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Acquired Immune Deficiency Syndrome Policies

in Central Illinois: A Survey, Analysis, and Model

(TITLE)

BY

Daniel Lathrop

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

Specialist in Education

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
CHARLESTON, ILLINOIS

1988

YEAR

I HEREBY RECOMMEND THIS THESIS BE ACCEPTED AS FULFILLING
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Acquired Immune Deficiency Syndrome Policies in Central Illinois A Survey, Analysis, and Model

By

Daniel Lathrop

Abstract of a Field Experience

Submitted in Partial Fulfillment of the Requirements

For the Degree of Specialist in

Educational Administration in the Graduate School

Eastern Illinois University, Charleston, Illinois

1988

Abstract

One purpose of this study was to develop model policies for school districts to use in dealing with Acquired Immune Deficiency Syndrome (AIDS). A second purpose was to identify which school districts in the Educational Service Region (ESR) comprised of Clark, Coles, Cumberland, Edgar, Moultrie, and Shelby counties had addressed the issue of AIDS policies. The population surveyed in the initial phase consisted of 22 superintendents within the ESR. A survey was developed utilizing many items from a national study (Keough and Seaton, 1987). The survey was administered during a monthly meeting of superintendents hosted by Regional Superintendent Rosemary Shepherd. A Likert scale was used where possible and means and positive percentages were calculated. Comparisons with the national results were made. The results clearly showed that local superintendents were representative of their national counterparts. 86% of the districts surveyed had developed or were developing AIDS policies. In developing model policies, the author gathered 14 national, state, and local policies dealing with AIDS. These policies were rated excellent, average, or poor on 13

different criteria suggested by the Illinois State Board of Education and the Illinois Department of Public Health. The results showed that most districts addressed AIDS within the context of a Chronic Contagious Disease Policy, that distinct student and employee policies were preferred, and that the policies were generally weak concerning student and employee rights. Model policies were then developed relying heavily on information gathered in the policy evaluation process.

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Chapter 1

Overview of the Study

Acquired Immune Deficiency Syndrome (AIDS) has rocketed into the collective consciousness of the American people in the last five years. Few issues have engendered the level of emotional outpouring exhibited in AIDS-school controversies. Public ignorance and misinformation have exacerbated a concern into a controversy. Law professor Robert Mnookin (1985) of Stanford University stated, "I'm concerned that school boards are acting out of fear and prejudice rather than the rational concern for the welfare of the children" (p. 21).

Background of the Problem

AIDS was first diagnosed in this country in 1981 in California (Reed, 1986). As of March 31, 1988 1,692 cases of AIDS had been diagnosed in Illinois, 53% of which had died (Illinois Public Health Report,March 31, 1988, IDPH).. The disease is carried by a virus that infects a particular type of white blood cell, weakening the immune system's ability to make antibodies, and thus gradually destroying the body's main defense against invasion by germs. Persistent diarrhea, weight loss, fungus infections, Pneumocystic Carinii pneumonia, and

Kaposi sarcoma, a rare form of skin cancer, are symptomatic of AIDS (Krajewski, 1985). The patient groups at highest risk are homosexual/bisexual men (77% of Illinois cases) and those persons using blood products or syringes (19%). Only 34 cases of AIDS in persons under the age of 19 have been reported in Illinois (IDPH, 1988). Nationally, the Center for Disease Control (CDC) in Atlanta, Georgia reports 886 children under 13 have been diagnosed with AIDS, of which 77% contracted the disease from their mothers while in the womb or at birth. An additional 19% were infected from blood products and 4% are still under investigation (Center for Disease Control Weekly Report, March 7, 1988). There is no known cure for AIDS. The symptoms are treated as they arise, but the condition is inevitably fatal.

How the AIDS virus is transmitted is the point which is of major concern to the school community. The AIDS virus has been isolated in virtually all body fluids, but experts think the virus can not penetrate normal unbroken skin or be inhaled through the air. Transmission occurs during an exchange of bodily fluid (Krajewski, 1985). The most often quoted authority on the matter, the CDC, in its "Morbidity and Mortality Weekly Report" stated, "Based on current evidence, casual person-to-person

contact as would occur among school children appears to pose no risk. Most of the children should be allowed to attend school in an unrestricted setting" (1985, Appendix A). However, the CDC is very careful to list specific exceptions and inherant precautions.

A specific case in point involved a Kokomo, Indiana youth named Ryan White. White is a hemophiliac who contracted AIDS through blood transfusions. In the fall of 1985, Ryan was denied attendance at eighth grade classes, but was provided instruction via telephone hook-up. His parents began legal proceedings and eventually, after a long, drawn-out sequence of court appearances, health examinations, injunctions, and appeals, the Charleston Times Courier reported that he was allowed to return to class on April 9, 1986 (1986). Even then, 27 parents pulled their children out of school and considered further appeals. During the summer of 1987, the Whites moved to Arcadia, Illinois. Education Week (1987) reported that Ryan began attending Hamilton Heights High School amid a calm, relaxed atmosphere in September, 1987.

A second case involved a similar situation, but was handled very differently. According to the School Administrator (1986), Superintendent John

McCarthy of Swansee, Massachusetts decided to admit an AIDS student to class and launched a public information campaign concerning the disease. Although the media tended to sensationalize the situation, the packet of information distributed by the school district tended to alleviate the problem. In fact, a group of the child's classmates raised $5000 to help with medical expenses.

Arcadia, Florida was the setting for another AIDS case that rose to national prominence. This case exemplifies how serious a situation can become. The Chicago Tribune (1987) reported that Richard and Louise Ray had three sons, all hemophiliacs and positive for the AIDS antibody test. Desoto county school officials banned the trio from attending school based on the positive tests. A court order, however, forced the school authorities to admit the Ray children despite widespread protest from the community. The family tried to remain in seclusion due to threats of violence and death. About half the students boycotted the classes. On the night of August 28, the Ray home was destroyed by fire in what was later to be determined to be arson. The Rays gave up the fight and moved to Sarasota county. These cases collectively point out the citizenry's general lack of knowledge concerning AIDS and the

unpreparedness of many school districts. These points are of major concern in this study.

Statement of Problem

The public hysteria that has accompanied the AIDS problem in this country has entangled schools in a morass of social, legal, and ethical questions. School districts are being encouraged to be proactive to the situation, rather than being forced to make expedient, pressure-filled decisions when an in-district AIDS case arises. Preparedness is the key to the smooth disposition of AIDS cases. Inadequate preparedness leads to confusion, enmity, and often violence.

The major goal of this study was to develop a process, a set of procedures for dealing with AIDS in the school, that could be implemented by local school districts. The study's first objective was to gauge how many local school districts had addressed AIDS policy formation. The superintendents of school districts in the Educational Service Region (ESR) comprised of Clark, Coles, Cumberland, Edgar, Moultrie, and Shelby counties were polled to obtain this information. A second objective was to discover how local superintendents felt concerning who should have a voice in the policy development as well as which

sources of information on the topic could be most trusted. A third objective of the study was to compare local superintendents opinion concerning AIDS with rational samplings to gauge national representativeness. With the data collected from the superintendents and information garnered from the professional literature and research, objectives four and five could be addressed. Objective four was to develop a model policy for dealing with an AIDS-infected student. Objective five was to develop a model policy for dealing with an AIDS-infected employee. The question as to whether these policies should be separate and distinct, or combined in one all-inclusive form was also addressed.

Limitations of the Study

The initial stage of the study was purposely limited to the 24 school districts making up the ESR. A localized body of knowledge was wanted so that area school districts could ascertain how they compared with their peers and the ESR office could use the collected information in the manner of a needs assessment, to help determine areas where it might be of assistance.

A second limitation of the study dealt with the model policies. Many professional groups, state

departments of education, school boards, and private attorneys have developed model policies. One individual estimated that nationally at least 200 law firms have developed policies to sell to interested parties (Janes, 1988). With the plethora of policies in existence, the author reviewed approximately 15 policies that were available and were believed to be representative of the four groups previously mentioned.

Definitions

AIDS infected individual. A person who has been diagnosed as having AIDS or who is an asymptomatic carrier, i.e., one who has been infected by the virus and is capable of transmitting it but who has not developed any of the symptoms.

AIDS curriculum. A body of information to be taught dealing with Acquired Immune Deficiency Syndrome, including specific objectives to be covered as determined by the local school district.

AIDS policy. Any written formulation by a school district as to the process or procedure to be followed in dealing with AIDS in the school. The policy may be labeled in other terms, such as "District Contagious Disease Policy".

Assumptions

The author assumes that:

1. AIDS will remain a controversial issue in schools until the public is educated sufficiently or a cure is discovered.

2. Developing AIDS policies before an AIDS case is identified in the school district is preferable to developing one in a crisis situation.

3. As publicity concerning AIDS increases, more school districts will become proactive to the issue.

4. Most districts will comply with state law and begin AIDS education in grades 6-12 in some fashion in 1988. It is further assumed that because of this, the likelihood of AIDS policy formation increases.

Chapter 2

Rationale, Review of Literature, and Research

Rationale

The dilemma of AIDS in this country has necessitated the creation of school policies to deal with the problem. The development of these policies reflects, to some extent, how aware the school district and the community are of the threat of AIDS. The rationale for this study was that it was important for local school districts to be involved in developing AIDS policies, not only to expedite the handling of future AIDS related incidents, but also to increase the awareness of the overall seriousness of the AIDS contagion within their communities. Logically, if one of the basic functions of the public schools is to prepare people for more healthful, successful, and productive lives, awareness of life-threatening conditions must be fostered (Maslow, 1970).

As a teacher for 20 years in East-Central Illinois, the author has witnessed how local school districts have reacted to other pleas for action. Some are always at the forefront; others must be coaxed out of lethargy. Another rationale for this study was to allow each local district in the ESR to

ascertain how it compared with its peers regarding AIDS policy formation. It was hoped that such comparison might prompt some districts into action.

It would be convenient to assume that the data collected within the ESR are typical of a broad range of school districts. That assumption, however, needs to be anchored to a data base. The survey of superintendents in the ESR provided data for comparison with national superintendent samples. This comparison reveals if local superintendents are representative of national trends pertaining to AIDS policy formation and other related concerns. Further, a review of related research and literature provides additional reference points.

Review of Literature

National and State Guidelines. In reviewing the literature pertaining to the development of policies dealing with AIDS in the school, one source is continually cited. The guidelines developed by the Center for Disease Control in Atlanta (1985) seems to be the common point of origin of most AIDS policies (Appendix A).

This federal agency gives recommendations for dealing with a victim of AIDS. Nine of the guidelines are related to schools. They are:

1) Decisions regarding the type of educational

setting for infected children should be based on the behavior, neurological development and physical condition of the child... These decisions are best made by using the team approach including the child's physician, public health personnel, the child's parents, and personnel asociated with the educational setting.

2) For most infected school-aged children, the benefits of an unrestricted setting would outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent non-existent risk of transmission of HTLV-IV/LAV (the AIDS virus).

3) For the infected preschool-aged child and some neurologically handicapped children who lack control of their body secretions or who display behavior, such as biting, and those children who have uncoverable, oozing lesions, a more restricted environment is advisable.

4) In any setting involving an infected person, good hand-washing after exposure to blood and body fluids and before caring for another child should be observed, and gloves should be worn if open lesions are present on the caretaker's hands.

5) Schools ... should adopt routine procedures for handling blood or body fluids of any student.

6) Evaluation to assess the needs for a restricted environment should be performed regularly.

7) Mandatory screening as a condition for school entry is not warranted based on available data.

8) Persons involved in the care and education of infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase (e.g., bleeding injury).

9) All educational and public health departments regardless of whether or not infected children are involved, are strongly encouraged to inform parents, children, and educators regarding AIDS and its transmision. Such education would greatly assist efforts to provide the best care and education for infected children while minimizing the risk of

transmission to others (p. 4-6).

A second document often quoted by AIDS policy-makers is the Surgeon General's Report on AIDS (Koop, 1986). The report states:

> No blanket rules can be made for all school boards to cover all possible cases of children with AIDS and every case should be considered separately and individualized to the child and the setting as would be done with any child with a special problem. A good team to make such decisions with the school board would be the child's parents, physician and public health officials. ...Education concerning AIDS must start at the lowest grade possible as part of any health and hygiene program... There is now no doubt that we need sex education in schools and that it must include information on heterosexual and homosexual relationships (p. 4).

