REPORT OF THE COMMISSION

TO STUDY

HEALTH SERVICES IN PUBLIC SCHOOLS

3449m

MEMBERSHIP OF THE COMMISSION

Senator Mary-Ellen Maybury, chair

Senator Stephen C. Estes

Representative Cushman D. Anthony

Representative Margaret Pruitt Clark

Representative Judy Paradis

Bruce Brown, M.D., Director of Adolescent and School Health Services, Department of Pediatrics, Eastern Maine Medical Center

Molly Call, R.N., Windham School Department

Phyllis A. Deringis, Ph.D., Director of the Division of Curriculum, Department of Educational and Cultural Services

Debbie Drew, Guidance Director, Stearns High School

Priscilla Hare, parent

Pamela S. Hennessey, Professor of Education, Athletic Director, Husson College

John Serrage, M.D., Director, Division of Maternal and Child Health, Department of Human Services

Carol Wishcamper, Member, State Board of Education

Staff:

John R. Selser, Legislative Analyst
Carolyn J. Chick, Legal Assistant
Office of Policy and Legal Analysis
State House Station # 13
Augusta, ME 04333

SUMMARY RECOMMENDATIONS OF THE COMMISSION TO STUDY HEALTH SERVICES IN PUBLIC SCHOOLS

1. **Assess the need. Communities should assess their adolescent health needs and should examine the utilization of existing health care resources by adolescents.** (page 33)

   Most communities have no idea of the health needs of their adolescents nor of the services which are available to meet those needs. Communities should assess these needs with the assistance, for instance, of a community-based advisory committee.

2. **Establish medical homes. The Commission believes that each adolescent needs a "medical home," i.e. a place where most or all of the adolescent's health needs can be met in a setting which ensures comfort, respect, effectiveness, and confidentiality.** (page 33)

   The medical home should be available in a wide variety of settings other than the traditional private physician's office. A medical home for adolescents can be provided in a school based setting. Other options include government or hospital sponsored health centers located at or near the schools or easily accessible within the community.

3. **Increase the availability of school-based health centers, especially the availability of mental health practitioners to address the emotional and mental health needs of the adolescent.** (page 34)

   For those communities without adequate health services capable of addressing adolescent health needs, participation and input from the existing health care providers can provide a major portion of the unmet health needs of adolescents.

4. **Role Models. Both adults and peers should work at becoming better role models within the school system.** (page 35)

   There are many ways both adults and peers can become better role models: peer counseling; wellness; social interaction training; preventive care; identification of role models; and adult role models.

5. Programmatic changes. (page 35) The Commission recommends programmatic changes in the following areas:

School nurse (establish and maintain pupil to nurse ratio.)
Guidance counselors (provide with training and time to deal with student mental health issues; establish ratio.)
Emergency medical coverage (local school system should provide at high risk sporting events - establish minimum guidelines.)
Wellness program (promote in schools.)
Adequate sports physicals (require more comprehensive physicals.)
Age appropriateness of particular sports (Commission supports work of middle level education Task Force in this area.)
Physical education position (create a position in Dept. of Educational and Cultural Services to coordinate P-E programs.)
Physical education instructor (encourage formal education.)

6. **Provide financial support for school-based health centers and for preventive health care funding.** (page 36 - see also proposed legislation, Appendix E, page 75)

State should fund the initial two year start-up costs for school-based health centers throughout the state.

Insurance companies, legislative and executive branches of government should help resolve the lack of third party reimbursement for preventive health care.

7. **The Commission recommends changes in education in the following areas:** (page 37)

Design fully integrated health education curriculum.

Offer adolescents the opportunity to develop spiritually, to develop a set of values and to examine the roles and relationships of mature and responsible members of the community.

Provide specific training for health care professionals in adolescent health issues.

Provide specific training for coaches in adolescent health issues.

Provide specific training for administrators in adolescent health issues.

Provide alternate methods of learning by offering access to alternative educational settings.

8. Authorize minors to consent to medical care in certain specific instances. (page 38)

See proposed legislation, Appendix E, page 75.

4968

TABLE OF CONTENTS

APPENDICES

I. INTRODUCTION

A. Purpose of Study and Committee Procedure

The 113th Legislature, during the First Regular Session, enacted a "RESOLVE, to Establish a Commission to Study Health Services in Public Schools" (Chapter 66, Resolves 1987. See Appendix A for complete text.) This Resolve established a 13 member Commission to Study Public School Health Services which provide counseling and other services related to adolescent health needs.

The membership was composed of legislators (2 Senators and 3 Representatives), the Commissioner of Human Services or his designee, the Commissioner of Educational and Cultural Services or her designee, one member of the State Board of Education, a nurse, a physician, a teacher, a guidance counselor, and a parent.

The purpose of the Commission was (1) to study existing adolescent health needs and concerns including, but not limited to: pregnancy, parenting, suicide, mental health, substance abuse, and sexuality, (2) to identify existing health services for adolescents, and (3) to recommend appropriate educational programs and health services which may be provided through the public schools.

The Commission met during the fall of 1987 and the winter of 1987-88. During the course of its proceedings, it sponsored a panel discussion to explore more fully the health needs of adolescents and the existing services designed to meet those needs. The panel included teachers, administrators, school nurses, high school students (peer counselors), key personnel from the Department of Educational and Cultural Services, and the Director of the YWCA Intervention Program.

This report contains the findings and recommendations of the Commission to Study Health Services in Public Schools, including implementing legislation. Due to the lateness of the introduction of the suggested legislation it is recommended that this legislation be introduced in the First Regular Session of the 114th Legislature.

B. A Brief History of Health Care in Public Schools[1]

Public school health programs developed in Europe during the 19th Century. France, Sweden, Germany, Russia, Austria, Belgium, Great Britain, and Romania all started school health programs during this period. The first programs charged school officials with responsibility for the sanitation of school buildings. Later, programs utilized physicians to inspect school buildings for sanitation and students for health and eventually added inspections by vision specialists and dentists.

America took a back seat to Europe in development of school health programs during the 19th Century. It was not until 1872

that the first "sanitary superintendent" was employed in a public school. The program was instituted in Elmira, New York, to deal with the prevalence of smallpox among the school population.

No further action was taken in the states until 1892 when the city of New York appointed the nation's first school medical officer. Two years later, Boston appointed 50 physicians as "medical visitors" to inspect the schools daily and examine all children suspected of having a communicable disease. The early school health programs were designed to address communicable diseases, a burgeoning problem in the unsanitary, poorly heated, and poorly ventilated school buildings.

By 1910, inspections of students were required in the schools of more than 300 cities. The standard practice was to send sick children home until they no longer posed a danger of transmitting the disease. Unfortunately, the success in identifying children with communicable diseases and the simple solution of dismissing them from school created new problems. Many children from poorer homes did not receive medical treatment and, thus, could not return to the classroom without a lengthy absence. In addition, large numbers of noncontagious diseases were being identified but remained untreated.

New York again provided the model program for the nation when they replaced the visiting school physician with a permanent school nurse. The nurse worked directly with the parents to assure that the children received proper care. By 1911, 102 cities in the nation employed 415 school nurses.

Other new programs soon followed the introduction of the permanent school nurse. Some schools maintained a bed at a local hospital to serve as a clinic for school children. (The first was initiated by the local Parent-Teachers' Association in Los Angeles.) As immunization and other medical advances reduced the danger of communicable diseases, school health programs began to deal with other health problems of their students. Dental clinics began to spring up across the country. In addition, clinics for eye, ear, and orthopedic defects and clinics to remove tonsils and adenoids became popular.

As our medical knowledge progressed and as we became more of an urban industrialized society, our philosophy of what education was began to change. The 19th Century focus of attention on reading, writing, and arithmetic began to expand to incorporate the growing needs of our society. The curriculum, it was argued, had to be expanded to take into account a vast array of social changes, including the influx of immigrants needing cultural adaptation, the decline of apprenticeship creating a need for vocational education, the change in family life characterized by both parents working, the effects of urbanization, and an increased concern for

health. By 1918, the National Education Association had listed health as one of its "seven cardinal principles" of education.

During the 1920's health programs became firmly established in the nation's schools. It was also during this period and the 1930's that the policies governing school health services were developed. Philosophical differences arose concerning the role of school health programs. Two major issues provided the focus for the debate: (1) should schools have a health program, and (2) if a school does have a health program, what should its role be?

The basic issue was whether schools should have a health program. Schools are institutions of education. At that time, many felt that a health program did not directly support the educational objective of that institution. Administrators focused mainly on the educational aspect of schools. The clear health services' priority of administrators was one of providing minor first aid.

Once beyond the basic question of whether or not a school should have a health program, the next issue was to determine the scope of that program. Typically, school administrators and school boards believed that school health programs should focus primarily on prevention, i.e. health education, first aid, and a safe school environment. This was partly a product of the strong belief that curative health care should only be delivered by physicians in private practice. A school health program's prevention measures were merely to supplement, not substitute or compete with, the private sector.

Public health professionals, on the other hand, wanted to focus on medical problems that affected learning ability and behavior. They also felt that some clinical treatment should be offered in the schools since many children were unlikely to obtain needed health care from the private sector.

This divergence of priorities between educators and public health professionals which began in the 1920's has continued to the present day. Historically, educators have exercised control in the vast majority of the cases and have consequently emphasized a non-medical approach for school health services. In most states, school health services have been limited to health appraisal, emergency care, and the counseling of students. Although never completely eradicated, the clinical component of school health services was greatly reduced during the 1920's. It was not until the 1960's and the increased social awareness and concern with public health that treatment once again became a viable function of school-based health services. Currently, model programs which include the delivery of primary health care as an integral part of a school health program are increasing in number.

There is a growing concern about the health of our nation's children. Many families are not monitoring their children's health care adequately. Adolescents present unique health care problems that are directly related to their age. It is a period when they are maturing rapidly and their bodies and their minds are trying desperately to keep up with the changes. In these times of scarce health care revenue, the delivery of health care services in a school-based setting may be the most efficient utilization of our resources.

Defining the role of school based health services in the 1980's will not be easy. Schools may already be overburdened by their current responsibilities. Adding more comprehensive health services increases the school's responsibilities. Federal and state budgets have only limited resources to devote to expanding school-based health services. Local communities will almost certainly be asked to share in these expenses. Determining the role of school based health services in this environment will be a challenge.

C. The Adolescent Need for Health Care

There appear to be contradictory perceptions of the health status of adolescents. On the one hand, many people believe that a person is most healthy during adolescence and has fewer health needs than an older or younger person. On the other hand, adolescents not only have many of the same health needs as other persons, but also experience unique problems associated with their age such as growth disorders, menstrual problems, acne, problems with their self-image (which may lead to early pregnancy, substance abuse or suicide), and psychosocial problems involving the changing nature of their relationships with family members, their peers, and school. Although society has targeted health programs for many special populations with unique health needs, very few are designed for adolescents.

Many adolescents report that they receive no regular medical care. Nationwide the number of 16 to 17 year olds having no regular source of medical care is nearing 15%. This compares with 7% for children under the age of 6. In economically deprived areas, the percentage may exceed 50%.

Charles E. Irwin, Jr. M.D. cites two studies in 1980 and 1981 that best characterize adolescent patients nationally.[2] The overall rate at which adolescents visit physicians is significantly lower than the rate for all other age groups. The number of visits increases slightly for older adolescents, largely due to the increase in visits by young female patients. This increase can be attributed to visits for obstetric and gynecologic services.

Forty to fifty percent of the visits by teens to physicians are for acute care. Twenty percent are for nonillness care. In more than 50% of the visits, teens see a physician for less than 10 minutes. This data seems to indicate that most of the visits do not represent regular check-ups, but are a response to acute problems such as a specific illness or injury or a medical condition (e.g. pregnancy).

The adolescent years are a time of experimentation. Teens are exploring who they are and who they could be. They are seeking their own limits, often by trial and error. Many teenagers feel invulnerable and take risks that adults, whose judgement is more mature and experienced, would not consider appropriate conduct. Occasionally, adolescents will engage in serious risk-taking activities with tragic consequences.

Frequent teenage risk-taking behavior is a topic of intensive, new research by behaviorial scientists. In addition to feelings of invulnerability and the importance of impressing one's peers (which often results in cavalier recklessness), evidence is mounting that some teens are unable to perceive and evaluate risks accurately.[3] Their risk taking behavior manifests itself in irresponsible motor vehicle use, substance abuse, failure to practice prevention of pregnancy and sexually transmitted diseases, attempted suicide, and dangerous athletic activities, often without appropriate safety equipment. The adolescent mortality statistics in Maine reflect this apparent disregard for the danger of taking excessive risks as evidenced by the high rate of motor vehicle accidents in the 10-19 age group. (See figure 1).

