History of the School Health Program in North Carolina

North Carolina takes the position that health and education are interdependent; therefore, the identification of health-related barriers to learning are crucial to the provision of an appropriate educational plan for every student. To meet that objective, North Carolina has instituted comprehensive school health services in every school district. Through the work of the North Carolina Division of Public Health, the North Carolina Division of Child and Family Well-Being, the North Carolina Department of Public Instruction, local health departments, Public School Units (PSU), and local hospitals/heath alliances/non-profits, the state makes comprehensive school health services a priority.

School Nursing

School nursing in North Carolina has evolved along the same path created by the public health nurses in New York City, credited as being the first school nurses in this country. From the early days of school nursing in the United States, the school health program has been part of public health nursing. The history of school nursing in North Carolina reflects that partnership.

Early History of Public Health in North Carolina

During the 1870s, a typhoid epidemic swept the country. State boards of health were created to limit the destruction of lives that the epidemic created. Through the efforts of Dr. Thomas Fanning Wood of Wilmington, the North Carolina Legislature passed a law in 1877 creating the North Carolina State Board of Health. By 1909, one of its divisions was Preventive Medicine and Hygiene. In 1915, Dr. George M. Cooper of Clinton was appointed Director of the Bureau of Rural Sanitation on the executive staff of the State Board of Health, a position that led to his later becoming Director of the Division of Preventive Medicine and Hygiene.

Dr. Cooper realized the need for a system of medical inspection of school children in elementary grades. He arranged to have inspections done during the school term with funds obtained from county authorities, private donations and social agencies. He wrote the law, enacted by the legislature in 1919, providing for periodic inspection of school children and an appropriation for the salaries of ‘agents’. The term ‘agent’ applied to physicians, dentists, teachers, and nurses. Dr. Cooper’s idea was to appoint capable, well-trained graduate nurses for the work of school inspections because they could reach mothers and teachers and would cooperate with physicians in private practice.

First School Nurses in North Carolina

As early as 1772, a North Carolina city, Salem, delivered public health services through a city health department, with a physician, midwife and nurses. Greensboro, in Guilford County, holds the distinction of having established the first county health department in the United States in 1911. In 1919, only 20 counties in the state had either a city or county health department. North Carolina's local health department system was similar to that in other cities and counties across the nation.

The first recorded school nursing in the state was offered by the Wayside Workers of the Home Moravian Church in East and West Salem Schools in 1911. This began a movement whereby various benevolent societies, civic organizations and public-spirited citizens marshalled forces to provide services for school-aged children. In 1915, the Durham City School Board employed a nurse, and in 1919, Guilford County hired two nurses to work in schools to improve management of contagious diseases.

Six nurses who were hired to work in the School Health Supervision Subdivision of the North Carolina Division of Preventive Medicine and Hygiene in 1919 are recognized as being the forerunners of school nurses in North Carolina. The school nurse movement in North Carolina was largely due to the splendid efforts of these first six nurses. "They traveled on foot, horseback, on rafts, by boat, tram cars, ox-carts – any way to reach the 'forgotten' child" (Wyche, 2011, p. 118). They worked in practically every county in the state, performing common health functions of the day: Weighing and measuring children, testing vision and hearing, examining teeth and throats, taking family and child histories relative to immunization status, and assessing for the presence of communicable diseases.

By 1922, school health efforts turned to correcting identified defects. Dr. Cooper instituted two new programs: Teaching oral hygiene and organizing tonsil and adenoid clinics. Six dentists gave demonstrations throughout the counties, using portable equipment to teach oral hygiene to school children. These efforts provided the impetus for the later development of a Dental Health Section in the State Board of Health. The nurses were instrumental in organizing the tonsil and adenoid clinics under the directions of eye, ear, nose and throat specialists. This clinic service continued for 12 years.

