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The Behavioral Health and Wellness of Students

Position Statement

NASN POSITION

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

BACKGROUND AND RATIONALE

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

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

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

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

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

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

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

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

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

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

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

REFERENCES


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

All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.
SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is a crucial member of the team participating in the prevention of bullying in schools. The school nurse role includes efforts to prevent bullying and the identification of students who are bullied, bully others, or both. The Framework for the 21st Century School Nursing Practice™ (NASN, 2016) provides direction for the school nurse to support student health and academic success by contributing to a healthy and safe school environment poised to prevent and mitigate bullying and cyberbullying.

BACKGROUND

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

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

Despite a dramatic increase in public awareness, the prevalence of bullying is still one of the most pressing issues facing our nation’s youth (Luxenberg, Limber, & Olweus, 2015). Bullying is a persistent public health concern that has a significant impact in the school setting (USDHHS, 2017a). However, until the past decade, bullying was often dismissed as normative and without long-term effects (Bradshaw, 2016). Research has led to a better understanding of the serious, often long-term, consequences of bullying. Society’s shifting perspectives on bullying have been driven by high-profile cases that have resulted in death or suicide. With the growing concern in the U.S. and throughout the world regarding school violence, researchers, educators, and healthcare providers have found that bullying affects students’ social-emotional health and has implications for school safety. Therefore, schools and public health officials are looking to understand why children bully and are seeking ways to develop effective strategies to reduce or eliminate risk factors for bullying (Bradshaw, 2016).

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

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

At present, no federal law directly addresses bullying. In some cases, bullying overlaps with discriminatory harassment when it is based on race, national origin, color, sex, age, disability, or religion. Federally funded schools have an obligation to resolve bullying and harassment. If the situation is not resolved, the U.S. Department of Education’s Office for Civil Rights and the U.S. Department of Justice’s Civil Rights Division may be able to help (USDHHS, 2017b).

RATIONALE

Bullying can have serious health, physical, and psychological effects on the student who bullies, the student who is bullied, or the student who both bullies and is bullied. Bullying is not an isolated incident but occurs repeatedly over time. Therefore, according to Selekman, Pelt, Garnier, and Baker (2013), the school nurse should

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

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

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

Bullying can have severe short- and long-term negative social and emotional effects on the student who is bullied, bullies others, or both. Creating a safe and supportive school environment is critical to preventing bullying and supporting learning and academic achievement. The school nurse is often the sole healthcare provider in an academic setting. Twenty-first century school nursing practice is student-centered, occurring within the context of the student's family and school community (NASN, 2016). School nurses are, therefore, ideally situated to work with other school-based professionals to facilitate bullying interventions (Pigozi & Jones Bartoli, 2016). The school nurse can support evidence-based interventions to prevent and mitigate bullying in the school. The school nurse provides key leadership to promote and enhance student safety, wellness, engagement, and learning.

REFERENCES


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All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.

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

BACKGROUND
Child maltreatment was initially recognized as a significant social problem in the 1960s when Henry Kempe published his article on battered child syndrome (Child Welfare Information Gateway, 2017). His work led to the adoption of a formal reporting system at the state and federal level and ultimately the passage in 1974 of the Child Abuse and Prevention and Treatment Act (CAPTA), the primary federal legislation addressing child abuse and neglect. CAPTA was most recently reauthorized in 2015 by the Justice for Victims of Trafficking Act and in 2016 by the Comprehensive Addiction and Recovery Act of 2016 (Child Welfare Information Gateway, 2017). CAPTA defines child maltreatment as the following:

"Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, (including sexual abuse as determined under section 111) or an act or failure to act which presents an imminent risk of serious harm" (U.S. Department of Health and Human Services [USDHHS], Administration for Children and Families [ACF], Administration on Children, Youth and Families [ACYF], Children’s Bureau, 2017, p. 7).

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

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

- Physical Abuse - intentional use of physical force against a child that results in or has the potential to result in physical injury
- Sexual Abuse – any completed or attempted (non-completed) sexual act, sexual contact with or exploitation of a child by adult
- Psychological Abuse - intentional caregiver behavior that conveys to a child that he/she is worthless, flawed, unloved, unwanted, endangered or valued only in meeting another’s needs

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

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

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

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

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

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

RATIONALE

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

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

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

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

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

CONCLUSION

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

REFERENCES


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


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SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is an integral member of the school team, promoting school attendance and combating student absenteeism by addressing the physical, mental, and social needs of the student. Chronic absenteeism puts students at risk for academic failure with effects that can last a lifetime and negatively impact education, health, financial stability, and employment (Robert Wood Johnson Foundation [RWJF], 2016).

BACKGROUND

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

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

RATIONALE

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

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

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

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

CONCLUSION

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

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School nurses: An integral member of the school team addressing chronic absenteeism (Position Statement). Silver Spring, MD: Author.

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Complementary and Integrative Therapies

Position Statement

NASN POSITION

When integrating complementary and integrative therapies into the school setting, the nurse steps beyond allopathic (conventional) treatments into therapies that may not be accepted as traditional. It is the position of the National Association of School Nurses (NASN) that the registered, professional school nurse (hereafter referred to as school nurse) advocates for evidence-based strategies that promote positive outcomes. It is important that when doing so, nurses familiarize themselves with the treatment requested and potential practice implications in light of federal and state regulations, district policy, and their state nurse practice act.

BACKGROUND AND RATIONALE

The use of complementary, integrative, and alternative approaches to health and healing is growing across the United States. Complementary and integrative medicine is an unconventional modality that is used in addition to standard Western medical treatments, while alternative medicine is used in place of standard medical treatments and is not usually evidence-based (McClafferty, 2017; Centers for Disease Control and Prevention, 2020; National Center for Complementary and Integrative Health (NCCIH), 2021). Use of complementary therapies is most often associated with adults; however, more parents and guardians are using integrative approaches as treatment modalities for their children (Beltz, 2018; NCCIH, 2021). Approximately 12% of children in the United States use complementary, integrative, and alternative medicine (Esparham, 2018; NCCIH, 2021).

The nursing profession has a long history of viewing and caring for individuals in a holistic manner. School nurses recognize cultural, psychosocial, and spiritual needs that can impact parents’ decisions about health care practices, as well as choices and preferences for traditional, complementary, or integrative treatments, or non-intervention for their child. School nurses interface with parents and guardians to understand and support their child in school, including the use of non-traditional complementary or integrative therapies (Nathenson, 2021; NCCIH, 2021).

When deciding whether or not to incorporate the use of non-FDA approved therapies or dietary supplements into school nurse practice, it is important that the school nurse first determine what is known about the product, such as ingredients, precautions, recommended dose, and any potential adverse effects. Secondly, determine whether administration is allowable under federal and state law, including applicable state nurse practice acts, and district policy. Additionally, complementary and integrative therapies in the school setting should not disrupt the educational process.

School nurses should familiarize themselves with complementary and integrative therapies that may be used to treat the students under their care, whether at home or in school. NASN supports the use of evidence-based complementary and integrative therapies in the school setting when the school nurse follows their state nurse practice act and the School Nursing: Scope and Standards of Practice, and when requested treatments are allowed under federal and state regulations and district policy.
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“To optimize student health, safety and learning, it is the position of the National Association of School Nurses that a professional registered school nurse is present in every school all day, every day.”

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Comprehensive Health Education in Schools

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that a comprehensive, developmentally appropriate, and evidence-based health education program be implemented for all students. NASN recognizes the vital role of parents and families as an integral source of health education. The registered school nurse (hereinafter referred to as the school nurse) is a valuable resource to parents and educators. NASN supports the implementation of comprehensive health education that promotes healthy development for all students.

BACKGROUND AND RATIONALE

Comprehensive health education should begin upon entry into school, continue through grade 12, and be inclusive and equitable. National Health Education standards provide a framework for schools to use to facilitate the mastery of knowledge and skills regarding health topics and promote healthy behaviors and outcomes for school-age youth (CDC, 2018).