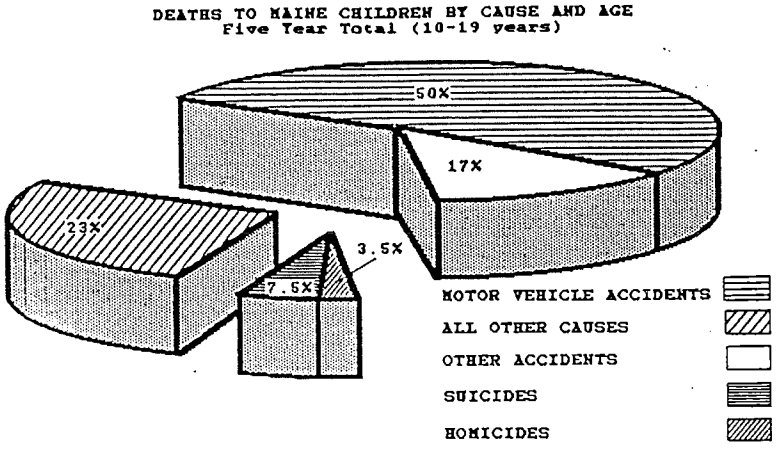

Figure 1. Adolescent death rates by cause[4]

The leading cause of death among adolescents is motor vehicle accidents. Although adolescents account for only 7% of the drivers in Maine, they represent 14% of all highway accidents and 19% of all alcohol-related accidents.[5]

A recent study conducted in Massachusetts points out the significant incidence of motor vehicle accidents among adolescents.[6] "Injuries caused more deaths among 1-19 year olds (59.5%) than all other diseases combined..."(p.2) The report found that injuries were not "random" occurrences but displayed predictable patterns which made it possible "to differentiate which populations are at highest risk for specific injury causes." (p. 17)

Motor vehicle accidents among teens was listed in the Massachusetts report as one of three causes of injuries that should receive priority attention. The report examined the pattern of motor vehicle accidents among teens and found that 16 year olds have higher crash rates than any other age. According to the Insurance Institute for Highway Safety, teens are most likely to be killed in nighttime crashes, in cars driven by other teens, and while under the influence of alcohol. The report concluded that "public policy and education need to address this population of drivers who are at relatively high risk." (p.23)

The Massachusetts report cited three measures noted by the Insurance Institute of Highway Safety (IIHS) that have proven effective in reducing motor vehicle accidents by teens: (1) enactment of curfew laws to prevent teens from driving during the hours they are most likely to be injured. (Massachusetts currently prohibits drivers under 18 with learners permits from driving between 1:00 and 5:00 a.m., unless accompanied by a parent or guardian with a Massachusetts driver's license.); (2) raise the minimum legal driving age to 17. (New Jersey, with a legal driving age of 17, had lower crash deaths among 16 year olds than did either Connecticut, with a 16 year old minimum, and Massachusetts, with a 16 1/2 year old minimum.); and, (3) require seat belts for all motor vehicle drivers and passengers under the age of 18. (Teen age use of safety belts is much lower, nationally, than for all drivers.)

The second single leading cause of death among Maine adolescents is suicide. In the 10 years from 1970 to 1980, Maine's suicide rate for 15 to 19 year olds increased from 7.4 per 100,000 to 9.3 per 100,000. In both 1970 and 1980, Maine's suicide rate was higher than any other New England state.[7] (See Figure 2)

	1970		1980	
State	No.	Rate	No.	Rate
Connecticut	17	6.4	18	6.2
Maine	7	7.4	10	9.3
Massachusetts	21	4.1	31	5.7
New Hampshire	2	3.0	6	6.8
Rhode Island	2	2.3	6	6.7
Vermont	4	9.0	7	13.6
Total NE	53		78	

Figure 2. Number of suicides and suicide rates for all persons 15-19 years of age

Poor self esteem, depression, low aspirations, and unmanaged stress are also frequent mental health problems for adolescents.

In addition, drug abuse, pregnancy, sexually transmitted diseases, smoking, and obesity are all significant health problems for Maine adolescents.

A 1985 report of the State of Maine Task Force on Adolescent Treatment Bed Needs found that 12% of Maine's high school students are currently chemically dependent and another 13% are at risk of dependency.[8]

Teen pregnancy is also a serious problem in Maine. Although data on sexual activity in Maine is not available, a 1979 study of metropolitan teenagers found that 69% of the females and 78% of the males had had intercourse by age 19.[9] The average age of first intercourse for U.S. females is 16.2 and for males is 15.7. The report of the Governor's Task Force

on Adolescent Pregnancy estimates that 50% of Maine females age 15-19 (21,000) are sexually active. Of these, 66% (14,000) do not use contraceptives. Among these 14,000 Maine teens, 3,000 pregnancies occur.[10] In other words, one out of every 14 female teens becomes pregnant. (See Figure 3)

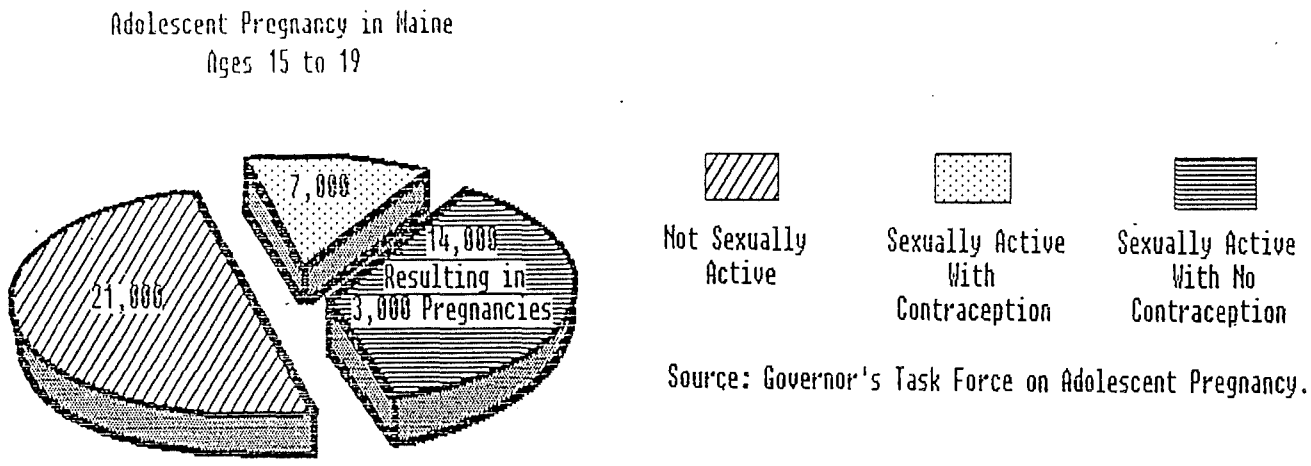

Figure 3. Adolescent pregnancy in Maine

Teenage pregnancy in Maine is a serious health, social, and economic problem. Pregnant teenagers are less likely to get prenatal care and good nutrition during pregnancy, resulting in a higher incidence of complications, low birthweight babies and infant mortality. The major cause of teenage women dropping out of school is pregnancy. Teenage mothers are more likely to be dependent on public assistance. The health, medical, and social services costs of adolescent pregnancy in Maine are estimated to be at least $60 million annually.[11]

Overall, as C.E. Irwin points out in a recent article, risk taking behaviors should be addressed in the context of the adolescent's life. Often, excessive risk-taking is a symptom of fundamental psychosocial problems in the teen; a sign of dysfunction in school, peer, or family relationships; or a reflection of a poor self-image. Unaddressed, risk-taking behavior often increases and results in serious health problems such as vehicular injury, premature pregnancy, or chemical dependency.[12]

The effects of students' health on their ability to learn has long been the subject of discussion by educators. Deputy Assistant U.S. Secretary for Health J. Michael McGinnis stated that "Unless a child is alert, healthy, well-fed, and fit, you cannot teach that child those subjects traditionally called

basics."[13] School nurses in Maine have stated this postulate succinctly in their motto: "Healthy children are better learners."

The Maine Coalition for School Health Education supports school health because: "Healthy children are more able learners - they can concentrate, read, write and do math better."[14] In addition, "lifestyle habits that lead to adult diseases usually begin in childhood."[15] The significance of the health of adolescents should not be underestimated.

II. IDENTIFYING ADOLESCENT HEALTH NEEDS

A. General Statement

Adolescents' health needs are unique to their age and to the rapid physical, emotional and social growth they experience during this time. In order to more fully examine the health needs of this population, the Commission divided an adolescent's health needs into 5 components: physical, mental-emotional, social, intellectual, and spiritual.

The Commission recognizes that there are many health needs which will logically fit into more than one category. Chemical dependency, for example, affects all categories because it concerns an adolescent's physical health, mental-emotional health, social health, intellectual health and spiritual health. Accordingly, although the Commission discussion may place a health need under one category, it is not intended to place a limitation on the effect of that health need. The main purpose of the groupings is to provide a convenient way to discuss similar health problems and to help show the complexity of the adolescent's health needs.

B. Physical Health Needs

1. Regular medical check-ups. The American Academy of Pediatrics recommends that an adolescent receive a comprehensive medical check-up every two years. Unfortunately, the adolescent age group is the least medically served. The American Academy of Pediatricians has published "Guidelines for Health Supervision"[16] which describe the general health characteristics of adolescents and guidelines for the medical examination and interview of the adolescent. The general health characteristics of adolescents are divided into three stages (early, middle, and late adolescence) and are summarized as follows:

a. Early adolescence. "Early adolescence, the period from 10-14 years of age, is characterized by rapid physical growth and sexual development (puberty). It is a time of beginning independence and separation from parents, changes in communication patterns, an unwillingness to participate in some family activities, incipient concentration on peer relationships, a casting-off of old patterns, sudden challenges to parental authority....There is an increased concern with the developing body...and much comparing of oneself with peers to assess one's normalcy." As with any period of developmental transition, this appears to be a time of particularly difficult adjustment for adolescents and parents.

b. Middle adolescence. "In middle adolescence (14-17 years), puberty is well underway and complete in many individuals. There is a decreased preoccupation with the body and an increased, intense involvement with peers. Conflicts with the parents over the issue of independence are maximal at this time. The peer group sets the behavioral standards. It is a time of sexual exploration and experimentation. At this stage the adolescent is frequently idealistic and altruistic."

c. Late adolescence. "In late adolescence (18 to 20 years), emancipation is nearly complete and there is an increased concern about a career choice. Social skills become enhanced and intimate relationships of a physical and psychological character occur. Body image and gender role-definition are nearly completed."

The Maine Department of Human Services has published Standards for Preventive Child Health Supervision, and is currently reviewing and revising these standards. These standards emphasize the assessment of the total child - not just isolated screening for specific diseases or problems.

Regular medical check-ups are a beneficial means of early diagnosis and prevention of disease. Regular check-ups also provide adolescents with practice in obtaining medical care. Hopefully, this practice affords adolescents the basis on which they will seek medical check-ups on their own initiative.

2. General fitness. Generally, one can be considered physically fit if one has the physical, emotional, social, intellectual, and spiritual dimensions functioning in a way that contributes to a satisfying and productive life.[17]

If one is physically fit, one's body will be capable of responding to many demands. Thus, fitness is often judged in terms of the physical dimension of one's health. Recent state and national studies appear to indicate that adolescents today face serious problems of physical fitness.

The American Association of School Administrators reports that at least one-third, and perhaps as many as 60 percent, of American youth already exhibit at least one of the prime risk factors for heart disease; that in the past 20 years, the incidence of obesity among teenagers has increased 39 percent; and that in a 1983-84 test of basic physical fitness, only 36 percent of American young people aged 6 to 17 met the standard for "average fitness."

The President's Council on Physical Fitness and Sports cited recent statistics which would seem to support concerns about the fitness of today's children:

-Forty percent of boys from the age of 6 through 12 cannot do more than one pullup; the same is true for 70 percent of girls from the age of 6 through 17;

-One-third of boys and 50 percent of girls from the age of 6 through 12 cannot run a mile in less than 10 minutes;

-Only 2 percent of the 18 million children who took the tests, "President's Challenge," a series of exercises that measure strength, flexibility and endurance, performed well enough to qualify for the council's award.

Some authorities blame television for this lack of fitness. Dr. Joseph Zanga, an American Academy of Pediatrics' official, explains: "We've given kids something [television] that not only doesn't encourage them to do anything, but something that actually discourages them from anything active." Dr. Joseph Zanga has stated that while parents are raising overweight children, school budget problems have led to fewer and less demanding physical education programs.[18]

In Maine, Holly Richardson-Lehnhard is heading a project to measure the fitness of Maine public school children. She indicates that the results of the study, which will probably be available in June, 1988, may reveal that Maine children generally receive less physical education and weigh more than children nationwide.. The completed study will survey 18,000 to 20,000 Maine children.[19]

For purposes of the Maine study, the definition of physical fitness includes assessment in three basic areas: cardiovascular, body composition (weight/skinfold tests), and lower back/lower hamstring (endurance of abdominal muscles). According to Richardson-Lehnhard, the study will help to determine how Maine children compare nationally to other children in the area of physical fitness.

Stephen Butterfield, the University of Maine's coordinator of health, physical education and recreation, says that overall, about 20 percent of American children are considered obese. He expects, though, that figure might be higher for Maine children because of a combination of long winters, TV and video games. The long sedentary period plus the lack of physical education encourages obesity.[20] Butterfield also said health workers have already found evidence of heart disease, high blood pressure and high cholesterol among Maine schoolchildren.

If the project to measure the fitness of Maine public school children does indicate that Maine children are less fit than children nationwide, what is the next step? Dr. Zanga has urged parents and educators to put pressure on their local school boards to at least maintain current funds for physical education, and also to seek more innovative ways to involve

children. He suggests simple classes with an eye toward aerobic or cardiovascular exercises, things that can be done to music and made fun as well as being effective.