Early Coordinated School Health

During Dr. Cooper's tenure, the State Department of Public Instruction and the State Board of Health cooperated on behalf of school children. Not until Charles E. Spencer was hired by the Department of Public Instruction in 1938 was serious concern and planning for health and physical education manifested. A $50,000 Rockefeller Board grant in 1939 funded the North Carolina School Health Coordinating Services, an advisory committee, to organize the school health program. Field work was initiated, and additional grants made workshops and consultants a reality. In 1947, the school health program expanded statewide and involved health and physical education, concern for a healthy environment, and health services. The School

Health Coordinating Service Committee also produced and distributed curriculum guides to schools.

Additional impetus was given to the development of the School Health Program in 1949 by a General Assembly appropriation of $55,000 for each year of the biennium to establish a Joint School Health Service Program of the State Board of Education and the State Board of Health. The School Health Coordinating Service Committee served as the designated administrative unit for the two departments in the Joint School Health Plan developed by the two agencies in 1949.

From 1949 on, the General Assembly appropriated funds ('School Health Funds') annually to the State Board of Education to be allocated to local school administrative units for school health services. In the early years of the School Health Coordinating Service Committee the funds were used for public health nurse salaries, physician services for health assessment, and treatment for the correcting of chronic remediable defects. However, the Budget Appropriation Act for the Biennium 1957-59 stipulated that "not less than 90 percent of the expenditures out of the appropriations for each year made to the State Board of Education under Nine Months School Fund for Child Health Program shall be expended for diagnosis and the correction of chronic remediable physical defects of public school children. An amount not in excess of 10 percent of the appropriation for each year may be expended for case finding, health education, and intensive follow-up services."

This legislation affected the existing pattern of school health service delivery in North Carolina because the 'Fund' could no longer be used to subsidize nurse salaries for needed case finding and follow-up services. Nursing was a necessary component of the Child Health Program for the Board of Education. The health service program, financed by school health funds, constituted a small part of the total school health program carried on by schools and health departments in 1957.

From 1949-1957, the General Assembly did not appropriate monies requested for the State Board of Health's general fund for aid to local health departments. However, the State Board of Health allocated about $330,000 for school health services each year.

Effect of Special Education of Children on School Health Programs

In 1963, the School Health Coordinating Service Committee published a guide for planning a total school health program entitled "Health Services in Our Public Schools." Its contents indicated that the State Board of Education and the State Board of Health were still planning together to provide for a school health program. Within five years, however, this committee was dissolved.

The dissolution of the committee may have been partially due to new directions from federal legislation and federal funding for school health services directed to Boards of Education. For example, the Elementary and Secondary Education Act (ESEA) was passed in 1965 and

was implemented in North Carolina in 1966. The act provided funds for nurses and other educational support service professionals to work with educationally and emotionally deprived children of school age. This included Native American and migrant children who were considered to have special educational needs. The act also provided funding for the support of instructional activities for the children identified as educationally disadvantaged. Under Title VI-B of ESEA, "funds were provided for initiation, expansion and improvement of programs and services for physically and mentally handicapped children at the preschool and elementary level." The Education of the Handicapped Act (PL. 94-142) incorporated Title VI-B of ESEA and broadened as well as strengthened the mandates of Boards of Education for implementation.

During the 1973 session of the North Carolina General Assembly (2nd session 1974), legislators ratified "An Act to Establish Equal Educational Opportunities in the Public School; and For Other Purposes." This bill transferred administration of the School Health Fund from the Department of Public Instruction to the Department of Human Resources. From July of 1974 until September 1999, the School Health Fund was used for the prevention, as well as the diagnosis and correction, of chronic, remediable physical defects of public-school children. Provision was made for the purchase of medications for eligible children when there was no other funding resource. The School Health Fund was not used for personnel salaries.

In 1977, the General Assembly enacted legislation that became the framework for the development of a North Carolina State Plan for the implementation of PL 94-142. The bill defined the exceptional child, provided funding for educational support services personnel, spelled out protocols for identification and placement in the development of the educational placement plan, and called for parent involvement in the development of the educational placement plan. Rules were developed by the North Carolina Department of Public Instruction's Division for Exceptional Children. The rules called for the identification of these children through a community 'Child Find' and referral mechanism.

