REPORT OF THE
SECRETARY OF HUMAN RESOURCES

The Health Needs of School-Age Children

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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The Secretary's Task Force on the Health Needs of School-Age Children

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LETTER OF TRANSMITTAL

To the Members of the General Assembly of Virginia:

It is with a great sense of concern tempered with cautious optimism that I release this report on the health needs of Virginia's school-age children. Over the course of the last few months, I have had the opportunity to meet with parents, health care providers, educators, school administrators, business leaders, social service providers, mental health professionals, governmental officials, and teenagers around the State to discuss the health problems of today's youths. We found that while school-age children statistically are a healthy segment of our population, they still face many problems. In addition to traditional diseases and injury, our children have new health concerns related to alcohol and drug abuse, teenage pregnancy, sexually transmitted diseases, violent behavior, suicide, depression, and other mental health problems. A generation ago, these problems did not seem as prominent as they do today.

During the course of the study, we also looked at the ability of our current school health services system to address the health problems of our school-age children. The picture which emerged shows tremendous disparity among Virginia's 134 school divisions. While some school divisions offer exciting, innovative school health programs, others have virtually no school health services at all. The integration of school health services as a part of a community overall health care resources also appears lacking in many areas.

Despite these concerns, I am extremely encouraged by high level of interest and participation displayed on the part of those involved with this study. Over 200 individuals representing communities around the State participated in the Community Round Table Discussions. A total of 130 school divisions returned completed surveys on the current status of school health services for a 97% response rate. The members of the Task Force Studying the Health Needs of School-age Children faithfully attended and energetically participated in the Task Force meetings.

I would like to acknowledge the commitment and continued support of all of those involved with the activities of this study. I would also like to recognize several other key individuals who made significant contributions in the planning, coordinating, and drafting of the report. They are Senator Robert C. Scott who introduced Senate Joint Resolution Number 76; David L. Temple, Jr., Deputy Secretary of Education; and Dr. S. John Davis, Superintendent of Public Instruction, and his staff. Also, special acknowledgement and thanks go to Deborah D. Oswalt, Special Assistant to the Secretary of Human Resources and Janet K. Abraham and Ann B. Carpenter from the Department of Health on special assignment to the Secretary's Office.

I am optimistic that the enactment of the recommendations generated through the activities of this study will go far in promoting and improving the health of Virginia's school-age children. It is essential that we focus our attention on this matter, for investing in the health and well-being of our children is a sound investment in the future of the Commonwealth.

Respectfully submitted,

Eva S. Teig

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Secretary of Human Resources

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EXECUTIVE SUMMARY

The Secretary's Task Force on the Health Needs of School-age Children was an outgrowth of Senate Joint Resolution Number 76 which requested the Secretary of Human Resources to study the health needs of school-age children. The Task Force, under the direction of Secretary of Human Resources, Eva S. Teig, consisted of The Honorable Robert C. Scott, The Honorable Stanley C. Walker, The Honorable J. Samuel Glasscock, the Deputy Secretary of Education, David L. Temple, Jr., the Commissioners of the Departments of Health, Mental Health and Mental Retardation, and Social Services; the Directors of the Departments of Medical Assistance, and Children; as well as representatives from the Virginia Chapter of the American Academy of Pediatrics, Action for Prevention, Inc., Virginia Congress of Parents and Teachers, Virginia Nurses Association, Tidewater Planning Council, Virginia Dental Association, and public/private sector health care service providers.

The following discussion will highlight the activities, findings, and recommendations of the Secretary's Task Force Studying the Health Needs of School-age Children.

ACTIVITIES OF THE TASK FORCE

The Task Force focused its work in three major areas in order to gather the information needed to meet the requirements of Senate Joint Resolution Number 76. The exchange of information, issues, and recommendations was generated through the following activities: 1) Task Force meetings; 2) A survey of school health services for students in Virginia; and 3) Statewide Community Round Table Discussions.

FINDINGS

The Task Force maintains that while the health of our school-age children has improved dramatically over the past decades, a look beyond the surface reveals that not all of Virginia's children share in this improvement. For example:

- Over 50% of Virginia's school-age population at any one time is in need of dental care for the restoration of decayed teeth.

- A total of 5,092 cases of gonorrhea in children were reported during 1984-85, constituting 27% of all reported cases in the State.

- It is estimated that 10-15% of school-age children are overweight and the incidence of bulimia and anorexia is increasing.

- In 1985, 101,517 children and young adults or about 10% of that population were in Special Education programs. Forty-four percent (44%) of enrollees were for learning disabilities, 29% for speech/language impairments; 14% for mental retardation; and 7% for serious emotional disturbances.

In addition to the prevalence of traditional illnesses in school-a children, Virginia's youths also face an additional set of health-rela conditions collectively termed as the "new morbidity". For school-a children, the "new morbidity" takes the form of problems such as alcohol a drug abuse, teen pregnancy, violent behavior, school drop-out, suici depression, and other mental health problems.

The ability of Virginia's current school health services system to m the traditional health needs of school-age children as well as the "n morbidity" varies dramatically across the State. The results of the survey school health services for students reveal the following about the curr school health services system:

- Across the State, there is an average of one school nurse for ev three schools.
- Fourteen school divisions have no school nurses.
- A majority of Virginia's school divisions have no medical direc or advisory body to assist with school health policies.
- Health instruction at the elementary level in Virginia's pub school appears to be inadequate.
- Compliance with mandatory health screenings decreases substantia at the middle and senior high school levels.
- A total of 18 school divisions have no established protocol emergency medical procedures; 31 school divisions report having documentation on student injuries occurring on the school grounds.
- While many exciting and innovative health activities are be offered by the current school health services system, there st remain unmet health care needs of children. More dental ca nutrition education, family life education, and substance abuse a psychological counseling were cited most often as unmet needs.

The Community Round Table Discussions further reinforced the findings the Task Force meetings and survey. Specifically, the community meeti acrossed the State highlighted the need for:

- Increased nursing personnel in Virginia's public schools;
- Minimum standards for school health services;
- Increased coordination among health and human services providers the State and local levels;
- Mandatory Family Life Education;
- Improved access to health care services for medically indig students; and

Increased health promotion and disease and injury prevention programs in the schools.

RECOMMENDATIONS

Based on its research and formal discussions, the Task Force recommends the establishment of the following recommendations to strengthen and coordinate school health services to meet effectively the health needs of school-age children in Virginia.

Specifically, the Task Force calls for:

1. THE NUMBER OF NURSES PROVIDING SCHOOL HEALTH SERVICES SHOULD BE INCREASED TO ALLOW FOR AT LEAST ONE NURSE IN EVERY SCHOOL OR A RATIO OF ONE NURSE PER 1,000 STUDENTS.

2. MINIMUM STANDARDS FOR SCHOOL HEALTH SERVICES IN VIRGINIA SHOULD BE DEVELOPED JOINTLY BY THE DEPARTMENTS OF EDUCATION AND HEALTH.

3. THE DEPARTMENTS OF EDUCATION AND HEALTH SHOULD ESTABLISH A NURSING POSITION WITHIN THE STATE DEPARTMENT OF EDUCATION TO SUPERVISE AND COORDINATE THE PROVISION OF SCHOOL HEALTH SERVICES IN THE COMMONWEALTH.

4. THE DEPARTMENT OF EDUCATION SHOULD MANDATE FAMILY LIFE EDUCATION CURRICULUM IN GRADES K-12 WITH AN EMPHASIS ON PROMOTING PARENTAL INVOLVEMENT AND THE FOSTERING OF POSITIVE FAMILY LIVING SKILLS IN ALL PUBLIC SCHOOLS IN THE COMMONWEALTH.

5. THE DEPARTMENTS OF HEALTH AND EDUCATION ALONG WITH THE VIRGINIA DENTAL ASSOCIATION SHOULD WORK TOGETHER ON A STATE AND LOCAL LEVEL TO COORDINATE DENTAL CARE RESOURCES AND TO INCREASE DENTAL SCREENINGS AND EDUCATIONAL PROGRAMS.

6. A FORMAL MEMORANDUM OF AGREEMENT SHOULD BE DEVELOPED BETWEEN THE SECRETARY OF HUMAN RESOURCES AND THE SECRETARY OF EDUCATION TO ADDRESS OVERLAPPING CONCERNS RELATED TO THE HEALTH NEEDS AND CARE OF SCHOOL-AGE CHILDREN.

7. THE BOARDS OF THE DEPARTMENTS OF EDUCATION AND HEALTH SHOULD ESTABLISH A FORMAL AGREEMENT TO MEET JOINTLY AT A MINIMUM OF TWICE YEARLY TO ADVISE EACH OF THE DESIGNATED AGENCIES ON MATTERS PERTAINING TO SCHOOL HEALTH SERVICES POLICY.

8. THE GOVERNOR'S TASK FORCE ON INDIGENT CARE AS WELL AS THE SECRETARY OF HUMAN RESOURCES SHOULD SPECIFICALLY ADDRESS THE SPECIAL HEALTH CARE NEEDS OF THE SCHOOL-AGE CHILD ESPECIALLY THE MEDICALLY INDIGENT.

9. THE DEPARTMENTS OF EDUCATION, HEALTH, AND MENTAL HEALTH AND MENTAL RETARDATION SHOULD CO-SPONSOR AT REGULAR INTERVALS CONTINUING EDUCATION OPPORTUNITIES FOR SCHOOL NURSING PERSONNEL ON A REGIONAL BASIS.

10. THE DEPARTMENTS OF HEALTH, EDUCATION, AND MENTAL HEALTH AND MEI RETARDATION SHOULD PROVIDE FOR SCHOOL PERSONNEL CONTINUING EDUCA OPPORTUNITIES ABOUT THE NEW MORBIDITY FACING TODAY'S SCHOOL-AGE CHILDI

11. EVERY SCHOOL DIVISION WITHIN THE STATE SHOULD HAVE A SCHOOL HE ADVISORY BODY COMPOSED OF PUBLIC AND PRIVATE SECTOR REP[illegible]NTATIVES ASSIST WITH SCHOOL HEALTH POLICY.

12. AN INTERDISCIPLINARY HEALTH CARE PLAN FOR SCHOOL-AGE CHILDREN AT LOCAL LEVEL SHOULD BE DEVELOPED WITH TECHNICAL ASSISTANCE FROM THE ST DEPARTMENTS OF EDUCATION, HEALTH, AND MENTAL HEALTH AND MEI RETARDATION AS REQUESTED. SUCH A PLAN SHOULD INCLUDE A COMPONENT METHODS OF FINANCING HEALTH CARE SERVICES TO SCHOOL-AGE CHILDREN.

13. EACH SCHOOL DIVISION WITHIN THE STATE SHOULD ESTABLISH FORMAL INTERAGE AGREEMENTS WITH APPROPRIATE COMMUNITY RESOURCES INVOLVED IN THE PROVIS OF HEALTH CARE TO SCHOOL-AGE CHILDREN. APPROPRIATE COMMUNITY RESOUI MAY INCLUDE, BUT SHOULD NOT BE LIMITED TO, LOCAL HEALTH DEPARTMEN COMMUNITY SERVICES BOARDS, SOCIAL SERVICES AGENCIES, INSTITUTIONS HIGHER EDUCATION, PRIVATE SECTOR HEALTH PROFESSIONALS, AND OTHERS.

14. LOCAL SCHOOL BOARDS SHOULD DEVELOP, WHENEVER POSSIBLE, STR RELATIONSHIPS WITH VOLUNTEER ORGANIZATIONS AND THE BUSINESS COMMUNITY IMPROVING THE DELIVERY AND FINANCING OF HEALTH CARE FOR SCHOOL-CHILDREN.

15. THE VIRGINIA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS SHC ENCOURAGE ITS MEMBERSHIP TO PROVIDE A LEADERSHIP ROLE AT THE LOCAL LE IN ADVOCATING FOR AND PROVIDING A COORDINATED SYSTEM OF HEALTH CARE SCHOOL-AGE CHILDREN.

16. THE VIRGINIA CONGRESS OF PARENTS AND TEACHERS (PTA) AND ALL OTHER PAR ORGANIZATIONS SHOULD VIGOROUSLY UNDERTAKE A PARENT AWARENESS CAMPAIGN EDUCATE PARENTS ABOUT THE HEALTH NEEDS OF SCHOOL-AGE CHILDREN AND INCREASE PARENTAL INVOLVEMENT IN THEIR CHILDREN'S HEALTH.

17. EVERY SCHOOL DIVISION SHOULD ESTABLISH A COOPERATIVE AGREEMENT WITI PHYSICIAN TO SERVE IN THE CAPACITY OF CONSULTING MEDICAL DIRECTOR PROVIDE MEDICAL CARE CONSULTAITON AND BACKUP TO NURSING PERSONNEL.

18. FORMAL, WRITTEN EMERGENCY MEDICAL PROCEDURES SHOULD BE DEVELOPED IN EV SCHOOL DIVISION WITHIN THE STATE.

19. THE STATE DEPARTMENT OF EDUCATION SHOULD DIRECT ALL SCHOOL DIVISIONS MAINTAIN APPROPRIATE DOCUMENTATION ON ALL STUDENT INJURIES AS PART O PROGRAM OF COMPREHENSIVE RISK MANAGEMENT.

20. THE STATE DEPARTMENT OF EDUCATION SHOULD CONTINUE TO MONITOR AND INS THAT ALL SCHOOLS COMPLY WITH STATE LAWS PERTAINING TO VISION AND HEAR ASSESSMENTS.

21. THE DEPARTMENT OF EDUCATION SHOULD DIRECT ALL SCHOOL DIVISIONS TO PROVIDE TIME IN THE CURRICULUM FOR HEALTH EDUCATION. FURTHER, THERE SHOULD BE A STRONG EMPHASIS ON HEALTH PROMOTION AND DISEASE AND INJURY PREVENTION PROGRAMS.

22. THE DEPARTMENT OF EDUCATION SHOULD ASSIST ALL SCHOOL DIVISIONS WITH GUIDANCE ON THE PHYSICAL EDUCATION CURRICULUM TO DEVELOP AND EMPHASIZE INDIVIDUAL FITNESS PROGRAMS.

23. THE DEPARTMENT OF EDUCATION SHOULD ENCOURAGE ALL SCHOOL DIVISIONS TO ESTABLISH AFTER SCHOOL PROGRAMS ADDRESSING HEALTH ISSUES AND CONCERNS.

I. INTRODUCTION

The health of Virginia's children and youth is of paramount concern t those of us involved in the delivery of health, education, and human service However, today the professionals involved in the delivery of health servic to our children face a tremendous challenge. We have before us -- a society a crisis in the health of our school-age children.

Assessing the health needs of school-age children presents a paradoxica dilemma. School-age children appear to be a part of the healthiest segment o our population; however, children do have ongoing health needs. Children ar socially vulnerable, dependent on others for resources, guidance, and support In most cases in fact, children do not have the capacity or foresight to dea with health concerns and/or needs that may have long-term negativ consequences on their lifestyle patterns and life expectancies.

The focus of these health concerns now beginning to be realized by mar families and citizens has broadened in recent years. Not only is the physica health of children of fundamental concern to health care service providers but there is a shift and a growing concern for the "new morbidities". "Ne morbidities" include issues such as alcohol/substance abuse, learnin disabilities, sexually transmitted diseases, accidents and injuries behaviorial/stress related disabilities, teenage pregnancy, as well as famil and interpersonal adjustment problems. Unfortunately, the list of concerns i the area of "new morbidities" goes on and on.

Today's changing society and its potential impact on school-age childre is also tremendously overwhelming. The majority of American children toda live in one-parent families or two-parent families where both parents work Low income, poverty, and the limited availability of health care resources t families also reduce the quality of health of our school-age children. I fact, it appears that many families in today's society are experiencin financial and social stress. It is becoming increasingly difficult for th family alone to meet the basic health needs of their children.