Schools have recently begun to recognize the importance of immunization for students. Failure to recognize this importance in the past has resulted in epidemics such as rubella. As a result of this recognition, schools are now requiring students to obtain immunization as a requirement for registration.

One innovative approach to encourage and develop fitness is the President's Council on Physical Fitness and Sports' exchange program with the Soviet Union. In February, 1987, an agreement was made with the Soviet Union in which youngsters in each country will take the physical performance test of the other county.

The Soviet test includes a 1,500 meter run, a shuttle run, consecutive alternate foot jumping, a target ball throw, pullups and 25 meter swimming. The U.S. test includes pullups, a one-mile run, curlups, V-sit reach and a shuttle run.

Maine has selected Rockport Elementary School, Cape Elizabeth Middle School, and Camden-Rockport High School to participate in the exchange program.

3. Sports fitness. Because of the emphasis on sports during the adolescent years, sports fitness is a crucial aspect of health fitness for adolescents. Sports fitness includes many components:

a. Adequate sports' physical examinations.

An optimal sports physical examination involves background information on an adolescent including an integral history for injuries and health problems which would prevent the adolescent from safely participating in sports. The examination pays particular attention to paired organs; the muscular/skeletal system; the cardiovascular system; and flexibility.

This type of physical and periodic review allows a match to be made between the athlete's biophysical characteristics and the physical activity of the sport in order to avoid putting the athlete at risk of injury. High school athletes have a health need not to be put at risk through their own ignorance, their parents, or by the school system.

b. Adequately trained coaching staff. Less than 20% of all coaches have a degree in physical education. Because many school systems lack teachers willing to coach, they are hiring community coaches from outside the school to coach team sports.

The American Coaching Effectiveness Program (ACEP) has been created in part to develop a common coaching curriculum. The University of Maine at Orono has been designated as the ACEP training center for the state of Maine and is currently researching the level of training for coaches in public schools. In its development of a common coaching curriculum, ACEP is concentrating on specific areas: sports physiology, sports psychology, sports injuries, pedagogy, time management skills, and effective communication with parents, among other areas. This curriculum includes a three-tier training level:

(1) introductory curriculum, certification

(2) more advanced coursework in the same areas

(3) advanced coursework (tier 3 is now in the design process)

Five hundred coaches (junior high and high school) around the state are currently certified at level one.[21]

c. Emergency medical treatment. There are few certified athletic trainers involved in adolescent athletics and most coaches are not trained to provide emergency medical treatment. In many situations involving injuries during athletic practices or events, a coach is the first and only person the injured teen sees for the injury. Often the coach is relied upon to provide advice to an injured athlete in the locker room, practice field/court, or on the playing arena. Nationally, only 10-15% of all school athletic programs have trainers.[22]

d. Interscholastic sports versus intramural sports. Young athletes may extend beyond their health limits by pushing too hard and failing to give their bodies time to grow. They can be inappropriately encouraged to complete the game or season, and encouraged to ignore pain, to their own detriment. The Middle Level Education Task Force of the Department of Educational and Cultural Services is currently discussing the relative value of interscholastic and intramural sports and the age-appopriateness of each. Interscholastic sports tend to be more specific activities requiring a higher degree of skill development. They are usually not sports which students would pursue outside of an academic setting. Intramural sports require more general, less specialized skills and are often activities which can be continued throughout the student's life. The pressure to compete often placed on young athletes can be tempered by creating age-appropriate athletic activities. Emphasizing intramural sports for the younger students may provide the balance needed to prevent serious health risks,

especially considering the fact that in middle schools the greatest variation in pubertal development, and therefore bone and muscle development, is observed. The Commission encourages the debate initiated by the Middle Level Education Task Force regarding appropriate athletic activities at each level of schooling.

C. Mental-Emotional Health Needs

Adolescence can be a difficult time emotionally for adolescents. It is a time of growing independence and responsibility, a time of greatly heightened physical and sexual awareness, a time to begin the life-long quest and discovery for personal and individual identity. Adolescence is marked by more change than any other period of human development.

Many adolescents exhibit behavior that is problematic to them, their parents and/or their school. Fortunately most teens, despite popular mythology, have a calm and untroubled adolescence. However, others exhibit behavior which could qualify them for diagnoses of bulimia, anorexia nervosa, substance abuse, conduct disorder, or dysthymic disorder (depression).

Often, the majority of teens requiring counseling services have mental health needs of low enough intensity to avoid qualifying for one of the above diagnoses. For this group, short-term supportive counseling is generally the most appropriate response to address their concerns. This support is often more easily accessible when provided in a school-based setting.

Teens who exhibit those characteristics more intensely (or who did not receive the short-term support which can often prevent a small but important problem from becoming a major health risk) may require more intensive psycho-therapy. Teens often know when they are in trouble, but make impulsive decisions about when and where to seek help. The availability of psycho therapeutic services would decrease the impact of these disorders on their lives and their education.

In the last 30 years, the suicide rate for 15- to 24-year olds has tripled. Nationally, a young person commits suicide every 100 minutes. (This figure reflects only the reported cases.) In Maine, suicide is the second leading single cause of adolescent death. Maine adolescent suicide rates are considerably higher than the

national average for the period from 1958 through 1982. During that period, an average of 10 Maine youths a year committed suicide. Approximately 280 attempted suicides are reported annually to hospital emergency room personnel for the same time period.

Unmanaged stress in adolescents is becoming a major health problem. In addition to the relentless physical and emotional changes that are taking place in their lives, adolescents may be assailed by external factors that tax their ability to cope. Their feeling of alienation (real or imagined) from their parents, their general refusal to accept help, the availability of drugs, their changing role in the family, peer criticism, overprotective or rejecting parents, pressure to excel academically, and limited socioeconomic status are but a few of the factors creating stress for the adolescent.

Unmanaged stress, low self-esteem, feelings of lack of control of one's own life, and fear of making decisions are some of the causes of eating disorders such as anorexia nervosa and bulimia. These eating disorders are characterized by food obsession, binging, vomiting, self-starvation or purging to achieve severe weight loss or maintain normal weight. The effects can permanently damage an adolescent's health or can be fatal.[23] These eating disorders represent a health problem of growing magnitude. The National Association of Anorexia Nervosa and Associated Disorders (ANAD) estimates that there are over 1,000,000 victims of eating disorders in this country. A University of Illinois, Champaign/Urbana study estimated that more than 10% of their female students were anorexic or bulimic.[24]

In March of 1986, Maine's Child and Adolescent Service System Project reported to the Commissioner of Mental Health and Mental Retardation about self-destructive adolescent behaviors and teen suicide. The report concluded that there was an alarming rise in adolescent self-destructive behaviors and called for a cooperative effort in state and community based service systems to address adolescent mental health needs. In light of these collective statistics, it is important to note that school based health centers nationwide report that mental health services are the most requested service that they offer.[25]

D. Social Health Needs

The period of adolescence in our modern culture has tripled in length. In the past, teens and young adults entered the work force earlier, married earlier, experienced menarche

later, and lived with their parents longer. Things are different now for teenagers than they were even 20 years ago.[26] Adolescent social health needs and how well these needs are recognized and considered legitimate by their peers and other adults and by adults (teachers, parents, others) can have a significant effect on the health and well-being of adolescents.

1. Independent growth. Adolescents need independence, but they need a safe way to experience and experiment with this independence, one which allows them to learn responsibility without life-threatening consequences. They need safe opportunities to try on new personae.

2. Personal relationships. Adolescents need to develop increasingly intimate relationships with peer groups and they need a place to go to comfortably relate to their peers--a milieu that encourages the development of healthy peer relationships. They need guidance in learning how to develop peer intimacy in an appropriate manner.

3. Role models. Adolescents need good role models. Role models play a significant part in the health education of adolescents. They are constantly examining and evaluating the conduct of the adults and peers with whom they have direct and indirect contact. These contacts will influence the adolescent to the extent that he or she allows that person into his or her "space".

Often adolescents receive mixed messages from the adults with whom they associate. School personnel should serve as positive role models for students. Smoking cessation programs, fitness programs, and alcohol abuse programs sponsored by the school for adults as well as adolescents would send a clear message to these youth. In addition, the commission believes that schools should be drug, alcohol, and smoke free.

One approach to increasing the physical fitness of Maine's youth involves the development and maintenance of healthy role models for school children. The Maine Wellness Conference has been developed to promote health in both staff attitudes and school environments. As a result of attending these Wellness Conferences, teachers set better role models for children as well as providing a better climate in which to learn.

Adolescents are constantly looking to their peers for role models. Peer counseling programs, such as the program operated by the YWCA of Lewiston and Auburn, train high school students to act as advisors to their peers. These peer counselors are a source of accurate and reliable information for their fellow students, give other students a chance to let off steam without reinforcing inappropriate behavior, and refer other students to professional help when needed.

Although insufficient research has been done to validate the actual influence of adolescents on their peers, several studies have evaluated peer influence on teen sexual and pregnancy risk-taking behaviors and support the hypothesis that peer influence is significant.[27]

A recent study by Kar, et. al. sought to assess the effectiveness of teen peer counselors in prevention of unwanted teen pregnancies and compare the peer counselors performance with adult professional counselors. They found that, although there was no significant difference in the knowledge gained by teen clients through the educational efforts by teen peer counselors and the adult professionals, the teen counselors were more effective in reaching their peers and in obtaining changes in behavior which resulted in fewer unwanted pregnancies. (Both contraceptive use and pregnancy rates were used as indicators for this study). In addition, more teen clients rated their peer counselors as "very good educators" than the adult professionals.[28]

4. Developing a sexual identity. Adolescents need guidance in helping them define their sexual identity and sexual activity in an appropriate manner.

5. Chemical free activities. Adolescents need acceptable social alternatives to substance abuse. Chemical free activities are an important adjunct to community life.

6. Family stability. Dysfunctional families and resulting family conflicts are high stress factors. What adolescents value most is a structured, healthy interaction between themselves and their family.

E. Intellectual Health Needs

There is a growing body of evidence that shows that health education not only affects students' knowledge, but positively influences their attitude and behavior.[29] "A comprehensive school health education program is a planned, sequential K-12 curriculum which is based upon students' needs and interests and current and emerging health concerns."[30]

The Commission recognizes the progress that has been made in development of health education curricula. Before 1985, health education was of uneven quality from school to school across the state. The development of curricula was largely a matter for each local school system. Schools reacted to health issues as they appeared without a comprehensive overall plan of action. Since 1985, schools are beginning to realize the

importance of comprehensive health education and should have instituted a proactive, planning approach to the development of a comprehensive school health curricula.

F. Spiritual Health Needs

Adolescents are at a crucial place in their lives, asking questions about their existence and how they relate to other human beings and to the world at large. They are beginning to think "outside of themselves." They are going beyond their own personal needs and thinking of life in its broader context.

They are asking such questions as "Who am I? Where am I going? What is the purpose of my existence? Is there more to life than making money?" They are thinking about such things as honesty and respect for other human beings. Adolescents are also experiencing fears which go beyond their own personal safety. They are worried about the destruction of all life on earth by nuclear holocaust. They are exposed to violence and worried about how prevalent it is and how it may affect them.

Spiritual well-being has been characterized as "a positive sense of meaning, purpose, loyalty, trust, commitment and self. It [spiritual well-being] acknowledges a relationship with mankind and a power beyond one's self. The lack of spiritual well-being may be manifest in behaviors which are socially disruptive and potentially self-destructive such as suicide, violent acts, isolation , and alcohol and other drug use."[31] Spiritual health directly affects an adolescent's total health.

Peer pressure is intense during this age and many adolescents are ill-prepared for making decisions independent of that pressure. The development of decision-making skills gives them a better ability to make their own decisions and provides more confidence in making decisions.

Adolescents will decide for themselves what the particular answers to life's questions are. Like most of us, they may spend their lifetime searching for these answers. The commission believes that the educational setting is one place, among many more traditional ones, where teens can practice this kind of problem solving and critical thinking and that an adolescent-focused health care system can be a valuable asset in this process.

III. EXISTING SERVICES TO MEET ADOLESCENT HEALTH NEEDS

There are many health care facilities and health care providers in existence that could meet the health needs of adolescents. These include the private physician, hospital clinic, rural health centers, family planning clinics, community mental health centers, community counseling centers, walk-in clinics, hospital emergency rooms, community health services, ambulatory care centers, and home health agencies. New services especially designed for the adolescent population are opening. Maine Medical Center has just opened a special clinic for the general health care needs of teens and young adults age 13-21. It provides physical examinations and diagnosis, treatment, and follow-up of medical problems.

For adolescents who do not take advantage of the existing health services and for those adolescents who do not have geographic or financial access to existing health services, a school based health service may be the only consistent medical attention they receive during their adolescence. School based health services include the following:

A. School nurse

Each school administrative unit is required to have at least one registered professional nurse to supervise and coordinate the health services and health-related activities required by state law as well as any other health-related activities assigned by the school board of that unit. (20-A MRSA § 6403) They are currently the primary health care providers in Maine schools and the only health care professionals employed by schools.

The number of students each nurse serves varies among the school systems. A survey conducted by the Department of Educational and Cultural Services found that almost half of the school nurses served student populations of between 1,001 and 3,000. (48%) Another 21 % served student populations of between 601 and 1,000 students. (25% of the nurses served student populations of 600 or less and 2% of the nurses served student populations over 3,000.)[32]

The majority of school nurses are employed directly by the school system. The remainder are contracted through private or state agencies. Most school nurses are required to divide their time between several school facilities either located in the same town or in the neighboring towns which comprise the school unit.