In 1986, the United States Congress passed the Amendments to the Equal Education of the Handicapped Act (PL 99-457) and additional amendments in 1991 through, the Individuals with Disabilities Education Act (IDEA) (PL 102-119). This new law reaffirmed all of the special education entitlement of PL 94-142 passed in 1976, but extended age eligibility down to birth. Two new programs emerged: The Infant and Toddler Grant Program (Part C), serving children birth to three years: and the Preschool Grant Program (Part B), serving children three to five. The Department of Public Instruction was chosen as the lead agency for The Preschool Grant Program (Part B) of Public Law 99-457 and implemented it in the 1991-92 school year. This program provides non-discriminatory testing, placement in the least restrictive environment, individualized education programs, related support services, and procedures for due process for children aged three to five.

North Carolina School Health Program Progress

In 1978, the North Carolina General Assembly ratified An Act to Establish a Statewide School Health Education Program Over a Ten-year Period. This bill defined what was meant by 'comprehensive school health education' and assigned responsibilities to the State Board of Education, the State Department of Public Instruction, and local educational administrative units for the development of a health education program for kindergarten through ninth grade. It called for the creation of a State School Health Education Advisory Committee and local school health education coordinators for each county. The following year, on February 16, 1979, the General Assembly ratified An Act to Rewrite the Immunization Law. This bill listed immunizations required by the Commission for Health Services and assigned responsibility for the enforcement of the rules to the Department of Human Resources. The bill also required that a **certificate of immunizations** indicating that the child had received all of the immunizations required by the General Statute 130-87 be presented to day-care facilities or schools as a condition for school attendance (K-12) by the 1980-81 school year.

During 1979, state legislators passed several other bills with implications for school health:

- **An Act to Provide Sports Medicine and Emergency Paramedical Services and Emergency Life Saving Skills to Students in the Public Schools.**

  This bill:
  - appropriated monies for the provision of sports medicine and paramedical life-saving services, and
  - appropriated monies for the in-service educational training of public-school personnel for the development of sports medicine and emergency paramedical skills.

- **An Act for the Defense of Certain Public-School Employees.**

  This bill:
  - defined the scope of duty of teachers to provide some medical care.
  - provided for legal defense mechanisms for public school employees against whom claims, or civil actions are commenced for personal injury because of an act done or omission made in the course of duties under General Statute 115C-307.
  - enabled public school employees when given such authority by the Board of Education or its designee, to:
    - administer drugs or medications prescribed by a doctor upon written request of parents.
    - give emergency health care when circumstances indicate that delay might seriously worsen the physical condition or endanger the life of the pupil.
    - perform any other first aid or life saving techniques in which the employee has been trained in a program approved by the State Board of Education.

The **Basic Education Plan (BEP)**, enacted by the legislature in 1985, made sweeping changes in North Carolina's education program. The plan spelled out the education that was to be available to every student in the state. The BEP described a program of instruction that included

traditional curricula as well as 'healthful living.' The program included support services such as guidance, health and psychological services; staff ratios; staff development; and facilities standards. The plan set a state-funding ratio for student support service positions, which included nurses. According to the BEP formula, there was to be one school nurse per 3,000 average daily membership (ADM) with at least one nurse per county funded by the state. The BEP formula for school nurses has not been changed since its enactment.

A **Kindergarten Health Assessment** (§ 130A-440) bill was ratified on May 1, 1987 with an effective date of January 1, 1988. That Legislation stated that every child who entered kindergarten in the public schools was required to have a health assessment, the results of which were sent to the school. Principals were made responsible for reporting to the State the number of kindergarten students meeting (or not meeting) this requirement. Exclusions from school resulted when a health assessment was not received within the designated time frame.