The Global School-Based Student Health Survey indicates priorities for health education as follows: alcohol, drug and tobacco use, dietary behaviors, hygiene, mental health, physical activity, protective factors, sexual behaviors, violence, and unintentional injury (WHO, 2016). An ideal curriculum supports the Whole School, Whole Community, Whole Child model (CDC, 2014). It provides students with education about their physical bodies, their emotions, their behaviors, and their relationships within their social and cultural environment, stressing the importance of personal responsibility and community standards for emerging adult responsibilities (CDC, 2014).

Social and health risk-taking behaviors by adolescents account for 6% of the world’s disease and injury (WHO, 2017). Preventable health risk behaviors established in adolescence may persist into adulthood and can lead to serious social, emotional, and physical health problems that are costly burdens on individuals, families, and the world. At the same time, the School Health Policy and Practices Study of K-12 schools found that there has been a decrease in the amount of instructional time allotted for health topics such as alcohol and other drug use prevention, HIV prevention, infectious disease prevention, and tobacco use prevention (CDC, 2017).

According to the 2019 Youth Risk Behavior Surveillance System Report of 9th-12th grade students in the United States (CDC, 2019):

- 46% played video or computer games 3 hours or more a day
- 40% had engaged in sexual intercourse
- 39% texted or emailed while driving
- 37% had experienced persistent feelings of sadness or hopelessness
- 32% used an electronic vapor product
- 30% used alcohol

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- 39% texted or emailed while driving
- 37% had experienced persistent feelings of sadness or hopelessness
- 32% used an electronic vapor product
- 30% used alcohol
• 21% used marijuana
• 16% did not eat breakfast
• 15% had obesity
• 15% inappropriately used prescription pain medicine
• 9% had attempted suicide
• 8% experienced dating violence
• 7% smoked cigarettes

Special consideration must be given to the 14% of students who receive special education services under the Individuals with Disabilities Education Act (IDEA, 2016; DeBrey et al., 2021). Schools often fail to deliver comprehensive health education to special education students, who experience a higher incidence of sexual abuse and exploitation, innate impairments to learning, and social vulnerability (Treacy et al., 2018). Health education for students with disabilities should be tailored to their ability, learning style, and maturity, in addition to parent values and beliefs (Nelson et al., 2020).

School nurses advocate for evidence-based health curriculums while accounting for existing laws and regulations that provide guidelines for the planning and implementation of health education (SIECUS, 2020). They use the principles of Community/Public Health from the Framework for 21st Century School Nursing Practice™ to guide teaching about health and safety in the health office, in the classroom, and with the entire school population (NASN, 2016). Parents and other family members play a crucial role in nurturing the education and health of their children. Research indicates that when parents are engaged in school health education efforts, students exhibit better behavior, better social skills, fewer health risk behaviors, and higher academic achievement (Kolbe, 2019).

Comprehensive health education empowers students to make appropriate decisions that may improve attendance and academic outcomes and ultimately contribute to their overall quality of life (Kolbe, 2019). School nurses are qualified and uniquely positioned in schools to advocate for and implement comprehensive health education that is available, inclusive, developmentally, and culturally appropriate, and evidenced to result in healthy behaviors.

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This position statement incorporates the retired position statement *Sexual health education in schools*. 


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Concussions: School Based Management

**Position Statement**

**NASN POSITION**

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) provides leadership/care coordination in collaboration with the school-based team to manage student concussion. The school nurse has the healthcare knowledge and skills to provide concussion prevention education to parents/guardians, students, and school staff; identify suspected concussions; and help guide students as they return to academics/learning, physical activities, and sports.

**BACKGROUND and RATIONALE**

A concussion is a type of traumatic brain injury (TBI) caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move rapidly back and forth. This sudden movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging brain cells (CDC, 2019a). The CDC has a checklist for initial assessment of possible concussion as well as danger signs for when the person should immediately be seen in an emergency department (CDC, 2019b). It should be noted that the initial assessment severity of TBI does not necessarily predict the extent of disability arising from TBI (NASEM, 2019).

Approximately 2.5 million or 15.1% of United States high school students reported having at least one concussion on the 2017 Youth Risk Behavior Survey (DePadiia et al., 2017). All 50 states have enacted a sports concussion law, establishing protocols such as removal from play, return to play protocols, and concussion information for student athletes and their parents (Green, 2018). However, many states do not have return to school / return to learning laws or guidelines. The 5th International Consensus Statement on Concussion recommended that children with concussion should be managed conservatively, with the emphasis on return to learn before returning to sports. (McCrory, Meeuwisse & Dvorak et al., 2017). Concussion in children and adolescents can also occur outside of sports, such as motor vehicle accidents, a fall or collision from riding a bicycle (Haarbauer-Krupa et al., 2018). Regardless of where or how a concussion occurs, it is vital to properly recognize and respond to a suspected concussion to prevent further injury and to help with recovery (CDC, 2019a).

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

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

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Do Not Attempt Resuscitation – The Role of the School Nurse

**Position Statement**

**SUMMARY**

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

**BACKGROUND**

In 1974 the American Heart Association declared that cardiopulmonary resuscitation (CPR) was not indicated for all patients. Individuals with terminal, irreversible illnesses where death is the expected outcome would not benefit from CPR (Larcher, Craig, Bhogal, Wilkinson, & Brierly, 2015). In 1994 the American Academy of Pediatrics (AAP) and the National Education Association (NEA) issued guidelines on foregoing life-sustaining CPR for children and adolescents (AAP, 2010). Originally, the physician order was referred to as a Do Not Resuscitate order (DNR), which evolved to Do Not Attempt Resuscitation (DNAR), and sometimes Allow Natural Death (AND) (Selekman, Bochenek, & Lukens, 2013).

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

Currently, the order to provide comfort care is part of a much broader palliative care plan that may include Medical Orders for Life Sustaining Treatment (MOLST) (APA, 2010). In some states, school nurses are required to honor DNAR orders. In the case of ABC and DEF School v. Mr. and Mrs. M in the state of Massachusetts (1997), the court ordered the school to honor the DNAR order for a medically fragile child (Adelman, 2010; Deutch, Martin, & Mueller, 2015; Putman, 2017). In addition, the court refused to allow the school to shield staff from liability should they choose not to honor the DNAR order (Adelman, 2010).

According to the 2011/2012 National Survey of Children with Special Health Care Needs (CSHCN), approximately 14.6 million children ages 0-17 years in the United States, or 19.8 %, have special healthcare needs. The percentages of CSHCN range from 14.4%-26.4% across 50 states and the District of Columbia (Centers for Disease Control and Prevention’s National Center for Health Statistics, n.d.). The AAP (2010) estimates that, on any given day, there are 3900 school-age children who are within six months of dying from chronic health conditions (as cited in Putnam, 2017). According to a Centers for Disease Control and Prevention [CDC] survey, the percentage of schools where health services staff reported the need to follow a DNAR order increased from 29.7% in 2000 to 46.2% in 2006 (Brener, Wheeler, Wolf, Vernon-Smiley, & Caldart-Olson, 2007).
Growing populations of students with chronic health conditions—including terminal and irreversible illnesses, congenital defects, injuries, and malignancies, where death may be the expected outcome—are now routinely attending school (Klick & Hauer, 2010; Adelman, 2010). The Office for Civil Rights of the DOE (2016) states that a free and appropriate public education must be provided to each person with a disability (a person with a significant mental or physical impairment, or history of such, that substantially limits a major life activity). Services must be provided in the least restrictive environment.

RATIONALE

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

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

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

CONCLUSION

School nurses play a pivotal role in supporting students with DNAR orders through the development of an IHP and ECP (AAP, 2010; Peate, 2015). The school nurse is the school health professional with the knowledge, experience, and skills to coordinate the care for a student with a DNAR order, linking the school with the medical and community services needed by the student, while advocating for the student and family to ensure access to a free and appropriate education (DeMitchell & Thompson, 2017; Selekmam et al., 2013). School nurses along with the school district should create clear, written policies related to DNAR with regard to their state laws and statutes (Perry, 2014).