The major focus of school nursing services is the prevention of illness and disability and the early detection and correction of health problems. The school nurse is specially trained in preventive health, health assessment, and referral procedures.

B. School physician

State law requires each school board to appoint one or more school physicians. A school physician advises the school unit on school health issues, policies and practices, and may provide other health-related services assigned by the school board such as examination and diagnosis of students who may have a communicable disease, performing physical education and sports physicals, and serving as medical consultant to the school nurse.

C. Guidance counselor services, school social worker services, home school counselor services, and home school coordinator services

Guidance counselor services, school social worker services, home school counselor services, and home school coordinator services are available and being provided in some instances. A guidance counselor is the person who has special training for assessing the specific needs of each individual and for coordinating an appropriate guidance program in the educational, vocational, and personal-social domains. The responsibility for leadership of the guidance program is one of the primary functions of the counselor.

The counselor has been trained in various helping skills and is prepared to work closely with individuals in assisting them with normal development concerns, decisions, sorting through options, problem solving, and planning, as well as coping with crisis. Unfortunately, the ratio of students to guidance counselors in Maine, according to estimates by the Department of Educational and Cultural Services, is approximately 600 to 1. One counselor working with 600 students can often do little more than respond to the students' most urgent needs.

D. School based health centers

Nationally, school based health centers are primary health care centers located on or adjacent to the school grounds. Although they come in a variety of sizes and shapes, they share

many common characteristics. They provide a comprehensive array of health services, usually including mental health care. They all share a common goal, i.e. to ensure that students are physically, mentally, and emotionally prepared to learn.

School based health centers have been developed in response to the health needs of adolescents in the particular community where they are located. Each program is created by and for the local community. Although some of the health centers are funded and administered by the local school system, most are supported by funding sources outside of the educational system and are run as non-profit foundations, financially independent of the school system within which they are established.

Among the range of services they provide are athletic physicals, general health assessments, laboratory and diagnostic screening (e.g. sickle cell anemia and STD screening), immunizations, first aid and hygiene, EPSDT testing, family planning counseling and services, prenatal and postpartum care, drug and alcohol programs, nutrition and weight reduction programs and referrals for special medical care. Not all clinics provide all services. The staff of school-based health centers reflects the comprehensiveness of the services offered.

A 1987 survey reported that 86% of the programs included a school nurse in the school. In almost half of those programs the school nurse worked as part of the health center staff, sometimes delivering primary care, more often coordinating a variety of essential follow-up activities. Referral to the health center is often by the school nurse. Other functions school nurses are performing include: participation in health center staff meetings and case conferences, program advisory boards, direct classroom education in addition to providing staff in-service training and health program development. "Survey responses indicate that the school nurse is not supplanted by the [health center]; rather the clinic joins with the school health staff to enlarge the scope of services provided to students. School health services are coordinated with and integrated into the clinic operation."[33]

Once within the health center system, the student may be treated by nurse practitioners, substance abuse counselors, mental health workers, or nutritionists. Each center has physicians who act as consultants and who often visit the center on a weekly basis to see referral patients. The medical records generated by those encounters are confidential, kept separate from educational files, and not available to school personnel without patient permission.

School based health centers are available in two Maine high schools: at Hampden Academy in Hampden and at Bonny Eagle High School in Buxton.

The Health Center at Hampden Academy is organized as a drop-in site for teens with health and psycho/social problems. It is staffed by a nurse who is on-site full time and by a health aide. The Health Center nurse also functions as a school nurse. In addition, adolescents served through the Center have access to a computerized health wellness survey which is designed to identify current and potential health problems; an immunization program offered to all freshmen and new students; yearly sports physicals done by the school physician; and assessment and referral of all illnesses, injuries, and psycho/social problems that arise in the course of a school day. Parental consent is required for students to use the Health Center.

The Health Center also provides personal assistance on an individual needs basis to students and their families in such areas as prenatal education, physical and emotional abuse, emotional distress, and drug and alcohol abuse.

Non-clinical objectives of the center include providing resource help to classroom teachers in such areas as chemical dependency, nutrition, weight control and exercise, communicable diseases, assertiveness and communication skills, and family life and human sexuality. Consultation to the teachers and staff is also available in the areas of needs of physically handicapped students; adaptive physical education concerns; support programs for students such as peer action activities; and accident prevention and safety issues.

The Hampden Academy Health Clinic is funded by a grant from the Maine Department of Human Services.

Bonny Eagle High School maintains an Adolescent Health Center, which focuses on prevention, education, and primary health care for all adolescents within the community. Parental consent is required for students to use the health center. The majority of the students who utilize the health center are referred by the school nurse. The health center is currently staffed 20 hours per week by a nurse practitioner.

Other important aspects of the Bonny Eagle program include visits by a drug counselor two days a week during the school year and support group meetings at the center for pregnant and parenting teens. Evaluation of the center after six months of operation indicates that many students are using the center on a regular basis. The center has seen over half the projected full-year total of 300 students. One reason for the success of the center is attributed to its location. The location of the health center on school grounds allows students easy access. As a result, students lose less time from school for health care reasons and are encouraged to seek health care in a more timely manner.

Funding for the program is provided primarily by the Department of Human Services. Bonny Eagle High School is currently seeking additional sources of funding, such as United Way.

At the present time, neither program provides or makes available contraceptives to the student population.

Bonny Eagle High School also operates a Parenting Center which is equipped as a day care facility to serve the children of teen parents who wish to continue their education. The primary objective of the Parenting Center is to educate the teens so they become more confident and knowledgeable in their roles as parents as well as to help them set goals and plan for a future of economic self sufficiency.

A second parenting center is in operation in Maine at Mount Desert Island High School in Bar Harbor. Through the employment of a full-time child care provider and a part-time lead teacher, Mount Desert Island High School offers teen parents in-school day care and parenting/life skills education. The students are fully enrolled at the high school in pursuit of academic credits for graduation.

The Teen Parent Program works cooperatively with the peer counseling group. Through education of the peer counselors, it is hoped that more males will be educated in preventing unwanted pregnancies. The Teen Parent part-time counselor will hold training sessions for the students.

E. Educational Curricula

Currently, Maine law requires an elementary course of study to include "health, hygiene and safety; physical education; and physiology and hygiene, with special reference to the effects of substance abuse, including alcohol, tobacco, and narcotics upon the human system" (20-A MRSA § 4711). (See Appendix B for complete text.) Secondary school instruction includes "health, safety and physical education..., and physiology and hygiene, with special reference to the effects of alcoholic drinks, stimulants and narcotics upon the human system" (20-A MRSA § 4723). (See Appendix B for complete text.) Chapter 127 of the Rules of the Department of Educational and Cultural Services includes instructional requirements and graduation standards.

Elementary instructional requirements state that health instruction shall be sequential and shall include "instruction in community health, consumer health, environmental health, family life, growth and development, nutritional health,

personal health including mental and emotional health, prevention and control of disease and disorders, safety and accident prevention, and substance use and abuse, including the effects of alcohol, tobacco, and narcotics." (Rule 127.09, op.cit.)

Secondary education requires one half credit in health education for a high school diploma. (Rule 127.12, op.cit.) Schools will offer the course for one half a year, 5 days a week or for an entire school year, 2 or 3 days a week. Health education instruction at the secondary level includes "instruction in community health, consumer health, environmental health, family life, growth and development, nutritional health, personal health including mental and emotional health, prevention and control of disease and disorders, safety and accident prevention which may include cardiopulmonary resuscitation (CPR), and substance use and abuse, including the effects of alcoholic drinks, stimulants, and narcotics upon the human system." (Rule 127.13, op.cit.)

The Department of Educational and Cultural Services does not specify a particular curriculum for the local school administrative units. They do provide a more detailed description of the health education content areas referred to in the rules as well as suggestions on developing and implementing a health curriculum. (A more complete description of the health education content areas is available in Appendix D.)

F. Physical Education Requirements

State law currently includes a physical education requirement at the elementary and secondary level (20-A MRSA § 4711 and § 4723). Chapter 127 of the Rules of the Department of Educational and Cultural Services includes instructional requirements and graduation standards.

Elementary instructional requirements state that "physical education instruction will promote physical well-being, self-esteem, self-awareness, sportsmanship and interpersonal skills. Sequential instruction in physical education shall be required. Such instruction shall include movement education, recreation and leisure activities, gross/fine motor skills, and perceptual-motor development." (Rule 127.09, op.cit.)

Secondary education requires one credit in physical education for a high school diploma. (Rule 127.12, op.cit.) A credit is awarded for completion of a course of instruction plus assigned homework for an entire school year. Physical education instruction at the secondary level is again designed to "promote physical well-being, self-esteem, self-awareness, sportsmanship and interpersonal skills. This requirement may

include, but need not be limited to: physical fitness, fundamental motor skills and patterns, adaptive physical education, individual and group sports. Physical education may include special physical education, movement education and motor development." (Rule 127.13, op.cit.)

IV. OBSTACLES TO MEETING ADOLESCENT HEALTH NEEDS

A. Health Care as a Priority.

Health care in general, and adolescent health care specifically, is seldom a high priority issue for the school system, the community, or the state. Society in general has viewed the period of adolescence as one of prime health and does not consider adolescents as having many (or any) health needs. Adolescents are too old to go to the traditional pediatrician and too young to seek health care on their own as an adult. Parents often do not view adolescent health care as part of their responsibility.

Understandably, the primary function of the school system is to provide an education for our youth. Health care has traditionally been the responsibility of organizations other than the school. However, the health of students is inextricably related to their ability to learn and their performance in school.

Most local school systems, acting through their school boards, have not identified adolescent health as a priority. This relatively low priority is evidenced in such ways by the frequent lack of trained emergency health personnel at athletic events and by the large student populations which each school nurse and each guidance counselor is expected to serve.

The role of public schools in providing health care is an inherently controversial issue. School systems, sensing a potentially hostile community reception to discussing or revamping the role of health care in the schools may never discuss their students' health needs and the role the school system could or should play in helping meet those needs.

B. Role Model Problems

Although adolescents are earnestly seeking their independence during this period in their lives, they still look to their peers and to adults as role models.

1. Adults. Many adults provide poor role models for adolescents, especially in regard to preventive health care. Most adults only seek health care for existing medical conditions. Adults themselves do not have an understanding of their own proper health care in all five areas of health needs. Many adults who serve as role models also lack a sensitivity to certain significant adolescent issues such as operating a motor vehicle under the influence of alcohol or other drugs. Adults do not view this behavior as a serious problem and the convey this attitude to adolescents. The substance abuse problems of some adults sends a message our

youth that it may be a problem, but not one they really need to worry about.

2. Peers. Peer pressure is prevalent during a child's adolescent years. Adolescents will often rely on their peers for health information. Unfortunately, too much of the health information they learn is from uninformed peers and is based on conjecture or myth.

3. Media. The media (television, radio, magazines, etc.) often influences the attitudes and behavior of adolescents. The media has initiated many helpful projects and programs to provide factual health information. The Commission recognizes the benefits of this positive influence which the media can exhibit on the health behavior of adolescents and encourages its continued presence.

Inconsistent media representation of appropriate self health care, however, provides misleading and inaccurate role models for today's youth. When the media portrays health care poorly, i.e. by glamorously portraying unprotected intercourse, inappropriate risk-taking behavior, substance abuse, and vehicular abuse, it is sending a message to adolescents that such behavior is acceptable. In addition, the media's and the public's absurd glorification of the ultra thin body, including its abuse in the advertising medium, plays on the adolescents' already excessive sensitivity about their body and appearance. Adolescents try to imitate this fashionable trend. The result can be eating disorders such as repeated dieting, fasting, anorexia nervosa, and bulimia.

C. Structural or Institutional Setting

Adolescents rarely seek preventive health care measures, generally responding only to health problems when they become unbearable. The amount of preventive health care they seek is significantly affected by the location of the facility. Many adolescents find transportation to a health care facility a problem, especially in rural areas. Adolescent utilization rates of health services drop dramatically the further a facility is located from their school.

Likewise, doctor's offices and clinics are frequently open only during school hours, further exacerbating the problem of access.

Adolescents who are uncomfortable with a particular setting and facility for health care may not participate in any health care services offered to them. In addition to geographic

accessibility, adolescents will look for a health care facility that is age appropriate (they do not wish to sit in the same waiting room with toddlers and coloring books) and one which offers them confidentiality.

The lack of comprehensive services at one facility often acts as a hindrance to an adolescent seeking health care. With every referral to another service to follow up a health problem, a percentage of adolescents drop out of the system. Often those adolescents who have the highest risk of health problems are those with the greatest need to get comprehensive services at one location and have the fewest skills or resources to pursue health care at multiple sites.

In some instances, the medical community has been reluctant to embrace an expansion of competing health services. There exists a potential conflict between traditional health providers and the initiation of school based health services. Some providers may feel that school based services would interfere with the continuity of care now available when adolescents do take advantage of existing health services. Other providers may fear a potential loss of revenue by the establishment of competing service.

D. Training for Health Care Professionals

Many health care practitioners are not proficient in adolescent health care. In 1986, Dr. Irwin wrote that "Physicians generally have been trained insufficiently in adolescent care and often lack the particular skills needed to offer high-quality medicine to the adolescent patient."[34]

Citing four recent surveys of physicians, Dr. Irwin found that doctors felt underskilled in adolescent history taking, counseling, and certain evaluations and treatments. The commission is concerned about the adequacy of training for physicians in adolescent health care, especially substance abuse and sexuality issues.