Progress for School Nursing

In the fall of 1991, the North Carolina State Board of Education adopted a policy requiring all newly employed school nurses to hold national school nurse certification through either the American Nurses Association or the National Association of School Nurses. The policy became effective July 1, 1993. The policy allows local education agencies (LEAs) to employ, if necessary, uncertified nurses; however, they must be hired with the stipulation that they become nationally certified within three years of their hire date. (Note: As of 2010, national certification for school nurses is available through the American Nurses Credentialing Center [ANCC] for renewals only and the National Board for Certification of School Nurses [NBCSN] for both renewals and new certification.)

A state salary schedule acknowledging both national certification and years of nursing experience was implemented in 1993. Beginning with the 1998-99 school year, certified school nurses employed by the public schools were paid on the 'G' salary schedule. Until national certification is attained, the nurse's salary is assigned according to the non-certified nurse schedule. During the 2001 Session the General Assembly changed the requirements for the national certification of school nurses. The language allowed school nurses employed in the public schools prior to July 1, 1998 to avoid requirement for national certification in order to continue employment. "School nurses not certified by the American Nurses Credentialing Center or the National Board for Certification of School Nurses shall continue to be paid based on the non-certified nurse salary range as established by the State Board of Education."

By 1992, there was sufficient interest among nurses employed in school nursing to form an organization that would advance the goals of school health in North Carolina. The **School Nurse Association of North Carolina (SNANC)** was organized in that year to provide an opportunity for school nurses to:

- network with other school nurses.
- obtain professional resources, including continuing education; and
- advocate for quality school health services.

The members later formed regional groups to provide local networking. They also created a link between the SNANC Executive Board and the ANANC (American Nurses Association of NC) and to the National Association of School Nurses (NASN).

In response to continued growth in the numbers of students with special health care needs, including those who were technology dependent, the North Carolina State Board of Education adopted a policy entitled '**Special Health Care Services.'** This policy, enacted on July 1, 1995, required each local school district to make a registered nurse available for assessment, care planning, and ongoing evaluation of students with special health care needs in the school setting.

In 1992, the General Assembly appropriated funds for Comprehensive Adolescent Health Care Projects in the form of **school-based and school-linked health centers.** These health centers are located on a school campus (school-based) or affiliated with schools in the community (school-linked). They employ a variety of professional health care providers to increase adolescents' accessibility to primary care, mental health, nutrition, health risk education counseling and preventive health services. Most are sponsored by a health care organization. The health centers in schools are established after broad-based community planning and endorsement and require informed, written parent permission prior to a student's participation. By the end of 2008, there were more than 50 school-based and school-linked health centers located across the state.

The School Health Nurse Consultant Team

In 1995, the state agency then known as the North Carolina Department of Environment, Health and Natural Resources (DEHNR) established regional **school nurse consultant** positions in addition to the central office **state school nurse consultant**. These regional consultants were placed in four DEHNR regions across the state. They were added to expand professional school nurse technical assistance to local health departments and LEAs and to augment the consultation provided by the state school nurse consultant. Two additional positions were added in the spring of 1997.

In 1996 after statewide organizational downsizing and restructuring, the Department of Environment, Health and Natural Resources underwent a change with the personal services programs of public health becoming part of a newly organized Department of Health and Human Services. In 1999, the Division of Public Health established the School Health Unit, which included the school health services programs as part of the Women's and Children's Health Section.

Coordinated School Health Programs Continue

In order to further promote the concept and work of coordinated school health services, North Carolina sought and received a grant from the Centers for Disease Control and Prevention (CDC) in 1998. Awarded to the Department of Public Instruction, the program, called NC Healthy Schools, supported the development of a planned and **coordinated school health**

program. The program consisted of eight components which included healthful school environment; health services; health education; physical education; counseling, psychological and social services; nutrition services; family and community involvement; and health promotion for staff. These components were represented to some extent in the state education agency, state health agency, and in local school districts. The program's design assisted in the development of an infrastructure (system of supports) at the state level that supported the prevention and reduction of health risks statewide through the establishment of coordinated school health programs at the local level. The five-year grant was renewed twice.