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Education, Licensure, and Certification of School Nurses

**Position Statement**

**NASN POSITION**
It is the position of the National Association of School Nurses (NASN) that every school-age child should have access to a registered professional school nurse (hereinafter referred to as the school nurse) who has a minimum of a baccalaureate degree in nursing from an accredited college or university and is licensed as a registered nurse through a board of nursing. These requirements constitute minimal preparation needed to practice at the entry level of school nursing (American Nurse’s Association [ANA] & NASN, 2017). Additionally, NASN (n.d.) supports state school nurse certification/licensure and endorses national certification of school nurses through the National Board for Certification of School Nurses.

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

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

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

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

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

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

Position Statement

NASN Position

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

Background

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

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

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

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

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

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

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

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

Conclusion

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

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Emergency Preparedness

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) provides expertise in school health and is a vital member of the school team who collaborates with community agencies to develop comprehensive emergency response procedures. The school nurse knowledgeable about the pathophysiology of physical and psychological trauma and is a valuable resource for the provision of health care and support in emergencies. (Kalekas, 2017).

BACKGROUND AND RATIONALE

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

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

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

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

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Environmental Health

Position Statement

NASN POSITION
It is the position of the National Association of School Nurses (NASN) that to protect and promote the health of all children, robust environmental health protections must be in place, and the inequities that lead to environmental injustice must be eliminated. The environment is a powerful social determinant of health and a critical factor in our children’s development, academic performance, and future socioeconomic status. The registered professional school nurse (hereinafter referred to as school nurse) assesses for environmental health hazards, implements and coordinates individual health and social interventions, and addresses social determinants of health based on the National Association of School Nurses (NASN) Framework for 21st Century School Nursing™ (NASN, 2016), to positively influence children’s environmental health (Campbell & Anderko, 2020).

BACKGROUND AND RATIONALE

The National Environmental Health Partnership Council defines environmental health as the branch of public health that focuses on the relationships between people and their environment, promotes human health and well-being, and fosters healthy and safe communities (American Public Health Association [APHA], 2020a, para. #1). Children are particularly vulnerable to the effects of the environment on their health (APHA, 2020b; World Health Organization [WHO], 2020a). Exposures to environmental hazards can occur at school, at home, or in the community (Firestone, Berger, Foos, & Etzel, 2016; Jones, Anderko, & Davies-Cole, 2020). Therefore, to protect and promote children’s environmental health—prevention, intervention, and mitigation efforts must focus on all of these settings. The vast majority of U.S. children and youth, 56.6 million in 2019, (National Center for Education Statistics, n.d.) attend public or private schools. Unhealthy school environments compromise health, attendance, concentration, and academic performance (Paulson & Barnett, 2016). School nurses are often the primary health professionals who protect and promote child health and focus much of their attention and interventions in the school setting (NASN, 2018). School nurses are also ideally situated to advocate for policies and programs that improve community environmental health, particularly in under-resourced communities (Chalupka & Anderko, 2019; Kranjac, Denney, Kimbro, Moffett, & Lopez, 2018; Jones, Anderko, & Davies-Cole, 2020; Campbell & Anderko, 2020). School nurses, as change agents, advocate for healthy communities and seek to build health equity into policy and school nursing practice.

The World Health Organization estimates that 24% of all global deaths and 26% of all deaths among children are linked to the environment (WHO, 2019). While most of the deaths occur in low- and middle-income countries, the United States has the highest environmental burden of disease compared to other high-income countries (Peterson-Kaiser Health System Tracker, 2017). Children are more highly exposed and vulnerable to environmental health hazards compared to other age groups due to a variety of physiological and behavioral factors (APHA, 2019; APHA, 2020b; Firestone et al., 2016; WHO, 2020b). While all children are disproportionately affected by environmental exposures, children living in under-resourced, minority communities are at even higher risk (Mohai & Saha, 2015; Bagby, Martin, Chung, & Rajapakse, 2019). In addition, rates of developmental disorders and other non-communicable diseases in children are rising, leading to additional concerns about the effects of the environment on child health (Koehler et al., 2018; Kranjac et al., 2018; Moffett, & Lopez, 2018; Landrigan, Sly, Ruchirawat, Silva, Huo, Diaz-Barriga et al., 2016; Naviaux, 2020). As cited in Galvez et al. (2019), associations have been identified between environmental exposures and increasing rates in the incidence and prevalence of pediatric asthma, birth defects, dyslexia, mental retardation, attention-deficit/hyperactivity disorder, autism, childhood leukemia, brain cancer, preterm birth, and obesity.

Key assessment areas to consider in order to identify potential environmental risks within the school, home, and community environment include
• Indoor and outdoor air quality (Jones, Anderko & Davies-Cole, 2020; Payne-Sturges et al., 2019; Everett-Jones, Foster & Berens, 2019),
• Water quality (Schaider, Swetschinski, Campbell, & Rudel, 2019),
• Building materials, cleaning products (Abrams, 2020),
• Chemical exposures (e.g. agricultural products, pesticides, radon, lead, mercury, arsenic) (Anderko, 2018; Anderson, Eure, Orr, Kolbe & Woolf, 2017; Hanna-Attisha, M., 2017; Tinney, Denton, Sciallo-Tyler, Paulson, 2016),
• Mold (Polyzoi, Polyzois, Koulis, 2017),
• Waste exposure, anthropogenic climate change (Chalupka & Anderko, 2019), and
• Environmental disasters, and energy use (U.S. Environmental Protection Agency [EPA], 2020a).

In the nursing profession, recognition that human health is inextricably dependent on the health of the environment is foundational (American Nurses Association [ANA], 2007). In a call to action, ANA (2007) set out principles and implementation strategies for all nurses to assess and address environmental issues in their practice. Nationally, the 1993 publication of the National Academy of Sciences Report, Pesticides in the Diets of Infants and Children, was a seminal event in the recognition of the unique vulnerabilities of children to environmental hazards (Galvez et al, 2019). Firestone et al., (2016) cites this report leading to the EPA’s increased consideration of environmental health risks to children. Despite this recognition, currently no federal, state, or local agency is authorized, funded, or staffed to protect children in the school setting from environmental health hazards (Paulson & Barnett, 2016). Voluntary guidelines do exist, notably the EPA State School Guidelines developed to assist states in establishing and implementing environmental health programs for schools (EPA, 2019).

A report from APHA (2019) recognized that there is no federal agency that guarantees the safety of school environments to protect school-age children from environmental hazards and risks. To address this deficiency, funding should be provided to federal agencies, including the Centers for Disease Control and Prevention and the EPA, to develop a coordinated strategy to address healthy school environments for all children. In addition, NASN supports

- Inclusion of EPA’s Healthy Schools Grant Program (EPA, 2019b), in yearly federal budgets.
- Passage of the Rebuild American Schools Act (GovTrack.us, 2021).
- Adequate funding of the EPA’s Green and Healthy Schools Initiative, Indoor Air Quality Tools (IAQ) for Schools, Integrated Pest Management (IPM), School Chemical Cleanout, Air Now/EPA Air Quality Flag, and Reducing Lead in Drinking Water programs.
- Robust environmental health protections in schools, for example, mandatory IAQ monitoring, use of green cleaning products, and annual drinking water testing.
- Timely data from the Government Accounting Office for use in America’s schools through the Condition of America’s Public School Facilities Report.
- Protection of the Clean Air Act and Safe Drinking Water Act to ensure that these safeguards remain in place and are enforced.
- Disaster preparedness plans that include climate change-related extreme weather events.