Based on this knowledge, it appears that we as Virginians face th following challenges:

- to improve the health care services reaching our school-ag children;
- to provide general guidance, support, and information to schoo children, their families, and educators on appropriate health car resources in their community;
- to increase the availability of needed health services to ou school-age population; and
- to reduce the prevalence of illness and other undesirable condition through preventive treatment and service delivery.

Origin of the Study

During the 1986 Session of the General Assembly, Senator Robert C. Scott introduced Senate Joint Resolution Number 76 which requested the Secretary of Human Resources to study the health needs of school-age children. In response to this resolution, the Secretary of Human Resources convened a Task Force composed of several members of the Virginia General Assembly and professionals in the fields of health, education, and human resources to assist in the efforts of this study. The Task Force, under the direction of the Secretary of Human Resources Eva S. Teig, consisted of The Honorable Robert C. Scott, The Honorable Stanley C. Walker, The Honorable J. Samuel Glasscock, the Deputy Secretary of Education, David L. Temple, Jr., the Commissioners of the Departments of Health, Mental Health and Mental Retardation, and Social Services, the Directors of the Departments of Medical Assistance, and Children; as well as representatives from the Virginia Chapter of the American Academy of Pediatrics, Action for Prevention, Inc., Virginia Congress of Parents and Teachers, Virginia Nurses Association, Tidewater Planning Council, Virginia Dental Association, and public/private sector health care service providers.

The Task Force adopted the following objectives to meet the requirements of Senate Joint Resolution Number 76:

1. To assess the health status of school-age children ;

2. To assess the status, quality, and effectiveness of the current school health service system in:

   A. promoting and maintaining the health of children, and

   B. providing for the early identification of high risk children and adolescents;

3. To identify gaps in the delivery of health services to school-age children; and

4. To determine the feasibility of establishing a statewide, coordinated, comprehensive school health service system.

The resolution further directed the Secretary of Human Resources to submit the findings and recommendations of the study to the 1987 Session of the General Assembly.

Activities of the Task Force

The Task Force focused its work in three major areas which will be discussed further in this report. The activities were concentrated as follows: 1) Task Force meetings; 2) Survey of school divisions in Virginia; and 3) Statewide Community Round Table Discussions.

With regard to the first activity as noted above, the Task For conducted a series of four meetings to hear presentations from professiona in the field with expertise in the delivery of health services to school-a children. The Task Force meetings were used generally for information briefings, as well as an opportunity for Task Force members to become mo familiar with the challenges and issues related to improving school heal services. The Task Force meetings also enabled members to exchange ideas a make recommendations for a more effective school health services system.

The second activity in which the Task Force participated was t administering of a comprehensive survey of school health services to a school divisions in Virginia. As a result of the cooperation received fr the Department of Education, the Task Force's survey response rate was 97%.

The third and final activity of the Task Force was the conducting of fo Statewide Community Round Table Discussions. The Task Force host discussions around the State to gather ideas and recommendations from t localities on what would result in a more effective school health servi delivery system. The Task Force also felt that it was extremely important visit the communities to hear how well the health needs of school-age childr in their area are being met. The Round Table Discussions further afforded t Task Force an opportunity to examine community resources and begin identifyi gaps in school health services.

The next four sections of this report will be devoted to a discussion the health needs of school-age children in Virginia. Section II will profi and discuss the health status of school-age children in Virginia. Followi this section will be a presentation of school health survey results contain in Section III. Section IV will highlight the Statewide Community Round Tab Discussions. The report will conclude with recommendations for strengtheni the school health service delivery system in an effort to meet effectively t health needs of school-age children in the Commonwealth of Virginia.

II. THE HEALTH STATUS OF SCHOOL-AGE CHILDREN IN VIRGINIA

School-age children are perceived as healthy children. The image of "young and strong" typifies our vision of today's youths. While the health of our school-age children has improved dramatically over the past decades, a look beyond the surface reveals that not all of Virginia's children share in this improvement. Many children still face traditional illnesses and health-related conditions such as vision and hearing impairments, dental problems, and nutrition problems.

In addition to these health concerns, there exists another set of health-related conditions that have been collectively termed the "new morbidity". The "new morbidity" is defined as disease which has social rather than biological causes and is associated with an increase in the pace of society and societal demands. For school-age children, the "new morbidity" takes the form of problems such as alcohol abuse, drug abuse, school drop-out, teen pregnancy, violent behavior, suicide, depression, and other mental health problems. A number of these conditions have been identified as the leading causes of death and disability among Virginia's youths.

Highlighted below are selected data related to the health status of school-age children in Virginia.

Population Estimates

The population of school-age children in Virginia in 1985 was estimated to be 1,242,574 constituting 22% of the total population. This will continue to decline over the next two decades to about 16% of the total population.

Mortality

The age groups 5-9 and 10-14 have the lowest mortality rates of all age groups. In 1984, there were 477 deaths statewide in the 5-19 year age group, 50% of which were due to accidents. In the 15-19 year age group, accidents were the leading cause of death followed by suicide and homicide. The rates for suicide are increasing in the 10-14 and 15-19 age groups. There are 50-100 suicidal gestures for every fatal suicide. Alcohol is implicated in 50% of motor vehicle fatalities and homicides.

Morbidity And Pregnancy

1. Injuries: Injuries are the leading cause for hospital visits and hospitalizations for males. The ratio of motor vehicle accident fatality to injuries is 1:100. The other common injuries are related to sports, athletics, bicycle and other recreational activities.

2. Pregnancy: In 1984, there were 19,872 pregnancies in teenagers under age 19. Fifty-three percent (53%) of these pregnancies terminated in live births. This proportion varies from 39% in the northern region to 62% in the southwest region. Sixty to ninety percent (60-90%) of pregnant teenagers drop out of school.

3. Gonorrhea: In 1984-85, there were 5,092 cases of gonorrhea in childr 10-19 years constituting 27% of all cases of gonorrhea in the State.

4. Abuse and Neglect: In 1983-84, 56% or 6,760 of the 12,072 of the repor of abuse and neglect were in the 7-18 age group.

5. Special Education: In 1985, 101,517 children and young adults or abo 10% of that population were in Special Education programs. Forty-fo percent (44%) of enrollees were for learning disabilities; 29% f speech/language impairments; 14% for mental retardation; and 7% f serious emotional disturbance.

6. Juvenile Arrests: In 1984, there were 33,622 arrests of childr under 18 of which 12,237 of the arrests were of children under years of age.

7. Substance Abuse: National estimates indicate that 72% of high scho seniors have used alcohol and 35% have smoked cigarettes within a day period. Cigarette smoking is increasing among female students.

8. Nutrition: About 10-15% of students are overweight. The incidence bulimia and anorexia is increasing.

Dental Health

Recent surveys conducted in the State indicate that over 50% of the schoo age children at any one time are in need of dental care for the restoration decayed teeth. Less than 33% of the primary and 55% of the permanent tee affected by dental decay have been restored as reported by the Department Education in their annual health screening program.

Clearly, Virginia's school-age children have health needs which must be m if they are to grow and develop both physically and mentally at an optim level. The next section of the report will examine the ability of o current school health services system to meet the health needs of Virginia school-age population.

III. THE STATUS OF SCHOOL HEALTH SERVICES IN VIRGINIA: SURVEY RESULTS

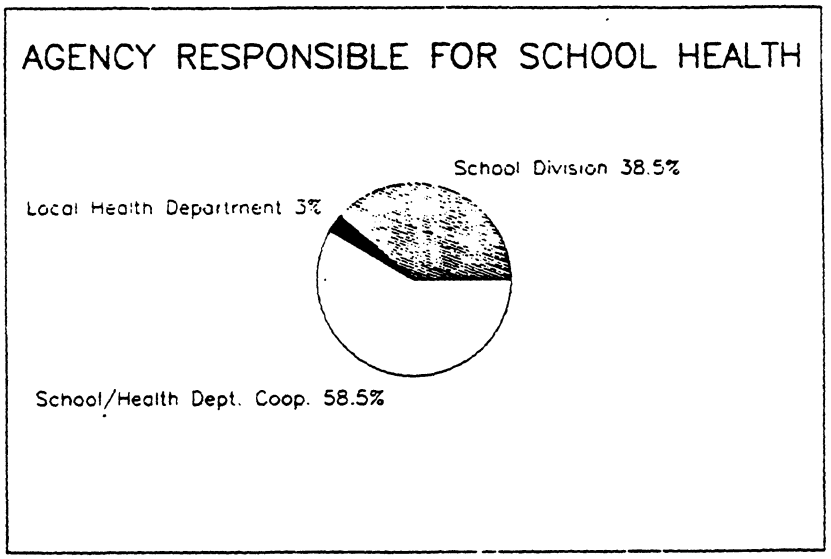
As part of its charge, the Secretary's Task Force to Study the Health Needs of School-Age Children undertook an assessment of the current status of the school health services system in Virginia. This assessment was made recognizing that school health services are only one component of health care for children of school-age. Health care is provided by a wide variety of professionals and paraprofessionals who function within a variety of settings. These include private providers such as pediatricians, family practice physicians, dentists, psychologists, and public sector health care providers such as local health departments. While these health care providers play an essential role in assuring the health of school-age children, the Task Force focused its assessment on school health services as directed by Senate Joint Resolution Number 76.

In order to examine the current status of the health services system within Virginia's public schools, the Department of Education in cooperation with the Secretary of Human Resources sent a survey to all school divisions in Virginia. The information from the survey was collected from October through December, 1986. Of the 134 school divisions receiving the survey, 130 returned the survey by December 15, 1986, for a 97% response rate. Additional data related to school health services were supplied by the Division of Management Information Service within the Department of Education and the Division of Public Health Nursing within the Department of Health. The following discussion will examine the findings of the survey under the categories of: administration of school health services, school health personnel, health education/instruction, school health services, training needs, and other information.

Administration of School Health Services

School divisions were requested to indicate on the survey the agency responsible for school health services. Figure 1 on the following page shows the agency reported as responsible for school health services by percentage of school divisions.

Figure 1



Source: Survey of School Health Services for Students, 1986, Department of Health and Education.

Respondents to the survey were also asked to identify other resource which assist in the provision of school health services. The following tabl depicts the number and percentage of school divisions reporting othe resources assisting with school health services.

Table 1

NUMBER AND PERCENTAGE OF SCHOOL DIVISIONS REPORTING OTHER RESOURCES WHICH ASSIST IN THE PROVISION OF SCHOOL HEALTH SERVICES

Other Resources	Number of School Divisions	Percentage o School Divisio
Private Practice Providers (e.g., family practice physicians, pediatricians)	102	78%
Public Health Agencies	109	84%
Social Services Agencies	81	62%
Clubs and/or Volunteer Organizations	82	63%
None	2	2%
Others	18	14%

Source: Survey of School Health Services for Students, 1986, Departments of Health and Education.

Additionally, the school divisions were asked to report on the existence of an advisory body to assist with school health policies. Ninety-percent (90%) of the school divisions reported "no" to having an advisory body while ten percent (10%) reported "yes". Three school divisions did not respond to the question.

School Health Personnel

Within Virginia's public schools, school nurses are employed directly by the school division in some localities; while in other localities, the public health departments provide school nursing personnel. In order to determine the total number of school nurse full-time equivalents (FTEs) in Virginia, data were compiled from the Departments of Education and Health. A total of 467.5 school nurse FTEs are employed by school divisions in Virginia. Local health departments supply an additional 92.5 school nurse FTEs for a statewide total of 560.0 school nurse FTEs.

Virginia's school nurse to student ratio is .58 school nurses per 1,000 students. This ratio varies widely across the State with Northampton County School Division experiencing the highest nurse to student ratio of 2.04 nurses per 1,000 students (this excludes Cape Charles which has one nurse for 214 students). Fourteen (14) school divisions have no school nurses. For more detailed information on the number of schools, student population size, and school nurse FTEs in Virginia, please refer to Appendix B.

School divisions responding to the survey were requested to check those health care specialists with whom they have access on a consulting basis for referrals or health information. Table 2 below indicates the number and percentage of school divisions reporting access to health care specialists.

TABLE 2

NUMBER AND PERCENTAGE OF SCHOOL DIVISIONS REPORTING ACCESS TO HEALTH CARE SPECIALISTS

Health Care Specialist	Number of School Divisions	Percentage of School Divisions
Pediatrician	53	41%
Ophthalmologist	43	33%
Dentist	84	65%
Psychiatrist	44	34%
Nurse	96	74%
Ears, Nose, Throat Specialist	34	26%
Family Physician	68	52%
Orthopedist	33	25%
Psychologist	92	71%
Social Worker	87	67%

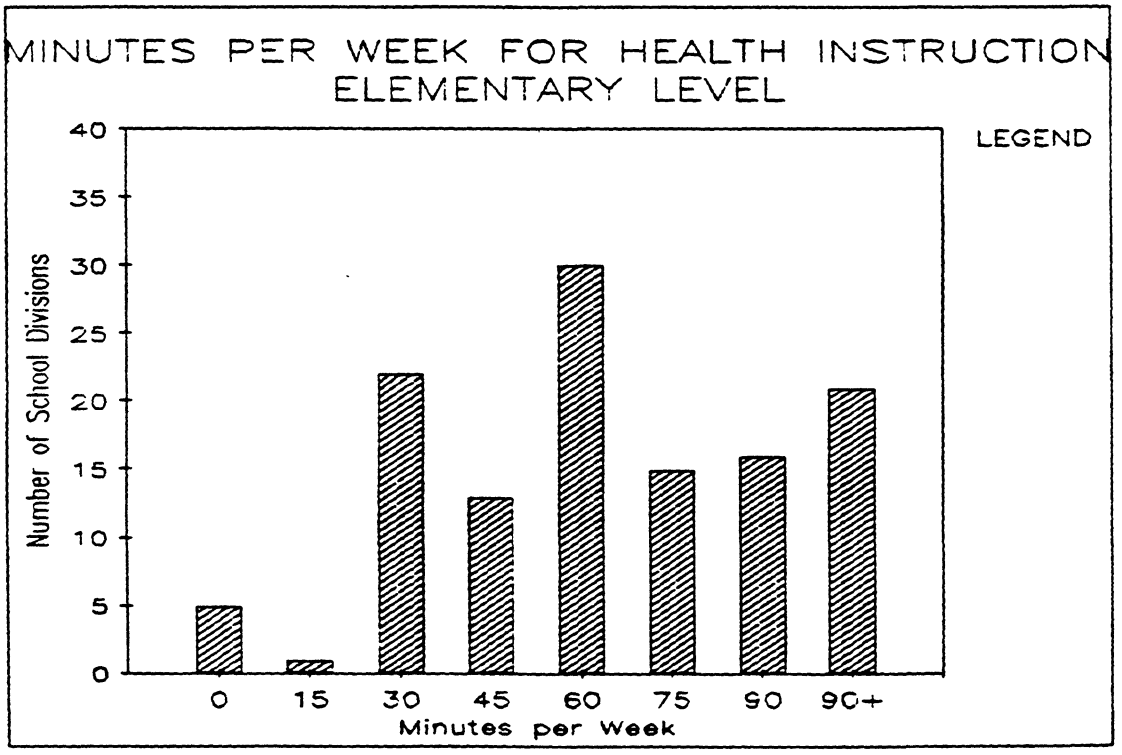
Source: Survey of School Health Services for Students, 1986, Departments of Health and Education.

A final question on the survey related to school health personne asked respondents if they have a medical director to assist with the schoc health program. Of those school divisions responding to the question, 87 answered "no" while 13% answered "yes". One school division did nc respond to the question.

