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

IN THE HOUSE OF REPRESENTATIVES

MAY 7, 2003

Mr. STEARNS (for himself, Mr. KENNEDY of Rhode Island, Mr. TOWNS, Mr. BARTON of Texas, Mr. ISSA, Mrs. CHRISTENSEN, and Mr. SMITH of New Jersey) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Asthmatic Schoolchildren's Treatment and Health Management Act of 2003".

SEC. 2. FINDINGS.

The Congress finds the following:

(1) Asthma is a chronic condition requiring lifetime, ongoing medical intervention.

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

(3) In 2001, 20,300,000 Americans had asthma; 6,300,000 children under age 18 had asthma.

(4) The prevalence of asthma among African-American children was 40 percent greater than among Caucasian children, and more than 26 percent of all asthma deaths are in the African-American population.

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

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

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

(8) Asthma is the most common cause of missed school days, accounting for approximately 14,000,000 missed school days annually.

(9) Working parents of children with asthma lose an estimated $1,000,000,000 a year in productivity.

(10) At least 18 States have legislation protecting the rights of children to carry and self-administer asthma metered-dose inhalers, and at least 8 States expand this protection to epinephrine auto-injectors.

(11) Mere guidelines do not necessarily protect the rights of children in every school—tragic refusals of schools to permit students to carry their inhalers and auto-injectable epinephrine have occurred, some resulting in death and spawning litigation.

(12) Schools that restrict or revoke the rights of children to carry such inhalers and auto-injectable epinephrine put themselves and students with asthma and severe allergic reactions, including anaphylaxis, at risk of death. Such schools also put other students at risk of witnessing a potentially life-threatening asthma attack.

(13) School district medication policies must be developed with the safety of all students in mind. Easy access to and correct use of asthma inhalers are necessary to avoid serious respiratory complica-

tions secondary to acute exacerbation and to improve the quality of life of students with asthma.

(14) No school should interfere with the patient-physician relationship.

(15) Anaphylaxis, or anaphylactic shock, is a systemic allergic reaction that can kill within minutes. Anaphylaxis occurs in some asthma patients. According to the American Academy of Allergy, Asthma, and Immunology, people who have experienced symptoms of anaphylaxis previously are at risk for subsequent reactions and should carry an epinephrine auto-injector with them at all times, if prescribed.

(16) Because asthma is a condition that often arises from allergies, it is critical to include anaphylaxis in asthma treatment. Specifically, the respiratory problems that arise during an asthma attack usually occur because of a reaction to certain allergens, including dust, pollen, molds, and specific foods.

(17) An increasing number of students and school staff have life-threatening allergies. Exposure to the affecting allergen can trigger anaphylaxis. Anaphylaxis requires prompt medical intervention with an injection of epinephrine.

(18) Avoidance, early recognition, and prompt treatment are essential to the management of life-threatening allergies. There are students and school staff who have known life-threatening allergies, and those who have not been identified. Prompt intervention with epinephrine is vital to saving lives.

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

(a) PREFERENCE.—The Secretary of Health and Human Services, in making any grant that is asthma-related (as determined by the Secretary) to a State educational agency or a local educational agency, shall give preference to any State educational agency or local educational agency that is located in a State that satisfies the following:

(1) IN GENERAL.—The State must require that each elementary school and secondary school (whether public or nonpublic) in that State will grant to any student in the school an authorization for the self-administration of medication to treat that student's asthma or anaphylaxis, if—

(A) a health care practitioner prescribed the medication for use by the student during

school hours and instructed the student in the correct and responsible use of the medication;

(B) the student has demonstrated to the health care practitioner (or such practitioner's designee) and the school nurse (if available) the skill level necessary to use the medication and any device that is necessary to administer such medication as prescribed;

(C) the health care practitioner formulates a written treatment plan for managing asthma or anaphylaxis episodes of the student and for medication use by the student during school hours; and

(D) the student's parent or guardian has completed and submitted to the school any written documentation required by the school, including the statement required by paragraph (5)(B) and the treatment plan formulated under subparagraph (C) of this paragraph.

(2) SCOPE.—An authorization granted under paragraph (1) must allow the student involved to possess and use his or her medication—

(A) while in school;

(B) while at a school-sponsored activity;

(C) during normal before-school and after-school activities, such as before-school or after-school care on school-operated property; and

(D) in transit to or from school or school-sponsored activities.

(3) DURATION OF AUTHORIZATION.—An authorization granted under paragraph (1)—

(A) must be effective only for the school year for which it is granted; and

(B) must be renewed by the parent or guardian each subsequent school year in accordance with this section.