The health and welfare of our nation’s children and youth are dependent upon the quality of the environment in which they live, learn, play, and work. NASN recognizes that increasing numbers of environmental hazards are contributing to a rise in the incidence of developmental disorders and non-communicable diseases. While all children are uniquely vulnerable to the negative effects of an unhealthy environment and require special protection, low income minority children are more likely to experience adverse effects from disparities in exposures, including unhealthy air, water, and toxic hazards (EPA, 2020a). To enable equitable environmental protections and support for the healthy development of all children, funding must be adequate and federal, state, and local agencies must coordinate efforts in data collection, communication, and enforcement of existing laws, rules, and regulations.
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“To optimize student health, safety and learning, it is the position of the National Association of School Nurses that a professional registered school nurse is present in every school all day, every day”

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Equitable Reimbursement for School Nursing Services

Position Statement

The National Association of School Nurses (NASN) believes school nursing services that are reimbursed in other healthcare environments should also be reimbursed in the school setting. The registered professional school nurse (hereinafter referred to as the school nurse) bridges education and healthcare and delivers quality, cost-effective healthcare in the school setting that is vital to supporting student learning and academic achievement (Maughan et al., 2018). Ensuring sufficient funding so that all children have access to necessary healthcare services provided by a school nurse is a matter of equity (Department of Health and Human Services and Centers for Medicare and Medicaid Services, 2022a).

BACKGROUND AND RATIONALE

When there is a school nurse present in school, all students have access to healthcare without the need for an appointment, referral, fees, insurance, or transportation (Gratz et al., 2020). However, over half of public school students in the U.S. do not have access to a school nurse all day, every day (Willgerodt et al., 2018). Funding school nursing positions is not always a priority in educational budgets. However, the types of public health services provided by school nurses have demonstrated significant positive returns on investment (McCullough, 2018; Minnesota Management and Budget, 2017). “Spending on school nurses ought to be viewed as an investment, not a cost … Supporting local school nurses is a sound investment not just for students and schools, but for the entire community” (Maughan, 2018, paras 17-18). Beyond a financial justification, evidence supports meeting the societal values of doing what is best for children, with benefits that are often realized over the lifetime of a child (McCullough, 2018).

For school-age youth, schools are an appropriate, safe, and least restrictive setting where school nurses can provide medically necessary care that will “improve health or lessen the impact of a condition, prevent a condition, or restore health” (National Academy for State Health Policy, 2021, para 4). However, both public and private insurer reimbursements for school nursing services are typically not commensurate with reimbursement for nursing services provided in other settings such as hospitals, clinics, and home care. For all students to have access to sustainable, quality school nursing services, sufficient funding for school nursing services should be supported by reimbursement through public and private insurers at levels equivalent to nursing services in other healthcare settings. The setting for the provision of needed healthcare should not determine payment or rates for a reimbursable service.

The Future of Nursing 2020-2030 specifically calls attention to the reality that school nurses are “inadequately supported by current funding mechanisms” (National Academies of Sciences, Engineering, and Medicine [NASEM], 2021, p. 176). In order for all students to have equitable access to quality school nursing services, there must be sufficient funding to cover the cost of providing full-time school nursing services (Weeks et al., 2021). “School and public health nurses play a vital role in advancing health equity. Adequate funding for these nurses is essential” (NASEM, 2021, p.10). The American Academy of Nursing asserts that “all students must have daily access to a full-time school nurse who is part of a comprehensive health-care and education system and is supported financially by health and education dollars” (Maughan et al., 2018, para 1).

Decision-makers and stakeholders from education, health, and governmental sectors need to collaborate to create and sustain “adequate and equitable funding models at the federal, state, and local levels” (National Healthy Schools Collaborative, 2022, para 4). Efforts to achieve equitable standards of care for all school-age youth require sustainable and flexible payment mechanism reforms that support school nursing (NASEM, 2021). “Adequate funding would enable these nurses to expand their reach and help improve population health and health equity” (NASEM, 2021, pp. 176-177).
With over half of children in the U.S. enrolled in Medicaid and/or Children’s Health Insurance Program (CHIP) for children in families that do not qualify for Medicaid and cannot afford private insurance, these public programs provide health insurance for a significant number of school-age youth. Medicaid reimburses certain aspects of school health services for enrolled children when a qualified provider provides a service approved by Medicaid guidelines (Department of Health and Human Services and Centers for Medicare and Medicaid Services, 2022b). Complicating matters, each state has different methods for applying Medicaid coverage for school nursing services. In some states, regulations are misaligned, precluding these states from taking advantage of expanded Medicaid coverage to reimburse school nursing and other health services (Mays & O’Rourke, 2022; Weeks et al., 2021; Hoke & McGowen, 2019).

Economic fluctuations and multiple priorities create competition for limited financial resources in school district budgets. Sustainable payment systems to sufficiently support school nursing services are necessary to equitably help all youth address health barriers to learning, to be able to meet their full educational potential. Insurance reimbursement for school nursing services comparable to other nursing settings can provide additional funding to support and strengthen the provision of essential, quality school nursing care for all children.

REFERENCES


Head Lice Management in Schools

Position Statement

NASN POSITION

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

BACKGROUND AND RATIONALE

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

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

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

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

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

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

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

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Healthy Communities

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that healthy and safe communities are essential for the optimal health, well-being, academic success, and lifelong achievement of all school age youth (NASN, 2022a). Bridging education and healthcare, the registered professional school nurse (hereinafter referred to as school nurse), is uniquely situated to protect and promote student and community health, to work collaboratively to respond to public and population health needs, and to contribute to building an equitable culture of health that places “well-being at the center of every life, decision and policy” (NASN, 2022b, p. 100).

BACKGROUND/RATIONALE

Healthy communities strive to provide safe, healthy, and supportive physical and social environments that enable all people to develop and thrive (Cassells, 2019). An actionable blueprint for healthy communities in the U.S is articulated in Healthy People 2030, a national healthcare framework that is updated every decade. This plan is comprised of evidence-based measurable goals and objectives to build a “society in which all people can achieve their full potential for health and well-being across the lifespan” (Office of Disease Prevention and Health Promotion, n.d., para 4).

The circumstances in which people are born, grow, work, live, and age are often referred to as social determinants of health (SDOH) (World Health Organization, 2022). These non-medical, upstream population-level social, political, and structural factors shape the conditions of daily existence and impact the opportunities and choices people have to lead healthy lives. Examples of SDOH include education, housing, transportation, employment, access to health care services, and food (Centers for Disease Control and Prevention, 2021). The availability and quality of SDOH in a community have a greater impact on long term health than clinical healthcare and are responsible for about 80% of health outcomes (County Health Rankings, 2022). A data map from the Centers for Disease Control and Prevention vividly demonstrates that life expectancy, a health status indicator (Li et al., 2018), differs depending on the communities where people live (Tejada-Vera et al., 2020).

School nursing addresses the health and social needs of individual students and their families and also incorporates a population and public health approach along a continuum of care that includes upstream prevention and system-level interventions (Campbell & Anderko, 2020; Ackerman-Barger et al., 2022). Community/public health is a key principle of NASN’s Framework for 21st Century School Nursing Practice™ (NASN, 2016; NASN, 2020) and school nurses are vital partners in “the complex work of integrating the social and health sectors in support of the health and well-being of individuals, families, and communities” (National Academies of Sciences, Engineering, and Medicine, 2021, p. xv). Data-informed evidence-based interventions that address barriers to health and learning, and that help build community conditions that create a healthy place to live, can lead to better lifetime educational and health outcomes for school-age youth (Rattermann et al., 2021). Health issues can pose significant barriers to learning that “affect children’s ability to see, hear and pay attention in the classroom, their ability and motivation to learn, their attendance, their academic performance, and even their chances of graduating from high school” (National Academies of Sciences, Engineering, and Medicine, 2019, p. 2-3). Children who encounter these types of health barriers to learning can benefit greatly from school nursing expertise and intervention. School nurses may also attend to population-level student health concerns, driven by social and economic conditions in communities by supporting the development of policies, regulations, and laws that foster the health of school age youth and families (Castrucci & Auerbach, 2019).