In May of 1985, the Illinois State Board of Education (1986) and the Illinois Department of Public Health joined forces to develop guidelines concerning the handling of chronic infectious diseases in schools in the state. These guidelines were published sixteen months later (Appendix B). These guidelines are important for several reasons.

They address a broader spectrum of contagion and are therefore more useful from a practical standpoint. They are very specific and utilitarian. They are consistent with the Center for Disease Control guidelines.

The Illinois Association of School Boards (IASB, 1986) also developed several sample policies dealing with AIDS prior to the passage of AIDS-related laws in the fall of 1987 (Appendix C). The IASB was careful to note, however:

> We emphasize that these policies represent only one approach, and that approach may not be the best or apropriate one for your district. We urge that the district's legal counsel be consulted on the issue of chronic infectious disease during the review of the ISAB policies or any other policies by the School Board (p. 123)..

One of the first sets of guidelines (Appendix D) to be published in this country was developed by the National Education Association (NEA, 1985). It embraces the CDC recommendations, but makes several additional points, including:

> The sexual orientation of a student or school employee shall not constitute reasonable cause to believe that he or she is an infected

> individual. No student, school employee, or potential school employee shall be required to provide information as to his or her sexual orientation... The determination of whether an infected employee should be permitted to remain employed shall be made by a team composed of public health officials, the employee's physician, the employee and/or his/her representative, and appropriate school personnel (p.3).

Several states, in addition to Illinois, have developed model policies and guidelines. Iowa begins by differentiating between a policy (a general statement) and a rule (a specific method developed by the district to implement the policy) (Iowa Department of Public Instruction, 1986). It pleads with the school districts not to adopt the model (Appendix E) verbatim, but to use it as a framework. The policy stresses confidentiality more than most states as evidenced by the statement, "Ideally, the process (of passing on information about an AIDS infected student) should be accomplished by direct person-to-person contact" (p.4). Written correspondence should be kept to a minimum.

The Montana Department of Health (1985) had

some very specific suggestions not included by other policy makers (Appendix F). These included discouraging mouth-to-mouth kissing and exchanging of food or gum. Another rule stated, "Any tools (scissors, nail files, or woodworking tools) which may potentially cause cutting injuries should not be shared among infected individuals and others" (p.5).

The Connecticut State Department of Education (1985) developed one of the earliest state-generated set of guidelines (Appendix G). They also are consistent with the CDC's main points. One point that is specifically addressed in the Connecticut document that is not addressed by some states' policies is the following:

> A child with AIDS/ARC, as with any other immune deficient child, may need to be removed from the classroom for his/her own protection when cases of measles and chicken pox are occurring in the school population. This decision should be made by the child's physician and parent/guardian in consultation with the school nurse and/or school medical advisor (p. 2).

Local Policies

Many school districts have developed policies based on the various state and federal guidelines previously mentioned. Some school districts have

used these guidelines as blueprints, while others have adopted them verbatim. The author reviewed policies or proposed policies from seven Illinois school districts (Appendices H-M). Most of these consist of a general policy statement followed by specific procedures to be utilized to implement the policy. The policy developed in Rockford is a prime example of this type (1987). This policy specifically addresses AIDS infection and does not include other chronic contagious diseases. It alludes to the findings of the CDC and other medical groups. It lists six findings and then makes several general statements outlining the main emphases of the policy. These findings include such points as:

1. Most HIV-infected students should attend school.
2. Those posing increased risk should be alternatively placed.
3. Physicians shall make periodic medical review.
4. The number of personnel aware of the child's condition must be kept to a minimum.
5. Procedures for hygienically handling blood and body fluids of ALL students must be implemented.

6. Routine screening of students is not necessary (p. 1).

Among the general statements were:

1. No reliable medical evidence supports the spread of the infection through casual contact.
2. An employee having the infection will be allowed to remain in his/her regular work assignment until it is medically determined that allowing him/her to do so is outweighed by potential of transmission of HIV infection to other staff members or students and/or increased likelihood of damage to the infected employee.
3. The Board will develop procedures for the management of students and employees having HIV infections consistent with the foregoing findings (p.2).

Included among the procedures enumerated later in the document is a statement which reads:

> Any district employee when diagnosed as having or reasonably suspected of having HIV infection will notify the Superintendent and then be monitored by a review team whose composition is similar to the review team convened for students with HIV infection except that inapplicable members of the student team such

> as parents and teachers will be replaced by the building principal and the senior administrative manager (p. 3).

This statement mandates that any employee who knows or reasonably suspects that he/she has AIDS must notify the superintendent.

The policy developed by Peoria addressed chronic contagious diseases, rather than AIDS alone (1987). It closely follows the state guidelines. In the procedural portion of the Peoria example, one important differentiation is emphasized between chronic contagious diseases and common ones. Specifically, "the policy and procedures do not apply to the common, acute, short-term childhood diseases such as chicken pox, impetigo, strep throat, and scarlet fever" (p.2).

A clause very typical of many policy statements is found in Danville's Chronic Communicable Disease Policy (1987). It is a basic enabling or empowering statement and reads thusly:

> The Superintendent is authorized to establish rules and regulations that are designed to implement this policy and that are consistent with the rules and regulations of the State of Illinois and the United States (p.1).

Belleville District 118 was one of the

Illinois school districts that had an AIDS-infected student enrolled last year. The procedures outlined for implementing Belleville's policy ere detailed end closely follow the State's recommendations (1987). Additionally, Belleville asked the St. Clair County Health Department to review the procedures prior to Board action. Belleville also began a staff development program to insure that the policy and procedures were made known to all staff members.

One of the briefest policy statements is contained in the proposed Chronic Infectious Disease Policy for Charleston (1988). It reads:

> The Charleston Community Unit No. 1 School Board recognizes that students or employees with chronic infectious diseases are entitled to all rights and privileges provided by law and the District's policies. The District shall balance those rights with the District's obligation to protect the health of all District students and staff. The District will provide information about chronic infectious diseases to students, parents, staff, and the public in general so that the best decisions can be made for all concerned in a calm, reasonable manner (p.1).

Legal Considerations

The literature dealing with AIDS policy formation is rife with legal references. A thorough review must therefore, examine the laws and court cases directing and impinging policy formation.

Federal and Illinois State Laws

The legal aspects of the school-AIDS situation which must be considered include the civil rights aspects of public school attendance, the protections for handicapped children under 20 U.S.C. 1401 et seq. and 29 U.S.C. 794, and the confidentiality of a student's school record under state laws and under 20 U.S.C. 1232g (The School Administrator, 1985). While the United States Constitution does not specifically reference education, the Illinois Constitution does. In Article 10-1, the document states: "A fundamental goal of the People of the State is the educational development of all persons to the limits of their capacities" (Illinois State Constitution, 1970). Any arbitrary abridgment of a student's opportunity to develop to his limits might be grounds for suit. An additional Illinois statute that might be pertinent in AIDS cases involves the student's right to privacy. Paragraph 50-6 of the School Code of Illinois details who has access to student records (School Records Act, 1976).

In September, 1987, Illinois Governor James Thompson took action on 17 controversial bills dealing with AIDS (Vedder, 1987). Of those becoming law, several impact the school directly. Directly affecting policy formation is H.B. 2044 which amends "An Act in relation to the prevention of certain communicable diseases" (Chapter 111 1/2, p. 22.12). It requires that whenever a case of AIDS or AIDS related complex (ARC) in a child of school age is reported to the Illinois Department of Public Health or a local health department, such department shall give prompt and confidential notice of the identity of the child to the principal of the school in which the child is enrolled. The principal may, as necessary, disclose the identity of an infected child to the school nurse at that school and the classroom teachers in whose classes the child is enrolled. In addition, the principal may inform such other persons as may be necessary that an infected child is enrolled at that school so long as the child's identity is not revealed (p.3).

Many school districts include in their policies a statement about educating the general public, staff, and students concerning AIDS. If they do, another state law may impact their policies. Public Act 85-0680 changes the title of the "Critical

Health Problems and Comprehensive Health Act" (Chapter 122, P863) to the "Comprehensive Health Education Program" and requires that such program include instruction in grades 6 through 12 in the prevention, transmission, and spread of AIDS. However, no pupil shall be required to take or participate in any class or course on AIDS instruction if his/her parent(s) or guardian(s) submits a written objection. Refusal to take or participate in such course or program shall not be reason for suspension or expulsion of such pupil.

The primary federal statute germane to the AIDS school situation appears to be the Rehabilitation Act of 1973. Section 504 of the act forbids discrimination on the basis of a handicap. Is a contagious disease such as AIDS a handicap? A recent court ruling may have considerable impact (Nassau County School Board vs. Arline, 1987). Gene Arline was hired as an elementary school teacher in Nassau County, Florida in 1964 while her tuberculosis was in remission. She had relapses in 1977 and 1978 and was dismissed. After exhausting state administrative proceedings, she filed suit in U.S. Middle District Court of Florida, alleging discrimination on the basis of a handicap in violation of Section 504. The District Court

dismissed the case saying that it was not the intent of Congress to include contagious diseases within the definition of handicaps. The 11th Circuit then heard Arline's appeal and reversed the lower court. After this decision was rendered, but before it was appealed to the Supreme Court, an interesting thing occurred. On June 23, 1986, Assistant Attorney General Charles Cooper issued a Justice Department opinion which appears to conflict with the spirit of the Arline decision. He wrote:

> Discrimination based on physical disability caused by Aids might be a violation of the law, but the statute does not restrict measures taken to prevent the spread of the disease. Therefore, an AIDS victim whose abilities are impaired may have protection against dismissal, but a fully fuctioning AIDS carrier may not, as long as the dismissal is based on fear of contagion (Newsweek, 1986).

The Justice Department opinion affects federal employees, recipients of federal funds, and federal contractors. The final disposition of the Arline case, if not the AIDS question, was arrived at on March 3, 1987, by the United States Supreme Court. The court ruled on two main points: 1) Is a person with the contagious disease tuberculosis considered

a "handicapped individual" within the meaning of Section 504, 2) Is the afflicted individual "otherwise qualified" under 504. Justice Brennan, delivering the majority opinion concluded Arline was handicapped under Section 504. The majority opinion read:

> Arline had a physical impairment as defined by the regulation. That impairment required hospitalization, a fact more than sufficient to establish that her life activities were substantially limited. Thus, Arline's hospitalization for tuberculosis in 1957 suffices to establish a "record of ... impairment" within the meaning of 29 U.S.C. 706 and is therefore a handicapped individual...Allowing discrimination based on the contagious effects of a physical impairment would be inconsistent with the basic purpose of Section 504, which is to ensure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or the ignorance of others. By amending the definition of "handicapped individuals" to include not only those who are actually physically impaired, but also those who are regarded as impaired and who, as a

> result, are substantially limited in a major life activity. Congress acknolwedged that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from the actual. Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness...The Act is carefully structured to replace reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments (p.7).

On the second point, the Court remanded the case back to the District Court to conduct an individualized inquiry and to make appropriate findings of fact. The basic factors to be considered are well established by precedent. The Supreme Court agreed with an "amicus" filed by the American Medical Association. In reading the Supreme Court decision, the author found direct reference to AIDS only in the explanatory footnotes. That reference, however, has direct bearing on relating Arline to the AIDS controversy. The footnote read:

> The United States argues that it is possible for a person to be simply a carrier of a

disease, that is, to be capable of spreading a disease without having a "physical impairment" or suffering from any other symptoms associated with the disease. The United States contends that this is true in the case of some carriers of the Acquired Immune Deficiency Syndrome (AIDS) virus. From this premise the United States concludes that discrimination based solely on the basis of contagiousness is never discrimination on the basis of a handicap. The argument is misplaced in this case, because the handicap here, tuberculosis, gave rise both to a physical impairment and to contagiousness. This case does not present, and we therefore do not reach, the questions whether a carrier of a contagious disease such as AIDS could be considered to have a physical impairment, or whether such a person could be considered, solely on the basis of contagiousness, a handicapped person as defined by the Act (p.8).

Of significance in Illinois was an appellate court decision made pertaining to another contagious disease (Community High School v. Denz, 1984). The case involved a Down's syndrome student who was afflicted with hepatitis B. The school district had removed the student from school and placed her in a

home-study program. The court ruled that the placement had violated the "main-streaming" proviso of PL 94-142 and that the home-study program was not the "least restrictive entironment".