In 1998, the General Assembly enacted historic legislation to help thousands of uninsured children and adolescents get health insurance under the North Carolina Health Choice for Children program. Funded by the federal government and the state, this program provides free or low-cost health insurance to children whose families cannot pay for private insurance and who do not qualify for Medicaid. The legislation also provided for revision of the state's School Health Fund guidelines. The new funding priorities included: 1) base-funding for school-based and school-linked health centers, 2) provision of funds for emergency dental services, and 3) purchase of bulk medications.

In September 2002, a law addressing **'Guidelines to support and assist students with diabetes,' N.C.G.S. 115C-375.3,** was passed by the General Assembly. It required the State Board of Education to adopt guidelines for the development and implementation of individual diabetes care plans. The guidelines, written in consultation with the North Carolina Diabetes Advisory Council, reflected reference to the American Diabetes Association for the Management of Children with Diabetes in the School and Day Care Setting.

Dr. Leah Devlin, (the state health director at the time) created a **School Health Matrix Team** in 2002 to bring together all the Division of Public Health's resources dedicated to the health of students. The School Health Matrix Team formalized a system by which all of the Division's 'school health players' could work together around the CDC's eight-component model of coordinated school health to improve the health status of students. In close collaboration with the Department of Public Instruction, The Matrix Team sought to improve the health and academic achievement of students through strengthened school health programs and policies.

In January 2003, the State Board of Education adopted the '**Healthy Active Children'** policy (HSP-5-000). In order for the policy to be fully implemented as required by the 2006-07 school year, schools were expected to:

- conduct a needs assessment on health services and programs.
- provide an action plan to the North Carolina Department of Public Instruction by July 15, 2004; and
- provide progress reports by July 15, 2005 and 2006.

In February 2003, the rule was changed regarding the **emergency administration of epinephrine** to people suffering an adverse reaction to agents that might cause anaphylaxis. While previous legislation had limited the administration of emergency epinephrine to people suffering an adverse reaction to insect stings, the rule change expanded the causes of

anaphylaxis in individuals who could be eligible to receive emergency treatment. The revised rule continues to allow a physician to authorize other practitioners to train people to administer epinephrine, making the physician doing so responsible for signing the application forms of these trained individuals, prior to sending them to the North Carolina Office of Emergency Medical Services (OEMS). This process was termed 'credentialing.'

Addressing Challenges in School Health

Major changes in ensuing years dramatically affected the delivery of school health services**.** These included:

1) an increase in the number and severity of illnesses in students who attend school,
2) the marked increase of social morbidities such as substance abuse, homicide, suicide, child abuse and neglect, and violence,
3) psychosocial and developmental problems, such as Attention Deficit/Hyperactivity Disorder (ADHD), depression, and eating disorders,
4) the impact of immigration, homelessness, and diverse cultural and linguistic groups,
5) changes in family structure (divorce, remarriage, working parents), and
6) threats of bioterrorism.

School Nurse Funding Initiative

Over the years, North Carolina has worked toward improving support resources for students, including a number of attempts to improve the **school nurse-to-students** ratio. In 2003, the N.C. General Assembly requested a formal study regarding school health needs. A special provision was added to the budget that required the State Board of Education to review the standards for the number of school nurses recommended in the Basic Education Program and to determine whether these standards were being met by the local school administrative units. The State Board was also asked to compare the current standards with standards recommended by national health organizations to determine whether the current standards were adequate to meet the changing needs and demands for health services in the current and projected school populations. The State Board of Education made the following recommendations to the Joint Legislative Education Oversight Committee in February 2004:

- Expansion of school nurse services in order to reach a 1:750 ratio by the year 2014.
- Provision of a process for lead health officials of NC DPI and NCDHHS to collaborate and coordinate the successful planning and implementation of the recommendations for increased school nurse-to-students ratio.
- Sustaining of current DPI standards and definitions of school nursing; and
- Encouraging ongoing dialogue with the Joint Legislative Education Oversight Committee to identify sources of revenue for expanded school nurse services funding.