Each community uniquely possesses strengths as well as challenges in handling preventable risks and harm that can lead to obesity, chronic diseases, substance misuse, mental health disorders, violence, injury, and the spread of infectious illnesses. By striving to provide clean air and water, sanitation services, and access to healthy foods, recreation, transportation, adequate healthcare, and quality education, including a full time school nurse,
communities contribute to the foundation of health for the nation’s youth, which enables children to learn better (Selekman, et al., 2019). Fostering the circumstances in which children achieve better academically supports the development of a stronger, more productive citizenry (Maughan et al., 2018; Kolbe, 2019). Healthy People 2030 affirms that “the health and well-being of all people and communities is essential to a thriving, equitable society” (Office of Disease Prevention and Health Promotion, n.d., para 11). In addition to the benefits for society, the Whole School, Whole Community, Whole Child (WSCC) model for addressing student health in schools brings the focus back to the long-term development and success of the whole child so that all children can be healthy, safe, supported, engaged, and academically challenged (ASCD, 2022).

The communities where children and families live, learn, work, and play strongly influence many aspects of physical and emotional health and well-being. Healthy communities provide the infrastructure and resources that create the conditions and opportunities to support healthy lifestyles. School nurses are indispensable partners in improving and enhancing school and community health by effectively collaborating across sectors to address barriers to health and learning and improving health processes and outcomes. School nursing is vitally integral to helping advance and sustain healthier, more equitable places to live (Schroeder et al., 2018). These efforts align with a vision where all students can be optimally healthy, safe, and ready to learn (NASN, 2022a).

REFERENCES


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Human Trafficking

Position Statement

NASN POSITION

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

BACKGROUND AND RATIONALE

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

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

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

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

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

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

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

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

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

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


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

Position Statement

NASN POSITION
It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as a school nurse) is an essential member of a multidisciplinary education team that identifies, evaluates, and monitors students who may be eligible for services through the Individuals with Disabilities Education Improvement Act (IDEIA) (2004) or Section 504 of the Rehabilitation Act of 1973.

BACKGROUND & RATIONALE
Federal and state laws define and protect a student’s right to education. Two, in particular, define how and what schools must do to support student learning when general education methods and supports are not enough. These are Section 504 of the Rehabilitation Act of 1973 and the Individuals with Disabilities Improvement Act of 2004.

Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112) as amended through the Americans with Disabilities Amendment Act (ADAA) in 2008 established legal support for individuals with disabilities, including students in federally funded programs and activities such as schools. This federal civil rights law ensures that every student is entitled to a free and appropriate public education (FAPE) (U.S. Department of Education, 2015). Under Section 504, FAPE provides a student with a physical or mental impairment that impacts one or more major life activities with related services and accommodations in the general education classroom. These services address the student’s individual educational needs to achieve equity with nondisabled students. A physical or mental impairment under Section 504 standards can be from a chronic disease or condition, a disability, or an injury and necessitates an evaluation by and input from a school nurse to determine if access to learning is impacted.

In 1975, Congress enacted the Education for All Handicapped Children Act (Pub. L. 94-142), with numerous amendments that further define and effect the meaning of disability as it relates to learning. The latest amendment titled the Individuals with Disabilities Education Improvement Act (2004) often referred to as IDEIA or IDEA includes specific provisions for identifying and evaluating students who may need special education services, its components, as well as procedural safeguards for implementation.

School districts are mandated to identify and evaluate all children who experience difficulty in accessing their education, regardless of severity, to determine if they qualify for education accommodations (with a 504 plan) or special education services (with an individual education program). This mandate includes the related service of school nursing and health services as needed (134 C.F.R. 104.32). IDEIA mandates that students receive a comprehensive, multidisciplinary evaluation conducted by individuals with the appropriate expertise in the areas of concern.

The school nurse is the team member qualified to evaluate the health needs of the student, many of which may not be apparent without a thorough health assessment. If health-related barriers are not recognized, appropriately interpreted, and addressed those students risk academic failure. Caution must be taken when an education team chooses not to evaluate a student’s health or chooses to have non-
nurse conduct the evaluation. Under IDEIA, the student’s federal civil right to a nondiscriminatory comprehensive evaluation is not upheld if non-nursing educational professionals who are unqualified to conduct a health assessment assume this role. (Alfano et.al 2017; Halbert & Yonkaitis, 2019)

The school nurse is the recognized healthcare expert in the school setting (AAP, 2016; ESSA, 2015). School nurses have the unique knowledge and experience essential to evaluate the health of students in order to identify health-related barriers to learning and the accommodations necessary to provide students proper access to education. School nurses work collaboratively with other team members to identify, evaluate, and develop plans for students in need of educational accommodations and special education services. School nurses are integral to ensuring the civil rights of all students so that they can achieve optimal educational success and well-being at school (Halbert & Yonkaitis, 2019).

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Immunizations

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that immunizations are essential to primary prevention of disease from infancy through adulthood and that childhood vaccinations are an effective way of preventing serious childhood illnesses (U.S. Department of Health and Human Services [USDHHS], 2017). NASN supports elimination of all exemptions except those necessary for valid medical contraindications.

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

BACKGROUND AND RATIONALE

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

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

As vaccine rates in the United States decline and cases of vaccine-preventable illness increase, access for parents to reliable information about the safety and efficacy of childhood immunizations and accurate tracking of children’s vaccination records becomes even more important. School nurses are well equipped to
inform about both. School nurses have regular access to students, are trusted by parents to deliver accurate health information, and have access to state immunization registries. One of the most practical solutions to increase vaccine availability and vaccine compliance is to support school-based vaccination clinics. The CDC (2014) notes that schools are one of the most efficient systems for providing health services to children and youth, because approximately 95% of U.S. children and youth attend school. NASN supports the ACIP vaccine recommendations adopted by the CDC and states and local vaccine mandates. NASN also supports full school nurse access to state registries, an important practice tool. School nurses use state registries to facilitate immunization compliance, identify the immunization status of students in the event of disease outbreaks, and prevent duplication of vaccinations when records have been lost, destroyed, or misplaced (CDC, 2013; AAP, 2006; Guide to Community Preventive Services, 2010). School nurses are strongly positioned within their communities to educate students, families, and school staff about the critical role vaccines play in preventing disease, allowing students and staff to remain healthy and in school.

REFERENCES


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Use of Individualized Healthcare Plans to Support School Health Services

Position Statement

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

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

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

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

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

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

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

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

REFERENCES


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LGBTQ Students

Position Statement

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

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

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

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

REFERENCES


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Naloxone in the School Setting

Position Statement

NASN POSITION

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

BACKGROUND AND RATIONALE

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

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

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

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

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

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

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

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

REFERENCES


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Supporting Scheduled Recess

Position Statement

NASN POSITION

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

BACKGROUND

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

RATIONALE

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

The school nurse supports and advocates for scheduled recess that

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

CONCLUSION

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

REFERENCES


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Use of Restraint and Seclusion in the School Setting

**Position Statement**

**NASN POSITION**

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

**BACKGROUND AND RATIONALE**

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

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

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

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

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

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

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

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

All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.
Safe, Supportive, Equitable Schools

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that every student should attend school in a safe, supportive, and equitable environment. Access to a registered professional nurse (hereinafter referred to as a school nurse) democratizes healthcare for the most vulnerable students and families.

BACKGROUND AND RATIONALE

Poverty, racism, homelessness, access to healthcare, food insecurity and other social determinants of health can have a significant impact on the health and well-being of students and school communities (CDC, 2021a; NASN, 2020). The *Future of Nursing Report* emphasizes the positive impact of school nurses on students’ clinical and social needs and highlights the urgent need to expand, strengthen, and diversify school nursing practice as a means to advance health equity for students (National Academies of Sciences, Engineering, and Medicine, 2021.) Learning is best achieved when the student’s physical, social, and emotional development are addressed in the school setting (CDC, 2018).