School districts need to consider the AIDS question from another perspective also, that of tort liability. What if a student or teacher sues the school district claiming that AIDS was contracted while in attendance at school? The National School Board Association offers the following information (Gregory and Hooper, 1986). The plaintiff must prove two points: 1) that AIDS was contracted at school, and 2) that the school was negligent in allowing the affected student or employee to stay in school or in its supervision of the child. Districts have a responsibility to minimize the risk of spread of any contagious disease, not to eliminate every possibility that an individual will contract it. They have a duty to provide reasonable care, they are not guarantors, of the safety of employees and students (Baum vs. Reed College, 1965).

Review of Research

The initial phase of this study involved gathering information from local school superintendents. To determine the type of

information needed, the author consulted with school law professor Dr. Larry Janes and Regional Superintendent Rosemary Shepherd and reviewed the professional literature and research. The most important research data relative to this study was supplied by a Phi Delta Kappa (PDK)-sponsored project (Keough and Seaton, 1987). The sample for this study consisted of 100 superintendents from among the 500 men and women identified to date as outstanding by Exectutive Educator, a publication of the National School Board Association. Each of these superintendents was sent a 57-item questionnaire focusing on his/her attitudes toward and perceptions of the AIDS crisis. The response rate was 96%.

The demographics of this sample may impact any comparison made with the local superintendents. The PDK respondents came from school districts with the following enrollments:

10,000 students or less	33%
10,000 to 25,000	26%
25,000 or more	41%

Additionally, only 4% of the sample characterized their district as rural. Other demographics revealed that 63% of the superintendents were between the ages of 46 and 55, 85% were white, and

the average length of tenure in the current district was 7.5 years. 22% said that their district had a teacher with AIDS and 10% had students with AIDS.

Particular points that the PDK study addressed that were incorporated into this author's study included:

1. Should AIDS education be part of the regular school program? (PDK 100% agree)

2. Should schools and outside health agencies coordinate their efforts to better meet the needs of students with AIDS? (100%)

3. Should school districts have a policy for dealing with AIDS? (97%)

4. Should students with AIDS be excluded from contact sports (55%)

5. Should students with AIDS be protected by federal anti-discrimination laws? (44%)

6. Should school districts treat AIDS differently from other communicable diseases? (42%)

7. Should the curriculum specifically address the moral issues and values related to AIDS? (60%)

8. Should employees undergo mandatory testing for AIDS? (7%)

9. Should students undergo mandatory testing

for AIDS? (3%)

10. Should contracts make AIDS testing a condition of employment? (22%)

16. What is your personal opinion as to the grade level at which AIDS education should begin?

K-3 (19%) 4-5 (39%) 6-8 (35%) 9-12 (7%)

The percentages obtained in this national sample will serve as the benchmark for comparison with local data collected.

The PDK study also alluded to findings uncovered in two other national polls of the general population. Newsweek conducted a national sampling in February (1987). 606 adults were surveyed. 71% said that they thought that food handlers and teachers should be tested for AIDS. NBC News and the Wall Street Journal conducted their poll in April (1987). Their sample consisted of 2304 adults. 42% of the sample believed that employers should have new employees tested for AIDS. These findings point out the wide difference of opinion that exists between professional educators and the general population.

Uniqueness of the Study

This study is unique in that no other study

dealing with AIDS and AIDS policy formation had ever been made in this particular locale. The author hopes that the information gathered and the conclusions will give area districts insight into how they compare with their peers concerning AIDS policies. Additionally, it is hoped that the model policies developed will be of use to local districts and others throughout the state.

Chapter 3

Design of the Study

General Design

The general design of the study was divided into two parts. The first section involved data collection from area superintendents. A questionnaire was utilized to obtain this information dealing with AIDS policies, attitudes, and opinions. Portions of these data were then compared to national samplings to ascertain if data from local superintendents were representative of the entire country. The data could also be used by local superintendents for peer comparison with other local districts.

The second section of the study concerned the development of model policies dealing with AIDS. The author collected, reviewed, and evaluated national, state, and local policies culminating in the development of the author's model policies.

Sample and Population

The population surveyed in the initial phase of this field experience consisted of 22 superintendents representing 23 school districts. One of the superintendents had a dual district superintendency, that is he served both an

elementary and secondary district. These school districts are located in the East-Central Illinois counties of Clark, Coles, Cumberland, Edgar, Moultrie, and Shelby. The enrollments of the districts administered by these superintendents is depicted in Appendix N (Regional Statistics Report, 1987). These districts were selected because they were in the same Educational Service Region as the author's district. All of the public school districts in the region, via their superintendents, participated in the study. The response rate was 100%.

Data Collection and Instrumentation

Primary instrumentation for the study consisted of a questionnaire to be administered to superintendents (see Appendix O). This instrument was developed by the author drawing heavily on the PDK study mentioned previously (see pp 35-36). Eleven of the 16 items directly parallel the items devised by Keough and Seaton (1987). Items 1-10 employed a Likert scale asking respondents to strongly agree (SA), agree (A), remain neutral (N), disagree (D), or strongly disagree (SD) (Moore, 1983). The remaining PDK item (#16) asked superintendents to indicate a specific grade level where AIDS education should begin. These 11 items

were selected for inclusion in the survey in order to gauge the superintendents' overall attitudes toward and opinions about AIDS. The data thus collected addressed objective 3 of the study (see Statement of Problem, p. 9) dealing with superintendent representativeness.

The other five items on the questionnaire were devised by the author to reveal information pertaining to objecives 1 and 2. Items 11 and 12 supplied data relative to the study's first objective: to determine how many local districts had addressed the issue of AIDS policy formation. Items 13 and 14 gave information relative to objective 2 of the study concerning sources of information on AIDS policies and those involved in policy formation. Item 15 was added to see if a relationship existed between level of perceived community concern and policy development as evidenced by items 11 and 12. Item 17 was included in order to compare where AIDS education actually begins in school with where the superintendents think it should begin (#16). Item 18, dealing with state-mandated AIDS education, was intended to reflect an attitude. A strong positive or negative response on this item might reflect directly on the superintendent's eagerness to develop AIDS policies.

A form for collecting the data generated by the questionnaire was also developed (see Table 1).

The second part of the study involved the development of model AIDS policies. Responses to some of the items (#12 and #13) on the questionnaire were used for that purpose. However, the main source of information relative to policy formation was an Educational Resources Information Center (ERIC) search undertaken to find examples of current AIDS policies and guidelines used in this country. As a result of that search, five sets of national and state guidelines were obtained. Additional state and local guidelines or policies were obtained from the Educational Administration Department of Eastern Illinois University, Regional Superintendent Rosemary Shepherd, and Charleston Superintendent William Hill. A total of 14 documents were reviewed by the author. The basis of review for national and state guidelines was comparison with the federal government's official standard, the Recommendations of the Center for Disease Control. Local policies and guidelines were compared to the State's recommended guidelines as published by the Illinois State Board of Education and the Illinois Department of Public Health. The documents were examined with respect to:

1. A general policy statement.

2. The individual's right to privacy.

3. The right of an infected student to a public education.

4. Individual evaluation on a case by case basis.

5. A specific plan for the individual's education.

6. The concept of least restrictive environment.

7. Provision for alternative school program.

8. Provision for temporary removal and conditions warranting it.

9. The right of the student to due process.

10. Safeguards for maintenance of confidentiality.

11. Provision for removal of student during other disease outbreaks.

12. Routine monitoring of all students having infectious diseases.

13. Routine and standard procedures of cleanliness and hygiene.

A review form was developed incorporating these points (see Table 3). Each policy was rated on each of these points and assigned a score such that excellent = 3, average = 2, and poor = 1.

Data Analysis

The data obtained from the survey of superintendents was analyzed in the following manner. Responses to those items utilizing a Likert scale were given a weighted value such that strongly agree = 5, agree = 4, neutral = 3, disagree = 2, and strongly disagree = 1. Means were then computed for each item based on the survey items (Table 2). As the mean approached 5, the more positive the suprintendents felt about that item; as the mean approached 1, the more negative they felt. Consequently, those items which engendered strong feeling were easily indentified. In addition to means, percentages were calculated indicating what proportion of the superintendents felt positive (either strongly agreed or or agreed) about each item. This was done to facilitate national comparisons. Most of the other items on the survey utilized a multiple choice scale other than a Likert. These were analysed using a percentage method. Internal comparison of responses between selected items were also made. Descriptive methods were used to compare the responses of items 12 and 15. Similarly, responses to items 16 and 17 were discriptively compared as were responses to items 12 and 18.

The data collected from the review of national, state, and local guidelines were also analyzed. Total scores for each policy were obtained by adding the point values assigned for each of the 13 subscores. Those policies having the highest total scores were the best overall policies in the author's opinion. However, the data must be examined with the intent of identifying those sections of selected policies which best deal with a particular problem. This type of data analysis is of prime importance in bringing together the best parts of many policies into a model policy.

Chapter 4

Results

The results of the study are presented in the following tables and accompanying explanations. Results concerning survey data from the questionnaire were dealt with on an item-by-item basis while the second portion of the study dealt with the strengths and weaknesses of different policies.

Table 1 - Data Collection Superintendents' Survey

Item	1	2	3	4	5	6	7	8	9	10	11	12	13
Respondent													
A	4	5	4	4	4	4	4	2	2	5	B	B	C
B	4	5	4	4	3	4	2	3	2	5	C	C	D
C	5	4	5	4	4	2	2	2	2	2	A	A	B
D	5	5	5	3	4	4	4	3	3	5	B	B	D
E	4	3	4	4	2	4	3	3	3	3	A	B	D
F	4	4	4	3	4	4	4	3	3	3	B	B	D
G	4	4	4	3	3	2	4	2	2	2	A	A	D
H	5	5	5	1	4	3	5	2	2	1	B	B	D
I	5	5	5	5	4	2	5	1	1	1	A	A	D
J	5	5	5	5	3	2	5	2	2	4	A	A	C
K	5	5	4	5	2	5	5	3	3	4	C	C	C
L	5	5	5	3	4	4	2	2	2	3	B	B	D
M	2	3	5	5	2	4	2	1	1	2	A	A	A
N	4	5	5	4	4	2	2	2	2	2	B	B	D
O	4	5	5	3	3	2	5	4	2	4	B	B	D
P	4	2	2	4	3	2	2	2	2	2	A	A	A
Q	4	4	5	3	2	4	4	2	1	3	B	B	C
R	5	4	5	5	4	4	4	2	2	2	B	B	C
S	4	5	4	5	4	5	4	4	4	5	B	B	D
T	4	4	4	4	4	2	3	2	2	2	A	A	A
U	4	4	4	4	2	2	5	2	2	2	C	C	B
V	5	5	4	3	3	3	4	2	2	3	B	B	D
	95	96	97	86	72	70	80	51	47	64	TOTAL POINTS		

Table 1 (Continued)

Item	14A	14B	14C	14D	14E	15	16	17	18
Respondent									
A	2	3	4	5	1	C	C	CD	3
B	2	3	4	5	1	B	C	C	4
C	4	2	5	3	1	B	C	CD	3
D	1	4	2	5	3	B	C	D	5
E	4	2	5	3	1	B	A	AD	2
F	1	3	4	5	2	C	B	CD	4
G	5	2	4	3	1	B	C	E	2
H	2	1	5	4	3	B	A	CD	5
I	1	3	5	4	2	C	B	CD	2
J	3	1	5	2	4	C	A	BD	4
K	5	2	3	4	1	C	C	E	5
L	-	-	1	-	-	B	A	C	4
M	4	1	5	2	2	B	C	E	2
N	1	3	4	5	2	B	C	CD	4
O	2	3	5	4	1	C	BD	CD	4
P	-	1	-	-	-	C	C	D	1
Q	2	3	5	4	1	C	C	D	4
R	3	3	3	3	3	B	C	CD	4
S	4	1	5	2	3	C	B	CD	4
T	-	-	-	-	1	B	C	C	2
U	3	4	5	1	2	B	C	CD	4
V	3	2	5	4	1	B	C	CD	3
Total Points	52	49	83	67	37				76

Discussion and Explanation

Table 1 shows the actual responses or weighted values that each superintendent respondent assigned to each item. The weighted values were assigned as outlined in the previous chapter. Each column of values was added to obtain the total value for that item.