That spring, in 2004, the legislature appropriated funds for a **School Nurse Funding Initiative** (SNFI). The funds provided 65 time-limited school nurse positions over a two-year period and 80 permanent school nurse positions. In July 2006, the General Assembly assured that the 65 time-limited positions would be permanent, and appropriated funding to bring the total to 145 full time school nurse positions supported through the School Nurse Funding Initiative. In July 2007,

additional funds were appropriated for an added 66 school nurse positions; further funding in July 2009 and in July 2011 brought the total of school nurse positions funded by the SNFI allocation to 235.75 by the start of the 2011-2012 school year.

The SNFI funds authorization act stated that DHHS/DPH "shall provide funds to communities to hire school nurses" and that criteria for the awarding of funds would include determining areas of greatest need and greatest inability to pay for school nurses. The budget specified that the following would be part of the criteria:

1) current school nurse-to-students ratio,
2) economic status of the community, and
3) health needs of area children.

All funds were to be expended for salary, fringe benefits, and training for direct school nurse services. The allocation of the positions according to the criteria developed by NCDHHS/DPH and NC DPI increased the number of LEAs meeting the recommended ratio of one nurse to no more than 750 students from 10 in the 2003-2004 school year to 42 by end of 2012-2013.

Continued Provisions for the Health Needs of Students

In April 2005, a law addressing **possession and self-administration of asthma medication** by students with asthma or students subject to anaphylactic reactions, or both,' N.C.G.S. 115C-375.2, was passed by the General Assembly. It required the local boards of education to adopt a policy authorizing a student with asthma or a student subject to anaphylactic reactions, or both, to possess and self-administer asthma medication on school property during the school day, at school-sponsored activities, or while in transit to or from school or school-sponsored events.

More school nurses were provided by the State of North Carolina in 2006, when 100 school nurses were added as part of **Child and Family Support Teams** in the schools. The NC DPI funded initiative provided recurring state funds to team 100 school nurse positions with an equal number of school social workers at 103 schools in 21 school districts across the state. The purpose of the program was to provide school-based professionals to screen, identify and intervene for children who are potentially at risk of academic failure or out-of-home placement due to physical, social, legal, emotional, or developmental factors.

In June 2006, the Kate B. Reynolds Charitable Trust funded a **School-Based Case Management Project.** The goals of the project were to: (1) Improve academic and health outcomes for children with chronic illness enrolled in a school-based case management program, and (2) Evaluate research findings in relation to the role of the school nurse in providing school-based case management.

The project was initially conducted in five northeastern North Carolina counties (Dare, Pamlico, Perquimans, Pitt, and Washington) in collaboration with East Carolina University, College of Nursing and the NC Department of Health and Human Services, Division of Public Health, Children and Youth Branch.

The study began during the 2006-2007 academic year. Its work has been chronicled in the ***Journal of School Nursing*** and its success led to additional funding for three years, to implement similar work in an additional number of counties throughout the state. The research and funding for the project concluded at the end of the 2010-2011 school year, and elements of the N.C. School Nurse Case Management Project have become parts of standard practice in North Carolina school nursing activities.

In July 2007, North Carolina joined the majority of states in enacting **tobacco-free policies** in schools and on school grounds. The new law required local boards of education to adopt, implement, and enforce a written policy prohibiting at all times the use of any tobacco product by any person in school buildings, in school facilities, on school campuses, and in or on any other school property owned or operated by the local school administrative unit by August 1, 2008. Less than two years later, January 1, 2010, all public restaurants and bars were also smoke-free by state law.

A major rewrite of the law that laid out how schools would approach **sexual health education** was passed in 2009 and took effect during the 2010-2011 school year. In addition to continuing to teach students abstinence from sexual activity outside of marriage, the **Healthy Youth Act** required that lessons starting in 7th grade would also include information about sexually transmitted infections, safety and effectiveness of FDA-approved contraceptive methods, and awareness of sexual assault and sexual abuse, with approaches to reducing such risks. The law also removed the requirement that school districts must hold a public hearing before engaging in comprehensive sexual health education, but parents could preview the curriculum and materials and could choose to withdraw a child from the instruction.