Health Education/Instruction

Respondents to the survey were asked to provide the estimated numbe of minutes per week allocated for health instruction at the elementar school level. As indicated in Figure 2 below, 60 minutes per week c health instruction was most frequently reported followed by 30 minutes Five respondents indicated that no health instruction is provided at th elementary level in their school division.

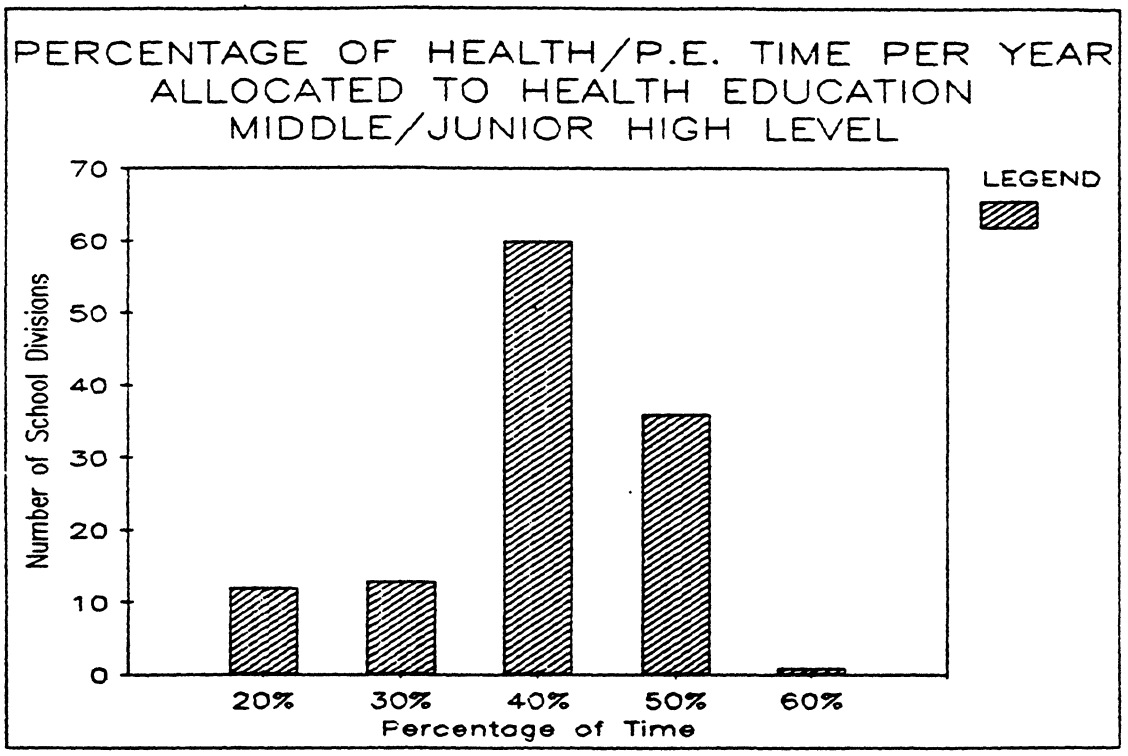
Figure 2



Source: Survey of School Health Services for Students, 1986, Departments c Health and Education.

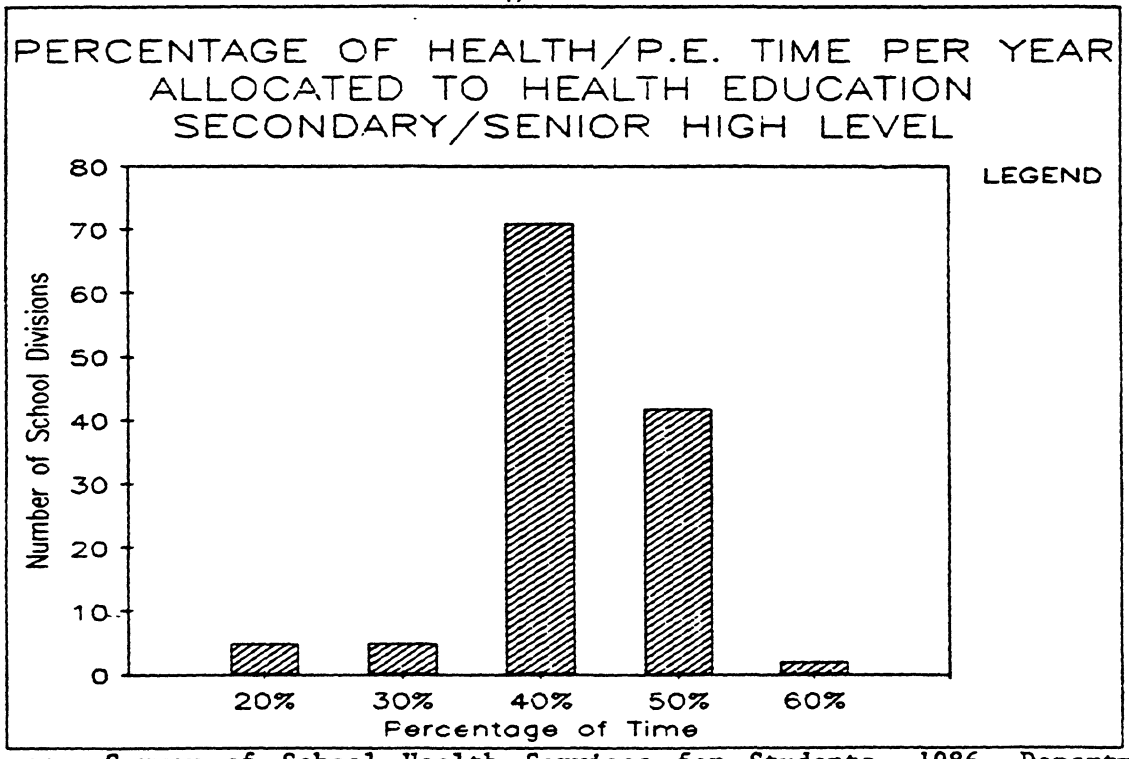
Respondents to the survey were also asked to provide the percentage c health/physical education time per year allocated to health education a the middle and senior high school levels as shown in Figures 3 and 4.

Figure 3



Source: Survey of School Health Services for Students, 1986, Departments of Health and Education.

Figure 4



Source: Survey of School Health Services for Students, 1986, Departments of Health and Education.

An allocation of 40% of the health/physical education time to healt education was most frequently reported at both the middle and senior hig school levels. Fifty percent was the second most frequently reported amoun at both levels. At the middle school level, 25 school divisions reported les than 40% of the health/physical education time allocated to health education Ten (10) divisions reported less than 40% allocated to health ed[illegible]ion at th senior high school level.

Health Screening Activities

The school divisions were asked on the survey to indicate healt screening activities performed by grade-level, and primary responsibility fc performing the activity. Table 3 on the following page shows the healt screening activities reported. It is important to note that visual screening and hearing assessments are required by State law to be performed on al children. While every school division reported providing visual and hearin assessments at the elementary level, the number of school divisions providin these screenings at the middle and secondary level drop off substantially This trend appears generally to hold true for other screening activities wit the exception of orthopedic screenings and blood pressure screenings. For complete listing of screening activities performed by school division, pleas refer to Appendix C.

It is also interesting to note those reported responsible fc performing the screening activities. While in the majority of th screenings the school nurse has primary responsibility, a variety of othe individuals also perform these activities.

Health Promotion Activities

Respondents to the survey were asked to provide information on healt promotion activities provided by the school division outside of regula classroom instruction. Table 4 depicts the number of school divisior performing health promotion activities by grade-level and primar responsibility for performing the activity. Substance abuse education wa mentioned most frequently as being provided by the schools as a healt promotion activity outside of regular classroom instruction. Safety ar accident prevention was the second most frequently reported activity. wide variety of individuals assume primary responsibility for healt promotion activities including nurses, teachers, volunteers, and others For a complete listing of health promotion activities by school divisior please refer to Appendix D.

TABLE 3

NUMBER OF SCHOOL DIVISIONS PERFORMING HEALTH SCREENING ACTIVITIES
BY GRADE-LEVEL AND PRIMARY RESPONSIBILITY

Screening Activities	Grade Level			Primary Responsibility				
	Elementary (K - 6)	Middle (7 - 9)	Secondary (10 - 12)	Nurse	Teacher	Volunteer	Other	Multiple
Visual Screening	129	120	109	60	20	3	4	42
Hearing Assessment	128	104	78	47	23	0	25	33
Orthopedic Screening (including Scoliosis)	124	127	18	71	16	0	3	37
Throat Screening	92	84	48	49	28	0	5	13
Dental Screening	114	96	70	53	24	0	16	20
Height/Weight	126	125	104	35	54	2	3	31
Immunization Levels	98	87	86	44	18	0	22	15
Posture Screening	71	68	45	29	26	0	4	13
Speech Screening	121	88	81	5	49	0	56	11
Blood Pressure Screening	24	26	28	29	0	2	2	2
Drug Testing	4	4	4	1	0	0	3	0
Psychological Screening	62	60	58	0	5	0	50	8

SOURCE: Survey of School Health Services for Students, 1986, Departments of Health and Education.

TABLE 4

NUMBER OF SCHOOL DIVISIONS PERFORMING HEALTH PROMOTION ACTIVITIES
(OUTSIDE OF REGULAR CLASSROOM INSTRUCTION)
BY GRADE-LEVEL AND PRIMARY RESPONSIBILITY

Health Promotion Activities	Grade Level			Primary Responsibility				
	Elementary (K - 6)	Middle (7 - 9)	Secondary (10 - 12)	Nurse	Teacher	Volunteer	Other	Multiple
Nutrition Education	60	44	38	18	21	4	7	17
Family Planning	5	23	32	15	9	2	2	8
Substance Abuse Education*	72	75	61	6	23	8	19	30
Family Life Education	33	38	28	14	13	2	4	13
Psychological/Emotional Health Promotion	48	52	51	8	17	0	20	13
General Health Education Instruction	49	41	39	15	24	2	3	11
Sexually Transmissible Disease Education	9	40	30	15	16	2	3	11
Safety/Accident Prevention	67	51	50	7	22	11	9	24

*Includes alcohol, tobacco, and drugs

TABLE 5

NUMBER OF SCHOOL DIVISIONS PERFORMING HEALTH CARE ACTIVITIES BY GRADE-LEVEL AND PRIMARY RESPONSIBILITY

Health Care Activities	Grade Level: Elementary (K - 6)	Middle (7 - 9)	Secondary (10 - 12)	Primary Responsibility: Nurse	Teacher	Dentist	Other	Multiple
Dental Care	78	48	35	11	11	32	3	23
				Nurse	Teacher	M.D.	Other	Multiple
Health Counseling (Students, teachers, and/or parents)	99	99	95	52	14	1	2	33
Acute Illnesses Care	73	72	68	34	6	3	9	23
Administration of Medication	102	96	91	33	13	0	26	31
Communicable Disease Control	87	88	83	53	10	1	8	18
First Aid/Emergency Care	108	110	104	38	21	0	5	39
				Nurse	Teacher	Guidance Counselor	Other	Multiple
Substance Abuse Counseling	51	70	65	3	9	17	11	31
Guidance for Pregnant Students	30	79	80	14	1	25	4	37
Psychological Counseling	89	91	90	0	0	8	71	13
				Nurse	Teacher	Speech Therapist	Other	Multiple
Speech Therapy	125	124	118	0	2	121	1	2
				Nurse	Teacher	Physical Therapist	Other	Multiple
Physical Therapy	100	96	97	0	1	90	7	3
				Nurse	Teacher	Occupational Therapist	Other	Multiple
Occupational Therapy	79	78	77	0	0	75	5	0

Health Care Activities

The school divisions were asked to identify health care activitie provided on the school premises by grade-level, and primary responsibility fc performing the activity. Information compiled from the surveys on health car activities is contained in Table 5. Speech therapy was mentioned most ofte as being provided by the schools followed by first aid and emergency care. A with the other school health services, primary responsibility for th activities extends across the range of health care professionals, teachers principals, school secretaries, and others. A complete listing of health car activities by school division is contained in Appendix E.

Respondents to the survey were requested to indicate if they have a established protocol for dealing with medical emergency procedures. C those school divisions responding to the question, 86% answered "yes" the do have an emergency protocol for emergency procedures, while 14% responde "no".

School divisions were also asked whether they maintain documentatic on the types of student injuries occurring on the school grounds Seventy-six percent (76%) of the school divisions responded "yes", whil 24% indicated they do not maintain documentation on student injuries.

Training Needs

In order to ascertain the availability of continuing education i school health, the school divisions were asked if they provide continuir education opportunities for their school health personnel. Of thos responding to the question, 67% reported "yes" they do provide continuir education in school health while 33% answered "no". The 10 most frequentl reported training needs of school health personnel are identified in Tabl 6 in rank order.

TABLE 6

10 MOST FREQUENTLY REPORTED SPECIAL TRAINING NEEDS IN HEALTH SCREENING, HEALTH PROMOTION, AND HEALTH CARE ACTIVITIES

1. Cardiopulmonary resuscitation (CPR)
2. Scoliosis screening
3. First aid
4. Recognizing and dealing with psychological and emotional problems
5. Health promotion activities
6. Recognizing and dealing with alcohol and drug abuse
7. Nutritional needs
8. Current practices and techniques in school nursing
9. Meeting the health needs of handicapped students
10. Supervisory position for school health services in the State Department of Education

Source: Survey of School Health Services for Students, 1986, Departments of Health and Education.

Other Information

Respondents to the survey were asked to identify the health needs of school-age children not being addressed through the current school health services system. Table 7 identifies the 20 most frequently reported health needs in rank order.

TABLE 7

20 MOST FREQUENTLY REPORTED HEALTH NEEDS OF SCHOOL-AGE CHILDREN NOT BEING ADDRESSED BY THE CURRENT SCHOOL HEALTH SERVICES SYSTEM

1. Increase nursing personnel for school health services
2. Dental care
3. Nutrition/diet/obesity
4. Family life education
5. Substance abuse (including alcohol, drugs, and tobacco)
6. Psychological and emotional problems
7. Teenage pregnancy
8. Family planning
9. Access to care for medically indigent students
10. Sexually transmitted diseases
11. Health education instruction
12. Eye examinations and glasses
13. Physical therapy/occupational therapy/speech and audiology
14. Parents need to follow-up
15. Health promotion/disease and injury prevention
16. Blood pressure screening
17. Hygiene and personal control
18. First aid/emergency care
19. Individual fitness
20. Physical examinations

Source: Survey of School Health Services for Students, 1986, Departments of Health and Education.

A final question on the survey asked the school divisions to describe special activities or initiatives which have been particularly effective in meeting the health needs of school-age children. A listing of the responses is contained in Table 8. These activities and initiatives can serve as models to be replicated in other areas of the State.