Table 2 Analyses of Items 1-10 and 18

Item #	Mean	Positive %	National %
1	4.32	95	100
2	4.36	91	100
3	4.41	95	97
4	3.91	59	55
5	3.27	50	44
6	3.18	50	42
7	3.64	64	60
8	2.32	9	7
9	2.14	5	3
10	2.91	32	22
18	3.45	55	--

Discussion and Explanation

Table 2 analyzes data from Table 1 and develops means and positive percentages for each item. A response was considered positive if it agreed or strongly agreed with the item. Additionally, on applicable items, a national percentage from the PDK study was included (Keough and Seaton, 1987).

Items 1, 2, and 3. These items met with near universal agreement among the local superintendents with 20 of the 22 indicating a positive response. These items dealt with AIDS education being part of the regular curriculum, better coordination by schools and health agencies, and school districts having an AIDS policy. These items also had the three highest ranking means. The national PDK data was slightly higher, but still within 2-9%.

Items 4 and 7

These items also received high positive percentages, though nearly 30% less than items 1, 2, and 3. 13 and 14 (respectively) of the 22 superintendents endorsed the ideas that AIDS students should be excluded from contact sports and that AIDS curriculum should address values and moral issues. The comparison with national data gave very similar results (within 4%).

Items 5, 6, and 18

These items dealt with protection under federal anti-discrimination laws, treating AIDS differently than other contagious diseases, and recent state AIDS mandates that were passed.

All of these items fell within 5% of a 50% positive rating. While their positive percentages were close (50%, 50%, and 55%), examination of Table 1 shows a marked difference in one respect. The number of superintendents indicating a negative response (a 1 or a 2) was noticeably different for item 6 (9 responses) as compared with item 5 (5) and item 18 (6). Negative percentages were 41%, 23%, and 27%. Only 2 superintendents remained neutral on item 6. This item stated that district policies should treat AIDS differently from other communicable diseases and it very clearly

illustrated that a dichotomy of opinion existed among the superintendents. They felt strongly one way or the other. The national data on itsms 5 and 6 showed lower percentages of agreement, yet still were within 6% and 8%. Item 18 queried the superintendents concerning their opinion on the recent legislation mandating AIDS education at the 6-12 grade levels. A Likert scale was used. A majority (59%) felt positive about the mandate, 14% were neutral, and 27% opposed it. A comparison was made between this item and item 11 dealing with policy formation. The data revealed that all the superintendents that felt negative or neutral about the mandates had AIDS policies in place or in developmental stages. However, 3 of the 13 superintendents that responded positively to the mandates had not addressed the issue of policy formation.

Items 8, 9, and 10

All of these items dealt with testing for AIDS. Items 8 and 9 had extremely low positive responses (9% and 5%) and item 10 scored considerably higher (32%). The superintendents disagreed strongly with mandatory testing of employees (item 8) and students (item 9). These percentages reflected the national data very closely. However, item 10, which on the

surface appears closely allied to item 8, illustrated a divergence of opinion. Item 10 states that contracts should make AIDS testing a condition of employment. Many of the superintendents see a great difference between requiring all employees to be tested and requiring those seeking employment to be tested. The national percentage was noticeably lower (22%) than the local sample.

Table 3 Analyses of Items 11-13

Item #	11	12	13
Response(%)			
A	36	32	14
B	50	55	9
C	14	13	23
D	--	--	55

Discussion and Explanation

These items dealt with AIDS policy formation. Items 11 and 12 helped define the present condition of AIDS policy formation in the ESR. Response A indicated a policy was in place; B indicated a policy was being developed; and C indicated the issue had not been addressed. The results show that 86% of the surveyed school districts either have or are developing AIDS policies for students, while 87% have done the same for employees. Item 13 was concerned with who should be involved in developing district AIDS policies. Response A involved the fewest participants in the policy making process,

while response D involved the most. The responses indicate that most superintendents believe the wider the involvement, the better.

Table 4 Analyses of Item 14

Response	Mean	Positive%
A(CDC)	2.74	47
B(IASB)	2.45	45
C(ISBE)	4.15	9
D(Other districts)	3.52	18
E(Lawyers)	1.85	64

Discussion and Explanation

Item 14 was unique in this study in that it required the superintendents to rank order five sources of information as to which was the most trustworthy. Blanks appear in Table 1 for superintendents L, P, and D because they expressed only a first choice. Likewise, superintendent R indicated that all the sources were equal. The author then assigned the median rank (3) to each. It is important to note that on this item the numbers in Table 1 reflect rank. For example, the choice receiving the most first place responses would have the lowest total score. Therefore, the lower the mean, the better the rank. In computing the positive percentage figure, a ranking of 1 or 2 was used. The respondents considered paid legal consultants the most trustworthy (64%) and the State Board of Education the least (9%).

Table 5 Analyses of Items 15-17

Item =	15 (Local %)	16 (Local %)	16 (PDK %)	17 (Local %)
A	0	18	19	5
B	50	23	39	9
C	50	55	35	73
D	--	0	7	73
E	--	5	0	14

Discussion and Explanation

Item 15

Item 15 asked respondents to gauge the level of concern about AIDS in their district. Response A indicated high concern, B moderate, and C low. None of the superintendents thought the concern level was high in their districts. By extracting data from Table 1, a comparison was made between responses to item 15 and item 12 which dealt with the existence of a district AIDS policy. Of those superintendents that expressed an answer of moderate on item 15, 3 indicated they had an AIDS policy, 7 indicated one was being developed, and 1 indicated the issue had not been addressed. Of those superintendents expressing a low level of concern, the numbers were respectively 4, 5, and 2. The similarity of results indicated that perceived level of concern does not have much effect on policy development.

Items 16 and 17

These items addressed AIDS education in the school. Item 16 asked the respondents to indicate when they thought AIDS education should begin. Response A indicated grades K-3, B indicated 4-5, C indicated 6-8, D indicated 9-12, and E indicated not at any level. 95% thought it should begin prior to eighth grade. The national data showed 93%. The biggest difference between the local and national samples was that locally 41% thought the program should begin by fifth grade, whereas nationally 58% thought it should begin by that level. One local superintendent indicated there should be no AIDS education in school.

Item 17 asked at what level or levels AIDS education was presently being taught in the local district. Only 9% of the superintendents indicated that AIDS education was occurring at the K-5 level. This is in sharp contrast to the 41% who thought it should be taught at this level. In this ESR, 73% have begun an AIDS curriculum by eighth grade.

Table 6

Student or Combined Student-Employee Policies.

Policy or Guideline	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Criteria	A	A	C	C	A	C	A	A	C	C	C	C	C	C
General Statement	-	2	3	3	3	3	-	2	-	3	3	3	3	Y
Right to Education	3	2	3	X	-	-	3	3	-	3	3	X	2	Y
Privacy	2	2	3	3	3	3	3	2	2	2	2	2	2	Y
Case-by-Case Team	3	3	3	3	-	2	1	3	3	3	2	3	3	Y
Educational Plan	2	2	3	X	3	3	3	3	1	3	3	3	3	Y
Least Restrictive Envrionment	3	-	2	X	3	3	3	3	1	3	2	3	3	Y
Alternative Program	2	3	3	X	3	3	3	2	2	3	3	2	2	Y
Temporary Exclusion	2	3	3	2	3	3	3	2	2	3	3	3	2	Y
Due Process	-	-	3	X	-	2	-	3	-	3	2	2	1	Y
Removal for own safety	2	-	3	X	3	3	3	3	1	X	2	3	-	Y
Routine Monitoring	3	-	3	X	-	1	3	3	3	X	3	3	3	Y
Hygiene Procedures	3	-	3	X	3	3	3	2	2	X	3	3	1	Y

Policies: 1 = Center for Disease Control (CDC), 2 = National Education Association (NEA), 3 = Illinois State Board (ISBE), 4 = Illinois School Board

Association (ISBA), 5 = Montana, 6 = Iowa, 7 = Connecticut, 8 = Rockford, 9 = Peoria, 10 = Danville, 11 = Belleville, 12 = Charleston, 13 = Palatine, 14 = Harmony

Explanation of Table 6

AIDS policies exist in three forms; student policies, employee policies, and inclusive student-employee policies. Table 6 considers only student and inclusive policies. The policy numbers at the top of the page represent the policies named at the bottom of the page. Directly under each policy number is a letter. An A indicates an AIDS policy; a C indicates a chronic or infectious disease policy. Each policy was rated on each criterion with 3 = excellent, 2 = average, and 1 = poor. Additionally, a dash meant the criterion had not been addressed and other symbols will be explained later in the discussion. Most of the criteria are self-explanatory with some exceptions. General Statement meant general statement of policy or intent. Case-by-case team meant an individual case-by-case approach by an evaluation team. Educational plan meant a specific individualized educational program. Removal for own safety meant removal during disease outbreaks at school such as mumps or chicken pox.

Policy 1

These CDC guidelines were the first guidelines published in this country dealing with handling AIDS in the school. They are the basis for most other guidelines. These guidelines strongly endorse the concept that each case should be evaluated by a team of professionals on its individual merits. They do not address the student's due process rights concerning appeal of placement.

Policy 2

The NEA guidelines were published two months after the CDC guidelines. Real weaknesses are evident in these guidelines as they avoid the issues of due process, monitoring, and hygiene practices. These guidelines are unique in that they define, at least partially, "reasonably suspected". Most guidelines require physical examination of those individuals reasonably suspected of having AIDS, but they never define the phrase. The NEA believes the phrase applies to those individuals who might, for example, have a spouse who has AIDS or has born a child who has AIDS. They further state that sexual orientation is not reasonable cause.

Policy 3

These guidelines were put out by the ISBE and the IDPH. The criteria for evaluation of the

policies in this study were supplied by this document. Consequently, it scored the highest of all the policies reviewed. The guidelines assert the rights of the infected individual in regard to public education, privacy, and due process; yet, they allow for alternative programs, exclusion, and monitoring.

Policy 4

The sample IASB policies were broad and general. The "X" symbol meant that the criterion was addressed in an all encompassing statement such as: "The rules and regulations of the State of Illinois shall govern".

Policy 5

The Montana State Guidelines gave extremely detailed direction concerning hygienic procedures and practices, but were very weak concerning routine monitoring of the infected person.

Policy 6

The Iowa guidelines dealt especially well with confidentiality. They stressed that the passing on of information about an AIDS student should be by person-to-person contact.

Policy 7

The Connecticut guidelines received a poor rating on the team evaluation item because while

they refer a placement team, they do not discuss the make up of the team. The language of these guidelines dealing with "removal for own safety" was very specific.

<u>Policies 8-14</u>

These local policies or proposed policies were from school districts located within the state. Many of them contain very similar language. The great majority of policies deal very well with the criteria labeled "general statement, right to education, case-by-case team, educational plan, last restrictive environment, temporary exclusion, and routine monitoring". Areas of weakness were evident in "privacy, alternative program, due process, removal for own safety, and hygiene procedures". Policy 9 from Peoria had several weaknesses. It used the phrase, "any student suspected of having AIDS", rather than using the almost universally accepted "reasonably suspected". The policy was very weak concerning students' rights.

Belleville and several other districts adopted that section of the ISBE guidelines dealing with hygiene procedures nearly verbatim. However, the local St. Clair County Department of Health was called in to review the procedures.

Under policy 14 the letter "Y" appears. This indicated that this policy was a photocopy of the ISBE policy with two minor changes. The changes involved removing the school nurse from decision-making involvement in two instances and replacing her with administrative representatives.

Table 7
Separate Employee Policies

City	Danville	Palatine	Charleston	Robinson
Criteria	C	C	C	C
Privacy	2	2	3	3
Case-by-case Team	3	3	3	1
Restrictive Environment	1	1	1	1
Alternative Placement	1	2	3	3
Temporary Exclusion	3	3	3	3
Due Process	-	-	-	2
Removal for Own safety	-	-	-	-
Routine Monitoring	3	3	3	2

Explanation of Table 7

This table considered policies that dealt only with employees. The "C" under each city indicated that the policy did not address only AIDS, but other chronic contagious diseases as well. The policies

were very similar in their weaknesses. Least restrictive environment here meant that the employee would be allowed to return to his/her position once the evaluation team had determined the employee was fit. This criterion was only peripherally addressed in all the policies. None of the policies specifically mentioned that the infected employee should be removed from contact with students during disease outbreaks at school. Most of the policies were silent concerning the due process rights of the infected person.