(4) STATE ACTION ON LIABILITY.—As an additional condition on receipt of a preference by a State educational agency or a local educational agency under this subsection, the State must address the potential liability of schools (including employees and agents of schools), parents, and guardians for any injury to a student or other individual resulting from the use or attempted use of the student's asthma or anaphylaxis medication. In addressing liability under this paragraph, a State must consult with stakeholders and interested parties, such as parents, representatives from education and health organizations and agencies (including the State board of edu-

cation, the State school board association, the State teacher association, the State medical association, and the State nurses association), and others in the educational or medical community.

(5) SCHOOL ACTION ON LIABILITY, INDEMNIFICATION.—A condition for an authorization under paragraph (1) is that, except for willful and wanton conduct—

(A) the school must, in writing, inform the parent or guardian of the student that the school (including its employees and agents) is to incur no liability as a result of any injury arising from self-administration of medication within the scope described in paragraph (2); and

(B) the parent or guardian of the student must sign a statement acknowledging that notwithstanding any provision of State law to the contrary—

(i) the school (including its employees and agents) is to incur no liability as a result of any injury arising from such self-administration of medication; and

(ii) the parent or guardian must indemnify and hold harmless the school (in-

cluding its employees and agents) against any claim arising out of such self-administration of medication.

(6) BACKUP MEDICATION.—The State must require that backup medication, if provided by a student's parent or guardian, be kept at a student's school in a location easily accessible to the student in the event of an asthma or anaphylaxis emergency.

(7) MAINTENANCE OF INFORMATION.—The State must require that information described in paragraphs (1)(C) and (1)(D) be kept on file at the student's school in a location easily accessible in the event of an asthma or anaphylaxis emergency.

(b) DEFINITIONS.—For purposes of this section:

(1) The terms ''elementary school'' and ''secondary school'' have the meaning given to those terms in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(2) The term ''health care practitioner'' means a person authorized under law to prescribe drugs subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)).

(3) The term ''medication'' means a drug as that term is defined in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321) and

includes inhaled bronchodilators, inhaled corticosteroids, and auto-injectable epinephrine.

(4) The term ''Secretary'' means the Secretary of Health and Human Services.

(5) The term ''self-administration'' means a student's discretionary use of his or her prescribed asthma or anaphylaxis medication, pursuant to prescription or written direction from a health care practitioner.

SEC. 4. SENSE OF CONGRESS REGARDING CDC'S STRATEGIES FOR ADDRESSING ASTHMA WITHIN A COORDINATED SCHOOL HEALTH PROGRAM.

(a) FINDINGS.—The Congress finds as follows:

(1) Possession and administration of medication is only 1 component of asthma and anaphylaxis management.

(2) The Centers for Disease Control and Prevention has identified 6 strategies for addressing asthma within a coordinated school health program. These strategies consist of the following:

(A) Establishing management and support systems for asthma-friendly schools.

(B) Providing appropriate school health and mental health services for students with asthma.

(C) Providing asthma education and awareness programs for students and school staff.

(D) Providing a safe and healthy school environment to reduce asthma triggers.

(E) Providing safe, enjoyable physical education and activity opportunities for students with asthma.

(F) Coordinating school, family, and community efforts to better manage asthma symptoms and reduce school absences among students with asthma.

(3) Providing appropriate school health and mental health services for students with asthma includes the following:

(A) Obtaining a written asthma action plan for all students with asthma, which plan—

(i) should be developed by a primary care provider and provided by parents; and

(ii) should include individualized emergency protocol, medications, peak flow monitoring, environmental triggers, and emergency contact information.

(B) Sharing the plan with appropriate faculty and staff in accordance with guidelines

under section 444 of the General Education Provisions Act (20 U.S.C. 1232g; commonly referred to as the ''Family Educational Rights and Privacy Act of 1974'') or with parental permission.

(C) Ensuring that—

(i) at all times students have options for immediate access to medications, as prescribed by a physician and approved by parents; and

(ii) specific options, such as allowing students to self-carry and self-administer medications, are determined on a case-by-case basis with input from the physician, parent, and school.

(D) Using standard emergency protocols for students in respiratory distress if they do not have their own asthma action plan.

(E) Ensuring that case management is provided for students with frequent school absences, school health office visits, emergency department visits, or hospitalizations due to asthma.

(F) Providing a full-time registered nurse all day, every day for each school.

(G) Ensuring access to a consulting physician for each school.

(H) Referring students without a primary care provider to child health insurance programs and providers.

(I) Providing and coordinating school-based counseling, psychological, and social services for students with asthma, as appropriate.

(J) Coordinating with community services.

(b) EXPRESSION OF SUPPORT.—The Congress supports the goals and ideals of the strategies identified by the Centers for Disease Control and Prevention for addressing asthma within a coordinated school health program.

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