Dr. Irwin views the recent American Academy of Pediatrics policy statement on pediatric training as strengthening the emphasis on adolescent medicine and encourages the family medicine and internal medicine societies to follow that lead.[35] The Commission is aware of a need for more specialized training in adolescent medicine.

E. Utilization of School Nurses and Guidance Professionals

Even when appropriately trained health professionals such as school nurses and guidance counselors are available to the schools, many school administrators are not familiar with the health needs of adolescents and do not structure the school health program appropriately in order to fully utilize these professionals.

School nurses are trained in a variety of adolescent-related issues such as nutrition, eating disorders, chemical dependency, handicapping conditions, sexuality, teen pregnancy, and sexually transmitted diseases. Unfortunately, in some instances, the school system may not fully utilize the training of the school nurse, limiting the nurse to such tasks as minor first aid, transporting ill children, or record keeping and clerical work.

Guidance counselors, whose tasks are divided between course changes and college admission guidance on the one hand and counseling and career guidance on the other, are already overloaded trying to balance both objectives.

F. Financial Obstacles

Many adolescents are financially unable to secure adequate health care for a variety of reasons.

1. Inadequate family financial resources. Inadequate family income and lack of health insurance make obtaining health care difficult. Some students do receive assistance from Medicare. Many adolescents cannot afford the cost of transportation to a health care facility. In some instances, students whose families do have insurance coverage may still lack access to health care due to confidentiality reasons (See section G for more details.)

2. Lack of Third-party Payments for Preventive and Mental Health Care. Preventive and mental health care is usually not included in third party payor agreements. Preventive health care is usually less costly than curative health care; however, payment for preventive health care is traditionally not covered by health insurance. Policy makers at the state and federal level have not been willing to dedicate adequate financial resources for preventive health care. Financial support for preventive health care does not appear to be a high priority among the many competing interests for taxpayer dollars.

When third party payments are available for mental health care, they are often accompanied by problems which inhibit access as effectively as if there were no third party payors.

Many mental health care professionals have elected not to accept Medicaid clients. Mental health insurance benefits, mandated in Maine, will only pay a portion of the mental health expenses. Many people choose not to go if they are unable to find a professional who will accept Medicaid or if they are unable to provide the expenses not covered by health insurance. This effectively denies access to mental health services to some adolescents, a regrettable occurrence, since adolescents often need more mental health services than physical health services.

3. Reimbursement for school based services. For those school systems which do choose to provide more comprehensive health services, the financial burdens can be significant. School based health services are reimbursable under the school funding formula. The cost of these health services would be partially funded by state revenue as an operating expense. However, the current school funding formula is based on expenses which occurred two years prior to the current year. Any reimbursement from the state would not begin until the third year of operating the school based health service. The local school unit would have to absorb 100% of the operating costs during that two year period. (The Department of Human Services is administering a grant program to assist with these costs. See discussion in Part III.)

Until the school reimbursement formula is based on actual cost and a solution is found to the two year delay, this method of funding is a disincentive to innovation in the area of providing health services through school based programs.

G. Confidentiality

Lack of confidentiality, or the perception thereof, is near the top of the list with regard to the obstacles to adolescent health care. The period of adolescence is marked by a drive for independence and a need for privacy. Adolescents need a facility where they can feel that their confidentiality is respected. In addition, paying for health care and transportation to a health care provider presents problems in confidentiality. For many teens, the only means of paying for health care, and thus the only access they have to health care, is by using their parents' health insurance. This automatically results in loss of confidentiality. Even finding transportation to a health care facility without asking their parents can be difficult.

Many adolescents would rather not obtain health care if confidentiality can not be maintained. Lacking an independent source of payment or an inexpensive health care facility, teens often forego health care rather than breach their own confidentiality.

H. Consent

Closely related to the issue of confidentiality is the right of adolescents to independent access to medical and counseling services without parental consent. A minor (under 18 years of age) may seek medical and counseling services without the consent of parent or guardian in a limited number of circumstances, i.e. if married, if in the armed services, or if emancipated under Maine law.

There are limited exceptions to this general rule. A physician may treat an adolescent in an emergency situation if the parents are unavailable immediately and it would be detrimental to the patient's health to delay treatment in order to obtain that consent. Also, although it is not as clear in the law, a brief initial consultation may be permitted without parental consent. School counselors may keep confidential information obtained during a "counseling relationship" with a student, except in a case involving suspected child abuse or situations involving clear and imminent danger to the student or others.

Lack of confidentiality potentially creates two problems: (1) an adolescent may not seek needed health care if confidentiality cannot be maintained; and (2) a physician may be placed in jeopardy by being subjected to litigation for treating an adolescent without parental consent. Both issues tend to inhibit the provision of health care for adolescents.

V. RECOMMENDATIONS FOR MEETING ADOLESCENT HEALTH NEEDS

This Commission assumes that adolescents want to be healthy in the fullest sense of that term. It also assumes that there are obstacles to realizing that goal, many of which are not the fault of the adolescent. We believe that those obstacles should be removed to the extent possible. Removing those obstacles would free adolescents to accept responsibility for their own health. Accordingly, we make the following recommendations to accomplish that purpose.

A. Assess the Need

Most communities have no idea of the health needs of their adolescents nor of the services which are available to meet those health needs.

Adolescents need total health care. Many communities do not currently have adequate services. These communities should assess their adolescent health needs and the utilization of existing health care resources by adolescents. This might be done or sponsored by a community based advisory committee. Such an advisory committee (or any group) could identify the adolescent health needs of the community, the utilization of existing health services, and how the complete health needs of community adolescents can best be met. If additional services are needed, the committee could determine how best to coordinate or add those services.

Such a community based survey can also be used to create an awareness in the community of the health needs of adolescents and to gather community support for meeting those health needs.

B. Medical Home

The Commission believes that each adolescent needs a "medical home", i.e. a place where most or all of the adolescent's health needs can be met in a setting which ensures comfort, respect, effectiveness, and confidentiality.

The medical home should be available in a wide variety of settings other than the traditional private physician's office. In many instances, access to the physician is a problem, either because both parents work and find it difficult to take the child for an examination or because they cannot afford a private physician. Adolescents are also not well motivated to continue routine medical check-ups with a private physician. Additionally, adolescents may have health problems which they do not wish to share with their parents.

It is especially important that the health professional in this medical home develop a relationship with the adolescent based on trust and recognize the independent and uniqueness of the adolescent. The development of trust is essential to obtaining accurate physical, mental, and social information regarding the adolescent's health.

Health services in alternative settings, such as the school, should be available. A medical home for adolescents can be provided in a school based setting by building onto the existing services of the school nurse and the school physician as an integral component of a student's medical home.

Other appropriate medical homes need to be established. There are a variety of options including government or hospital sponsored health centers located at or near the schools or easily accessible within the community. These health centers should be staffed by health professionals with diagnostic and treatment skills in adolescent medicine.

C. School Based Health Centers

A school setting for health services, integrated with existing services, can remove many obstacles to adequate adolescent health care. For those communities without adequate health services capable of addressing adolescent health needs, participation and input from the existing health care providers can provide a major portion of the unmet health needs of adolescents.

School based health services can provide comprehensive preventive and initial diagnostic services for adolescents, including mental health services. The Commission recognizes the need for an increase in the availability and competency of school based mental health practitioners to address the emotional and mental health needs of the adolescent. Physical and emotional health services provided in a school based setting should work within a family context whenever possible, assisting parents in communication with adolescents and involving them whenever possible in the therapeutic process.

D. Role Models

Both adult and peer role models play a significant role in an adolescent's life. It is important that these role models present appropriate health information. There are many ways that both adults and peers can become better role models within the school system. These include:

1. Peer counseling. Establishing peer counseling programs to provide accurate information and healthful role models.

2. Wellness. School systems should encourage participation in wellness programs for staff in order to provide effective role models for students.

3. Social interaction training. Providing training for parents, teachers, and students in social interaction skills.

4. Preventive care. Providing educational programs for parents and teachers in healthful, preventive self-care which encourages them to practice those measures.

5. Identification of role models. Encouraging students to identify good role models.

6. Adult role models. Encouraging adults to become good role models.

E. Programmatic changes

The following programmatic changes are recommended by the Commission:

1. School Nurse. Local school systems should strive to establish and maintain a pupil to nurse ratio at a level consistent with the recommendation of the National Association of School Nurses (at least 1 nurse per 750 students).

School administration needs to be informed of the breadth of services a school nurse can offer. School nurses must work to educate both administrators and themselves on these available services.

2. Guidance counselors. Provide guidance counselors and school social workers with adequate training and time to deal with student mental health issues. Commit sufficient resources to allow a reasonable student to counselor ratio.

3. Emergency medical coverage. The local school system should provide adequate emergency medical coverage at high risk sporting events for boys and girls. The Maine Secondary School Principals' Association should establish minimum guidelines for adequate coverage.

4. Wellness program. The Commission supports the concept of promoting a wellness program in the schools, which may include participation by the school system in a Wellness Conference.

5. Adequate sports physicals. Local school systems should require more comprehensive sports physicals. A sports physical should be given no less frequently than every other year. The physical should concentrate on musculo-skeletal system, flexibility, and body maturity. An interval medical history should be done prior to each sporting season and positive responses reviewed for referral to school or personal physician.

6. Age appropriateness of particular sports. The Commission supports the continuing dialogue, currently conducted by the middle level education Task Force, evaluating the appropriateness of competitive sports at various age levels. The Commission encourages this kind of debate to continue regarding appropriate athletic activities at all levels of schooling.

7. Physical education position. Advocate a physical education position in the Department of Educational and Cultural Services.

8. Formal education for physical education instructor. Encourage formal education for physical education instructors. (See G-4).

F. Financial

1. Start up funding for school based health center. For those communities that choose to establish a school based health center, fund the initial two years start up for School Based Health Centers through the state. The state should be primarily responsible for start-up funding costs. Long-term financial support could come from other governmental grants, organizational contributions, community based sources (such as United Way, etc.), and existing community or regional medical institutions or medical professionals.

2. Preventive health care funding. The Commission recommends that insurance companies, the legislative and executive branches of government help resolve the lack of third party reimbursement for preventive health care.

G. EDUCATIONAL

1. Health education curriculum. In designing a health education curriculum, care must be taken to make it comprehensive. One of the most neglected elements of a complete health education program are issues relating to sexuality. Included in this curriculum should be a factual discussion of traditional and alternative sexual lifestyles (both heterosexual and homosexual) and high risk sexual practices that effect health, e.g. pregnancy, AIDS, and other sexually transmitted diseases.

Health education should be regarded as an integral part of the curriculum. The health curriculum should be relevant, interesting, useful, and sequential. Textual materials should bring together the many divergent subjects into one coherent whole. Selected aspects of health education should be integrated into other classroom materials.

A fully integrated health education curriculum should encourage and promote self-esteem and confidence and should begin in the primary and middle schools.

While the Commission recognizes the responsibility of the local board and the community to identify the specific content of a health education curriculum, that responsibility must be balanced with the overwhelming need of adolescents to learn, in a truly educational setting. The information learned in the classroom is likely to be more reliable than that found written on bathroom walls.

2. Spiritual development. Health education curriculum should be sensitive to and responsive to the need for spiritual development in adolescents. Adolescents are experimenting with how to meet their spiritual needs They need a chance to practice these developing skills. Adolescents should be offered an opportunity to develop a set of values and to examine the roles and relationships of mature and responsible members of a community. This should be integrated into the entire school curricula. These skills and experiences will not be limited to one segment of a student's life and should not be limited to one class.

The Commission believes that there is a place within formal education where students can learn to develop ways to define their own values.

3. Specific training for health care professionals. The Commission recognizes the need for physicians and nurses to be specifically trained in adolescent health and in communicating with adolescents. It encourages this training of the state's health professionals through continuing medical education offered by their respective professional societies.

4. Specific training for coaches. All school coaches should complete an accredited training course in sports medicine, first aid, sport psychology, sport physiology, and sport trainer skills. Local school systems should require coaches to maintain competence by successful completion of a "coaching effectiveness" program. Any educational program for coaches should include training on how to coach adolescents in a developmentally appropriate manner for sporting skills.

5. Specific training for administrators. The Maine School Management Association, the Maine Secondary School Principals' Association, Principal's Academy, and the post secondary institutions should coordinate their efforts in educating administrators in adolescent health issues.

6. Alternative learning organizations. Adolescents need alternative organizations to the traditional educational institutions. All students do not learn in the same educational setting. Traditional educational settings create feelings of failure in some students. This creates feelings of poor self-esteem which greatly hinder their learning capability and often leads to early drop-outs. Alternate methods of learning should be available to these students.

H. Consent

The consent of a minor to medical treatment is an area fraught with legal uncertainty and emotional and ethical conflict and pain. There is an inherent conflict between the right and responsibility of a parent to determine what is best for their minor children and the needs and rights of maturing adolescents for confidentiality and self-consent to medical treatment. There are certain instances in which, if a minor is forced to choose between obtaining necessary health care and revealing certain facts regarding his medical condition to his parents, the minor will remain silent and forgo the needed medical treatment. In some circumstances, it is more important that the youth receive health care than that the parents obtain the medical information.