Chapter 5

Findings, Conclusions, and Recommendations

Findings

1. On 10 of the 11 PDK items, the local superintendents were within 10% of the national sample.

2. Eighty-five percent of the surveyed districts have or are developing AIDS policies.

3. Seventy-eight percent of the local superintendents indicated that the group developing the policy should include at least the administration, board, legal counsel, health officials and staff.

4. Nine of the 14 policy-making bodies chose to deal with AIDS in the context of a Chronic Contagious Disease Policy.

5. Of the local school district policies reviewed, three chose an inclusive student-employee policy while four chose separate student and employee policies.

6. In considering the source of information for developing AIDS policies, 65% of the respondents ranked paid legal consultants highly.

7. One hundred percent of the superintendents perceived that district concern about AIDS was not

high.

8. Ninety-five percent of the superintendents believed AIDS education should begin prior to eighth grade.

9. Less than 10% of the respondents agreed with the concept of mandatory testing of all students and staff.

10. Ninety to 95% of the local superintendents indicated that AIDS should be part of the regular curriculum and that school and health officials needed to better coordinate their efforts.

11. Superintendent reaction was mixed concerning exclusion from contact sports (59%), protection under anti-discrimination laws (50%), and treating AIDS differently from other contagious diseases (50%).

12. The great majority of local policies (over 70%) ranked high concerning a general policy statement, case-by-case team approach, specialized educational plan, and routine monitoring.

Conclusions

1. The superintendents in the local sample are representative of superintendents throughout the country.

2. The great majority of superintendents have reacted responsbily to develop or initiate

development of AIDS policies.

3. The group charged with developing the AIDS policy should be broad based.

4. Professional legal consultants should play a key role in policy development and review.

5. School districts should develop broad spectrum contagious disease policies, rather than policies dealing only with AIDS.

6. Separate student and employee policies are preferable to an inclusive policy because they tend to be more detailed and specific.

7. In developing AIDS policies, more emphasis should be placed on specifying and enumerating student and employee rights.

Recommendations

1. Copies of Chapters 4 and 5 of this study should be made available to participating superintendents and the regional education office.

2. The Illinois State Board of Education should actively address the lack of trust school districts apparently have in the information the ISBE provides.

3. The group responsible for developing district AIDS policies should include, but not be limited to, representatives from the administration, school board, certified and non-certified staff,

legal counsel, health officials, students, and community representatives. Final approval rests with the board.

4. The policies should deal with Chronic Contagious Diseases and there should be distinct student and employee policies.

5. The author recommends these Model Policies which were assembled using an eclectic approach from the policies reviewed in the study. The author added definitions, modified sections, and composed new language where needed. Any district wishing to use these policies should first have them reviewed by legal counsel.

Model Chronic Contagious Disease Policy - Student

I. The School Board recognizes that students with chronic contagious diseases (as defined by the ISBE Guidelines) are entitled to the right of a public education, privacy, and due process as well as the other privileges provided by law and District policy. The rights of the individual to be educated in the least restrictive environment shall be balanced against the District's obligation to protect the health of the school population. Each incidence of a chronic contagious disease shall be evaluated on a case-by-case basis.

II. Upon being informed that a student has, or

is reasonably suspected to have a chronic contagious disease, the Superintendent, in consultation with those persons deemed necessary, shall decide whether temporary exclusion is warranted. "Reasonably suspected" means that a direct link exists between the suspected carrier and a person known to have the disease. This link must be of a nature that medical science accepts as a mode of transmission. If that determination is made, the Superintendent will immediately notify the student's parents/guardians of the temporary exclusion pending determination as to placement. The parents/guardians shall be advised that the placement could be the normal classroom setting or an alternative education outside the normal classroom.

III. The Superintendent may require a medical examination, including blood tests, from the student at District expense. Refusal of the student to submit to the examination will result in continued exclusion until results of a medical examination are forthcoming.

IV. A student medically identified as having a chronic contagious disease shall be evaluated by a review team to determine how the physical condition or behavior of the student effects the placement decision. This team may include, but is not limited

to, the Superintendent, building principal, teacher(s), legal counsel, medical and health advisors, and a representative of the student. This committee will recommend a course of action to the Board regarding placement. The Board, during executive session, will review the findings. The parents/guardians will be offered the opportunity to be heard before the Board. When the Board has made a decision, that decision shall be communicated via certified mail to the parents/guardians.

V. If the Board has determined that exclusion is no longer warranted, the student will be reinstated in the regular program. If the Board has determined that an alternative program is necessary, an Individualized Educational Plan will be developed specifying that program's venue and content. A decision on a student's placement or Individualized Educational Plan may be appealed in accordance with the School Code and the Rules and Regulations to Govern the Administration and Operation of Special Education.

VI. The student's right to privacy shall be maintained as described in current state and federal statute. Only those persons considered to have a direct need to know will be given the identity of the student. Confidentiality will be stressed and

written correspondence containing such information shall be kept to a minimum. The principal of the effected building may inform such other persons as may be necessary that an infected student is enrolled at that school as long as the child's identity is not revealed as per Chapter 111 1/2 paragraph 22.12a of the School Code.

VII. In the event of an outbreak of a common infectious disease in the school setting, the student infected with the chronic contagious disease may be excluded from attendance for the student's own protection. This decision will be made by the principal, school nurse, and medical authorities acting in concert.

VIII. The condition of the student shall be monitored on a monthly basis by the school nurse to determine if any change in placement or program is necessary. If such change is necessary, the review team will reconvene and determine the necessary adjustments in the Individualized Educaitonal Plan. The review team will meet at least once a year for each chronically infected student.

IX. Prevention of infectious diseases depends on basic principles of cleanliness and hygiene. Information concerning these basic principles shall be made available through in-service training to all

district personnel. The procedures contained in the procedures section of this policy were taken from the recommendations of the Illinois State Board of Education and the Illinois Department of Public Health (Appendix B).

Model Chronic Contagious Disease Policy - Employee

I. As incidents of chronic contagious disease (as defined by ISBE guidelines) occur among employees, they will be dealt with on a case-by-case basis. Any employee infected with a chronic contagious disease shall immediately notify his/her supervisor of the infection. Upon being informed that the employee has, or is reasonably suspected of having a chronic contagious disease, the Superintendent may temporarily exclude the employee from normal duties. "Reasonably" means that a direct link exists between the suspected carrier and a person known to have the disease. This link must be of a nature that medical science accepts as a mode of transmission.

II. The Superintendent may require a medical examination including blood tests of the employee at District expense. Refusal by the employee to submit to a medical examination may be considered grounds for disciplinary action as well as continued

exclusion.

III. A determination of the employee's medical condition as it relates to the performance of regular duties will be made by a review team including, but not limited to the Superintendent, building principal, medical advisors, school nurse, health officials, the employee's physician, and the employee. If the employee's medical condition prohibits return to normal duty, the employee may use sick leave or may be required, subject to a hearing as required by law, to take a leave of absence during the period of risk. The review team may also recommend some form of alternative job program or position.

IV. At all times the District shall endeavor to protect the confidentiality of the employee. The identity of the infected employee will be released on a strict need to know basis and will be limited to the Superintendent, building principal, Board of Education, legal counsel, medical advisors, and any other person who, in the opinion of the Superintendent, must be informed of the condition of the employee so as to protect the health of the students and other employees. Any discussion by the Board of the infected employee shall be in closed session in accordance with the Open Meetings Act.

V. The condition of the employee will be monitored on a monthly basis by the school nurse in concert with appropriate medical personnel. If medical conditions change, the review team will reconvene and determine the best course of action.

VI. In the event of an outbreak of a common infectious disease in the school setting, the employee infected with the chronic contagious disease may be excluded from attendance for the employee's own protection. This decision will be made by the employee, principal, school nurse, and medical advisors acting in concert.

VII. Prevention of infectious diseases depends on basic principles of cleanliness and hygiene. Information concerning these basic principles shall be made available through in-service training to all District personnel. The procedures contained in the procedures section of this policy were taken from the recommendations of the Illinois State Board of Education and the Illinois Department of Public Health (Appendix B).

Appendix A

Recommendations of the Center for Disease Control

1. Decisions regarding the type of education and care setting for HTLV-III/LAV-infected children should be based on the behavior, neurological development and physical condition of the child and the expected type of interaction with others in that setting. These decisions are best made using the team approach including the child's physician, public health personnel, the child's parents or guardian and personnel associated with the proposed care or education setting. In each case, risks and benefits to both the infected child and to others in the setting should be weighed.

2. For most infected school-age children, the benefits of an unrestricted setting would outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent nonexistent risk of transmission of HTLV-III/LAV. These children should be allowed to attend school and after-school day care, and be placed in a foster home in an unrestricted setting.

3. For the infected preschool-age child and for some neurologically handicapped children who lack control of their body secretions or who display

behavior such as biting and those children who have uncoverable, oozing lesions, a more restricted environment is advisable until more is known about transmission in these settings. Children infected with HTLV-III/LAV should be cared for and educated in settings that minimize exposure of other children to blood or body fluids.

4. Care involving exposure to the infected child's body fluids and excrement, such as feeding and diaper changing, should be performed by persons who are aware of the child's HTLV-III/LAV infection and the modes of possible transmission. In any setting involving an HTLV-III/LAV-infected person, good handwashing after exposure to blood and body fluids and before caring for another child should be observed, and gloves should be worn if open lesions are present on the caretaker's hand. Any open lesions on the infected person should also be covered.

5. Because other infections in addition to HTLV-IIILAV can be present in blood or body fluids, all schools and day-care facilities, regardless of whether children with HTLV-III/LAV infection are attending, should adopt routine procedures for handling blood or body fluids. Soiled surfaces should be promptly cleaned with disinfectants, such

as household bleach (diluted 1 part bleach to 10 parts water). Disposable towels or tissues should be used whenever possible, and mops should be rinsed in disinfectant. Those who are cleaning should avoid exposure of open skin lesions or mucous membranes to the blood or body fluids.

6. The hygienic practices of children with HTLV-III/LAV infection may improve as the child matures. Alternatively, the hygienic practices may deteriorate if the child's condition worsens. Evaluation to assess the need for restricted environment should be performed regularly.

7. Physicians caring for children born to mothers with AIDS or at increased risk of acquiring HTLV-III/LAV infection should consider testing the children for evidence of HTLV-III/LAV infection for medical reasons. For example, vaccination of infected children with live virus vaccines, such as the measles-mumps-rubella vaccine (MMR), may be hazardous. These children also need to be followed closely for problems with growth and development and given prompt and aggressive therapy for infections and exposure to potentially lethal infections, such as varicella. In the event that an antiviral agent or other therapy for HTLV-III/LAV infection becomes available, these children should be considered for

such therapy. Knowledge that a child is infected will allow parents and other caretakers to take precautions when exposed to the blood and body fluids of the child.

8. Adoption and foster-care agencies should consider adding HTLV-III/LAV screening to their routine medical evaluations of children at increased risk of infection before placement in the foster or adoptive home, since these parents must make decisions regarding the medical care of the child and must consider the possible social and psychological effects on their families.

9. Mandatory screening as a condition for school entry is not warranted based on available data.

10. Persons involved in the care and education of HTLV-III/LAV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase (e.g., bleeding injury).

11. All education and public health departments, regardless of whether HTLV-III/LAV-infected children are involved, are

strongly encouraged to inform parents, children and educators regarding HTLV-III/LAV and its transmission. Such education would greatly assist efforts to provide the best care and education for infected children while minimizing the risk of transmission to others.

Appendix B

Illinois State Board of Education

and

Illinois Department of Public Health

Management of Chronic Infectious Diseases in School Children

Development of an Infectious Disease Program

Policies and Procedures

An infectious disease program should include the following components: 1) policies and procedures related to identification, placement, and school management of students with infectious diseases; 2) an infectious disease review team which consists of the school medical advisor, the school nurse, and the school administrator and is generally responsible for planning and managing the educational program for the individual student with an infectious disease; 3) maintenance of routine hygienic procedures to assure a clean, safe, healthful school environment; and 4) a health education/health counseling program to educate school staff, students and parents.

The first step in establishing an infectious disease program is the development of appropriate policies and procedures. The school board is

legally responsible for the formulation and adoption of all school policies. In view of the scope of the infectious disease program, it is recommended that school officials establish a task force consisting of the school administrator, the school medical advisor, the school nurse and representatives from the school board, local health department, teaching staff, PTA or PTO, custodial staff, food service staff, etc., to assist in the development of the infectious disease program and to serve in an advisory capacity to the school board in the development of policies to implement the program.