TABLE 8

SPECIAL ACTIVITIES AND INITIATIVES EFFECTIVE IN MEETING THE HEALTH NEEDS OF SCHOOL-AGE CHILDREN

Administrative Activities	Programmatic Activities
Clinic Health Cards	Regularly Scheduled Classroom Programs
Assistance from Health Department Nurses	"Hugs and Kisses"
Nurse in Every School	Weight Control Programs
Involvement of Community Resources (churches, PTA, fire departments, Lions Clubs, etc.)	Health Education Curriculum
Health Advisory Committees	Individual and Group Counseling
Assistance from Local Health Professionals	Audio-Visual Aids
School Nurse Achievement Program	Dental Screening Programs
Annual Inservice for School Nurses	"Especially for You"
Programs Provided by Virginia State Nurses Association	"Growing Healthy"
Mandatory Reporting of Child Abuse/ Neglect	Health Career Clubs
Immunization Regulations	Children's Museum
Follow-up on Referrals by School Nurse	Health and Dental Fairs
Adoption and Implementation of SJR 76	Parent Study Groups
Provision of Screenings by School Nurses Rather Than Teachers	Prenatal Classes
Use of LPNs	"DARE"
Assistance from Medical Students	Pediculosis Screening
Interagency/Interdisciplinary Teams to Coordinate Services for Students	"Child Find"
Inservice for School Staff on Crisis Intervention and Group Counseling Techniques	Immunization Clinics
Teacher Inservice on Prevention of Child Abuse	Dental Services
Crisis Teams for Coordination of Crisis Intervention	School-age Parent Program
Passage of No Smoking Regulations by School Boards	Wellness Programs
Special Provisions for Handicapped Students	Student Trainer Program for Athletic Teams
State Sponsored Conference for School Nurses	"Just Say No"
Parent Volunteers to Assist with Screenings	SADD Clubs
Monthly Meetings for School Nurses and Assistant Superintendents	Smoke-Out Day
"SNAP" - Continuing Education for Nurses	"Operation Aware"
	Blood Pressure Classes
	Scoliosis Screening
	"Role Changes"
	Drug Curriculum in Elementary Schools
	"Julie's Story"
	"Project Touch"
	VA Dairy Council Nutrition Education
	American Cancer Society Breast Self-Exam and Film
	Fairfax Substance Abuse Program
	Fluoride Mouthrinse Program
	Vision and Hearing Screenings
	"Smoky the Bear"
	Peer Counseling Groups
	Support Groups Lead by High School Counselors
	Parent Resource Center

TABLE 8 (Continued)

Administrative Activities	Programmatic Activities
Chronic Illness Alert Folders	Dairy Day
Head Trauma Sheets Sent Home with Students with Head Injuries	Initial Screening of All New Students
Daily Records of Illnesses/Accidents/ Injuries	"Kids on the Block"
Policy on Administration of Medication	Chesterfield County School Health Program
Use of Pedicatric Nurse Practitioner	Free Lunch and Breakfast Program
Full-time Clinic Aid	Blue Ridge Health Conference
Cooperative Parents	CPR Course
Safety Committee	Classes for Boys on Personal Care and Adolescent Changes
Annual Mult-disciplinary clinic provided by local physicians	Nutrition Programs for Overweight Students
	Mini-courses After School for Interested Students
	Annual Multi-disciplinary Clinic Provided by Local Physicians
	Free Walk-in Clinics
	"Friends Who Care"
	Health Day Activities
	Seizure Survey for 3rd Graders
	Project HEAR

Findings and Conclusions

1. During the 1985-86 school year, there were 1,735 public schools Virginia serving 968,104 students. A total of 560.0 school nur full-time equivalents were available through the school divisions a local health departments for the school-age population. On a statewi average, this amounts to one school nurse for every three schools or . school nurses per 1,000 students. The school nurse to student ratio Virginia is substantially below the recommended ratio of the Natior Education Association of one RN per 1,000 school-age population.

2. In almost 60% of the school divisions, the schools and the local heal departments jointly share responsibility for school health services. variety of other health care professionals and organizations, soci services agencies, clubs, and voluntary groups assist with school heal services. A majority of the schools, however, report having no medic director or advisory body to assist with their school health program.

3. A total of 102 school divisions report spending 90 minutes a week or le for health instruction at the elementary level. The time allocated health instruction appears to be inadequate as national guidance i elementary education recommends an average of 100-150 minutes per wee While most school divisions at the middle and senior high school leve report 40% or more of the health/physical education time allocated health education, 25 school divisions at the middle school level and school divisions at the senior high school level reported less than 4(The Standards for Accrediting Schools in Virginia require forty perce (40%) of instructional time to be devoted to health education.

4. The Code of Virginia requires school divisions to provide all sch children with vision screenings on an annual basis and hear assessments at selected intervals. All of the school divisions rep providing these screenings at the elementary level; however, compliar with the law appears to decrease at the middle and senior high sch levels.

5. The range of other health services provided in the school appears vary widely across the State. Those individuals assuming prim responsibility for performing the activities also appear to vary w involvement including nurses, teachers, volunteers, school principa school secretaries, and others. This variance may result largely f the fact that school health services are left to the determination local school boards.

6. While a majority of the school divisions report having an establis protocol for medical emergency procedures, 18 school divisions have procedure. A total of 31 divisions report having no documentation the types of student injuries occurring on the school grounds.

7. Many of the school divisions offer continuing education opportunit for school health professionals. Yet, there remain training ne

which are unmet. Cardiopulmonary resuscitation (CPR), scoliosis screening, and first aid were cited most often as unmet training needs. Of the top ten (10) most frequently mentioned training needs, four (4) are directly related to the "new morbidity" faced by today's school-age population.

8. An increase in school nursing personnel was identified as the top health need of school-age children not being addressed by the current school health services system. Closely following this was the need for increased dental care. Of the top 10 items most often mentioned, four are related to family life education concerns.

9. There appear to be a number of innovative and effective school health programs currently underway within Virginia's public schools. These programs can serve as models to be replicated in other areas of the Commonwealth.

This section has examined the status of the school health services system in Virginia and has identified needs and gaps within that system. The next section will further investigate barriers and gaps in meeting the health needs of school-age children through the Community Round Table Discussions and will look at possible solutions.

IV. COMMUNITY MEETINGS: HIGHLIGHTS OF DISCUSSIONS AROUND THE STATE

In an effort to determine how well the health needs of Virginia's schoo age children were being met, a series of Community Round Table Discussio were held around the State. The informal discussions generally focused examining how community resources could be better coordi[illegible] me identified gaps in our school health service delivery system. Of particul interest to the Task Force were those ideas and program initiatives whi would result in a more effective school health service delivery system.

The following discussion will highlight by region the issues a recommendations raised with regard to effectively meeting the health needs our school-age children.

Hampton Roads

The professionals in this area identified many problems, gaps, and nee of the school-age child. The following narrative represents what t community generally identified with respect to meeting the health needs of t school-age child, as well as improving the current school health servi delivery system.

Needs

1. In this community, a primary need identified was to strengthen scho curriculum and educational activities in the areas of preventing drug a alcohol abuse and teenage pregnancy. Professionals in this community al indicated a need in the schools to promote preventive mental and physic health. It was pointed out further by several in the group that children a clearly a medically underserved group. They have limited access to physic examinations and general health care services.

2. There is also a need to promote proper dietary and nutritional habi through nutritional counseling and educational programs. Dental care, throu the provision of dental care examinations and preventive services, also seem to be a need that has been evidenced by children in the schools. To de generally with the incidence of sexually transmitted diseases in the schoo and the need to focus on the development of the "family unit", it w suggested that there be a strong family life education program instituted the schools.

3. It was also reported that there is limited access to mental heal services for medically indigent children. These limited services could resu in children with increased mental health needs such as severe depression, la of self-esteem, as well as teenage suicide. Additionally, many of the heal professionals indicated a need for additional funding to support the provisi of adolescent mental health services.

4. Another area that seemed to be problematic is the shortage of alternati home placements, programs, and resources for children with special need

With regard to the "slow learning child", there also seemed to be a need for the development and expansion of programs and resources in this area. The slow learning child excludes children in need of special education services.

5. The need for curriculum development in wellness education was also discussed. It was further noted that there was a need to provide physical examinations to children. This activity could also assist the school in identifying potential child abuse and neglect problems and early disease symptoms. The ongoing need for evaluating health education programs with regard to their efficiency and effectiveness was also discussed.

6. Finally, there were two issues that seem to continually challenge educators and health care professionals in the school system. Those issues are: the negative effect television advertising can have on children's health and the problems school officials have with parents failing to respond to the health needs of their children.

The next section of this narrative will outline possible solutions set forth by the participants of the Tidewater area's discussion group to improve our school health service delivery system.

Solutions

The Hampton Roads Round Table Discussion offered some excellent solutions for the Task Force's consideration. They were as follows:

1. State mandate that school nurses (RN's) shall be in all of the schools to offer health care services.

2. State certification of school nurses, making continuing education a requirement for all school nurses.

3. Development of guidelines for all procedures in the school nurse's manual, as well as the establishment of minimum standards of health care for all students.

4. Increasing the availability of continuing education programs and opportunities for school school nurses.

5. Development of stronger interagency working relationships between State and local agencies.

6. The development of legal recourse for insuring proper follow-up of parents with regard to children's health problems.

7. Increased funding for prevention programs specifically with an emphasis on teenage pregnancy prevention.

8. Mandated family life education curriculum.

9. Increased development of curriculum and programs in the follow areas: nutritional education programs, drug/alcohol abuse, teenage pregnancy.

10. Development of a statistical data bank of identified students w health problems.

11. School-based clinics to meet students' comprehensive health c needs.

12. Increased public/private sector partnerships.

13. Local advisory planning councils should be established to deve community strategic plans and to coordinate child health needs.

14. Development of a position within the State Department of Educat to coordinate school health services on a statewide basis.

Charlottesville/Richmond

The Charlottesville/Richmond Community Round Table Discussion identif similar issues to those identified in the Tidewater area. This community a identified the need for preventive health services, as well as the need the provision of adequate resources for such service delivery. The needs specifically discussed are identified in more detail below.

Needs

1. One of the underlying needs identified at this meeting was the lack agreement on the definition of health services with regard to public/priv sector responsibility. It was suggested that before one can truly coordin the health needs of school-age children, a definition of health services m be established. There then needs to be clarification on the school's p with regard to its mission in providing health care to its students. It also suggested by many of the professionals at this meeting that there i need for continued coordination with the private sector service providers. was further noted that often competitiveness among agencies and health c service providers exists. This is attributed to inadequate financ resources and reimbursement for the provision health care services.

2. Many of the participants also reported that they see a need for increa funding for prevention and promotional activities in the schools. Some of needs that must be addressed are as follows: drug and alcohol abu adolescent pregnancy, teenage suicide, obesity, eating disorders, nutritional problems.

3. There are also needs in the development of vocational programs choices for children. It was noted that self-esteem programs do not exist the schools, and that children would benefit from programs and curriculum w an emphasis on decision-making and goal setting.

4. In the area of health education, it was suggested that teachers need more preparation and continuing education in this subject area in order to be effective health education instructors. It was further noted that children would benefit from increased health education in the area of family planning/family living skills.

5. Another suggestion indicated that children are in need of increased physical fitness programs and activities. Many professionals felt that the schools do not have adequate fitness programs that challenge the physical stamina of our youngsters. This may be attributable to the influence of the media and the availability of television to our children after school hours. The concern was: are we in fact raising a generation of physically unfit children?

6. Another issue raised relative to the provision of health services to children was the lack of comprehensive health services and the limited availability of staff to perform such services in the schools. Many participants in the discussion indicated that there was a tremendous need for additional nursing staff to perform specific activities such as health screenings, physical examinations and assessments. Along the same lines, it was indicated that there is also an apparent lack of on-site medical services available to children in the schools.

7. Access to care and inadequate reimbursement for care to the indigent child were also identified as needs. It appears that families and communities have limited financial resources that prohibit them from obtaining necessary health care services.

8. Stress related problems as evidenced by learning problems and anti-social destructive behaviors also seem to be on the increase. As indicated earlier in this discussion, programs and curriculum that stress coping skills and positive self-esteem seem to be needed in the schools.

9. There is also an increased need for dental examinations, as well as the establishment of fluoridation programs in the schools where unavailable. Participants felt this can have a tremendous long-term positive effect on preventing dental and gum diseases in children.

10. Finally, the issue of motivating parents to obtain the necessary follow-up health services for their children is continually a challenge for the professionals in this area. Outlined are possible solutions to the health needs of school-age children as identified by the Charlottesville/Richmond Community Round Table Discussion participants.

Solutions

The statements summarized below are representative of the solutions se forth by the participants of the Charlottesville/Richmond Community Roun Table Discussion.

1. Development of a mission statement and/or definition with regard t the delivery of health services delineating responsibilities, re sources, and guidelines for meeting minimum standards of qualit health care.

2. Development of an interdisciplinary health care plan with Stat coordination.

3. Increased continuing education opportunities for health and physica education instructors.

4. Increased funding and FTE's for the school's and community' delivery of health services.

5. Development on a State level standards of basic health services an optional secondary services for community guidance and compliance.

6. Initiation of comprehensive family life education in schools.

7. Development of a strong vocational education program component i all school curriculums.

8. State supported programs mandating health care in schools.

9. Development of individual physical fitness programs in schools wit less emphasis on team oriented sports.

10. Increased health promotion and prevention programs in all schools.

11. Include health education in the standards of quality of education.

12. Increased pupil/nurse ratios for the provision of more comprehensiv health services.

13. Utilization of volunteers in the schools to provide counseling t students.

14. Development of a coordinated approach to link community resource with regard to the provision of health care services to school-ag children.

15. Develop stronger relationships with the private sector ar businesses in the delivery and financing of health care services.

16. Community based advisory boards should be developed to assess the communities health care needs and to advise school divisions with regard to the most effective, comprehensive way to deliver health services to children.

17. The development of nutritional programs with a specific emphasis on obesity are needed in the schools.

18. The development of models for funding school health programs.

19. Development of a position on the State level to coordinate health care services for children.

20. Development of special programs and services to meet the needs of the handicapped child.

Northern Virginia

The Round Table Discussion participants in this area seemed to focus primarily on the identification of needs and gaps, rather than focusing their discussion as vigorously on the identification of recommendations for the Task Force's consideration. The following discussion highlights the discussion relative to the health needs of the school-age children in Northern Virginia.

Needs

1. Many of the professionals in Northern Virginia indicated a need for community based clinics and/or adolescent health centers. It was proposed that this intervention could potentially assist in the delivery of comprehensive health services and would give families and their children ready access to necessary health care services.

2. Many of the discussion participants also indicated a need in the schools to assist children in building mental health and lifetime health skills. Mental health skills, provided through educational programs, could help children develop better communication skills, resist peer pressure, develop strong self-concepts, and increase self-esteem. Lifetime health skills could focus on prevention of negative health habits with an emphasis on nutrition, exercise, and "better mental energy", etc. The concept of lifetime health skills is demonstrated in the Blue Ridge School Conference for teachers which challenges teachers to lead positive, healthy life styles.

3. Early substance abuse education was another need identified by many of the participants in the discussion group. The need for early intervention for students and families with alcohol and drug abuse problems is also desirable.

4. Another problem echoed by many professionals was that in Northern Virginia there are many single-parent households which create a variety of problems and needs ranging from resource difficulties to access to care. The problem of access to care must be addressed. Access problems are often due to

the lack of health insurance and to the unavailability of a working parent to care for a child. Children could potentially develop chronic health problems as a result of long-term access difficulties to the health care system.

5. The issue of preventing and dealing with teenage pregnancy is increasingly seen as a need in the schools. It was pointed out that better health education curriculum components should be implemented in the schools not only to educate teenagers on the pregnancy issue, but also to provide general information on pregnancy related issues.

6. There is also a need to promote preventive mental and physical health. The need for programs in these areas are evidenced by the problems children have in the areas of suicide, drug and alcohol abuse, stress factors and anxiety, low self-esteem, teen pregnancy, behavioral and eating disorders. The Task Force was encouraged to advocate for prevention programs in the schools to assist children in dealing with problems before they arise.

7. It was also pointed out by many of the professionals in this group that there is a general need for a higher level of funding for programs and services which address the health needs of children. Virginia needs to provide funding for health programs and take the burden off the back of education. There is also a need to collaborate, coordinate, and link services available in the community. It was reported that much of a child's health care in Northern Virginia is fragmented. It was further noted that professionals need to strive to provide more comprehensive health education and core services.