This Commission recognizes that there are limited circumstances where it is necessary to ensure that medical care is given at the expense of parental notification and recommends that legislation be enacted to accomplish this.

FOOTNOTES

1. Michael Kort, "The Delivery of Primary Health Care in American Public Schools, 1890-1980", Journal of School Health, Vol. 54, No. 11, December 1984, pp. 453-457.

2. Irwin, Charles E., Jr. M.D.; "Why Adolescent Medicine?"; Journal of Adolescent Health Care, 1986;7:pp.2S-12S.

3. Daniel Goleman, "Teen-age Biology (and) Peers Prompt Risk-taking Acts", The New York Times, 1987

4. Maine Department of Human Services, Children's Deaths in Maine: 1976-1980 Final Report, "Deaths to Maine Children by Cause and Age", Appendix 2.3,

5. Ibid., pp. 21-22

6. Massachusetts Department of Public Health, Injuries in Massachusetts: A Status Report, "Summary and Recommendations", June 1897.

7. AJ Rarig, "Fact Sheet on Injuries", prepared for NECON Conference "Achieving Health for All New Englanders," Boston, November 7, 1987.

8. Citation for "The State of Maine Task Force on Adolescent Treatment Bed Needs", 1985.

9. Katner and Zelnik, "Sexual Activity, Contraceptive Use and Pregnancy Among Metropolitan-Area Teenagers: 1971-1979, as cited in "Adolescent Pregnancy: The Challenge," The Appendix. Governor's Task Force. (undated).

10. Maine Department of Human Services, "Adolescent Pregnancy: The Challenge", The Governor's Task Force on the Prevention of Adolescent Pregnancy and Parenting, 1986, pp.12-13

11. Ibid., pp.9-10

12. Irwin, C.E., et.al., "Biopsychosocial Correlates of Risk-Taking Behaviors during Adolescence", Journal of Adolescent Health Care, 1986;7: pp. 82S-96S.

13. American Assoc. of School Administrators, "Why School Health", 1987.

14. The Maine Coalition for School Health Education, "Healthy Maine Youth: A Basic Key to the Future", information brochure.

15. Ibid.

16. Guidelines for Health Supervision, American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine, 1981.

17. "Understanding Your Health"

18. New York Times, August 27, 1987

19. Telephone conversation with Holly Richardson-Lehnhard, January 25, 1988

20. Bangor Daily News, June 6, 1987.

21. Conversation with Steven Butterfield and Dr. Joseph Pechinski, Department of Health, Physical Education, and Recreation, University of Maine at Orono, Feb. 5, 1988.

22. "Scholastic Sports America", a sports news program by ESPN television network, February 3, 1988.

23. National Association of Anorexia Nervosa and Associated Disorders (ANAD); newsletter, October 1984.

24. ANAD Fact Sheet.

25. Plenary Sessions, New England Conference on School-Based Clinics, April, 1987, Springfield, Massachusetts.

26. Information from David Walch, Ph.D, Director of Behavioral Services, Fairview Southdale Hospital, Minneapolis, Minnesota.

27. Chilman, C.S. Adolescent Sexuality in a Changing American Society, US/DHEW (NIH79-1426) 1979.; Zelnick and Shah. "First Intercourse Among Young Americans, "Family Planning Perspectives, Vol. 15, Number 2 (March]April), 1983; Zelnick, M. and Kantner, J. "Reasons for Nonuse of Contraception by Sexually Active Women Aged 15-19", Family Planning Perspectives, Vol. 11]5, 1979, pp. 289-296; Jessor, R. and Jessor, S. Problem Behavior and Psychosocial Development: A Longitudinal Study of Youth, NY Academic Press, 1977; and others.

28. Snehendu B. Kar, John Talbot, Carl Coan, "Peers As Health Promoters Among Adolescents", University of California, Los Angeles; presented at The Fourteenth Annual Psychosocial Workshop of the Population Association of America, San Francisco, April 1986.

29. Connell, David B. and Ralph R. Turner. "The Impact of Instructional Experience and the Effects of Cumulative Instruction," Journal of School Health, Kent OH: American School Health Association, October 1895, pp. 324-331; and Pine, Patricia. "Promoting Health Education in Schools - Problems and Solutions." Critical Issues report. Arlington, Va: American Association of School Administrators, 1985;

30. Foster, Joni and Katherine M. Wilbur, "Health Education: A Comprehensive Approach." Maine Department of Educational and Cultural Services,undtd.

31. Division of Alcohol and Drug Education Services, Department of Educational and Cultural Services, definition

32. Lovick, Sharon R., "The School-Based Clinic: Update 1987", The Support Center for School-Based Clinics, Houston, Texas, undtd, p. 7.

33. Profile of the Maine School Nurse, June, 1987, Department of Educational and Cultural Services, distributed by the School Nurse Exchange in Maine, 1987. 143 total respondents.43. Some of the questions were not pertinent for all schools so the resulting percentages do not always total 100%.

34. Irwin, "Why Adolescent Medicine?", op. cit., p. 9S.

35. Ibid., p. 5S

APPENDIX A

APPROVED

JUN 29'87

BY GOVERNOR

CHAPTER

66

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-SEVEN

H.P. 802 - L.D. 1076

Resolve, to Establish a Commission to Study Health Services in Public Schools.

Emergency preamble. Whereas, Acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this resolve establishes a commission to study health services in public schools; and

Whereas, in order to complete the study by February 1, 1988, it should be started as soon as possible; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Study commission created. Resolved: That there is established the Commission to Study Health Services in Public Schools which provide counseling and services related to adolescent health needs; and be it further

Appointment. Resolved: That the commission shall consist of 13 members, appointed in the following manner: Two Senators appointed by the President of the Senate; 3 Representatives appointed by the Speaker of the House; the Commissioner of Human Services or his designee; the Commissioner of Education-

al and Cultural Services or his designee; one member of the State Board of Education, selected by the board; one guidance counselor, selected by the Maine Association of Guidance Counselors; one parent, one teacher and one physician appointed by the Governor; and one nurse selected by the Maine Nurses Association. The appointments shall be made within 30 days of the effective date of this Act. Those appointing or selecting members of the commission shall notify the Chairman of the Legislative Council of their appointments; and be it further

Covening of commission. Resolved: That when the appointment of all commission members is completed, the Chairman of the Legislative Council shall convene the first meeting within 15 days. The commission shall choose a chairman from among its members; and be it further

Duties. Resolved: That the commission shall undertake to study the need for school-based health services established to address adolescent health needs and concerns including, but not limited to, pregnancy, parenting, suicide, mental health, substance abuse and sexuality and recommend appropriate educational programs and health services which may appropriately be provided in the public schools; and be it further

Report. Resolved: That the commission shall present its findings, together with any recommended legislation to the Second Regular Session of the 113th Legislature by February 15, 1988; and be it further

Assistance. Resolved: That, if staff assistance is desired, assistance shall be requested from the Legislative Council; and be it further

Compensation. Resolved: That the members of the commission who are Legislators shall receive the legislative per diem, as defined in the Maine Revised Statutes, Title 3, section 2, for each day's attendance at commission meetings. All members of the commission shall receive reimbursement for expenses upon application to the Executive Director of the Legislative Council; and be it further

Appropriation. Resolved: That the following funds are appropriated from the General Fund to carry out the purposes of this resolve.

	1987-88
LEGISLATURE	
Commission to Study Health Services in Public Schools	
Personal Services	$1,650
All Other	5,800
Total	$7,450

Emergency clause. In view of the emergency cited in the preamble, this resolve shall take effect when approved.

In House of Representatives, ... 1987

Read and passed finally.

..... Speaker

In Senate, ... 1987

Read and passed finally.

..... President

Approved 1987

..... Governor

APPENDIX B

SUBCHAPTER II

ELEMENTARY SCHOOLS

§4711. Elementary course of study

The basic course of study for the elementary schools shall provide for the instruction of all students in the English language, including reading, writing, spelling and grammar; library instruction; mathematics; science; music, art and drama; American history and government; social studies; Maine studies, including the history, geography, culture and natural and industrial resources of the State; health, hygiene and safety; physical education; and physiology and hygiene, with special reference to the effects of substance abuse, including alcohol, tobacco and narcotics upon the human system. 1983, c. 859, Pt. C, §§5, 7 (new) Eff. 8/1/88.

1983, c. 859, Pt. C, §§5, 7 (new) Eff. 8/1/88.

§4723. Health and physical education

The secondary course of study shall include instruction in health, safety and physical education, as prescribed by the commissioner, and physiology and hygiene, with special reference to the effects of alcoholic drinks, stimulants and narcotics upon the human system. 1983, c. 859, Pt. C, §§5, 7 (new) Eff. 8/1/88.

1983, c. 859, Pt. C, §§5, 7 (new) Eff. 8/1/88.

APPENDIX C

TITLE 20-A

CHAPTER 223

HEALTH, NUTRITION AND SAFETY

SUBCHAPTER I

STUDENT HEALTH

§6301. Student health

The following provisions apply to student health.

1. Duty of teacher. A teacher who believes that a student is so filthy or diseased as to be offensive or dangerous to others, or the bearer of vermin or parasites, or has a communicable disease of the skin, mouth or eyes, shall inform the superintendent.

2. Duty of superintendent. A superintendent informed by a teacher under subsection 1 shall:

A. Inform the student's parent:

(1) To cleanse the clothing and bodies of their children; and

(2) To furnish their children with the required home or medical treatment for the relief of their trouble so defined in subsection 1;

B. Exclude the student from the public schools until the student is no longer offensive or dangerous; and

C. Exclude the student from public school as soon as safe and proper transportation home is available.

3. Duty of parent. A parent informed by a superintendent under subsection 2 shall promptly do what is reasonably necessary to ensure that the student is no longer offensive or dangerous.

4. Penalty. Any parent who fails to comply with subsection 3 shall be fined not more than $5 for the first offense or $10 for subsequent offenses.

5. Exclusion.

5-A. Notification. The superintendent shall cause notice of the communicable disease to be given to the Department of Human Services, in accordance with the requirements of Title 22, chapter 251, and rules issued under that chapter.

6. Authority and duties of the Department of Human Services. The Department of Human Services shall have the authority and duties prescribed in Title 22, chapter 251 on communicable diseases.

SUBCHAPTER II

IMMUNIZATION

§6351. Immunization

1981, c. 693, §§5, 8 (new). 1983, c. 661, §7 (rp); c. 806, §61 (amd); c. 862, §59 (rp).

§6352. Immunization

To assure a safe and healthful school environment, the Legislature intends that the provisions of this subchapter on immunization shall apply in the schools of the State.

§6353. Definitions

As used in this subchapter, unless the context indicates otherwise, the following terms have the following meanings.

1. Certificate of immunization. "Certificate of immunization" means a written statement from a physician, nurse or health official who has administered an immunizing agent to a child, specifying the dosage administered and the date it was administered.

2. Child. "Child" means and includes every child entering school.

3. Disease. "Disease" means diptheria, measles, mumps,

pertussis, poliomyelitis, rubella and tetanus.

4. Immunizing agent. "Immunizing agent" means a vaccine, antitoxin or other substances used to increase an individual's immunity to a disease.

5. Parent. "Parent" means a child's parent, legal guardian or custodian. A person shall be regarded as a child's custodian if that person is an adult and has assumed legal charge and care of the child.

6. Public health official. "Public health official" means a local health officer, the Director of the Bureau of Health, Department of Human Services, or any designated employee or agent of the Department of Human Services.

7. School. "School" means any public or private elementary or secondary school in the State.

8. Superintendent. "Superintendent" means the superintendent of schools of a school administrative unit, or a person designated by the superintendent, and the chief administrative officer of a private school.

§6354. Immunization

1. Immunization required. Except as otherwise provided under this subchapter, every parent shall cause to be administered to his child an adequate dosage of an immunizing agent against each disease.

2. Immunizing agent to meet standards. Any such immunizing agent shall meet standards for such biological products, approved by the United States Public Health Service and the dosage requirement specified by the Department of Human Services.

§6355. Enrollment in school

No superintendent may permit any child to be enrolled in or to attend school without a certificate of immunization for each disease or other acceptable evidence of required immunization or immunity against the disease, except as follows.

1. Written assurance. The parent provides a written assurance the child will be immunized within 90 days by pri-

vate effort or provides, where applicable, a written consent to the child's immunization by a health officer, physician, nurse or other authorized person in public or private employ.

2. Physician's statement. The parent or the child provides a physician's written statement that immunization against one or more of the diseases may be medically inadvisable.

3. Moral, philosophical or personal reasons. The parent states in writing a sincere religious belief which is contrary to the immunization requirement of this subchapter or an opposition to the immunization for moral, philosophical or other personal reasons.

§6356. Exclusion from school

1. Public health official action. When a public health official has reason to believe that the continued presence in a school of a child who has not been immunized against one or more diseases presents a clear danger to the health of others, the public health official shall notify the superintendent of the school. The superintendent shall cause the child to be excluded from school during the period of danger or until the child receives the necessary immunizing agent.

Whenever, as a result of this section, a child is absent from the public school for more than 10 days, the superintendent shall make arrangements to meet the educational needs of the child.