The school board should make public its policies on management of students who have chronic infectious diseases. Copies of the school board policies should be distributed to all parents in the district and to all school staff.

Legal Considerations Related to Chronic Infectious Diseases

Federal and state courts have held that children affected with chronic infectious diseases are entitled to a free appropriate public education in the least restrictive environment and are covered by the substantive and procedural protections incorporated in the statutes (c.f. White v Western School Corp. #IP 85-1192-C. U.S.D.C.S.D. Ind..

Indianapolis Div., Comm. High Sch. Dist. 155 v. Denz 463 N.E. 2d 998; Ely v. Howard County Bd. of Ed. 3 EHLR 553 288 D.C. M.D. 1982. New York State Ass'n for Retarded Children v. Carey, 612 F. 2d 644 (1979).

Students who have chronic infectious diseases may, but do not necessarily require special education or adaptive programming. Each student should be individually evaluated to determine the most appropriate educational placement.

Guidelines for Development of Policies and Procedures

Related to Infectious Diseases

The following guidelines are intended to provide local school districts with a framework for developing policies and procedures related to infectious diseases.

1. All children in Illinois including those with chronic infectious diseases have a right to a free public education. Students with chronic infectious diseases are eligible for all rights, privileges, and services provided by law and the local policy of each school district.

2. The school should respect the right to privacy of the individual; therefore, knowledge that a student has an infectious disease should be confined

to those persons with a direct need to know (e.g. principal, school nurse and student's teacher). Those persons should be provided with appropriate information concerning such precautions as may be necessary and should be aware of confidentiality requirements.

3. Students known to have chronic infectious diseases should be individually evaluated in order to determine if their behavior or physical condition poses a high risk of spread of disease. The school infectious disease review team should work with local, regional or state health officials, the family physician, the student, the student's teacher and the student's parents to establish the most appropriate education program for a student identified as having an infectious disease. Policies and procedures should be in place to protect the infected student's rights to an appropriate education, as well as to ensure a safe classroom environment for all students.

4. As a consequence of the evaluation, there should be a specific plan for the education of the student. This individual student plan should identify the student's educational program, the health-related conditions of the placement (For example, the student is to be educated in a regular classroom

with other studnts except when certain conditions related to the infectious disease are present.), specific health instructions, and other relevant information.

5. In most cases, students with chronic infectious diseases should be allowed to attend school in a regular classroom setting. Adaptations of classroom environment or curricular offerings should be provided as needed by the student. Note: Although most of the case law relating to students with chronic infectious disease is in the area of special education, this does not mean that a student with such a disease should automatically be considered for special education placement. Unless the student is otherwise in need of special education services, such programs should be considered only as a resource for meeting special needs of the individual child -- for example, temporary services in the home or hospital.

6. Under certain circumstances, it may be necessary to provide the student with a chronic infectious disease with an alternative school program or to remove the student from the school setting for a period of time.

a. Certain changes in the student's health condition may require temporary removal from

his/her regular program. Generally, if the student develops a temporary condition which poses a risk of transmission of disease to others (for example, if the student develops open lesions), the student should be removed from the regular program until he or she may be safely returned to the classroom. The decision to remove the student from school should be based upon public health recommendations specific to the transmissibility of disease. Readmission should occur only with medical documentation and after consultation with the school nurse.

b. Under the following circumstances a student with an chronic infectious disease may pose an ongoing risk of transmission to others: if the student lacks toilet training, has open sores that cannot be covered, or demonstrates behavior (e.g. biting) which could result in direct inoculation of potentially infected body fluids into the bloodstream. If any of these circumstances exist, the review team should consult with the student's physician and the local health authorities regarding the risks involved to determine whether the student should be educated in an educational

environment separate from other students. The school district policies should specifically identify the decision-making process for such placement.

c. Exclusion from the school should not be construed as the only response to reduce risk of transmission. The school district should be flexible in its response and attempt to use the least restrictive means to accommodate the student's needs.

7. State health regulations regarding the health-related exclusion of students who have acute contagious diseases are specific regarding the length of time a student must remain out of school. Recommendaions concerning the removal of students who have chronic infectious diseases are not as clearly defined; therefore, the length of time the student with a chronic infectious disease should be kept out of school should be determined on a case-by-case basis.

8. Each student should have the right to due process. If the parents or guardians disagree with the student's educational placement or change of placement due to factors described in #6 above, there should be a process by which such objections can be considered including, at a mimimum, notice

and an opportunity to be heard. Parents or guardians should be offered the opportunity to be heard within ten (10) days of their request. Written policies should be in place to guarantee this process.

9. The maintenance of confidentiality is of the upmost (sic) importance; school board meetings to discuss matters relating to an individual student should be closed in accord with the Open Meetings Act, Illinois Revised Statutes, Chapter 102. par. 41 et. seq.

10. In some instances, students who have an immunodeficiency may need to be removed from the classroom, for their own protection--for example, if there is an outbreak of a contagious disease. This decision to remove the student from school should be made by the student's physician and parent/guardian in consultation with the school nurse.

11. Individual health conditions permitting, a student who is removed from the school should be provided with a continuing education program until it is determined that the student can be safely returned to the classroom. If it is expected that the student will be out of the school setting for more than 10 school days, 23 Illinois Administrative Code 226.115 and 226.350 et seq. regarding home and

hospital programs may apply. The school district should do everything possible to ensure that the student's educational progress is maintained.

12. The school nurse should routinely monitor all students identified as having infectious disseases:

a. Students in classroom attendance should be monitored continuously in order to determine if their behavior or medical condition has altered in such a way as to affect their transmissibility status.

b. When a student is removed from normal school attendance as described in #6, the student should be placed on a monitoring schedule appropriate to the infectious disease and the condition precipitating the removal or change, for the purpose of alternative educational programming or reintegrating the student into the public school setting.

c. Students with infectious disease should be educated in the least restrictive environment possible, and even those children whose behavior or physical condition precludes school attendance should be continually evaluated for return to the classroom.

13. Routine and standard procedures of cleanliness and hygiene should be used to clean up after any student has an accident or injury at school. Blood or other body fluids (saliva, vomitus, feces, urine) emanating from any student, including ones known to have infectious diseases, should be treated cautiously. The district policies for managing infectious disease should ensure that all school staff are instructed regarding the hygienic procedures necessary to maintain a safe, clean school environment. See Chapter Three, Section II for more details regarding the procedures to be used.

Implementing and Maintaining The Infectious Disease Program

An effective program requires the full participation and support of all school officials, local health department officials, local physicians, parents and all school staff. After the infectious disease program and policies have been developed, the school administrator should delegate to the appropriate school staff the responsibility for implementing and maintaining the program. In delegating the specific tasks, the school administrator must be sure that each staff person

fully understand his or her responsiblity in implementing the program.

The school nurse is the most appropriate person to coordinate the school's infectious disease program. The coordinator of the infectious disease program should:

1. interpret infectious disease policies and procedures to school personnel, parents, and students;
2. provide health education and health counseling regarding infectious diseases;
3. orient, instruct and supervise the maintenance of hygienic procedures as described in Chapter Three;
4. develop the health component of the student's educational plan;
5. monitor and assess students with infectious diseases;
6. recommend modification of the school program of infected students as needed.
7. serve as the advocate for the infected student;
8. act as the liaison between the school, home, community health agencies and the private medical sector; and
9. keep up with current information, rules and regulations, policies and procedures relating to

infectious diseases.

The spread of infectious diseases can be controlled by individual behavior. Extreme measures to isolate students with chronic infectious disease are not necessary. Many irrational fears can be mitigated through planned health education and health counseling programs. The school infectious disease task force should plan for an ongoing education program for school staff, students and parents. The educational programs should include information regarding the mode of transmission and the methods of preventing the spread of infectious diseases. See Chapter Two for more details regarding specific, chronic infectious diseases.

Infectious Diseases

An understanding of the different types of infectious diseases is essential in planning and implementing an effective infectious disease management program. This chapter provides a brief description of the chronic infectious diseases, the ways the diseases are transmitted to others, the methods of preventing the diseases and suggestions on how to manage students who have infectious diseases in the school setting.

Decisions regarding the educational and care setting for an infected student should be based on

the behavioral, neurological and physical condition of the particular student and the expected type of interaction with others in that setting. The decisions are best made using the infectious disease review team, which should include the student where appropriate, the student's parent or guardian, the student's physician, the school nurse, local public health authorities, and personnel associated with the proposed care or educational setting. In each case, risks and benefits to both the infected student and others in the setting should be weighed.

For infected students including preschool and neurologically handicapped students who lack control of body secretions or who display behavior such as biting and students who have uncoverable, oozing lesions, the review team shall consider recommending a more restricted environment.

Congenital Rubella Syndrome (CRS)

Congenital rubella syndrome (CRS) is a severe disease caused by rubella virus infection usually contracted by a woman who is in her first trimester of pregnancy. Approximately 25 percent of such infections will result in disease in the developing fetus that is recognizable at birth. Of the remaining 75 percent who appear normal at birth, 55 percent may be found to be affected by age two. The

incidence of fetal infection is much less when infections occur later in pregnancy. Fetuses exposed after 16 weeks of gestation have a 10-20 percent risk of infection. Infections beyond the 20th week of gestation rarely result in defects. Affected children may have mental retardation, cataracts, glaucoma, heart defects, hearing defects, and bone defects. Rubella infections acquired after birth result in a mild disease with a risk, a low fever, swollen lymph nodes and painful joints.

In past years, rubella infections occurred often, primarily in young children, but now they occur infrequently due to the widespread use of rubella vaccine. Cases that occur now are equally distributed among young children, adolescents, and teenagers. Infection with this virus provides lifelong immunity, as does vaccination with rubella vaccine. Between 15 and 25 percent of adults are not immune to rubella infection.

Hepatitis B

Hepatitis B is a viral infection of the liver. When it produces illness, the person will have a loss of appetite, tenderness in the upper right abdomen, extreme fatigue, and often jaundice. Approximately 50 percent of adults and approximately 90 percent of young children who are infected with

this virus will not develop symptoms. Most persons infected with this virus recover completely, but six to ten percent become chronic carriers. Persons with abnormalities in their immune systems and persons with Down's syndrome, if exposed to the virus, are more likely to become chronic carriers than other exposed persons. In fact, persons with Down's syndrome have a carrier rate that may be as high as 50 percent.

Specific blood tests will determine if a person is a chronic hepatitis B carrier. The hepatitis B surface antigen (HBsAg) test must be positive on two occasions at least six months apart before a person can be identified as a chronic hepatitis B carrier.

Most children and adults who are infected with this virus will exhibit no symptoms. The few who develop symptoms will usually have an illness resembling infectious momonucleosis with fever, swollen lymph nodes, and sore throat. These infections do not result in serious long-term effects. Rarely children and adults infected with this virus will experience pneumonia or will have liver abnormalities which may include jaundice. Serious disease can occur when a child or adult with an impaired immune system is infected or when a developing fetus is infected.

Acquired Immunodeficiency Syndrome (AIDS) and
AIDS-Related Complex (ARC)

The Acquired Immunodeficiency Syndrome (AIDS) is a serious disease caused by infection with the human T-lymphotropic virus type III (HTLV-III). Persons with AIDS have developed a defect in the functioning of their immune systems as a result of HTLV-III infection. These persons are extremely susceptible to certain types of opportunistic infections and to certain rare forms of cancer. No treatment is currently available to reverse the immune system deficiency.

AIDS patients must be diagnosed as having an opportunistic infection such as Pneumocystis carina pneumonia, a rare form of cancer known as Kaposi's sarcoma, or other opportunistic diseases highly suggestive of faulty immune systems (see Appendix A). Not all persons infected with the HTLV-III virus develop AIDS. In some infected persons, the infection leads to detectable but apparently less severe, abnormalities of the immune system that do not result in the development of the diseases listed in Appendix A. This condition is called the AIDS-related complex (ARC). Some persons with ARC will develop AIDS and others will not. The percentage who will develop AIDS remains unknown.

Because ARC patients are infected with the HTLV-III virus, they may be capable of transmitting infection to others. The same precautions to prevent spread of HTLV-III infection apply to both AIDS and ARC patients.