The death and/or serious disability of some student athletes following head injuries resulted in passage of the **Gfeller-Waller Concussion Act** in 2011. Named after two high school students who suffered post-concussion head injuries that resulted in death, the law governs eligibility to return to practice or games following concussions.

In August 2011, Session Law 2011-164/Senate Bill 8 was approved, removing all limits on the number and enrollment increases of **charter schools** allowed in the state, lowering minimum enrollment numbers, and eliminating provisions that guard against schools being created to serve only specific subcategories of students (e.g. gifted students, students with disabilities, students of the same gender). Charter schools are tuition-free, independent public schools exempt from most of the rules, regulations, and statutes that apply to other public schools. In North Carolina, charter schools are vetted by an advisory council, approved by the State Board of Education, funded with taxpayer dollars, and are governed by private, nonprofit organizations.

As a result of Senate Bill 8 the number of charter schools approved each year has grown. In response, the Division of Public Health's School Health Unit expanded the School Health Consultant team to include a Charter School Health Program Consultant. The Charter School Health Consultant served as the initial point of contact for North Carolina charter schools for identification and assistance in accessing resources needed to meet student health and school health program needs. This position was also responsible for assuring charter school compliance with

mandated health services and related reporting requirements. The position was later converted to a nurse consultant position.

In 2013, the North Carolina Department of Public Instruction, Healthy Schools Section was awarded funding from the CDC related to **HIV/STD prevention** in schools and communities. The funding was provided to support efforts to conduct school-based surveillance on youth risk behaviors and school health policies and practices; implement school-based programs and practices designed to reduce HIV infection and other STDs among adolescents; and reduce disparities in HIV infection and other STDs among specific adolescent populations.

The Division of Public Health, Chronic Disease and Injury Section was simultaneously awarded funding from the CDC to support statewide implementation of cross-cutting approaches related to nutrition, physical activity and the management of chronic diseases, specifically asthma and diabetes in the school setting. Collaboration between these two projects was a funding requirement. As work continued related to this grant, the management of chronic diseases portion was removed beginning with the 2015-16 school year. This work was largely already a component of the service delivery for the School Health Unit Nurse Consultant team.

The objectives of the **Child and Family Support Teams** were viewed as institutionalized during the development of the 2013-2015 biennial budget process. As a result, administrative support and program requirements were eliminated during these two years and transitioned to maintenance at the local level.

In 2014, G.S. 115C-375.2A was amended to address '**A Supply of Emergency Epinephrine Auto-injectors on School Property**.' This statute provided for a minimum of two epinephrine autoinjectors for use by trained school personnel to provide emergency medical aid to individuals suffering from an anaphylactic reaction at school.

Beginning with school year 2016-17, House Bill 13 amended G.S. 130A-440 to change the NC Kindergarten Health Assessment to a **Health Assessment** requirement for each child who is presented for admission into kindergarten or a higher grade to NC public schools for the first time. The form used to transmit required information to the school was also modified to be compliant with information included in the bill.

On November 3, 2016, the State Board of Education adopted a resolution establishing the **Whole School, Whole Community, Whole Child (WSCC) model** as the framework for supporting the health behaviors and academic performance of students. The WSCC model was encouraged for adoption by all LEAs and School Health Advisory Councils and provided the next step in coordinated school health.

During the 2016-2017 school year the Legislature directed the Program Evaluation Division to complete a study on funding streams and models for school nurses. That study resulted in a report, ***Meeting Current Standards for School Nurses Statewide May Cost Up to $79 Million Annually,*** which was released through the Legislative Oversight Committee on January 22, 2018. The findings of the study included:

1. School nurse duties have increased in scope and complexity due to federal and state legislation, an increase in student health issues, and other cultural and contextual factors.
2. North Carolina neither met the State Board of Education's recommended nurse-to-student ratio by its target date of 2014 nor is it meeting the National Association of School Nurses' current recommendation of one nurse per school.
3. The two state-funded school nurse programs are only accessible to schools and districts that meet certain criteria, and these criteria are not reevaluated at regular intervals.
4. The North Carolina Medicaid program pays for nursing services provided in schools, but most LEAs do not seek reimbursement for Medicaid-eligible students.
5. The State's education budget subsidizes health care costs when school personnel other than nurses perform health care services.