8. As noted above, there is a tremendous need for strong health education programs in the schools. Programs need to be developed to deal with special groups in need of services. For example, pregnant teenagers and parenting teens could benefit from support groups that assist them in dealing with their situations. Along the same lines, it was noted that school-age children are in need of family life education programs in the schools.

9. Another problem identified with regard to services was the need for better access to mental health care. Adolescents particularly have difficulties in obtaining needed mental health services.

10. Multi-cultural services and resources also need to be developed to meet the special health needs of ethnic groups. Northern Virginia, with a growing population of refugees and aliens, is especially vulnerable with regard to access to health care services. Many in this group do not speak English and this further complicates the issue.

11. Dental care was also identified as a service that should be provided to children or at least be accessible to children in the schools. It was further pointed out that children do not get general health services often times as a result of not being allowed to leave schools. This is an issue that should be addressed by health and educational professionals on the State level.

12. The issue of medical care to medically indigent children was also discussed in great detail. There is a tremendous void in the delivery of such services to this population of children.

13. Another concern identified by the Northern Virginia Community was the issue of confidentiality. School personnel feel obligated to call home to inform parents of serious situations that develop with their children; however, often this complicates matters and inhibits the ability of a teacher or guidance counselor to work effectively with the child. It was noted that perhaps the age of the emancipated minor needs to be examined in more detail.

14. The final issue identified was the need for more nurses in the schools and the availability of nurses to perform screening activities, provide health education instruction, and provide general health care services.

The next section of this discussion is a listing of the recommendations derived from the Northern Virginia Community Round Table Discussion.

Solutions

1. Establishment of health education programs taught by professionals with expertise in health education.

2. Coordinate services between schools and alcohol/drug treatment centers.

3. Legislation mandating teachers to report suspected drug and alcohol abuse.

4. Mandate family life education in schools.

5. Broaden services and financial eligibility for medically indigent children through the Bureau of Crippled Children.

6. Increased outreach for families with limited resources.

7. Establishment of regional training centers for human relations.

8. Mandate school nurses to perform screening activities and special screenings for special education children.

9. Establish stronger standards and guidelines for school nurses.

10. Increase mental health counseling programs in schools.

11. Mandate insurance payments for well-child visits.

12. Establish peer operated hot-lines for counseling.

13. Assure that all communities have adequate home based teaching services.

14. Establish comprehensive health centers in non-threatening community based environments.

15. Establish mandatory parenting classes in schools.

16. Institute stress management classes in schools.

17. Health departments should assist schools in the review of records of all children with excessive absences to assure if health related that appropriate health services are made available.

Roanoke and Southwest Virginia

The Southwest Community Round Table Discussion participants identified an exhaustive list of problems, gaps, needs, and recommendations. The issues identified seemed to be basic and fundamental, relating to the core of health care service delivery. Detailed below are the needs as discussed specifically in the southwestern part of the State.

Needs

1. One of the underlying problems in this part of the State is the high rate of unemployment. Unemployment in some areas is estimated to be as high as 25%. This often translates into children observing parents out of work with little or no hope of gainful employment. Professionals in this area advised that often children suffer from severe depression as a result of a feeling of "no sense of future". Schools are in need of counseling programs or access to mental health facilities to provide necessary services to children suffering from depression and other stress related factors. It was also pointed out that children could benefit from living skills programs, as well as programs that enhance communication and coping skills.

2. Another issue that seemed to be important in this community was the need to promote health awareness through the provision of nutritional programs with an emphasis on diet and weight control. It was pointed out that schools are also in need of experienced health educators to assist children with regard to health education issues.

3. Drug and alcohol abuse, teen pregnancy, access to general health care services, dental care, child abuse and neglect, negative impact of television advertising, and the need for more full-time nurses were some of the major needs identified in the Southwest communities.

4. The issue of coordination of services was also discussed in great detail. There seems to be a need for more coordination of health services in the schools. The issue of coordination also applies to the community. The public and private sector need to define clearly their responsibility with regard to

coordination of time expenditure and resources. It was also reported that localities can not deal with all of their problems alone. There needs to be more collaborative public/private sector efforts to assist schools in identifying and delivering health services.

5. It was furthur noted that there seems to be a disparity of school health services provided in Virginia. Many schools simply do not have the resources for basic health service delivery. As a result of the lack of resources, many health problems are not identified. A child may appear healthy but be in need of diagnostic or treatment services. Professionals in this area also indicated a need for more preventive health services to assist in early identification of symptoms and treatment needs.

6. Another issue identified as a problem in the schools was that coaches in the athletic departments often act as negative role models. It was further noted that in some schools tobacco and snuff are being used.

7. Of major concern to those in attendance at the meeting were the tremendous problems associated with the delivery of health services to indigent children. It was noted that pediatricians in the area will accept new Medicaid patients, however, will not accept patients without any source of payment. Access to care is a another problem for many of the children in the southwestern part of the State. Often to receive care, parents must travel with their children to the University of Virginia Hospital in Charlottesville. In many cases, parents perceive their child's health care as having low priority in their value systems. There is often limited follow-up on identified defects or chronic abnormalities of their children. The lack of follow-up may be attributed to the absence of financial resources or perhaps the limited time a parent may have available to seek such medical care.

8. Two final issues were identified as gaps or needs in the Southwest Virginia area. The first was that family life education is an essential element that is absent from many school curriculums. The second issue was that programs and school health services need to be better planned and coordinated.

The next section of this narrative will outline the specific solutions set forth by the Southwest Virginia Round Table Discussion participants.

Solutions

Summarized below are solutions set forth by the participants of Southwest Virginia Community Round Table Discussion.

1. The establishment of a liaison between the schools and the local Community Service Boards.

2. Establishment of more elementary guidance counselor positions in the schools to assist children with problems of low self-esteem.

3. Legislation should be adopted to control television advertising and the potential negative impact it can have on children.

4. Provision of experienced health educators in all of the schools.

5. The development of increased numbers of after school programs.

6. Comprehensive school based clinics.

7. Mandate for a school health care professional to coordinate school health services.

8. Increased number of full-time nurses in the schools.

9. Mandatory Family Life Education in the schools with an emphasis on family living skills development.

10. The development of a supervisory nursing position on the State level in the Department of Education.

11. Increased public and private sector coordination.

12. Create incentives for health care professionals to locate in the southwestern part of the State.

13. The establishment of minimum standards for health care.

14. Increased funding for the provision of health care services.

15. Increased development of promotion and prevention health programs in all school curriculum.

16. The Secretary of Human Resources should be given more power to enforce coordination of health services for school-age children.

17. Athletic departments within the schools should closely monitor the activities of their coaches to ensure positive role models for school-age children.

18. Encourage coordination and communication among community resources agencies whenever possible.

19. Technical assistance should be available from the State to the localities to develop programs that employ positive incentives for school-age children.

V. RECOMMENDATIONS

The picture which emerges from the survey process and the Community Round Table Discussions reveals that inequities exist among Virginia's 134 school divisions. Health services for children enrolled in the State's public schools range from no health services at all to very innovative programs of health services and education.

While the Task Force does not advocate that health services in all school divisions should be identical, there is a need for more effective planning and coordination at both the State and local levels, to assure that school health programs augment other community health services for children. The scope of health services provided in schools should be dependent on the health needs of the school division's children and also what is available through other community resources. These needs will vary depending on the economic, social, and cultural makeup of each community.

The Task Force believes the challenge is to make school health services a part of the overall plan for community health services. The ultimate goals of the plan as it relates to the health of school-age children should include:

- improving and monitoring the quality of health care,
- increasing the availability and accessibility of needed services,
- providing necessary health care to those unable to pay for health services,
- reducing preventable diseases and illnesses among children,
- maximizing the health of children through early identification and intervention, and
- guiding children and families to appropriate community resources.

OUTLINED BELOW ARE THE RECOMMENDATIONS OF THE TASK FORCE.

1. THE NUMBER OF NURSES PROVIDING SCHOOL HEALTH SERVICES SHOULD BE INCREASED TO ALLOW FOR AT LEAST ONE NURSE IN EVERY SCHOOL OR A RATIO OF ONE NURSE PER 1,000 STUDENTS.

Discussion

The need for increased school nursing personnel was the most pervasive health care need identified through out the course of activities undertaken by the Task Force. At the present time, there is one school nurse for every three public schools on a statewide average. Clearly, this situation is inadequate to meet even the most basic health needs of school-age children. At least one nurse in every school would provide each school with a health care professional trained to provide essential nursing services.

2. MINIMUM STANDARDS FOR SCHOOL HEALTH SERVICES IN VIRGINIA SHOULD BE DEVELOPED JOINTLY BY THE DEPARTMENTS OF EDUCATION AND HEALTH.

Discussion

The need for minimum standards for school health services was identified through the Community Round Table Discussions and through the survey process. At the present time, health services are left to the discretion of the local school boards. The development of minimum standards for school health services would allow for the provision of a basic level of care while permitting individual localities to build on the minimum standards if so desired.

3. THE DEPARTMENTS OF EDUCATION AND HEALTH SHOULD ESTABLISH A NURSING POSITION WITHIN THE STATE DEPARTMENT OF EDUCATION TO SUPERVISE AND COORDINATE THE PROVISION OF SCHOOL HEALTH SERVICES IN THE COMMONWEALTH.

Discussion

An emerging issue around the State noted widely from the Community Discussions was the ongoing need for comprehensive, coordinated health services. It was noted that in order to meet the changing morbidity patterns of children in the State, it is essential to examine, redefine, and potentially reorganize health services with regard to the provision and supervision of school health services statewide. It appears that the school health services in Virginia could be strengthened if there were increased State level guidance and supervision provided to the localities. It would be desirable for this position to be established within the Department of Education and coordinated by the Departments of Health and Education. Additionally, it would be desirable for the Department of Health to review its coordination mechanism with the Department of Education at the State level.

4. THE DEPARTMENT OF EDUCATION SHOULD MANDATE FAMILY LIFE EDUCATION CURRICULUM IN GRADES K-12 WITH AN EMPHASIS ON PROMOTING PARENTAL INVOLVEMENT AND THE FOSTERING OF POSITIVE FAMILY LIVING SKILLS IN ALL PUBLIC SCHOOLS IN THE COMMONWEALTH.

Discussion

The Task Force maintains that school-age children can benefit from ongoing education in this area to assist in the general awareness of various issues related to family living skills in an effort to strengthen the "family unit." It is further believed that issues such as positive life coping skills, human sexuality, abstinence, positive self-esteem building, child abuse and neglect,

and parenting, can be addressed in the family life education curriculum. Family life education programs where local communities have worked closely with available public and private resources have been most successful. The Task Force advocates and encourages the involvement and participation of community leaders, religious institutions, parents, and educators to assure that the development of such a curriculum meets community needs. It was further noted through the Community Round Table Discussions that the development of a family life educational curriculum will enable both parents and educators to provide the children of the Commonwealth with the resources and knowledge they need to make responsible, educated decisions about their lives.

5. THE DEPARTMENTS OF HEALTH AND EDUCATION ALONG WITH THE VIRGINIA DENTAL ASSOCIATION SHOULD WORK TOGETHER ON A STATE AND LOCAL LEVEL TO COORDINATE DENTAL CARE RESOURCES AND TO INCREASE DENTAL SCREENINGS AND EDUCATIONAL PROGRAMS.

Discussion

It has long been established that preventive dental health care screenings and education can have a tremendous long term effect on preventing dental disease. The establishment of appropriate preventive dental programs in the schools is not only cost-effective, but it also gives children the opportunity to receive preventive dental services in areas that would perhaps otherwise be medically underserved. It would also be desirable for the Department of Education to provide assistance in reviewing and developing curriculum guidelines to assure that accurate dental information is being disseminated in the schools.

6. A FORMAL MEMORANDUM OF AGREEMENT SHOULD BE DEVELOPED BETWEEN THE SECRETARY OF HUMAN RESOURCES AND THE SECRETARY OF EDUCATION TO ADDRESS OVERLAPPING CONCERNS RELATED TO THE HEALTH NEEDS AND CARE OF SCHOOL-AGE CHILDREN.

Discussion

The Task Force believes that the exceptional degree of interest and cooperation displayed during the course of this study at the Cabinet Secretary level should be continued. The health needs of school-age children cut across agency lines requiring the coordination of a variety of disciplines including health, education, mental health and mental retardation, social services, medical assistance, and others. It is appropriate that both Secretariats develop a formal agreement to continue the momentum begun with this study in order to improve the health of Virginia's school-age children.

7. THE BOARDS OF THE DEPARTMENTS OF EDUCATION AND HEALTH SHOULD ESTABLISH A FORMAL AGREEMENT TO MEET JOINTLY AT A MINIMUM OF TWICE YEARLY TO ADVISE EACH OF THE DESIGNATED AGENCIES ON MATTERS PERTAINING TO SCHOOL HEALTH SERVICES POLICY.

Discussion

Many of the concerns with regard to school health services are overlapping in terms of agency responsibility. At the present time, however, no formal means of communication has been established between the State Boards of Health and Education. The Task Force believes that ongoing linkage between the two boards is essential to facilitate the development of quality school health programs at the local level.

8. THE GOVERNOR'S TASK FORCE ON INDIGENT CARE AS WELL AS THE SECRETARY OF HUMAN RESOURCES SHOULD SPECIFICALLY ADDRESS THE SPECIAL HEALTH CARE NEEDS OF THE SCHOOL-AGE CHILD ESPECIALLY THE MEDICALLY INDIGENT.

Discussion

A comment frequently noted at the Round Table Discussions around the State was the special health needs of medically indigent children. The Task Force believes that the health needs of the indigent school-age child is an appropriate issue that should be examined in great detail in an effort to offer workable solutions for the financing and provision of health care services to this population.

9. THE DEPARTMENTS OF EDUCATION, HEALTH, AND MENTAL HEALTH AND MENTAL RETARDATION SHOULD CO-SPONSOR AT REGULAR INTERVALS CONTINUING EDUCATION OPPORTUNITIES FOR SCHOOL NURSING PERSONNEL ON A REGIONAL BASIS.

Discussion

Although a majority of the school divisions reported the availability of continuing education opportunities, it appears that there are still many training needs among school health professionals which remain unmet. Of particular concern is dealing with the "new morbidity" facing today's youths. Addressing the changing morbidity patterns in children requires different skills such as self-esteem building. Many health care professionals are inadequately trained for the identification and treatment of these disorders. An intensive campaign of continuing education for health care providers is needed to meet the "new morbidity" in children and adolescents.

10. THE DEPARTMENTS OF HEALTH, EDUCATION, AND MENTAL HEALTH AND MENTAL RETARDATION SHOULD PROVIDE FOR SCHOOL PERSONNEL CONTINUING EDUCATION OPPORTUNITIES ABOUT THE NEW MORBIDITY FACING TODAY'S SCHOOL-AGE CHILDREN.

Discussion

The Task Force believes that it is essential for school personnel to be informed and educationed about the new morbidity facing today's youths. School personnel should be adequately trained to identify signs of problems such as alcohol and drug abuse, suicidal behavior and depression in the school-age population, and to refer children to appropriate interventions.

11. EVERY SCHOOL DIVISION WITHIN THE STATE SHOULD HAVE A SCHOOL HEALTH ADVISORY BODY COMPOSED OF PUBLIC AND PRIVATE SECTOR REPRESENTATIVES TO ASSIST WITH SCHOOL HEALTH POLICY.