Persons at increased risk for AIDS/ARC include homosexual or bisexual men, abusers of intravenous drugs, patients with hemophilia, sexual partners of the above groups, and sexual partners of AIDS cases. Additionally, a small number of cases have occurred in blood-transfusion recipients, and some infants have acquired the disease from their infected mothers before birth, at the time of birth, or during the first few months of life possibly from breast milk. HTLV-III virus has been found in blood, semen, saliva, and tears of AIDS patients. Saliva and tears contain the virus only occasionally, and when present, the virus is found in low concentrations compared to the concentrations found in blood and semen.

Herpes Simplex

Herpes infections are caused by two subtypes, herpes simplex virus type 1 (HSV-1) and herpes simplex virus type 2 (HSV-2). Although HSV-1 is most often associated with cold sores and fever blisters and HSV-2 is most often the cause of

genital herpes, either virus can cause infection in either anatomical site. Twenty-five percent of genital herpes infections are caused by type 1, and 10 percent of oral herpes infections are caused by type 2. Although much public attention has been drawn to type 2 genital herpes infections, there is little distinction between the symptoms produced by these viruses, and their methods of control are the same.

Initial infection with these viruses is sometimes followed by recurrent episodes in subsequent months or years. Infections with these viruses are common, with 50-90 percent of adults showing evidence of past infections. The majority of primary infections produce no symptoms. Of those who do develop symptoms (10-50 percent), there will be an illness comprised of fever and malaise lasting for approximately one week and a vesicular lesion or lesions (raised sore) on the lip, mouth, throat, eye, external genitalia, or vagina four to five days following exposure. Secretions from these lesions are most infectious during the 24 hours after they appear and remain infectious for about two weeks. Some people, particularly those with genital infections, have recurrent episodes which are similar, but milder, than the original infections.

Many recurrent infections are limited to appearance of the fever-blister-type sore. Secretions from recurrent infections are infectious for about 7 days.

Regardless of the recurrence of symptoms, some people who have been infected with either of these viruses are periodically infectious. The saliva is periodically infectious in some people who have oral infections, and genital secretions are periodically infectious in some persons whose infections are at that anatomical site.

At any given time, an estimated 2-10 percent of the population is shedding either of these herpes viruses.

Procedures for School Management of Infectious Disease

Prevention of infectious diseases depends on basic principles of cleanlines and hygiene. The transmission of these infectious diseases may be prevented by using standard procedures to maintain both personal and classroom cleanliness and by monitoring the actions of suspected and known infected students. The procedures listed in this chapter should be employed at all times when providing care for all students regardless of their

infectious-disease status.

Teaching and supervising staff who perform these preventive measures for the control of infectious diseases is a school nursing function which does not require a physician's authorization. Personnel responsible for carrying out these procedures include the infectious disease review team, teachers, teachers' aides, care workers, custodial staff, food handlers, volunteers and anyone who may have direct contact with the students, equipment and supplies, including eating utensils and play objects. Responsibility also extends to such areas as contaminated floors, walls, toilets, sinks, and changing surfaces, as well as contaminated clothing or cleaning equipment such as mops.

I. Guidelines for Establishing Infectious Disease Prevention Procedures:

A. Transmission of infectious diseases may occur more readily where close personal contact is involved in student care. Preschool and kindergarten settings, as well as special facilities for handicapped students, need special attention for the prevention of infectious diseases.

B. Preventing the spread of infection requires that personal and environmental cleanliness techniques be

practiced at all times in every school setting.

C. Prior to the enrollment of continued attendance in the regular or special classroom of an infected student, the school nurse shall develop specific procedures appropriate to the student's age and the stage of development for the specific disease. The school nurse should carry out the following procedures:

1. Conduct a health and developmental assessmnent, including a review of the student's medical records. Collaborate with parents and physician to ensure that the records are complete.

2. Identify student and school personnel who may be at risk, such as those who are chronically ill, pregnant, capable of childbearing or taking immunosuppressant medication.

3. Identify appropriate personal and environmental cleanliness techniques in accordance with student and staff needs.

4. If the regular education program cannot be modified and the student is identified as an individual with exceptional needs, write appropriate health objectives for the student's Individualized Education Program (IEP).

5. Orient and train all staff members, including custodians, substitute teachers, volunteers, and bus drivers. Orientation and training must be ongoing and must be scheduled to include new personnel.

6. Maintain ongoing communication with parents and the primary physician regarding the student's status.

7. Verify the school district's efforts to prevent the spread of infection and to protect the health of employees and students by documenting the training and supervision of employees.

II. Guidelines for Maintaining a Safe Healthful School Environment. These guidelines and procedures should be followed regardless of the presence or absence of a student known to have an infectious disease:

A. All facilities should make provisions for personal and environmental cleanliness.

1. Allow sufficient time for hand washing after using the toilet and before eating meals and snacks.

2. Provide ready access to hand-washing facilities. These should include hot and cold running water and liquid soap in a workable

dispenser.

3. Provide disposable paper towels. The use of cloth towels is discouraged; however, if cloth towels are used, discard them with other contaminated linens after each use.

4. Maintain storage areas for linens, utensils, equipment, and disposable items. These areas must be separate from areas used for storage of soiled items.

5. Keep soiled disposable items in covered waste receptacles lined with disposable plastic bags. At the end of each day, the plastic bags are to be sealed and discarded. Do not reuse.

B. Hand washing is the most important technique for preventing the spread of disease and should be done frequently. Proper hand washing requires the use of soap and water and vigorous washing under a stream of running water for at least 10 seconds. Rinse under running water. Use paper towels to thoroughly dry hands.

1. Before putting on lab coat or smock (or large blouse or shirt to cover street clothing) in preparation for working with the students.
2. Before drinking, eating, or smoking
3. Before handling clean utensils or equipment
4. Before and afer handling food.

5. Before and after assisting or training the student in toileting and feeding

6. After going to the bathroom

7. After contact with body secretions, such as blood (including menstrual flow), urine, feces, mucus, saliva, semen, tears, drainage from wounds, etc.

8. After handling soiled diapers, menstrual pads, garments, or equipment.

9. After caring for any student, especially those with nose, mouth, eye, or ear discharge

10. After removing disposable gloves

11. After removing lab coat or smock when leaving the work area.

C. All staff members should practice specific hygienic principles designed to protect themselves and others from infection.

1. Maintain optimum health through effective daily health practices such as adequate nutrition, rest, exercise, and appropriate medical supervision.

2. If a careprovider has a cut or an open lesion on his/her hands, disposable gloves must always be worn when providing direct care for any student where there is contact with bodily excretion or secretions.

3. Avoid rubbing or touching eyes

4. Refrain from kissing or being kissed by students

5. Wash hands frequently

6. Avoid the use of jewelry such as rings, danging bracelets, and earrings during working hours.

7. Use one's own personal care items such as combs, fingernail files, nail clippers, lipsticks, and toothbrushes

8. Keep fingernails clean and trimmed short.

III. Procedures for Cleaning Up Body Fluid Spills (blood, feces, urine, semen, vaginal secretions, vomitus). These procedures should be used for all students regardless of their infectious-disease status:

A. Wear disposable gloves. When disposable gloves are not available or unanticipated contact occurs, hands and other affected areas should be washed with soap and water immediately after contact.

B. Clean and disinfect all soiled hard, washable surfaces immediately, removing soil before applying a disinfectant.

1. Use paper towels or tissues to wipe up small-soiled areas. After soil is removed, use clean paper towels and soap and water to clean

area.

2. Disinfect area with a dilution of 1:10 household bleach solution or another disinfectant. (See section VI for selection of a disinfectant.)

3. Apply sanitary absorbent agent for larger soiled areas. After soil is absorbed, vacuum or sweep up all material.

4. Disinfect area with a clean mop. (See Section VI for selection of a disinfectant).

C. Clean and disinfect soiled rugs and carpets inmediately.

1. Apply sanitary absorbent agent, let dry and vacuum.

2. Apply rug shampoo (a germicidal detergent) with a brush and revacuum.

D. Clean equipment and dispose of all disposable materials.

1. Soiled tissue and flushable waste can be flushed in toilet. Discard paper towels, vacuum bag or sweepings in a waste receptacle lined with a plastic bag.

2. Rinse broom and dust pan in disinfectant solution.

3. Soak mop in disinfectant solution and rinse thoroughly or wash in hot water cycle after soakig in disinfectant.

4. Disinfectant solution should be promptly disposed of down a drain.

E. Clothing and other nondisposable items (e.g. sheets, towels) soaked with body fluids should be rinsed and placed in a plastic bag to be sent home or laundered.

F. Remove disposable gloves and discard in waste receptacle.

G. Wash hands.

H. Plastic bags holding contaminated waste should be secured and disposed of daily.

I. Large waste containers (dumpsters or other containers which are impervious to animals) containing potentially contaminated waste should be located in a safe area away from the playground or other areas used by students.

IV. Special Procedures for Early Childhood, Day Care, and Special Classroom Settings. These procedures should be used for all students regardless of their infectious-disease status.

A. Guidelines for Diapering

1. Purpose: to avoid cross-contamination when

diapering.

2. Equipment

a. Changing table; student's own bed, cot, mat; or safe, firm, nonporous surface (clean and sanitized).

b. Readily accessible hand-washing facility, including hot and cold running water, liquid soap in workable dispenser and disposable paper towels.

c. Supplies for cleaning student's skin, disposable baby wipes, soap, water and cotton balls or soft tissue.

d. Plastic bags for student's soiled clothing.

e. Covered waste receptacle inaccessible to students lined with a disposable plastic bag for disposable diapers.

f. The use of cloth diapers is discouraged. However, if cloth diapers are used, a covered receptacle lined with a disposable plastic bag should be used for each student. Soiled cloth diapers should be stored in an area inaccessible to the students.

g. Plastic bag ties or masking tape for sealing disposable plastic bags at time of discard.

h. Disposable plastic gloves (medium or large size, nonsterile) for use with cloth diapers.

i. Disinfectant for cleaning changing surface (see Section VI).

3. Procedure

a. Wash hands

b. Place student on clean changing surface.

c. Remove soiled diaper and place in appropriate receptacle.

d. If other clothing is soiled, remove, rinse and place it directly in a plastic bag that can be marked with student's name, secured and sent home at the end of the day.

e. Cleanse the perineum and buttocks thoroughly with disposable baby wipes or soap and water.

f. Rinse well and dry skin prior to applying clean diaper.

g. Wash student's hands.

h. Wash own hands.

i. Return student to class activity.

j. Wear disposable plastic gloves to rinse and wring out in toilet any cloth diaper soiled with feces.

k. After rinsing, place the cloth diaper in the appropriate receptacle.

l. Remove gloves and discard them in the appropriate receptacle.

m. Wash hands.

n. Report abnormal conditions to the appropriate personnel, school nurse, or school administrator.

o. Use disinfectant to clean changing area and other contaminated surfaces (see Section VI).

B. Guidelines for Classroom Cleanliness

1. Purpose: To prevent the transmission of infectious disease.

2. Equipment

a. Lab coat or smock (large blouse or shirt to cover street clothes).

b. Covered waste receptacles with disposable plastic bags.

c. Plastic bags that can be labeled and sealed for individual's soiled laundry.

d. Disposable plastic gloves (medium or large size, nonseterile) if needed.

e. Disinfectant (see Section VI).

f. Hand-washing facility, including hot and cold running water, liquid soap in workable

dispenser and disposable paper towels.

g. Washer and dryer if disposable linens are not available.

h. Dishwasher (if disposable eating ustensils are not available).

3. Procedure

a. Wash hands

b. If a lab coat or smock is worn:

(1) Use a clean garment each day

(2) Always hang the garment right side out when leaving the work are for breaks or lunch.

c. If there are open cuts, abrasions or weeping lesions on hands, wear disposable plastic gloves.

(1) Use a new pair of gloves in each situation in which hand washing is indicated

(2) Discard used gloves in plastic bag in covered waste receptacle.

d. Store and handle clean clothing and linens separately from soiled clothing and linens.

(1) Immediately place each student's soiled clothing and linens in an individually labeled plastic bag,

which is to be sealed and sent home at the end of the day.

(2) Immediately place all soiled schoollinens in a plastic bag in a covered waste receptacle. Launder linens daily.

C. Techniques for Storing, Cleaning, and Disposing of Classroom Equipment, Supplies and Other Items

1. Immediately after use, discard any soiled disposable items by placing them in a plastic bag in a covered waste receptacle.

2. Store each student's personal grooming items (combs, brushes, toothbrushes) separately.

3. In handling disposable diapers, at least once a day, seal and discard the disposable plastic bag used to line the covered receptacle.