All students have a right to learn in a safe environment. Structural and systemic barriers, both within and outside of schools, have created environments in which students may feel disconnected and unsafe. Issues related to safety, racism, and violence impact all students; however, they may disproportionately impact racial, ethnic, and gender-sexual minority students (Brookings, 2020). Students who do not feel safe are unable to learn; therefore, they may be chronically absent, may not actively engage in learning, or may drop out of school.

Students struggling with mental health issues, including isolation, stress, anxiety, depression and the effects of bullying, may avoid school if they do not feel a sense of safety and belonging (Baek et al., 2019; Eugene et al., 2021). Thirty-six percent (36%) of U.S. high school students identified being treated unfairly or badly due to their race or ethnicity, with those who indicated poorer mental health and less school connectedness reporting the highest incidence of racism (Mpofu et al., 2022). Minority stress also places students at additional risk for depression and suicidal ideation or attempts (Kosciw et al., 2020). Furthermore, safe and supportive school environments provide opportunities for LGBTQ+ youth to socialize and build positive, identity-affirming relationships that are pivotal in improving their mental health and physical well-being (McCabe et al., 2022).

School connectedness is a protective factor that supports youth physical, mental, and emotional well-being, fosters resilience, and is a significant predictor of healthy behaviors (Steiner et al., 2019; Eugene et al., 2021; Osher et al., 2021) and academic success (Reynolds et al., 2017). School nurses promote connectedness through communication, advocacy, and by establishing trusting and caring relationships with all youth, including youth from marginalized groups (McCabe et al., 2022). A schoolwide approach to connectedness also involves the integration of trauma sensitive schools (TSS) and social emotional learning (SEL) (Osher et al., 2021).

Adverse childhood experiences (ACEs) have been linked to long-term impact on physical, social, and mental health (CDC, 2021b). This is more prevalent in black and brown communities and escalated
during the COVID-19 pandemic (Martin et al., 2022). Issues of structural racism, intentional or unintentional, must be eradicated. For example, it is well known that school discipline policies related to expulsion and suspension have been unevenly applied toward ethnic minority and special education students (Steinberg & Lacoe, 2018). School nurses are well-positioned to address systemic inequities and to influence school policies and practices, working in concert with other school support personnel. These include disciplinary and other practices involved in treatment of racial, ethnic, and gender-sexual minority students (Willgerodt et al., 2021).

Youth violence is a public health concern. Half of U.S. students have experienced violence in the school setting (David-Ferdin et al., 2021). Black, Indigenous, and people of color (BIPOC) and LGBTQ+ teens are at a greater risk of experiencing violence than their peers (CDC, 2021c; 2022). A majority of U.S. children and teens worry that a school shooting may occur at their school (Cogan et al., 2019; Graf, 2020). Teens who experience violence in and out of the school environment may be at risk for:

- Missing school due to safety concerns
- Risky sexual behavior
- Low academic achievement
- Overweight or obesity
- Access to a weapon
- Feelings of sadness or hopelessness
- Suicidal thoughts or behavior
- Substance use (David-Ferdon et al., 2021)

Students who experience or fear violence, at home or at school, report that a positive school climate with supportive adults helps them to feel safer (Baek et al., 2019). Students and school communities require safe and supportive environments to flourish. A safe, trauma-sensitive school is one where teaching and learning are collectively embraced; equity is centered as a shared value; strategies to minimize disruptive behaviors and address the root causes of violence are prioritized; students' voices are included in shared governance; school community norms are clearly communicated, and restorative justice practices are implemented.

School nurses possess the skill and judgment to identify and address the structural and systemic barriers that impact the attainment of safe, supportive, and equitable school environments which contribute to students’ ability to achieve wellness and academic success.

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The School Health Services Team: Supporting Student Outcomes

Position Statement

NASN POSITION

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

BACKGROUND AND RATIONALE

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

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

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

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

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

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

REFERENCES


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

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NASN POSITION

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

BACKGROUND AND RATIONALE

Since 1902, school nurses have contributed to individual and population health, in ever-expanding ways (Rogers, 1903/2014). Laws implemented in the 1970s established the rights for all students, even those with significant health needs, to attend public school, and led to recommendations for school nurse-to-student ratios. These laws included the Rehabilitation Act of 1973, Section 504 (1973), and Public Law 94-142, the Education for all Handicapped Children Act (1975), reauthorized in 2004 as the Individuals with Disabilities Education Improvement Act (IDEIA). Changes in these laws increased the role and responsibilities of the school nurse.

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

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

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

Little data exists on validated tools to determine school nurse staffing. Current best practice for staffing involves analyzing complex factors including number of students, social determinants, acuity levels, other responsibilities, barriers to care, current use of technology, and health care to adequately meet the health and safety needs of the children whose care is entrusted to schools (Jameson et al., 2018). Such a structure helps detail a 21st-century context for nurse staffing that recognizes the individual contribution and added value of each individual nurse as a provider of care (ANA, 2020). NASN recommends ongoing research to develop evidence-based health assessment and other tools that consider multiple factors for the development of staffing and workload models.

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

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

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School-located Vaccination

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that reaching high vaccination coverage of school-age children, as outlined in Healthy People 2030 (U. S. Department of Health and Human Services [USDHHS], 2021), is an essential public health objective. The National Strategic Plan for the United States 2021-2025 highlights the importance of increasing the availability of vaccines and removing barriers to access in non-traditional healthcare settings. School-located vaccination (SLV) can enhance other emerging non-traditional vaccination sites (USDHHS, 2021). The registered professional school nurse (hereinafter referred to as the school nurse) is in a critical position to create awareness, influence action, and provide leadership in the development of SLV programs.

BACKGROUND AND RATIONALE

SLV has a long history in the United States and has successfully contributed to lower morbidity and mortality due to vaccine-preventable diseases (Park et al., 2021). In 1875, New York City used schools to deliver the smallpox vaccine. Schools were again utilized in the 1950s to deliver the Salk polio vaccine. In 1969, schools held vaccine clinics to administer the rubella vaccine, in the 1990s to conduct hepatitis B catch-up clinics, and again in 2009 for varicella and H1N1 vaccines (Mazyck, 2010; Hodge & Gostin, 2002).

The school is an ideal place to reach 50.6 million children from all cultures, socioeconomic groups, and age groups who attend each day; further, the school is conveniently located in a familiar and trusted community environment (Hanson, 2021). Studies show that SLV is key for adolescents, who have significantly lower rates of vaccination due to lower rates of office-based visits (Bernstein & Bocchini, 2017). School districts providing SLV must have support from the school administration and may require additional staffing to facilitate this effort.

The COVID-19 pandemic has highlighted the value of SLV and administering vaccines in the school setting as a primary mitigation strategy to provide protection against communicable diseases, including SARS-CoV-2. A decline in routine vaccination occurred in children due to the pandemic, related to healthcare provider office closures, stay-at-home orders, caregiver fears in accessing primary care related to COVID-19 exposure, and virtual schools’ lack of exclusion from non-compliance with state and territorial mandates (Patel et al., 2020; CDC, 2021). CDC recommends that decisions to include COVID-19 vaccines in SLV are best determined at the local level, working with community partners to support equitable access to the vaccine (CDC, 2021).

The school nurse can play a critical role in planning and executing SLV. For example, school nurses:

- have experience collaborating with community partners, including local and state public health departments, school officials, other nurses, teachers, emergency planning authorities, child health agencies, families, community leaders, and local healthcare providers.
are a trusted source of health information for school boards and school officials, providing evidence of the impact of vaccination on school attendance.

- can provide accurate information and dispel myths about vaccines. School nurse relationships with parents/families can be critical in obtaining consent for vaccination.

- can identify students who have missed vaccines (Swallow & Roberts, 2016).