Discussion

The survey of school health services found that 90% of the school divisions in Virginia do not have an advisory body to assist with school health policy. Yet, those localities with advisory bodies have found them to be quite useful in improving the overall quality of school health services. The Task Force believes that an appropriate mix of public and private sector representation on the advisory body will further enhance the integration of school health as a part of each community's overall plan for health services.

12. AN INTERDISCIPLINARY HEALTH CARE PLAN FOR SCHOOL-AGE CHILDREN AT THE LOCAL LEVEL SHOULD BE DEVELOPED WITH TECHNICAL ASSISTANCE FROM THE STATE DEPARTMENTS OF EDUCATION, HEALTH, AND MENTAL HEALTH AND MENTAL RETARDATION AS REQUESTED. SUCH A PLAN SHOULD INCLUDE A COMPONENT ON METHODS OF FINANCING HEALTH CARE SERVICES TO SCHOOL-AGE CHILDREN.

Discussion

Based on the Community Round Table Discussions and the other overall activities of the Task Force, many individuals involved in this study encouraged increased coordination and cooperation among State and community resources. It was further noted that often health care to school-age children is fragmented and not well planned. The Task Force, though, was extremely encouraged by many of the activities they observed taking place on the local level. However, in order to maximize the effectiveness of community resources in an effort to truly link and coordinate existing health care services, it is believed by the Task Force that the development of an interdisciplinary health

care plan is essential. Such a plan will not only facilitate community coordination, but will also foster a team approach and a health care service system that meets the health needs of school-age children.

13. EACH SCHOOL DIVISION WITHIN THE STATE SHOULD ESTABLISH FORMAL INTERAGENCY AGREEMENTS WITH APPROPRIATE COMMUNITY RESOURCES INVOLVED IN THE PROVISION OF HEALTH CARE TO SCHOOL-AGE CHILDREN. APPROPRIATE COMMUNITY RESOURCES MAY INCLUDE, BUT SHOULD NOT BE LIMITED TO, LOCAL HEALTH DEPARTMENTS, COMMUNITY SERVICES BOARDS, SOCIAL SERVICES AGENCIES, INSTITUTIONS OF HIGHER EDUCATION, PRIVATE SECTOR HEALTH PROFESSIONALS, AND OTHERS.

Discussion

The Task Force views school health services as an important part of a community's total health care resources. In order to provide health care in a coordinated and integrated manner, it is essential that key linkages be established with other health care providers in the community.

14. LOCAL SCHOOL BOARDS SHOULD DEVELOP, WHENEVER POSSIBLE, STRONG RELATIONSHIPS WITH VOLUNTEER ORGANIZATIONS AND THE BUSINESS COMMUNITY FOR IMPROVING THE DELIVERY AND FINANCING OF HEALTH CARE FOR SCHOOL-AGE CHILDREN.

Discussion

The Task Force believes that the private sector can play an important role in assisting the localities with health services to school-age children. The private sector can continue to work with the public sector in playing a major role in providing communities with limited resources necessary health care services. The increased development of public/private sector partnerships can also help provide the health care system with efficiency of service delivery, development of creative health care financing formulas, and equal access to care for all school-age children.

15. THE VIRGINIA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS SHOULD ENCOURAGE ITS MEMBERSHIP TO PROVIDE A LEADERSHIP ROLE AT THE LOCAL LEVEL IN ADVOCATING FOR AND PROVIDING A COORDINATED SYSTEM OF HEALTH CARE FOR SCHOOL-AGE CHILDREN.

Discussion

While health care services for children vary dramatically across the State, it is essential that they be coordinated with community resources to the fullest extent possible. Pediatricians and other physicians providing health care to school children are in a position to exert leadership in this area. The pediatric community has a tremendous breadth of knowledge with regard to effectively delivering health care while meeting children's preventive health care needs. A soundly implemented, coordinated system of care can only help to strengthen school health services.

16. THE VIRGINIA CONGRESS OF PARENTS AND TEACHERS (PTA) AND ALL OTHER PARENT ORGANIZATIONS SHOULD VIGOROUSLY UNDERTAKE A PARENT AWARENESS CAMPAIGN TO EDUCATE PARENTS ABOUT THE HEALTH NEEDS OF SCHOOL-AGE CHILDREN AND TO INCREASE PARENTAL INVOLVEMENT IN THEIR CHILDREN'S HEALTH.

Discussion

A comment frequently noted on the survey of school health services was that often parents do not follow-up on health problems detected through school health screenings. This concern was also echoed at the Community Round Table Discussions. The Task Force believes that active parental involvement in the health care of children is an essential ingredient in improving the overall health status of the school-age population.

17. EVERY SCHOOL DIVISION SHOULD ESTABLISH A COOPERATIVE AGREEMENT WITH A PHYSICIAN TO SERVE IN THE CAPACITY OF CONSULTING MEDICAL DIRECTOR TO PROVIDE MEDICAL CARE CONSULTAITON AND BACKUP TO NURSING PERSONNEL.

Discussion

According to the survey of school health services 87% of the school divisions indicated that they did not have a medical director to assist with the school health program. The Task Force believes that nursing personnel and school officials would benefit from an ongoing medical care consultation arrangement with a local physician.

18. FORMAL, WRITTEN EMERGENCY MEDICAL PROCEDURES SHOULD BE DEVELOPED IN EVERY SCHOOL DIVISION WITHIN THE STATE.

Discussion

The survey of school health services revealed that 18 school divisions have no established procedure for dealing with medical, dental, and mental health emergencies. The Task Force believes that the establishment of such a procedure is an essential component to school health services. The Task Force maintains that it is also desirable for every school to have a professional available on the school premises with expertise and training in cardiopulmonary resuscitation (CPR).

19. THE STATE DEPARTMENT OF EDUCATION SHOULD DIRECT ALL SCHOOL DIVISIONS TO MAINTAIN APPROPRIATE DOCUMENTATION ON ALL STUDENT INJURIES AS PART OF A PROGRAM OF COMPREHENSIVE RISK MANAGEMENT.

Discussion

According to the responses received from the survey of school health services, twenty-four percent (24%) of the school divisions indicated they do not maintain documentation on school injuries. The Task Force believes that the establishment of such documentation is essential to the provision of comprehensive school health services. It is desirable for all school divisions to maintain a summary of school injuries as part of a comprehensive risk management program to assist school officials in the establishment of a well documented, accountable school health system.

20. THE STATE DEPARTMENT OF EDUCATION SHOULD CONTINUE TO MONITOR AND INSIST THAT ALL SCHOOLS COMPLY WITH STATE LAWS PERTAINING TO VISION AND HEARING ASSESSMENTS.

Discussion

As noted in the information and analysis received from the health services survey, all of the school divisions provide visual and hearing assessments at the elementary level; however, compliance with the law appears to decrease at the junior and senior high school levels. Preventive health screening activities afford professionals the opportunity for early identification and correction of diseases and preventive long-term health care planning for school-age children.

21. THE DEPARTMENT OF EDUCATION SHOULD DIRECT ALL SCHOOL DIVISIONS TO PROVIDE TIME IN THE CURRICULUM FOR HEALTH EDUCATION. FURTHER, THERE SHOULD BE A STRONG EMPHASIS ON HEALTH PROMOTION AND DISEASE AND INJURY PREVENTION PROGRAMS.

Discussion

Currently, health education is a part of the State Department of Education's required curriculum component. It was noted, however, by many health and educational professionals around the State that children would truly benefit from increased programming in the areas of substance abuse, human sexuality, emotional problems, nutrition and diet, stress management, and positive self-esteem building. The educational areas mentioned above are essential to the positive, long-term physical and mental development of children. They must be presented in a constructive manner so as to encourage the desire for children to want to learn and stay responsibly informed.

22. THE DEPARTMENT OF EDUCATION SHOULD ASSIST ALL SCHOOL DIVISIONS WITH GUIDANCE ON THE PHYSICAL EDUCATION CURRICULUM TO DEVELOP AND EMPHASIZE INDIVIDUAL FITNESS PROGRAMS.

Discussion

National surveys have shown that children today are less physically fit because more emphasis is put on team oriented sports than individual fitness programs. Many children do not participate in such activities because of perceived deficiencies in certain areas. It was further noted by the results of the school survey and at the community discussions, that it appears that many children are not being physically challenged with regard to the development of physical stamina. The Task Force believes that it is extremely important to develop individual physical fitness programs that not only stress physical fitness, but also build positive self-esteem. The Task Force also maintains that Virginia's schools should have a daily physical education requirement to challenge the physical stamina of school-age children.

23. THE DEPARTMENT OF EDUCATION SHOULD ENCOURAGE ALL SCHOOL DIVISIONS TO ESTABLISH AFTER SCHOOL PROGRAMS ADDRESSING HEALTH ISSUES AND CONCERNS.

Discussion

An essential ingredient in the provision of health care services is the provision of health education and healthy lifestyles. It was noted on the survey of school health services and at the community discussions that after school programs could facilitate this unmet need of school-age children. It was further noted that many school-age children do not have parental supervision after school hours, and these programs could potentially offer a solution of providing constructive activities to children after school hours.

SENATE JOINT RESOLUTION NO. 76

Requesting the Secretary of Human Resources to study the health needs of school-age children.

Agreed to by the Senate, February 11, 1986
Agreed to by the House of Delegates, February 27, 1986

WHEREAS, there are 1,248,574 children and adolescents five to nineteen years of age in Virginia, constituting twenty-two percent of the State's population; and

WHEREAS, the Legislative Task Force on Infant Mortality found that health services to school-age children are provided by a wide variety of professionals and paraprofessionals in both public and private settings; and

WHEREAS, these services vary in range, scope and quality across the Commonwealth and often, the access to, and the availability, utilization and effectiveness of health services are limited; and

WHEREAS, testimony to the Legislative Task Force on Infant Mortality revealed the following facts:

1. Of Virginia's 1,248,574 children and adolescents five to nineteen years of age, nearly fifteen percent have a chronic health impairment limiting their school attendance and performance.

2. It is estimated that thirty-five percent of males and twenty percent of females under sixteen are sexually active and in 1983, there were 20,220 pregnancies in women under nineteen, with sixty-four percent in white and thirty-six percent in nonwhite women.

3. In 1983, twenty-nine percent of all abortions in the Commonwealth were to school-age women, forty-one percent of school-age pregnant women did not receive adequate prenatal care and eighty percent of pregnant teenagers dropped out of school.

4. In 1984, twenty-seven percent of reported cases of gonorrhea were in school-age children and there were 345 cases in children under fourteen.

5. In 1984, fifty-six percent of 12,072 reports of abuse and neglect were in school-age children and ninety-seven percent of missing children in Virginia are runaways.

6. Approximately five percent of children drop out from high school every year in the Commonwealth, averaging 17,000 dropouts a year for the last four years.

7. It is estimated that seventy-two percent of high school seniors have used alcohol, thirty-five percent have smoked cigarettes within a thirty-day period, five and one-half percent use alcohol on a daily basis, twenty percent use cigarettes daily, five percent use marijuana on a daily basis, ten percent of school-age children are obese and the rates of bulemia and anorexia nervosa are increasing.

8. Approximately fourteen percent of children six to eleven years and seven percent of children twelve to seventeen years have never received dental care and fifty percent are in need of dental care.

9. Less than thirty percent of children are covered by health insurance for physician services and only ten percent of physician visits by school-age children are for preventive health care; and

WHEREAS, children and adolescents require comprehensive health care including mental health, dental, nutrition, special education and rehabilitation services; and

WHEREAS, there is a need to determine whether the current system of school health services promotes and maintains the health of children, whether it provides for the early identification of high risk children and adolescents, and whether there is a need for a coordinated, comprehensive school health service system; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Secretary of Human Resources is requested to study the health needs of school-age children.

The study is requested to determine the status, quality and effectiveness of the current school health service system to identify gaps in the delivery of services and to determine the feasibility of establishing a statewide coordinated, comprehensive school health service system. All agencies of the Commonwealth shall assist the joint subcommittee as it deems appropriate, upon request.

The Secretary shall submit her findings and recommendations to the 1987 Session of the General Assembly.

SELECTED STATISTICS ON VIRGINIA'S PUBLIC SCHOOLS FOR 1985-86

Counties	Number of VA Public Schools 1985-86	Number of Students in VA Public Schools 1985-86	School Division School Nurse FTEs	Local Health Department School Nurse FTEs	Total School Nurse FTEs	Total School Nurse FTEs Per 1,000 Students
Accomack	15	5,082	3.0	0.0	3.0	.59
Albemarle	20	8,897	0.0	.5	.5	.06
Alleghany Highlands	8	3,545	0.0	.2	.2	.06
Amelia	3	1,540	1.0	.1	1.1	.71
Amherst	11	4,755	2.0	0.0	2.0	.42
Appomattox	4	2,323	4.0	0.0	4.0	1.72
Arlington	28	14,481	0.0	.2	.2	.01
Augusta	21	9,780	0.0	1.3	1.3	.13
Bath	3	949	0.0	.2	.2	.21
Bedford	17	7,548	3.0	0.0	3.0	.39
Bland	5	1,164	0.0	0.0	0.0	0.00
Botetourt	10	4,369	0.0	.2	.2	.05
Brunswick	6	2,770	2.6	.1	2.7	.97
Buchanan	18	8,014	2.0	0.0	2.0	.25
Buckingham	7	2,170	0.0	.1	.1	.05
Campbell	17	8,959	2.0	0.0	2.0	.22
Caroline	6	3,610	1.0	0.0	1.0	.28
Carroll	16	4,542	1.0	.1	1.1	.24
Charles City	4	1,214	1.0	0.0	1.0	.82
Charlotte	7	2,361	0.0	.2	.2	.08
Chesterfield	43	36,866	0.0	15.2	15.2	.41
Clarke	5	1,636	1.0	0.0	1.0	.61
Craig	3	757	0.0	.3	.3	.40
Culpeper	7	4,368	1.0	.1	1.1	.25
Cumberland	2	1,408	1.0	.1	1.1	.78
Dickenson	9	4,212	6.0	0.0	6.0	1.42
Dinwiddie	9	3,785	1.5	0.0	1.5	.40
Essex	3	1,482	0.0	0.0	0.0	0.00

Counties (Continued)	Number of VA Public Schools 1985-86	Number of Students in VA Public Schools 1985-86	School Division School Nurse FTEs	Local Health Department School Nurse FTEs	Total School Nurse FTEs	Total School Nurse FTEs Per 1,000 Students
Floyd	5	1,958	1.0	0.0	1.0	.51
Fluvanna	6	2,052	0.0	0.0	0.0	0.00
Franklin	13	6,241	5.0	.1	5.1	.82
Frederick	11	7,046	6.0	0.0	6.0	.85
Giles	9	3,186	1.0	0.0	1.0	.31
Gloucester	6	4,698	4.0	0.0	4.0	.85
Goochland	6	1,775	1.0	0.0	1.0	.56
Grayson	10	2,102	0.0	0.0	0.0	0.00
Greene	3	1,657	1.0	0.0	1.0	.60
Greensville/Emporia	6	3,100	0.0	.1	.1	.03
Halifax/South Boston	16	7,281	1.1	.2	1.3	.18
Hanover	15	9,871	1.0	0.0	1.0	.10
Henrico	49	30,713	46.0	.1	46.1	1.50
Henry	25	10,075	0.0	.2	.2	.02
Highland	2	402	0.0	.2	.2	.50
Isle of Weight	6	3,840	6.0	0.0	6.0	1.56
King George	4	2,353	2.5	0.0	2.5	1.06
King and Queen	3	978	0.0	0.0	0.0	0.00
King William	2	1,392	1.0	0.0	1.0	.72
Lancaster	3	1,616	1.0	0.0	1.0	.62
Lee	15	5,388	0.0	.1	.1	.70
Loudoun	30	12,898	8.5	.5	9.0	.30
Louisa	7	3,471	1.0	0.0	1.0	.29
Lunenburg	6	2,219	1.0	0.0	1.0	.45
Madison	5	1,766	0.0	.1	.1	.06
Mathews	3	1,240	1.0	0.0	1.0	.81
Mecklenburg	11	5,221	0.0	.1	.1	.02
Middlesex	2	1,174	0.0	0.0	0.0	0.00
Montgomery	17	8,525	1.0	0.0	1.0	.12
Nelson	7	2,121	0.0	0.0	0.0	0.00