2. Superintendent's action. Notwithstanding the provisions of this subchapter on immunization against specified diseases, a superintendent shall exclude from the public schools any child because of filth or communicable disease, in accordance with section 6301, and the superintendent shall exclude from school any child or employee who has contracted or has been exposed to a communicable disease as directed by a local health officer, the Department of Human Services or the school physician.

§6357. Records; report

1. Record keeping. Each superintendent shall keep uniform records of the immunizations and immunization status of

each child based on the certificate of immunization, other acceptable evidence and other available documents. The records shall be part of the child's permanent education records. These records shall be confidential, except that state and local health personnel shall have access to them in connection with an emergency, as provided by the United States Family Educational Rights and Privacy Act of 1974, Public Law 93-380, United States Code, Title 20, Section 1232g(b) (1) (I) and regulations adopted under that Act.

2. Annual report of immunization status. By December 15th of each year, each superintendent shall submit to the Director of the Bureau of Health, Department of Human Services, and to the commissioner a summary report of immunization status of the children entering school, as prescribed by rule.

§6358. Rules; requirements; reports

1. Rules authorized. The commissioner and the Director of the Bureau of Health, Department of Human Services, shall jointly issue rules necessary for the effective implementation of this subchapter, including, but not limited to, rules establishing immunization requirements for each disease, school record keeping and reporting requirements or guidelines and procedures for the exclusion of nonimmunized children from school.

2. Local requirements authorized. Immunization requirements more stringent than the provisions of this subchapter may be adopted by ordinance enacted by a municipality, by regulation of a school board or by policy of a private school's governing board.

§6359. Immunization of students

1. Definitions. As used in this section, unless the context indicates otherwise, the following terms have the following meanings.

A. "Certificate of immunization" means a written statement from a physician, nurse or health official who has administered an immunizing agent to a student, specifying the dosage administered and the date it was administered.

B. "Chief administrative officer" means the person des-

ignated by the legal governing authority as president, administrator or director of a public or private post-secondary school.

C. "Disease" means diphtheria, measles, rubella and tetanus.

D. "Immunizing agent" means a vaccine, antitoxin or other substances used to increase an individual's immunity to a disease.

E. "Parent" means a student's parent, legal guardian or custodian. A person shall be regarded as a student's custodian if that person is an adult and has assumed legal charge and care of the student.

F. "Public health official" means a local health officer, the Director of the Bureau of Health or any designated employee or agent of the Department of Human Services.

G. "School" means any public or private, post-secondary school in the State including, but not limited to colleges, universities, vocational-technical institutes and schools for the health professions.

H. "Student" means any person born after 1956 who attends school full time or who is a candidate for a degree, diploma or graduate certificate.

2. Immunization. Except as otherwise provided under this section, every student shall have administered an adequate dosage of an immunizing agent against each disease.

Any such immunizing agent shall meet standards for the biological products, approved by the United States Public Health Service and the dosage requirement specified by the Department of Human Services.

3. Enrollment of school. No chief administrative officer may permit any student to be enrolled in or to attend school without a certificate of immunization for each disease or other acceptable evidence of required immunization or immunity against the disease, except as follows.

A. The parent or the student provides a physician's written statement that immunization against one or more

of the diseases may be medically inadvisable.

B. The student or the parent, if the student is a minor, states in writing a sincere religious belief, which is contrary to the immunization requirement of this subchapter or an opposition to the immunization for moral, philosophical or other personal reasons.

4. Exclusion from school. When a public health official has reason to believe that the continued presence in a school of a student who has not been immunized against one or more diseases presents a clear danger to the health of others, the public health official shall notify the chief administrative officer of the school. The chief administrative officer shall cause the student to be excluded from school during the period of danger or until the student receives the necessary immunizing agent.

5. Records; report. Each chief administrative officer shall keep uniform records of the immunizations and immunization status of each student, based on the certificate of immunization, other acceptable evidence and other available documents. The records shall be part of the student's permanent records.

By December 15th of each year, each chief administrative officer shall submit to the Director of the Bureau of Health a summary report of immunization status of the students entering school, as prescribed by rule. A blank summary report form will be provided to each chief administrative officer by the Bureau of Health.

6. Rules; requirements; reports. The Director of the Bureau of Health shall issue rules necessary for the effective implementation of this subchapter, including, but not limited to, rules establishing immunization requirements for each disease, school record keeping and reporting requirements or guidelines and procedures for the exclusion of nonimmunized students from school.

Immunization requirements more stringent than the provisions of this subchapter may be adopted by a school board or by policy of a private school's governing board.

SUBCHAPTER III

SCHOOL HEALTH SERVICES

§6401. School Nurse Coordinator

1. Coordinator within department. There shall be a health professional, acting as a School Nurse Coordinator, within the department. This person must be licensed as a registered nurse in the State and must have education and experience in school health or community nursing and, if possible, a master's degree in nursing.

2. Duties. The coordinator shall have the following duties:

A. To provide orientation for new local school nursing personnel, and to assist them in writing comprehensive job descriptions and implementing local health policies;

B. To assist local school nursing personnel in advocating and planning comprehensive, sequential health education programs for students;

C. To assist the department in establishing certification standards for school nursing personnel;

D. To assist local school nursing personnel in understanding new legislation and to refer to appropriate department legal staff questions of legal liability and other legal issues;

E. To assist school nursing personnel in becoming knowledgeable members of pupil evaluation teams in effecting placement and programs for exceptional students;

F. To instruct school nursing personnel in the organization of health services with minimal disruption to the educational process;

G. To coordinate appropriate educational programs and workshops for school nursing personnel and to work with institutions of higher education to make relevant courses and degree programs available to nurses in all areas of the State;

H. To interpret the role of school nursing personnel to local administrators and educators;

I. To assist in establishing communication between the Department of Human Services and the Department of Edu-

cational and Cultural Services and to seek input from local school nursing personnel in formulating guidelines for services to students;

J. To attend courses, workshops and conferences relevant to school nursing and to disseminate current health information of local school nursing personnel on a regular basis;

K. To assure communication and coordination among school nurses, physicians and other resource agencies providing health services;

L. To serve as an official representative and spokesman for the School Nurse Division of the Maine Association for Health, Physical Education, Recreation and Dance, voicing the group's stand on legislation, health topics and educational issues which affect the health of the state's children; and

M. To serve as a resource person to other agencies and organizations, including the State Principal's Association, the Maine Lung Association, the School Health Board of Directors, the Maine State Nurses' Association and the Maine Teachers' Association.

§6402. School physicians

1981, c. 693, §§5, 8 (new) Eff 7-1-83. 1985, c. 258, §1 (rp).

§6402-A. School physician

Each school board shall appoint one or more school physicians.

1. Duties. The school physician shall advise the administrative unit on school health issues, policies and practices and may also perform any other health-related functions assigned by the board.

2. Other functions. A school physician may perform other medical and health-related duties assigned by the school board which may include all or some of the following:

A. Examine and diagnose students referred by teachers and other school employees to protect against the outbreak of contagious diseases in the schools;

B. Examine students for participation in physical education and athletic activities;

C. Advise and serve as medical consultant to the school nurse; or

D. Examine school employees and property if the physician believes it is necessary to protect the health of students.

3. Prohibition. A school physician may not treat any student examined under this subchapter unless the physician is also the student's personal physician.

4. Appointment. Appointment shall be on a yearly basis.

§6403. Referral for examination

1981, c. 693, §§5, 8 (new) Eff 7-1-83. 1985, c. 258, §3 (rp).

§6403-A. School nurse

Each school board shall appoint at least one school nurse for the school administrative unit.

1. Duties. The school nurse shall supervise and coordinate the health services and health-related activities required by this Title.

2. Other functions. The school nurse shall also perform such other health-related activities as are assigned by the school board.

3. Appointment. To fulfill the role of school nurse, the school board shall appoint a registered professional nurse who meets any additional certification requirements established by the state board.

4. Special contract for services. The school board may provide school nurse services through special agreements with a public health agency. All nurses who serve as school nurses under those agreements shall be registered professional nurses who meet applicable certification requirements.

5. Guidelines. The commissioner shall issue guidelines

on the provision of school health services and health-related activities.

SUBCHAPTER IV

HEALTH SCREENING

§6451. Health screening

1. Student right to screening for sight and hearing defects. Each student shall be screened periodically to determine whether they have sight or hearing defects.

2. Commissioner's duties. The commissioner shall:

A. After consultation with the Commissioner of Human Services, adopt rules and provide school administrative units with assistance and materials to carry out this subsection;

B. Furnish to the administrators of the school administrative units the prescribed directions for the tests of sight and hearing; and

C. Furnish test cards, record and report forms and other useful materials for carrying out the purpose of this section.

3. Exempt students. A student whose parent objects in writing to screening or religious grounds shall not be screened unless a sight or hearing defect is reasonably apparent.

§6452. Screening for scoliosis and related spinal abnormalities

1. Intent. The screening program for scoliosis and related spinal abnormalities is intended to alert parents or guardians to potential spinal problems which could affect the physical development of their child. The public schools shall supervise the screening and notify parents or guardians of postural defects which should be investigated further by qualified personnel. The Department of Human Services shall provide consultation, technical assistance and training to the schools or their agents.

2. Screening program; rules. A screening program shall

be instituted according to the following provisions.

A. The school board of school administrative units shall require that students in the public schools be screened to determine if any student has a postural defect. The screening shall be performed by personnel who are approved by the Commissioner of Human Services for this purpose. Screening for postural defects shall be performed at least once annually in grades 5 to 8.

B. The Commissioner of Human Services shall, after consultation with the Commissioner of Educational and Cultural Services and the Bureau of Health, promulgate rules in accordance with section 3, for the screening test and shall furnish the rules to the administrative officers of the school administrative units. These rules shall include the frequency of the tests, the manner in which the schools or their agents conduct the tests, the qualifications of personnel conducting the screening, the method by which prior notice of the screening or the notice of any defect or possible defect detected shall be sent to the parent or guardian of the student and that the notation of the screening and any follow-up activity shall be kept with the student's school health records.

3. Exceptions. This section shall not apply to any student whose parent or guardian demonstrates by a written statement a religious, moral, philosophical or other personal objection.

4. Effective date. The Commissioner of Human Services shall promulgate the directions for implementation of this section no later than 30 days after the effective date of this section. School boards of administrative units shall have postural screening programs in effect by the start of the school year 1984-85.

5. Funding. In the event federal funds are not available for this program, the State or municipalities shall be under no obligation to utilize any state or municipal funds to carry out the purposes of this section.

§6453. Notice to parents of result of screening

The school board shall inform the parent of a student suffering from a disease or defect.

SUBCHAPTER V

SANITARY FACILITIES

§6501. Sanitary facilities

Sanitary facilities shall be provided as follows.

1. Toilets. A school administrative unit shall provide clean toilets in all school buildings, which shall be:

A. Of the flush water closet type and connected to a sewer, filter bed or septic tank, or of another design approved by the Department of Human Services;

B. Separated according to sex and accessible only by separate entrances and exits;

C. Installed so that privacy, cleanliness and supervision are assured; and

D. Free from all obscene markings.

2. Maintenance. Each school administrative unit shall provide for the cleaning and repair of its toilet facilities.

3. Inspection. The school board shall annually cause an inspection of the sanitary conditions of the school administrative unit's school buildings to insure compliance with this section.

4. Rules. The state board may adopt or amend rules to implement this section.

5. Penalty. Failure to comply with this section shall be subject to penalties under section 6801.

SUBCHAPTER VI

SAFETY

§6551. Tuberculosis controls

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Infectious tuberculosis" means a disease demonstrated by symptoms which lead to a medical diagnosis of active tuberculosis.

B. A person remains "infectious" until:

(1) Tuberculosis has been eliminated as the cause of the symptoms; or

(2) Tuberculosis has been made "inactive" as defined by the American Thoracic Society.

C. "Employed," for purposes of this section, means engaged to work in a public or private school in any position requiring regular physical presence within the school or exposure to school children.

D. "Superintendent," for purposes of this section, means all superintendents of schools, directors of vocational regions and chief administrative officer of private schools within the State.

2. Exclusion from school. No person with infectious tuberculosis may be employed in any elementary or secondary school in the State.

3. Current employees. Current employees excluded from employment under subsection 2 may use sick leave and shall retain the rights and privileges earned while employed.

4. New employees. The following provisions apply to new employees.

A. No person may begin employment in a school in this State without a demonstration that he is free of contagious tuberculosis in the manner described in this subsection.

B. Each person prior to employment shall file with the superintendent a certificate which indicates that the person has had, within 90 previous days, a standard tuberculin skin test and meets one of the following conditions:

(1) The test was negative;

(2) The test was positive but a subsequent chest x

ray was negative;

(3) The test was positive and a subsequent abnormal chest x ray showed no active tuberculosis; or

(4) The person has evidence of completion of preventive chemotherapy.

C. A person whose previous employment within 90 days was in another school in the State may transfer his certificate to the new school and need not undergo a new test or x ray.

D.

5. Retesting. The following provisions apply to retesting.

A. A person employed in a school who has a positive tuberculin test and an abnormal chest x ray must submit evidence of a chest x ray that shows no active tuberculosis to the superintendent on or before December 1st, biennially, or evidence of completion of preventive chemotherapy.

B. The certificate shall:

(1) State:

(a) That within the preceding 90 days that person has had a standard tuberculosis skin test and that the results were negative; or

(b) If the results of the skin test were positive, the results of a standard full-size chest x-ray taken within 90 days were negative; and

(2) Be signed by either a physician, registered nurse or other person approved by the Department of Human Services to administer and interpret tuberculosis tests.