Beginning with FY 2019, the NCDHHS Division of Public Health received funding for an additional nurse consultant position though the Center for Disease Control 1801 Notice of Funding Opportunity, awarded to the North Carolina Department of Public Instruction. The focus of the grant is ***Improving Student Health and Academic Achievement Through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools***. The purpose of the position, funded for five years, is to improve the capacity of school nurses and school staff to manage chronic health conditions in schools, and to promote growth in the number of LEAs doing this through a formal, district-wide, standards-based program. The addition of this position brought the consultant team to nine nurses.

To support and bridge services for children, the **North Carolina Integrated Care for Kids,** a federally funded program and partnership with Duke, UNC, NCDHHS and communities, was created. NC InCK began planning in 2020 and implemented the program in Alamance, Durham, Orange, Granville and Vance counties in January 2022. The School Health Nurse and Integration Consultant for the NC InCK role is dedicated to children in grades K-12 who are enrolled in NC Medicaid or CHIP and increased the consultant team to 10 nurses in January 2021. Following changes in CDC grant requirements for NC InCK the School Health Nurse Consultant position was dissolved by the end of 2020.

The COVID-19 pandemic altered the course of school nursing services during the 2019-2020 school year with the abrupt closure of in-person school attendance. Due to school nurses' role in pandemic response and school closures, school nursing services data collection was halted for the 2019-2020 and 2020-2021 school years. The 2020-2021 school year for school nurses was largely dedicated to COVID-19 mitigation and response efforts. As a result, traditional nursing activities directed to reducing health related barriers to education were much less frequently addressed. While school nursing position numbers grew during this school year, those positions were largely supported through temporary COVID-related funds and sometimes difficult to fill during the pandemic.

In July 2021, NCDHHS launched and expanded a K-12 COVID-19 testing program that included additional funding to support school health staffing. School nursing positions continued to

increase amid barriers related to temporary funding, sustainability concerns, and attrition. This same funding was used to expand the School Health Nurse Consultant Team by three positions, including an additional charter nurse consultant and two regional consultants. This allowed coverage to match the eight NC State Board of Education Districts and the consultant team grew to 13. In March 2022, the School Health Unit transitioned from the Division of Public Health, Children and Youth Branch to the Division of Child and Family Well-Being, Whole Child Health Section, School Adolescent and Child Health Unit. Due to COVID-19 related funding ending during the 2024-2025 school year, the nurse consultant team returned to six regional and one charter consultant.

The National Association of School Nurses announced a revision of the 21st Century School Nursing Practice Framework in May 2024. The purpose of the updated model was to "ensure continued alignment with the education and health care landscape" (NASN School Nurse, May 2024). Standards of Practice, Care Coordination, Leadership, Quality Improvement, and Community/Public Health are the practice principles within the framework intended to guide school nursing practice and support student well-being.

In July 2025, Session Law 2025-60/Senate Bill 600 was signed into law. This legislation removed the previous national certification requirement for school nurses and established criteria for hire and salary by the State Board of Education. Session Law 2025-60/Senate Bill 600 also revised the language for emergency treatment using epinephrine from auto-injectors to epinephrine deliver systems. Additionally, the State Board of Education adopted 16 NCAC 06C.0110 Qualifications Of School Nurses which established the qualifications and training required to be hired or contracted as a school nurse. The Administrative Code took effect August 1, 2026.

Reference

NASN School Nurse. (2024, May). *A Contemporary Framework Update for Today's School Nursing Landscape: Introducing the School Nursing Practice Framework*. 39(3), 140-147. doi:10.1177/1942602X241241092

Wyche, M. L. (2011). *The History of Nursing in North Carolina.* The University of North Carolina Press.