Counties (Continued)	Number of VA Public Schools 1985-86	Number of Students in VA Public Schools 1985-86	School Division School Nurse FTEs	Local Health Department School Nurse FTEs	Total School Nurse FTEs	Total School Nurse FTEs Per 1,000 Students
New Kent	3	1,739	1.0	0.0	1.0	.58
Northampton	7	2,448	5.0	0.0	5.0	2.04
Northumberland	4	1,384	1.0	0.0	1.0	.72
Nottoway	7	2,581	1.0	0.0	1.0	.39
Orange	6	3,586	0.0	0.0	0.0	0.00
Page	7	3,468	2.0	.1	2.1	.61
Patrick	7	2,981	1.0	0.0	1.0	.34
Pittsylvania	26	11,719	2.0	.2	2.2	.19
Powhatan	4	2,142	0.0	.1	.1	.05
Prince Edward	2	2,372	3.0	.1	3.1	1.31
Prince George	10	5,086	1.0	0.0	1.0	.20
Prince William	53	36,824	0.0	2.1	2.1	.06
Pulaski	13	6,745	1.0	.1	1.1	.16
Rappahannock	2	971	0.0	.1	.1	.10
Richmond	3	1,279	0.0	0.0	0.0	0.00
Roanoke	27	13,725	2.0	1.1	3.1	.23
Rockbridge	11	3,014	0.0	.4	.4	.13
Rockingham	21	9,114	0.0	.9	.9	.10
Russell	17	6,158	0.0	.1	.1	.02
Scott	14	4,685	1.0	0.0	1.0	.21
Shenandoah	14	4,746	1.0	0.0	1.0	.21
Smyth	13	6,224	0.0	0.0	0.0	0.00
Southampton	7	2,530	1.0	0.0	1.0	.40
Spotsylvania	14	9,054	7.0	0.0	7.0	.77
Stafford	12	10,313	11.0	.1	11.1	1.08
Surry	2	1,156	1.0	0.0	1.0	.87
Sussex	6	1,828	0.0	0.0	0.0	0.00
Tazewell	24	10,040	3.0	0.0	3.0	.30
Warren	6	3,804	1.0	.1	1.1	.29

Counties (Continued)	Number of VA Public Schools 1985-86	Number of Students in VA Public Schools 1985-86	School Division School Nurse FTEs	Local Health Department School Nurse FTEs	Total School Nurse FTEs	Total School Nurse FTEs Per 1,000 Students
Westmoreland	5	1,988	2.0	0.0	2.0	1.01
Wise	16	9,678	2.0	0.0	2.0	.42
Wythe	11	4,759	0.0	.2	.2	.04
York	15	8,680	7.0	0.0	7.0	.81
Cities						
Alexandria	17	10,344	14.5	.5	15.0	1.45
Bristol	7	3,055	1.0	0.0	1.0	.33
Buena Vista	4	1,315	0.0	.1	.1	.08
Charlottesville	9	4,655	5.0	.3	5.3	1.14
Chesapeake	34	25,361	26.0	0.0	26.0	1.03
Colonial Heights	5	2,800	1.0	.1	1.1	.39
Covington	4	1,288	0.0	.1	.1	.08
Danville	14	7,311	2.3	.1	2.4	.33
Falls Church	2	1,101	0.0	.7	.7	.64
Franklin	4	1,936	1.0	0.0	1.0	.52
Fredericksburg	3	2,230	3.0	.1	3.1	1.39
Galax	2	1,271	1.0	0.0	1.0	.79
Hampton	34	20,046	21.5	0.0	21.5	1.07
Harrisonburg	6	2,783	0.0	.8	.8	.29
Hopewell	8	4,068	2.0	0.0	2.0	.49
Lexington	2	501	0.0	.1	.1	.20
Lynchburg	16	9,730	8.0	.1	8.1	.83
Manassas	5	3,747	1.0	.3	1.3	.35
Manassas Park	4	1,458	0.0	.1	.1	.07
Martinsville	6	3,063	2.0	.2	2.2	.72
Newport News	33	25,853	36.0	.1	36.1	1.40
Norfolk	58	36,044	2.0	39.6	41.6	1.15
Norton	2	990	0.0	0.0	0.0	0.00
Petersburg	10	6,435	5.0	0.0	5.0	.78

Cities	Number of VA Public Schools 1985-86	Number of Students in VA Public Schools 1985-86	School Division School Nurse FTEs	Local Health Department School Nurse FTEs	Total School Nurse FTEs	Total School Nurse FTEs Per 1,000 Students
Portsmouth	30	18,640	28.0	0.0	28.0	1.50
Radford	5	1,651	0.0	.1	.1	.06
Richmond	56	29,160	32.0	.1	32.1	1.10
Roanoke	29	14,615	2.0	.9	2.9	.20
Salem	6	3,593	1.0	.3	1.3	.36
Staunton	2	2,969	1.0	.5	1.5	.51
Suffolk	17	8,719	10.0	0.0	10.0	1.15
Virginia Beach	63	59,936	63.0	.2	63.2	1.05
Waynesboro	6	2,505	0.0	.4	.4	.16
Williamsburg/James City	7	5,191	8.0	0.0	8.0	1.54
Winchester	6	3,068	3.0	0.0	3.0	.98
Towns						
Cape Charles	1	217	1.0	--	1.0	4.61
Colonial Beach	1	516	0.0	--	0.0	0.00
Fries	1	428	0.0	--	0.0	0.00
West Point	2	678	1.0	--	1.0	1.47
STATE TOTAL	1,735	968,104	467.5	92.5	560.0	.58

SOURCE: Number of Schools by Type and Division for the 1985-86 School Year, Fall Membership in Virginia's Public Schools 1985-86, 1985-86 FTE of School Nurses, Division of Management Information Service, Department of Education. Summary of LHS - 169 Activities Patient Visits for FY 1985-86, Summary of LHS - 169 Activities Other than Patient Visits for FY 1985-86, Division of Public Health Nursing, Department of Health.

SCREENING ACTIVITIES PROVIDED BY SCHOOL DIVISIONS
An X indicates that a division provides the service.

COUNTIES	Visual Screening	Hearing Assessment	Orthopedic Screening (including Scoliosis)	Throat Screening	Dental Screening	Height/ Weight	Immunization Levels	Posture Screening	Speech Screening	Blood Pressure Screening	Drug Testing	Psychological Screening	Other
Accomack	X	X	X	X	X	X	X	X	X	X		X	
Albemarle	X	X	X		X	X	X	X	X	X			X
Alleghany Highlands	X	X	X	X	X								
Amelia	X	X	X	X	X	X	X	X	X				
Amherst	X	X	X	X	X	X	X	X	X	X	X	X	X
Appomattox	X	X	X	X	X	X	X	X	X			X	
Arlington	X	X	X			X	X		X				X
Augusta	X	X	X		X		X						
Bath	X	X	X		X	X	X		X			X	
Bedford	X	X	X	X	X	X	X	X	X				X
Bland	X	X	X	X	X	X	X	X	X			X	
Botetourt	X	X	X		X	X	X	X	X				
Brunswick	X	X	X	X	X	X	X	X	X	X			
Buchanan	X	X	X			X	X	X	X			X	X
Buckingham	X	X				X	X		X				X
Campbell	X	X	X	X	X	X	X	X	X			X	
Caroline	X	X	X	X	X	X	X	X	X	X	X	X	
Carroll	X	X	X			X	X		X			X	
Charles City	X	X	X	X	X	X	X	X	X			X	
Charlotte	X	X	X	X	X	X	X		X				
Chesterfield	X	X	X	X	X	X	X	X	X	X		X	X
Clarke	X	X	X	X	X	X	X	X	X				
Craig	X	X	X	X	X	X	X	X	X				
Culpeper	X	X	X	X	X	X	X	X	X				
Cumberland	X	X	X		X	X	X		X				
Dickenson	X	X	X	X	X	X	X	X	X			X	
Dinwiddie	X	X	X	X	X	X	X	X	X				X
Essex	X	X	X	X	X	X	X	X	X	X		X	X
Fairfax	X	X	X	X	X	X	X	X	X			X	X
Fauquier	X	X	X	X	X	X	X		X				
Floyd	X	X	X	X	X	X	X		X	X			
Fluvanna	X	X	X	X	X	X	X		X			X	
Franklin	X	X	X	X	X	X	X	X	X			X	
Frederick	X	X	X	X	X	X	X	X	X				
Giles	X	X	X	X	X	X	X	X					
Gloucester	X	X	X	X	X	X	X	X	X				X
Goochland	X	X	X		X	X	X	X	X				
Grayson	X	X	X	X		X	X	X	X			X	

SCREENING ACTIVITIES PROVIDED BY SCHOOL DIVISIONS
An X indicates that a division provides the service.

	Visual Screening	Hearing Assessment	Orthopedic Screening (including Scoliosis)	Throat Screening	Dental Screening	Height/ Weight	Immunization Levels	Posture Screening	Speech Screening	Blood Pressure Screening	Drug Testing	Psychological Screening	Other
COUNTIES (cont.)													
Halifax/South Boston	X	X	X	X	X	X	X	X	X	X			
Hanover	X	X	X	X	X	X	X	X	X				X
Henrico	Survey not returned.												
Henry	X	X	X	X	X	X	X	X	X			X	X
Highland	X	X	X	X	X	X	X		X			X	
Isle of Wight	X	X	X	X	X	X	X	X	X			X	
King George	X	X	X	X	X	X	X	X	X			X	
King and Queen	X	X			X	X	X	X	X			X	
King William	X	X	X	X	X	X	X			X		X	
Lancaster	X	X	X			X	X		X				X
Lee	X	X	X			X	X	X	X			X	X
Loudoun	X	X	X	X	X	X	X	X	X				
Louisa	X	X	X		X	X	X		X			X	
Lunenburg	X	X	X	X	X	X	X	X	X	X		X	
Madison	X	X	X		X	X	X		X				
Mathews	X	X	X		X	X	X		X				
Mecklenburg	X	X	X	X	X	X	X	X	X				
Middlesex	X	X	X	X	X	X		X	X	X		X	
Montgomery	X	X	X	X	X	X	X	X	X				X
Nelson	X	X	X		X	X	X	X	X			X	
New Kent	X	X	X	X	X	X	X	X		X		X	
Northampton	X	X	X	X	X	X	X	X	X	X		X	X
Northumberland	X	X	X	X	X	X	X	X	X	X			
Nottoway	X	X	X		X	X	X		X			X	
Orange	X	X	X		X	X	X		X			X	
Page	X	X	X	X	X	X	X	X	X	X		X	X
Patrick	X	X	X		X	X	X		X				X
Pittsylvania	X	X	X		X		X		X				X
Powhatan	X	X	X	X	X	X	X		X				
Prince Edward	X	X	X	X	X	X	X	X	X	X		X	
Prince George	X	X	X	X	X	X	X	X	X			X	
Prince William	X	X	X	X	X	X	X	X	X			X	
Pulaski	X	X	X	X	X	X	X	X	X			X	
Rappahannock	X	X	X	X		X	X		X				
Richmond	X	X	X	X	X	X	X	X	X			X	
Roanoke	X	X	X	X	X	X	X	X	X				
Rockbridge	X	X	X	X	X	X	X	X	X				

SCREENING ACTIVITIES PROVIDED BY SCHOOL DIVISIONS
An X indicates that a division provides the service.

	Visual Screening	Hearing Assessment	Orthopedic Screening (including Scoliosis)	Throat Screening	Dental Screening	Height/ Weight	Immunization Levels	Posture Screening	Speech Screening	Blood Pressure Screening	Drug Testing	Psychological Screening	Other
COUNTIES (cont.)													
Shenandoah	X	X	X	X	X	X	X	X	X	X		X	X
Smyth	X	X	X	X	X	X	X	X	X			X	
Southampton	X	X	X	X	X	X	X	X	X				
Spotsylvania	X	X	X	X	X	X	X	X					
Stafford	X	X	X	X	X	X	X	X	X	X	X	X	X
Surry	Survey not returned.												
Sussex	X	X	X	X	X	X	X	X	X				
Tazewell	X	X	X	X	X	X	X	X	X			X	X
Warren	X	X	X	X	X	X	X	X	X				
Washington	X	X	X	X	X	X	X	X		X		X	X
Westmoreland	X	X	X	X	X	X	X	X	X				
Wise	X	X	X	X	X	X	X	X	X	X			
Wythe	X	X	X			X	X						
York	X	X	X	X	X	X	X	X	X			X	
CITIES													
Alexandria	X	X	X		X	X	X	X	X	X		X	X
Bristol	Survey not returned.												
Buena Vista	X	X	X	X	X	X	X	X	X	X	X	X	
Charlottesville	X	X	X										
Chesapeake	X	X	X	X	X	X	X	X	X	X		X	X
Colonial Heights	X	X	X	X	X	X	X	X	X				
Covington	X	X	X	X	X	X	X	X	X	X		X	
Danville	X	X	X			X	X	X	X				X
Falls Church	X	X	X			X	X	X	X	X		X	X
Franklin City	X	X	X	X	X	X	X	X	X				X
Fredericksburg	X	X	X	X	X	X	X	X	X			X	
Galax	X	X	X	X	X	X	X	X	X	X		X	X
Hampton	X	X	X	X	X	X	X	X	X	X		X	X
Harrisonburg	X	X	X	X	X	X	X	X	X	X		X	
Hopewell	X	X	X	X	X	X	X	X	X				
Lexington	X	X	X	X	X	X	X		X	X		X	
Lynchburg	X	X	X			X	X	X	X			X	
Manassas	X	X	X			X	X	X	X				
Manassas Park	X	X	X				X		X				
Martinsville	X	X	X	X	X	X	X		X			X	
Newport News	X	X	X	X	X	X	X	X	X			X	
Norfolk	X	X	X	X	X	X	X	X		X		X	X

SCREENING ACTIVITIL VIDED BY SCHOOL DIVISIONS
An X indicates that a division provides the service.

	Visual Screening	Hearing Assess-ment	Orthopedic Screening (including Scoliosis)	Throat Screening	Dental Screening	Height/ Weight	Immuni-zation Levels	Posture Screening	Speech Screening	Blood Pressure Screening	Drug Testing	Psycho-logical Screening	Other
CITIES (cont.)													
Portsmouth	X	X	X	X	X	X	X	X	X	X		X	X
Radford	X	X	X	X	X	X	X	X	X	X		X	
Richmond City	X	X	X	X	X	X	X	X	X				
Roanoke City	X	X	X		X	X	X		X				
Salem	X	X	X	X	X	X	X	X	X				
Staunton	X	X	X	X	X	X	X	X	X				
Suffolk	X	X	X	X	X	X	X	X	X	X		X	
Virginia Beach	X	X	X	X	X	X	X	X	X	X		X	
Waynesboro	X	X	X	X	X	X	X		X			X	
Williamsbg/James Cty	X	X	X	X	X	X	X		X				X
Winchester	X	X	X		X	X	X			X			
TOWNS													
Cape Charles	X	X	X	X	X	X	X	X	X	X			
Colonial Beach	X	X		X	X	X	X		X			X	
Fries	X	X	X	X	X	X	X	X	X			X	
West Point	X	X	X	X	X	X	X		X			X	

HEALTH PROMOTION ACTIVITIES OUTSIDE OF REGULAR CLASSROOM INSTRUCTION PROVIDED BY SCHOOL DIVISIONS

An X indicates that a division provides the service.