C. School employees who complete a preventive drug program approved by the Department of Human Services shall not be required to get a chest x-ray.

6. Modifications. The Commissioner of Human Services may alter the requirements of this section for any geographic area of the State whenever that alteration would not pose a threat to public health or whenever more frequent testing is necessary to protect the public health. Modifications may not extend beyond 4 years and shall be included in any rules adopted pursuant to subsection 9.

7. State assistance. The Department of Human Services shall help provide medical services to comply with this section. The department may:

A. Provide medicine for preventive drug programs for school employees; and

B. Pay for x-rays required in preventive drug programs for school employees.

8. Duty of school officials. Each school superintendent shall provide tuberculosis testing data to the Department of Human Services on the department's request.

9. Rules. The Department of Human Services may adopt rules to carry out this section.

10. Penalties. A person who fails to comply with this section shall be fined not less than $20 nor more than $200. Each day of noncompliance shall be considered a separate offense.

11. Department of Human Services. In addition to the authority prescribed in subsection 9, the Department of Human Services shall have the authority and duties prescribed in Title 22, chapter 251 on Communicable Diseases.

§6552. Firearms

1. Prohibition. A person may not possess a loaded firearm on public school property or discharge a firearm within 500 feet of school property.

2. Exception. Subsection 1 shall not apply to:

A. Law enforcement officials; or

B. A supervised educational program.

3. Penalty. A person who violates this section is guilty of a Class E crime.

SUBCHAPTER VII

SCHOOL LUNCH AND MILK PROGRAM

§6601. Acceptance of federal law

The State shall comply with the following laws in consideration of the receipt of benefits under them:

1. The National School Lunch Program Act. The National School Lunch Program Act, enacted June 4, 1946, and applicable amendments; and

2. The Child Nutrition Act. The Child Nutrition Act, enacted October 11, 1966, and applicable amendments.

§6602. School food service programs

Public schools shall provide nonprofit school food service programs as follows.

1. Participation. A public school shall participate in the National School Lunch Program. It shall provide Type A meals as determined by the United States Department of Agriculture. The school board or committee for a public school designated as especially needy shall be required to hold a public hearing during the school year 1985-86 to determine if there is parental interest for that school to participate in the National School Breakfast Program. The commissioner shall designate a school as especially needy whenever 50% or more of the children in attendance are eligible for free or reduced price meals under applicable federal regulations.

2. Exceptions. The following shall be exempt from subsection 1:

A. All secondary schools limited to students in grades 9, 10, 11 and 12; and

B. A school administrative unit authorized by the commissioner under subsection 9 to postpone the establishment of the program.

3. Administration. The school board shall administer

and operate the food service programs. The school board:

A. Shall make all contracts to provide material, personnel and equipment necessary to carry out section 6601; and

B. Shall hire the necessary employees to manage and operate their school food service programs.

4. Funds. The following shall be used to pay for the administration and operation of food service programs:

A. State funds, gifts and appropriations for school food service programs; and

B. Receipts from the sale of meals under food service programs.

5. Rules. The commissioner shall adopt or amend, with the state board's approval, rules under this subchapter, including rules about the qualifications of food service programs' personnel.

6. Nutrition report. The commissioner may assess the nutritional benefits of school lunch programs and report to the state board.

7. Technical assistance. The commissioner may give technical assistance to a school board concerning a food service program and may assist in training food service program personnel.

8. Application for postponement. An administrative unit, which had been authorized by the commissioner to postpone the establishment of a National School Lunch Program, may apply to the commissioner for a renewal of the postponement. The commissioner may grant the requested postponement provided that:

A. The school board has held a public hearing on its proposed application; and

B. One of the following conditions is met:

(1) It has been documented to the commissioner's satisfaction that the administrative unit lacks space for the program and there is no appropriate

alternative source of meals for the students;

(2) It is impossible for the administrative unit to contract for or to otherwise procure Type A meals for its students; or

(3) The lack of need for the program, as determined by the school board is documented to the commissioner's satisfaction and was evident at the public hearing.

If the postponement is granted for the conditions in paragraph B, subparagraphs (1) and (2), it shall be for 3 years. If the postponement is granted for the condition in paragraph B, subparagraph (3), it shall be for 4 years.

8-A. State board review of commissioner's decisions. A school administrative unit or interested parties may request that the state board reconsider decisions made by the commissioner in subsection 8. The state board shall have the authority to overturn decisions made by the commissioner. In exercising this power, the state board is limited by this section.

9. Annual review of postponement. The commissioner shall annually review the conditions in the school administrative units which have been granted a postponement. On finding that the conditions in a unit have changed so that a postponement is no longer warranted, the commissioner may require that the unit establish a National School Lunch Program at the start of the next school year.

10. Petition by 1% of residential unit. Whenever petitioned by 1% of the residents of a unit, the commissioner shall call a public hearing on the postponement prior to the next annual review.

11. The state may administer. The state may administer the programs under the United States Child Nutrition Act, Public Law 89-642 in nonprofit, private schools, provided that the State shall not be required to appropriate or distribute state funds for meals served in private schools to those private schools.

§6603. Federal funds

The Treasurer of State shall receive and disburse all

federal funds received under this subchapter.

§6604. Substance abuse programs

1. Definitions. As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings:

A. "Chemical health coordinator" means a person who serves as the coordinator of a local school administrative unit's chemical primary and secondary prevention and education program.

2. Local programs. School units may institute special programs to address health and related problems.

To further these objectives, school units may employ specialized personnel such as chemical health coordinators and others knowledgeable in the field of substance abuse and may cooperate with public and private agencies in substance abuse education, prevention, early intervention, rehabilitation referral and related programs.

§6605. Department role

1. Personnel. The commissioner shall appoint, subject to the Civil Service Law, supervisors and consultants knowledgeable in the area of substance abuse.

2. Technical assistance. The department, through its supervisors and consultants, shall offer technical assistance to public and approved private schools and cooperating community-based organizations to aid in the establishment and implementation of school-based substance abuse programs and health education curricula.

3. Cooperation; coordination. The department shall carry out its planning activities related to alcohol and drug education and prevention subject to coordination with the Alcohol and Drug Abuse Planning Committee.

4. Information collection and sharing. The Department of Educational and Cultural Services shall be authorized to gather information about substance abuse prevention and intervention programs initiated by state or federal agencies whose efforts are directed toward private and public schools of the State, for the purpose of sharing that information

with school administrative units.

APPENDIX D

DESCRIPTION OF RECOMMENDED CONTENT AREA

The 10 content areas mandated by the instructional standards' and graduation requirements of the 1984 Education Reform Act for a comprehensive school health education program are given below. Following each content area is a brief list of topics that might be included when teaching the content areas. You will find that many topics are interrelated and may be included in more than one content area. It should be noted that this section is meant to provide examples and thus is not all inclusive.

1. Community Health

Healthful school, home, work and community environment; community health resources and facilities; community and state health agencies; health service careers; safety hazards; natural disasters; community health planning.

2. Consumer Health

Advertising; laws for consumer protection (product labeling); consumer protection agencies; health agencies and organizations; health insurance; selection and use of medical services; quackery; reliable sources of health information; evaluating health products and services.

3. Environmental Health

Causes and prevention of environmental pollution, including air, water, soil, radiation, noise and solid waste; effect of environment on health; environmental protection agencies; population growth; world health.

4. Family Life Education

Family structure, roles and responsibilities; selecting a compatible life partner; sexual stereotypes; marriage; divorce; contraception and family planning; the reproductive process; pre-natal care; heredity; parenting; physical and sexual abuse; "latch key kids"; babysitting skills/responsibilities.

5. Growth and Development

Growth patterns including sexual development and maturation; sexual orientation; stages of life, including childhood, adolescence, young adulthood, middle age, old age; death and dying.

6. Personal Health including Mental and Emotional Health

Physical fitness and lifetime physical activities; cardiovascular health; sleep, rest, relaxation, and recreation; personal hygiene; dental health; vision and hearing; body systems and their functions; self-concept; personality;

emotions; responsibility; motivation; independence; mental disorders; coping with stress; mental health services; understanding individual differences; dealing with societal problems such as child abuse and neglect, rape, crime and violent behavior; bioethical issues; communication skills; decision making skills; peer influence; stress management; suicide prevention.

7. Nutritional Health

Elements in food that contribute to good nutrition, factors influencing choices; individual nutritional requirements; food groups and nutrients; food sources; weight control; effects of nutrition on growth; activity and health status; additives; food preparation and storage; consumer skills; nutrition and its relationship to chronic disease; national and worldwide food supply; consumer protection.

8. Prevention and Control of Disease and Disorders

Historical and current research; cause, treatment and prevention of chronic and communicable disease; sexually transmitted diseases, including AIDS; immunization; lifestyle and diseased; community efforts and services.

9. Safety and Accident Prevention

Attitudes toward safety; causes of accidents; home and school safety; traffic (pedestrian, auto, bicycle, school bus) safety; fire prevention; survival skills; injury control; environmental hazards; accident prevention; first-aid and emergency health care, including CPR; safety personnel; personal safety precautions, including assault and child abuse and neglect prevention; recreational and hunting safety; occupational safety; resources and agencies; safety rules and laws.

10. Substance Use and Abuse

Classification of substances and their short and long term effects on the body and health; use and misuse of tobacco, smokeless tobacco, alcohol, caffeine, OTC drugs, and illegal drugs; self concept and drug use and abuse; environmental influences on drug use and abuse; societal and legal impact of substance use and abuse; chemical dependency; the relationship of drug use and accidents; treatment and rehabilitation programs.

4802m

APPENDIX E

PROPOSED LEGISLATION

21 MARCH 1988
4420m

SECOND REGULAR SESSION

ONE HUNDRED AND THIRTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY SEVEN

AN ACT to Provide for Consent of Minors for Health Services

Be it enacted by the People of the State of Maine as follows:

Sec. 1. XX MRSA, Chapter XXX, is enacted to read:

CHAPTER XXX

CONSENT OF MINORS FOR HEALTH SERVICES

§ 1001. Definitions

As used in this Chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Health care provider. "Health care provider" means an individual who is licensed in this state to provide health care, including but not limited to medical, mental, dental and other health counseling and services.

2. Minor. "Minor" means any person under 18 years of age.

§ 1002. Consent for health services

Notwithstanding any other provision of law, a minor may give consent to medical, mental, dental, and other health care in the following circumstances:

1. Emancipated. Any minor who is legally emancipated, who is or was ever married, who has had a child, or who has become a member of the armed forces of the United States;

2. Living independently. Any minor who is living separate from his or her parents or legal guardian for whatever reason and is self-supporting;

3. Specified health services. Any minor who seeks care for:

A. mental or emotional problems,

B. alcohol or drug abuse,

C. sexually transmitted diseases,

D. family planning services, or

E. prenatal care

4.Consent for child. Any minor who may give consent for his or her own health care services as provided in this chapter may also give consent for health care services for his or her child of whom he or she has legal custody.

§ 1003. Good faith reliance on consent.

Any health care provider who relies in good faith upon the representation of a minor that he or she may give consent as provided in this chapter shall not be liable for failing to have acquired consent of the minor's parent or guardian prior to providing health care services to the minor.

§1004. Confidentiality.

A. Except as otherwise specifically provided in this chapter, any minor who may consent to health care services, as provided in this chapter, shall be entitled to the same confidentiality afforded to adults.

B. A health care provider may notify the parents or guardian of a minor who has sought health care under this chapter, if, in the judgement of the provider, failure to inform the parent or guardian would seriously jeopardize the health of the minor or would seriously limit the health care provider's ability to provide treatment.

§ 1005. Voluntary notification by a minor.

The health care provider shall encourage the minor to involve his or her parents or guardian in health care decisions whenever to do so will not jeopardize the health of the minor.

§1006. Financial responsibility

Unless the parent or guardian expressly agrees to assume full or partial responsibility, any minor who consents to health care services as provided in this chapter is responsible for the costs of those services. No minor shall be denied benefits or services to which he or she is entitled from a health care provider, insurer or public agency because the minor has given consent as provided in this chapter.

4795m
CC 3/31/88

SECOND REGULAR SESSION

ONE HUNDRED AND THIRTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY SEVEN

AN ACT to Provide Funds for Start-up of School-Based Health Centers and Creation of Position of Educational Specialist II

Be it enacted by the People of the State of Maine as follows:

Section 1. Appropriation. The following funds are appropriated for the purposes of this Act.

EDUCATION AND CULTURAL SERVICES, DEPARTMENT OF

	Fiscal Year 1989-1990
General Purpose Aid for Local Schools	$500,000

Provides funds to assist school units with initial two-year funding for school-based health centers for those communities that wish to establish them.

Liability of the State will be limited to funds appropriated by the Legislature for this purpose.

Curriculum Education

Positions	(1)
Personal Services	27,872
All Other	3,540
Capital Expenditures	600
	$32,012

Provides funds for an Educational Specialist II position, travel, and related costs.

STATEMENT OF FACT

This Act provides funds to carry out proposed legislation introduced in the final report of the Commission to Study Health Services in Public Schools. That report recommended the establishment of school-based health centers in those communities that choose to establish those centers. The report also recommended the creation of an Education Specialist II position to serve as a physical education coordinator.