- can identify and secure spaces within schools which have the capacity to host SLV (e.g. gymnasium, library, cafeteria).

- can offer a convenient option for parents to have their children receive needed vaccinations without having to arrange for a healthcare provider visit or taking time off from work; children also miss less instructional time if vaccines are provided onsite.

- can assist with securing volunteers, such as healthcare professionals and/or nursing students, to participate in SLV efforts.

SLV can reach children in the school environment and can improve vaccination rates for children and communities (Park et al., 2021). NASN believes that immunizations are essential to primary prevention of disease from infancy through adulthood and continues to support the efforts of school nurses in developing SLV opportunities.

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School-sponsored Trips - The Role of the School Nurse

Position Statement

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

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

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

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

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

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

Planning steps may include

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

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

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

CONCLUSION

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

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Service Animals in Schools

Position Statement

NASN POSITION

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

BACKGROUND AND RATIONALE

Americans with Disabilities Act (ADA) regulations, Section 504 of the Rehabilitation Act of 1973, Individuals with Disabilities in Education Act, as well as state and local laws, support children who may require a service animal in school (Brennan & Nguyen, 2014). The Americans with Disabilities Act regulations define a service animal as “a dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability” (United States Department of Justice [USDJ], 2011, para 3). A separate provision includes miniature horses in the definition of a service animal (USDJ, 2011). Disabilities for which service animals are used include physical, sensory, psychiatric, intellectual, or other mental disability. Service dogs and horses can be especially beneficial in improving the educational experience of children with special needs (Harris & Sholtis, 2016).

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

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

Students with disabilities utilize service animals for a variety of tasks, allowing greater access to education (Harris & Sholtis, 2016). Communication and planning with all stakeholders is essential in supporting the student with a service animal. The school nurse plays a key role in facilitating this communication and planning process.

REFERENCES


Acknowledgment of Authors

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Student Access to School Nursing Services

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that all students should have access to school nursing care by a registered, professional school nurse (hereinafter referred to as school nurse) all day, every day. For students who face barriers to accessing healthcare, especially those living in predominantly low-income, rural and minority communities, a school nurse may serve as their only regular healthcare provider. School nurses provide students, staff, and school communities with quality healthcare that is critical for health promotion, disease prevention, health maintenance, and health equity (National Academy of Medicine, 2021).

BACKGROUND AND RATIONALE

About 56 million students attend school in the United States; about 6% or 3.3 million do not have health insurance coverage (NCES, 2020; US Census Bureau, 2020). School nurses provide all students equitable access to healthcare when they teach, assess, and support physical and mental health, and remove barriers to community-based healthcare through care coordination and case management (Maughan et al., 2016).

Several barriers may impact a family’s ability to seek medical care or advice (Johnson, 2017). This may be related to a lack of insurance or an available healthcare provider. Other barriers, such as job or transportation constraints, can impact parents’ ability to take a child for treatment. Whatever the reason, the school nurse is often the healthcare provider who provides assessment and episodic care for the student. The school nurse also provides care coordination by helping families to enroll in public health insurance programs, finding a medical home and even arranging transportation to appointments (American Academy of Pediatrics, 2016). Support of a school nurse may be even more essential in schools where socioeconomic and geographic disparities exist (Gratz et al., 2021).

School nurses empower students to be well; they teach, treat, counsel, and support students to increase classroom seat time and decrease trips to the health office and absences from school (Best et al., 2021). School nurses support student health in a variety of ways. School nurses may teach students how to manage their own health and wellness; monitor student immunization status, conduct vision and hearing screening, and refer students for treatment; participate in 504/IEP meetings, contribute to individualized education programs and/or develop individualized health care plans (American Academy of Pediatrics, 2016). School nurses are often the first to identify and address student behavioral health concerns and serve as an early warning system for children and families in crisis or otherwise at risk of abuse and neglect. School nurses provide support and care for students with special healthcare needs/chronic conditions through care management and direct care, including medication administration and health procedures.

School nurses use their public health expertise to advocate for healthier communities by leading school wellness teams and developing health and wellness policies addressing issues such as quality air,
healthier lunches, and barriers created by health disparities (Johnson, 2017). School nurses support the school community through constant surveillance of student and staff conditions to prevent and control spread of communicable disease and prepare for and respond during emergencies (Shannon et al., 2020).

School nurses provide care and support to all students using the Framework for 21st Century Practice model (NASN, 2016). The model is student-centered and includes five nonhierarchical key principles: Standards of Practice, Care Coordination, Leadership, Quality Improvement, and Community/Public Health. The principles of the Framework help to describe many of the practice activities nurses perform each day to support student health and learning. The Framework is aligned with the Whole School, Whole Community, Whole Child movement and its interdisciplinary approach to student health and learning (NASN, 2020; CDC, 2014)

School nursing plays an essential role in keeping children healthy, safe, and ready to learn so that they may grow into healthy and productive adults. The school nurse is a member of a unique, specialized discipline of professional nursing and is often the sole healthcare provider in an educational setting (NASN, 2016). It is essential that all students have access to a full-time school nurse all day, every day to level the playing field with regard to health equity and to support student physical health, mental wellness and academic readiness (Council on School Health, 2016).

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**Acknowledgment of Authors**

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

*All position statements from the National Association of School Nurses will automatically expire five years after publication unless renewed, revised, or retired at or before that time.*
SUMMARY

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

BACKGROUND

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

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

RATIONALE

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

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

Clinical supervision

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

**Administrative supervision**

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

**Supervision and evaluation models**

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

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

**CONCLUSION**

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

**REFERENCES**


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Telehealth: Equitable Student Access to Health Services

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that utilization of telehealth technology is a valuable tool that can assist registered professional school nurses (herein referred to as a school nurse) to enhance access to school and community health services. A substantial number of students experience health disparities related to lack of access to primary and specialty services and to school nurse services. The school nurse is on the frontlines of student health and has the expertise to provide a critical link and oversight to implement telehealth in the school setting (National Academies of Sciences, Engineering, and Medicine [NASEM], 2021).

BACKGROUND AND RATIONALE

The U.S. Health Resources and Services Administration (HRSA, 2021) defines telehealth as “the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, health administration, and public health”. A variety of technologies can be used when integrating telehealth into school health practice. Principles to consider when seeking to implement school-based telehealth services include connectivity, affordability, literacy, structural competence, inclusivity, and elimination of disparities (American Telemedicine Association, 2021).

Prior to COVID 19 school nurses forecasted the growth of technology use in practice and recognized its potential to change practice (Morse et al., 2020). Lessons learned from rapid initiation of telehealth services during the COVID-19 Pandemic have proven a valuable stimulus to expedite expansion of this service model (Thomas, 2020). School nurses adapted how they connected with students by creating virtual health offices and providing interventions such as brief physical and behavioral health assessments and health education to meet student needs (Williams et al., 2021; Marrapese et al, 2021). During the pandemic, policy changes such as the removal of reimbursement barriers facilitated telehealth access for a larger portion of the general population (National Council of State Legislatures, 2021).

Utilizing sound telehealth delivery principles and complying with current FERPA, HIPAA, and other federal, state, and local regulations, public schools can be ideal locations to implement telehealth. The Society for Developmental and Behavioral Pediatrics (SDBP) position on telehealth highlights the importance of conducting telehealth services in a familiar environment, such as the school (Keder, et al., 2022). As of 2019, 99% of America’s K-12 public schools have the necessary fiber-optic connections to meet the FCC’s internet access standard (Education Superhighway, 2019).