	Nutrition Education	Family Planning	Substance Abuse Education	Family Life Education	Psychological/ Emotional Health Promotion	General Health Education/ Instruction	Sexually Transmissible Disease Education	Safety/ Accident Prevention	Others
COUNTIES									
Accomack								X	
Albemarle		X	X	X	X		X	X	
Alleghany Highlands			X						
Amelia									
Amherst	X	X	X	X	X	X	X	X	
Appomattox	X		X			X		X	
Arlington	X	X	X		X	X	X	X	
Augusta									
Bath	X		X		X	X	X	X	
Bedford	X								
Bland	X	X	X	X	X	X	X	X	
Botetourt									
Brunswick	X	X	X	X	X	X	X	X	
Buchanan			X						
Buckingham									
Campbell			X						
Caroline	X		X			X		X	
Carroll			X	X		X	X	X	X
Charles City									
Charlotte	X		X		X	X		X	
Chesterfield	X	X	X	X	X	X	X	X	X
Clarke					X				
Craig		X	X	X					
Culpeper	X					X		X	
Cumberland				X					
Dickenson			X		X			X	
Dinwiddie									
Essex	X	X	X		X	X		X	
Fairfax	X		X		X	X	X	X	
Fauquier			X	X	X		X		
Floyd	X	X	X			X	X	X	
Fluvanna								X	
Franklin	X		X	X		X		X	
Frederick				X					
Giles	X	X	X	X		X	X	X	
Gloucester	X		X		X	X		X	X
Goochland									
Grayson	X		X		X	X	X	X	

HEALTH PROMOTION ACTIVITIES OUTSIDE OF REGULAR CLASSROOM INSTRUCTION PROVIDED BY SCHOOL DIVISIONS
An X indicates that a division provides the service.

	Nutrition Education	Family Planning	Substance Abuse Education	Family Life Education	Psychological/ Emotional Health Promotion	General Health Education/ Instruction	Sexually Transmissible Disease Education	Safety/ Accident Prevention	Others
COUNTIES (cont.)									
Halifax/South Boston			X					X	
Hanover					X		X		X
Henrico	Survey not returned.								
Henry	X	X	X	X	X	X		X	
Highland			X	X					
Isle of Wight	X		X		X	X		X	
King George									
King and Queen	X	X	X	X	X	X	X	X	
King William	X		X	X		X	X	X	
Lancaster			X						
Lee									
Loudoun									
Louisa	X	X	X	X	X	X			X
Lunenburg									
Madison			X						
Mathews	X		X		X		X	X	
Mecklenburg									
Middlesex			X					X	
Montgomery									
Nelson									
New Kent	X		X	X	X	X	X	X	
Northampton	X		X		X	X		X	X
Northumberland			X					X	
Nottoway	X		X		X			X	
Orange		X					X		X
Page	X		X	X				X	
Patrick			X	X			X	X	
Pittsylvania	X		X		X	X		X	
Powhatan			X		X			X	
Prince Edward	X	X	X	X	X	X		X	
Prince George									
Prince William	X		X		X			X	
Pulaski									
Rappahannock	X					X			
Richmond	X							X	
Roanoke									

HEALTH PROMOTION ACTIVITIES OUTSIDE OF REGULAR CLASSROOM INSTRUCTION PROVIDED BY SCHOOL DIVISIONS
An X indicates that a division provides the service.

	Nutrition Education	Family Planning	Substance Abuse Education	Family Life Education	Psychological/ Emotional Health Promotion	General Health Education/ Instruction	Sexually Transmissible Disease Education	Safety/ Accident Prevention	Others
COUNTIES (cont.)									
Shenandoah	X		X	X	X	X		X	X
Smyth				X	X				
Southampton	X	X	X			X	X	X	
Spotsylvania			X			X		X	
Stafford		X	X	X	X		X	X	
Surry	Survey not returned.								
Sussex	X		X			X		X	
Tazewell	X		X	X		X	X	X	X
Warren		X	X				X		
Washington	X						X	X	
Westmoreland				X					
Wise	X	X	X	X	X	X	X	X	
Wythe									
York	X		X		X				
CITIES									
Alexandria	X	X	X	X	X	X	X	X	X
Bristol	Survey not returned.								
Buena Vista	X	X	X	X	X	X	X	X	
Charlottesville									
Chesapeake	X		X		X				
Colonial Heights									
Covington	X		X			X		X	
Danville	X	X	X		X	X	X		
Falls Church						X		X	
Franklin City	X		X	X	X	X	X	X	X
Fredericksburg	X	X	X	X	X	X	X		
Galax					X				
Hampton			X	X			X		X
Harrisonburg	X	X	X		X	X	X	X	
Hopewell	X		X					X	
Lexington			X					X	
Lynchburg	X	X	X	X	X		X	X	
Manassas									
Manassas Park	X	X	X	X	X	X	X	X	
Martinsville									
Newport News	--	--	X	X	X	X	X	X	X

HEALTH PROMOTION ACTIVITIES OUTSIDE OF REGULAR CLASSROOM INSTRUCTION PROVIDED BY SCHOOL DIVISIONS
An X indicates that a division provides the service.

	Nutrition Education	Family Planning	Substance Abuse Education	Family Life Education	Psychological/ Emotional Health Promotion	General Health Education/ Instruction	Sexually Transmissible Disease Education	Safety/ Accident Prevention	Others
CITIES (cont.)									
Portsmouth	X	X	X	X	X	X	X	X	X
Radford	X	X	X	X	X	X	X	X	
Richmond City	X	X	X		X	X	X	X	
Roanoke City				X					
Salem	X		X	X	X		X	X	X
Staunton	X	X	X	X	X	X	X	X	
Suffolk	X		X		X	X	X	X	
Virginia Beach	X		X	X		X	X	X	X
Waynesboro			X					X	
Williamsbg/James Cty	X	X	X	X	X	X	X	X	
Winchester			X	X		X		X	X
TOWNS									
Cape Charles	X		X	X		X	X	X	
Colonial Beach									
Fries	X		X		X	X	X	X	
West Point	X		X	X	X		X	X	

HEALTH CARE ACTIVITIES PROVIDED BY SCHOOL DIVISIONS
An X indicates that a division provides the service.

COUNTIES	Dental Care	Health Counseling	Acute Illnesses Care	Administration of Medication	Communicable Disease Control	First Aid/ Emergency Care	Substance Abuse Counseling	Guidance for Pregnant Students	Psychological Counseling	Speech Therapy	Physical Therapy	Occupational Therapy	Others
Accomack		X				X	X	X	X	X		X	
Albemarle	X	X	X	X	X	X	X	X	X	X	X	X	
Alleghany Highlands		X		X		X	X	X	X	X	X	X	
Amelia		X	X	X	X	X	X			X	X	X	
Amherst		X	X	X	X	X	X	X	X	X	X	X	
Appomattox	X	X	X	X	X	X		X		X	X		
Arlington		X	X	X	X	X	X	X	X	X	X	X	
Augusta					X	X	X						
Bath	X		X	X	X	X	X	X	X	X	X		
Bedford	X	X				X		X					
Bland	X		X	X	X	X	X	X	X	X	X		
Botetourt	X	X				X	X	X	X	X			
Brunswick	X	X		X	X	X	X	X	X	X	X	X	
Buchanan		X	X	X	X	X	X	X	X	X			
Buckingham				X				X		X			
Campbell	X			X		X				X	X	X	
Caroline	X	X	X	X	X	X	X	X	X	X	X	X	
Carroll	X	X	X	X	X	X				X	X		
Charles City	X			X						X			
Charlotte				X		X	X	X		X			
Chesterfield	X	X	X	X	X	X	X	X	X	X	X	X	
Clarke	X	X	X	X	X	X	X		X	X	X	X	
Craig	X	X		X	X	X	X	X		X			
Culpeper	X	X	X	X	X	X	X	X	X	X	X		
Cumberland	X					X		X		X			
Dickenson		X		X	X	X	X	X	X	X			
Dinwiddie	X	X	X			X			X	X	X	X	
Essex		X		X	X	X	X		X	X	X	X	
Fairfax	X	X	X	X	X	X	X	X	X	X	X	X	
Fauquier	X	X		X	X	X		X	X	X	X		
Floyd	X	X			X	X		X		X	X		
Fluvanna				X		X	X	X	X	X	X	X	
Franklin	X	X	X	X	X	X		X	X	X			
Frederick	X	X	X	X	X	X	X	X	X	X	X	X	X
Giles	X	X	X	X	X	X	X	X		X	X		
Gloucester		X	X	X	X	X	X	X	X	X	X	X	
Goochland		X	X	X	X	X	X	X	X	X	X	X	

HEALTH CARE ACTIVITIES PROVIDED BY SCHOOL DIVISIONS

An X indicates that a division provides the service.

	Dental Care	Health Counseling	Acute Illnesses Care	Administration of Medication	Communicable Disease Control	First Aid/ Emergency Care	Substance Abuse Counseling	Guidance for Pregnant Students	Psychological Counseling	Speech Therapy	Physical Therapy	Occupational Therapy	Others
COUNTIES (cont.)													
Halifax/South Boston			X	X		X			X	X	X	X	
Hanover		X	X	X	X	X	X	X	X	X	X	X	
Henrico	Survey not returned.												
Henry	X	X	X	X	X	X	X	X	X	X	X	X	
Highland	X			X	X	X				X			
Isle of Wight	X	X	X	X	X	X	X	X	X	X	X	X	
King George		X	X	X	X	X	X	X	X	X	X	X	
King and Queen	X	X	X	X	X	X	X	X	X	X	X	X	
King William	X	X		X		X	X	X	X	X	X	X	X
Lancaster		X					X	X	X	X	X	X	
Lee	X								X	X			
Loudoun	X	X	X	X	X	X	X	X	X	X	X	X	
Louisa	X	X		X		X	X	X	X	X	X	X	
Lunenburg	X					X	X	X	X	X			
Madison				X		X	X	X		X			X
Mathews	X	X		X	X	X		X		X		X	
Mecklenburg									X	X	X		
Middlesex		X					X	X	X	X	X		
Montgomery		X	X	X		X	X	X		X	X	X	
Nelson	X	X		X	X	X	X	X	X	X	X	X	
New Kent	X	X	X	X	X	X	X	X	X	X	X	X	
Northampton	X	X	X	X	X	X		X	X	X	X	X	
Northumberland	X	X	X	X	X	X	X	X	X	X	X	X	X
Nottoway		X	X	X	X	X	X	X	X	X	X		
Orange	X						X			X	X	X	
Page	X	X	X	X	X	X	X	X	X	X	X	X	
Patrick		X	X	X		X	X	X	X	X			
Pittsylvania	X	X			X	X	X	X		X	X	X	
Powhatan		X		X		X	X	X	X	X	X	X	
Prince Edward		X	X	X	X	X	X	X	X	X	X		
Prince George	X				X	X			X	X		X	
Prince William		X		X	X	X	X	X	X	X	X	X	
Pulaski	X	X	X	X	X	X		X		X	X	X	
Rappahannock				X				X	X	X	X		
Richmond		X	X	X		X	X	X	X	X	X	X	
Roanoke		X	X	X	X	X	X	X	X	X	X	X	
Rockbridge		X				X	X	X	X	X	X	X	
Rockingham	X	X		--	--								

HEALTH CARE ACTIVITIES PROVIDED BY SCHOOL DIVISIONS

An X indicates that a division provides the service.

	Dental Care	Health Counseling	Acute Illnesses Care	Administration of Medication	Communicable Disease Control	First Aid/ Emergency Care	Substance Abuse Counseling	Guidance for Pregnant Students	Psychological Counseling	Speech Therapy	Physical Therapy	Occupational Therapy	Others
COUNTIES (cont.)													
Shenandoah	X	X	X	X	X	X	X	X	X	X	X	X	X
Smyth	X	X		X	X	X	X	X	X	X	X		
Southampton		X	X		X	X			X	X	X		
Spotsylvania	X	X	X	X	X	X	X	X	X	X	X	X	
Stafford	X	X	X	X	X	X	X	X	X	X	X	X	
Surry	Survey not returned.												
Sussex		X			X	X	X	X		X			
Tazewell	X	X	X	X	X	X	X	X	X	X	X		X
Warren	X	X	X	X	X	X	X	X	X	X	X	X	
Washington	X	X		X	X	X				X	X		
Westmoreland		X		X	X	X	X	X	X	X	X	X	
Wise	X	X		X	X	X		X	X	X	X		
Wythe	X						X	X	X	X	X	X	
York	X	X	X	X	X	X	X	X	X	X			
CITIES													
Alexandria		X		X	X	X	X	X	X	X	X	X	
Bristol	Survey not returned.												
Buena Vista	X	X	X	X	X	X	X	X	X	X	X	X	
Charlottesville		X	X	X			X	X		X	X	X	
Chesapeake	X	X	X	X	X	X		X	X	X	X	X	X
Colonial Heights		X		X	X	X	X	X	X	X	X	X	
Covington	X	X					X	X	X	X	X	X	
Danville		X	X	X	X	X	X			X	X	X	
Falls Church	X	X	X	X	X	X	X	X	X	X	X	X	
Franklin City	X	X	X	X	X	X	X	X		X	X	X	
Fredericksburg	X	X	X	X	X	X				X			
Galax	X	X	X	X	X	X	X	X	X	X	X		
Hampton		X	X	X	X	X	X	X	X	X	X	X	
Harrisonburg	X	X	X	X	X	X	X	X	X	X	X	X	
Hopewell	X	X	X	X	X	X	X	X		X	X	X	
Lexington	X	X		X		X	X		X	X	X		
Lynchburg	X	X		X	X	X	X	X	X	X	X	X	
Manassas				X		X	X	X	X	X	X	X	
Manassas Park	X	X		X	X	X	X	X	X	X	X	X	
Martinsville		X	X	X	X	X	X	X	X	X	X	X	
Newport News	X	X	X	X	X	X	X	X	X	X	X	X	X

HEALTH CARE ACTIVITIES PROVIDED BY SCHOOL DIVISIONS
An X indicates that a division provides the service.

	Dental Care	Health Counseling	Acute Illnesses Care	Administration of Medication	Communicable Disease Control	First Aid/ Emergency Care	Substance Abuse Counseling	Guidance for Pregnant Students	Psychological Counseling	Speech Therapy	Physical Therapy	Occupational Therapy	Others
CITIES (cont.)													
Portsmouth	X	X	X	X	X	X		X	X	X	X	X	X
Radford		X				X	X	X	X	X	X		
Richmond City		X	X	X	X	X		X	X	X	X	X	
Roanoke City	X	X	X	X		X		X	X	X	X	X	
Salem	X	X	X	X	X		X	X	X	X	X	X	X
Staunton													
Suffolk	X	X	X	X	X	X	X	X	X	X	X	X	X
Virginia Beach	X	X	X	X	X	X	X	X	X	X	X	X	
Waynesboro								X		X	X	X	
Williamsbg/James Cty	X	X	X	X	X	X	X	X	X	X	X	X	X
Winchester		X	X	X	X	X	X	X		X		X	
TOWNS													
Cape Charles	X	X		X	X	X	X	X					
Colonial Beach	X			X	X		X	X	X	X	X	X	
Fries	X				X	X				X			X
West Point	X	X	X	X	X	X	X	X		X	X	X	

PRESENTERS TO THE SECRETARY'S TASK FORCE ON THE HEALTH NEEDS OF SCHOOL-AGE CHILDREN

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