EMT-1)	01/31/05	06/02/05	Loken

These are current classes registered with the state EMS office. The ETT classes are part of the statewide (ETT in the High School Program" which began in Kotzebue, and then spread out.

The standard hours for a state ETT course are 50 hours. The standard hours for state EMT-1 course are 120 hours. This far exceeds requirements of the basic bill. I would like to make sure that there are measures in place so a student with an advanced certification can have that credited for the graduation requirement.

Let e know if you need anything else.

BRIAN L. WEBB, FF2/MICP
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3/9/2005