Recent policy statements from the American Academy of Pediatrics (AAP) (Coffman et al., 2021) and SDBP (2022) recognize the value of telehealth as a tool to reduce disparities and provide equitable access for families to primary and specialty healthcare. The AAP (2021) also recognizes the value of telehealth for students with complex needs who require intense, collaborative care. Telehealth services have been shown to decrease hospitalization, emergency care and school absenteeism; diminish the financial burden on families; and reduce healthcare costs in general (Lang Kamp et al., 2015; Reynolds &
Telehealth law, institutional policy, contracts, and funding are necessary to effectively develop telehealth school nurse services as well as visits with community-based providers (Curfman et al., 2021; Graber et al. 2021). The need for additional advocacy exists to allow for simultaneous reimbursement for the school nurse site facilitator and clinician when utilizing telehealth (Watkins & Neubrander, 2020; Curfman et al., 2021; Thomas et al., 2020).

School nurses routinely coordinate student health care services between the medical home, family, and school (Gillooly, 2020). The COVID-19 pandemic reinforced this crucial role, as school nurses conducted virtual care coordination to reduce healthcare barriers for students in low-income, medically underserved, or geographically challenged local communities. This connected students and families to needed services and improved communication between home, school, and healthcare providers. (Campbell et al., 2020; Reynolds & Maughan, 2015). School nurses have the education and experience in assessment, intervention, and outcome evaluation; understand healthcare and educational systems’ process, language, and norms; and are familiar with both FERPA and HIPAA rules to protect confidentiality. Additional training in telehealth process and delivery (Rutledge et. al., 2021) in combination with the nursing skill set, makes school nurses the ideal school-based professional to facilitate telehealth services.

Utilization of school nurse telehealth visits provides guidance from a trusted health professional while limiting the burden on clinicians (Watkins & Neubrander, 2020). Via telehealth school nurses can provide care coordination and health education for students with special health needs and facilitate monitoring by primary and specialty care providers to prevent fragmented care and unnecessary medical expenses (Curfman et al., 2021).

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

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Transition Planning for Students with Healthcare Needs

Position Statement

NASN POSITION

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

BACKGROUND

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

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

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

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

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

RATIONALE

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

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

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

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

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

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

CONCLUSION

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

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


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Position Briefs
Eliminate Racism to Optimize Student Health and Learning

Position Brief

SUMMARY

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

RATIONALE

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

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

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

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

- Review school policies and practices to uncover and eliminate racism, for example;
  - Examine relationship between racial achievement gaps and racial discipline gaps and propose interventions (Pearman et al., 2019)
  - Address racism in bullying and violence policies
- Advocate for system changes that celebrate diversity, equity, and inclusion;
- Annually engage school staff on education on cultural diversity, discrimination and racism
- Hire and retain staff with diverse backgrounds
- Provide evidence-based curriculum that teaches students and families how to recognize implicit bias and address racism;
- Promote empathy by actively listening to lived experience of racism as told by students, families, colleagues, and community members;
- Improve student and teacher interactions to increase students' sense of belonging and connectedness

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

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Safe and Humane Treatment of Refugee and Immigrant Children

Position Brief

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

Adopted: August 2019

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Joint Statements
Early School Start Times

Joint Statement

SUMMARY STATEMENT

Optimal sleep during growth and development is critical for the health, safety and academic success of our nation’s youth. Over half of high school youth and near one third in middle school report 7 hours or less sleep on school nights (National Sleep Foundation, 2014). These reports are in sharp contrast to recommended adolescent (age 12-17) sleep requirements of approximately 9 to 10 hours (Carskadon, 2011). The registered professional school nurse (hereinafter referred to as school nurse) is in a pivotal position to collaborate with students, families, teachers, pediatric nurses, school administration officials, and other health care professionals to address factors contributing to insufficient sleep. A significant modifiable factor contributing to insufficient sleep during adolescence is early school start times during middle school and high school. The National Association of School Nurses (NASN) and the Society of Pediatric Nurses (SPN) support delaying school start times for middle school and high school students as proposed in the policy statement on School Start Times for Adolescents by the American Academy of Pediatrics (Adolescent Sleep Working Group, 2014). This recommendation is based upon the following key factors in adolescent sleep:

- Adolescents require approximately 9-10 hours of sleep nightly (Carskadon, 2011).
- Developmental and physiological changes in adolescent sleep contribute to shifts in nighttime sleep times and later bedtimes, but not necessarily a decrease in sleep requirement (Carskadon, 2011).
- Home electronic media use by adolescents before bedtime affects sleep quality (National Sleep Foundation, 2014).
- Parents/guardians are unaware of adolescent sleep needs and/or the sleep duration of their adolescents (American Academy of Pediatrics [AAP] Adolescent Sleep Working Group, 2014).
- Parent/guardian enforced bedtimes throughout adolescence is associated with longer sleep duration (Short et al., 2011).
- Delaying school start times for adolescents to no earlier than 8:25 am is associated with longer sleep duration on school nights (Boergers, Gable, & Owens, 2014).
- Delay of school start times is associated with improved mood and reduced daytime sleepiness (Boergers, Gable, & Owens, 2014).
- Insufficient sleep and irregular sleep/wake patterns are associated with an increased risk for daytime sleepiness, academic and emotional difficulties, safety hazards, and cardio-metabolic disease (AAP, Adolescent Sleep Working Group, 2014).
- Sufficient sleep on a regular basis provides the opportunity for better attention, behavior, emotional control, and quality of life (Paruthi et al., 2016).
• Sleeping less than the recommended 9-10 hours can result in learning problems, injuries, obesity, and hypertension (Paruthi et al., 2016).

RATIONALE

The need for sleep is a biological necessity for all mammals, and studies have shown that the absence of sleep results in impairment of functional ability (Iber, 2013). During the four stages of sleep – REM, N1, N2, and N3 - task learning is refined through the enhancement and pruning of synaptic connections. Each sleep stage has a responsibility for temporarily storing, evaluating, discarding “nonsense” information and preserving new and valued knowledge (Iber, 2013).

During adolescence, the secretion of the melatonin hormone begins later in the day resulting in a corresponding delay in the desire to sleep (Carskadon, 2013). The postponement of this biological event is further delayed if the adolescent is not in a dimly lit environment – often the case if there is homework to finish. However, although staying awake longer is easier for the adolescent, the desire to sleep longer is unavoidable. This becomes problematic when the total amount of sleep is reduced, as is often the case during the school year. In addition, studies have shown that children and adolescents from low income or racial and ethnic minorities are at a greater risk for sleep disorders due to overcrowding, excessive noise, and concerns for their own or their family safety (Owens, 2014).

In Healthy People 2020 (2014), a new core indicator has been developed entitled Sleep Health which calls for a reduction in

• adolescent sleep loss;
• unhealthy sleep behaviors (irregular sleep/wake patterns, overuse of electronic media in the bedroom, and the consumption of excessive caffeine); and
• the potential consequences of inadequate sleep (depression and suicidal ideation, obesity, auto accidents attributed to drowsiness, and poor academic performance) (Owens, 2014).

NASN and SPN highlight a contributing – and modifiable – factor to promoting an increase in sleep obtained by teenagers is to delay the start of school day for middle and high school students. NASN and SPN acknowledge the challenges of alterations in after-school sports and activities, along with adjustments to parental/guardian schedules and other modifiable factors such as the need for families to

• self-regulate sleep habits;
• set bedtime limits;
• set limits on social networking; and
• discuss the use of electronic media in the bedroom.

SPN and NASN stand ready to collaborate with administrators, teachers, parents, school boards and communities to address this public health issue by

• Working with parents to understand developmental changes in sleep/wake patterns during adolescence.
• Educating parents on the importance of setting bedtime limits.
• Identifying adolescents at risk.
• Working with teachers and parents to monitor academic course loads and extracurricular activities.
• Identifying strategies to promote optimal sleep.
• Limiting the use of caffeine and other stimulants.
• Limiting the use of electronic media and social networking.

Adolescence is a time when sleep patterns change and biological clocks alter, often leading to poor quality and insufficient sleep. Their ability to concentrate, problem-solve and assimilate new information is impaired. SPN and NASN encourage all parties involved to consider implementing later school start times for teens.
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