4. When laundry facilities are available at school, launder diapers, sheets or other cloth items soiled in the school setting daily.

a. Launder diapers or other items soaked with body fluids separately.

b. Presoak heavily soiled items.

c. Follow the manufacturer's directions on the label to determine the amount of

detergent to be added.

d. If the material is bleachable, add 1/2 cup of household bleach to the wash cycle.

e. If the material is not colorfast, add 1/2 cup of nonclorox bleach (e.g., Chlorix II, Borateam, etc) to wash cycle.

f. Use hot cycle on washer and dryer.

5. Seal and discard the soiled plastic bag used to line the covered waste receptacle at least once a day.

6. Establish a routine cleaning and disinfecting schedule.

a. Clean protective floor pads, bolsters, wedges, and so forth after each nonambulatory student has been removed and at the end of each day.

b. Wash all toys with soap and water and rinse thoroughly as needed and at the end of each day.

c. Clean all equipment at the end of each day.

d. If a rug or carpet becomes soiled, clean it immediately (as described in Section III,C).

e. Clean changing surface, bathtubs, sinks, portable potties, and toilet seats after

each use. Rinse with clear water and wipe dry.

V. Guidelines for Maintaining a Clean School Environment. These guidelines and procedures should be followed regardless of the presence or absence of a student known to have an infectious disease.

A. Clean the following areas and items daily.

1. Classrooms, bathrooms, and kitchen.
2. Floors
3. Sinks and faucet handles
4. Cabinet drawer handles
5. Doorknobs
6. Soap dispenser spigots and/or bar soap containers
7. Walls behind sinks
8. Toilets

B. Vacuum carpets daily. If a rug or carpet is soiled, it should be disinfected immediately (see Section III.C).

C. Clean waste receptacles at least weekly.

D. Empty soap dispensers, wash and air-dry monthly.

E. Steam-clean carpets quarterly.

F. If heavy nondisposable gloves are worn when a disinfectant is being used, they must be washed and air-dried after each use. They must be stored in the room of use in the area reserved for soiled articles.

G. Techniques for Handling Food and Utensils.

1. Maintain a clean area of the kitchen for serving food.

2. Maintain a separate area of the kitchen for cleanup.

3. All leftover food, dishes, and utensils should be treated as if they were contaminated.

4. Scrape food from soiled dishes and/or place disposable dishes in plastic-lined, covered waste receptacles.

5. Pour liquids into sink drain.

6. Rinse dishes and utensils with warm water before placing them in the dishwasher.

7. Clean sinks, counter tops, tables, chairs, trays, and any other areas where foods or liquids have been discarded or spilled; use approved disinfectant (see Section VI).

8. Wash hands prior to removing clean dishes from the dishwasher and storing them in a "clean" area of the kitchen.

VI. Selecting an Appropriate Disinfectant.

A. Any liquid or bar soap is acceptable for routine hand washing.

B. Select and stock a sanitary absorbent agent for cleaning body fluid spills.

C. Select an intermediate-level disinfectant which

will kill vegetative bacteria, fungi, tubercle bacillus and virus. Aerosol sprays are not recommended because of possible inhalant problems and flammability.

1. Select an agent that is registered by the U.S. Environmental Protection Agency (EPA) for use as a disinfectant in schools.

2. Select an agent that belongs to one of the following classes of disinfectants:

   a. Ethyl or isopropyl alcohol (70-90 percent).

   b. Quarternary ammonium germicidal detergent solution (2 percent aqueous solution).

   c. Iodophor germical detergent (500 ppm available iodine).

   d. Phenolic germicidal detergent solution (1 percent aqueous solution)

   e. Sodium hypochlorite (1:10 dilution of household bleach). This solution must be made fresh daily.

3. Use all products according to the manufacturer's instructions.

4. Store all disinfectants in a safe area inaccessible to students.

Appendix C

Illinois Association of School Boards

Sample Policy

To: School District

From: (policy consultant)

Re: Policies 256.03, 256.04, 720.18, Chronic Infectious Disease Control

Acute contagious/infectious disease is not a new phenomenon to school districts. The more common childhood diseases -- chicken pox, measles, mumps and whooping cough -- have a history of plaguing classrooms. While these diseases pose a temporary threat to a child's well being, serious long-term consequences to the infected child and those persons exposed are usually minimal. In recent years modern sanitary practices and increased inoculation against disease have generally reduced the incidence of an outbreak of a chronic infectious disease reaching epidemic proportions.

But just when we thought we had most chronic infectious disease under control, a new one, Acquired Immune Deficiency Syndrome, AIDS, thrust itself upon the public health scene. As information

regarding the fatal disease of AIDS has been released, public school officials agree that a somewhat complacent attitude needs to be replaced by a new awareness of chronic infectious disease.

During the past few months, the public has been in the grips of hysteria over AIDS. Many School Boards and school district administrators have turned the pages of their District's policy manual hoping to find direction should a student become an AIDS victim. Rarely, if at all, does a school district's current policy on communicable disease offer the directives which reassure that not only AIDS, but all chronic infectious diseases, are going to be dealt with in a fair, rational and intelligent manner.

The IASB Policy Department has received numerous calls in regard to the issuance of a policy on chronic infectious disease, including AIDS. We do not have a definitive statement of policy embodying the "correct" approach to handling children with infectious disease such as AIDS. What we have done in the Department's Master File of sample policy statements is include a series of sample chronic infectious disease policies representing one

approach to the problem.

Policies 256.03, 256.04, and 720.18 are three sample statements regarding chronic infectious disease which address school district policy and provision for administrative procedures. There is a policy which establishes a Chronic Infectious Disease Program Task Force, a policy which establishes a Chronic Infectious Disease Review Team and a policy on chronic infectious disease. We emphasize that these policies represent only one approach, and that approach may not be the best or appropriate one for your district. We urge that the District's legal counsel be consulted on the issue of chronic infectious disease during the review of the IASB policies or any other policies by the School Board.

256.03

Board of Education

Advisory Committees to the Board - Chronic Infectious Disease Program Task Force

The School Board is cognizant of the public's continued concern regarding chronic infectious disease and therefore directs the establishment of a Chronic Infectious Disease Program Task Force.

The Task Force will assist the school district in the development of a chronic infectious disease program that is consistent with the policies of the School Board and state and federal laws and regulations. The Task Force will serve in an advisory capacity to the School Board in the development of policies and implementation of the program.

The School Board President, with concurrence from the Board, shall appoint to the Task Force the following persons: the Superintendent, or the Superintendent's designee, the school medical advisor, the school nurse and representatives from

the School Board, the local health department, the P.T.A., the professional staff and other employee groups. The School Board shall reassess the need for the Task Force after one year.

256.04

Board of Education

Advisory Committee to the Board - Chronic Infectious Disease Review Team

The School Board recognizes that the management and control of a school environment which is free from communicable disease requires the cooperation and effort of the school staff and community. In order to promote and ensure appropriate employee and student health standards, a District Communicable Disease Review Team shall be appointed by the Board. Team members shall include the District's medical advisor, a school nurse and the Superintendent or the Superintendent's designee.

The responsibilities of the Chronic infectious Disease Review Team shall be determined by the School Board and shall include the reponsibility:

- to review, on an individual basis, the

medical case history of the student who has a communicable disease.

- to recommend to the School Board the most appropriate educational setting for the student and the most appropriate work assignment for the employee who has a chronic infectious disease;
- to recommend the possible temporary removal of the student from his or her regular educational setting;
- to recommend the possible temporary removal of the employee from his job assignment;
- to recommend when the student may return to his or her regular educational setting;
- to recommend when the employee may return to his or her job assignment.

The Chronic Infectious Disease Review Team shall be guided by the policies of the School Board, rules and regulations promulgated by the Illinois Department of Public Health and all other relevant state and federal laws and regulations, and shall consult the student's personal physician and officials of the local health department before taking any action or making any recommendations.

In the exercise of its responsibilities, the Chronic Infectious Disease Review Team shall respect the privacy rights of each employee and student and take such precautions as may be necessary to secure the student's confidentiality.

LEG. REF.: Family Educational Rights and Privacy Act, 20 U.S.C. (1974)
Ill. Rev. State.,ch. 122, para. 50-1 et. seq.
Rules and Regulations for the Control of Communicable Disease, issued by the Ill. Department of Public Health (1977).
23 Illinois Administrative Code 226.115
23 Illinois Administrative Code 226.350 et. seq.

CROSS REF.: 720.18

720.18

Students

Student Welfare - Chronic Infectious Disease

The School Board recognizes that the student with a chronic infectious disease is eligible for all rights, privileges and services provided by law and the District's policies. The District shall balance those student rights with the District's obligation to protect the health of all District students and staff.

The Board directed the administration to observe all rules of the Illinois Department of Public Health regarding chronic infectious disease. The Superintendent shall develop and implement procedures for the District to report to the local health authority, where appropriate, known or reasonably suspected cases of a chronic infectious disease involving a District student. The collection and maintenance of the student's medical information shall be done in a manner to ensure the strictest confidentiality and in accordance with federal and state laws regarding student records.

The determination of whether the student with a chronic infectious disease shall be permitted to attend school in a regular classroom setting or participate in school activities with other students shall be made on a case-by-case basis by the Chronic

Infectious Disease Review Team in direct consultation with the student's personal physician and local health authorities.

If the infected student is not permitted to attend school in a regular classroom or participate in school activities with other students, due to a determination that he or she poses a high risk of transmission of a chronic infectious disease to other students and staff, every reasonable effort shall be made to provide the student with an adequate alternative education. State regulations and school policy regarding homebound instruction shall apply. Temporary removal of the student from the District's classroom(s) may be appropriate when:

- the student lacks control of bodily secretions;
- the student has open sores that cannot be covered;
- the student demonstrates behavior (e.g. biting) which could result in direct inoculation of potentially infected body fluids into the bloodstream.

Temporary removal of the student from the classroom for those reasons listed above is not to be

construed as the only response to reduce risk of transmission of a communicable disease. The District shall be flexible in its response and attempt to use the least restrictive means to accomodate the student's needs.

The removal of a student with a chronic infectious disease from normal school attendance shall be reviewed by the Chronic Infectious Disease Review Team, in consultation with the student's personal physician and local public health authorities at least once every month to determine whether the condition precipitating the removal has changed.

When a student returns to school after an absence due to a chronic infectious disease, the school administration may require that he or she present a certificate from a physician licensed in the State of Illinois stating that the student is free from disease or otherwise qualifies for readmission to school under the rules of the Illinois Department of Public Health which regulates periods of incubation, communicability, quarantine and reporting.

If the parents/guardian disagree with the student's alternative educational placement or program, they

shall be offered the opportunity to an appeal to the School Board within ten (10) days of their notification of the decision of the Chronic Infectious Disease Review Team.

The Superintendent or the Superintendent's designee shall be reponsible for communicating and interpreting the District's chronic infectious disease policies and procedures to school district personnel, parents, students and community persons.

LEG. REF.: Ill. Rev. Stat., ch. 122, para. 50-1.
Rules and Regulations for the Control of Communicable Diseases, Ill. Dept. of Public Health (1977).

Illinois Association of School Boards, Policy Department
Please review this policy with your School Board attorney before Adoption.

Appendix D

National Education Association
Recommended Guidelines
For Dealing With AIDS In The Schools

Every school district, college and university should establish guidelines for dealing with the problems presented by students and school employees who have or could transmit AIDS to other students or school employees. The recognized employee organization should be involved in the development of these guidelines, and any dispute as to their meaning or application should be subject to the appropriate grievance/arbitration procedure. The guidelines should be reviewed periodically, and revised as necessary to reflect any medical information regarding AIDS.

On the basis of presently available medical information, NEA recommends the following guidelines (the terms "infected student," "infected school employee," and "infected individual" are used in these guidelines to apply both to persons who have been diagnosed as having AIDS and to persons who are "asymptomatic carriers," i.e., those who have been infected by the AIDS virus and are capable of transmitting it but who have not developed any of

the symptoms of AIDS):

1. (a) Infected neurologically handicapped students who lack control of their bodily secretions, or who display behavior such as biting, vomiting, etc., and infected students who have uncoverable, oozing lesions, shall not be permitted to attend classes or participate in school activities with other students.

(b) The determination of whether an infected student who is not excluded pursuant to Section 1 (a) above shall be permitted to attend classes or participate in school activities with other students shall be made on a case-by-case basis by a team composed of public health personnel, the student's physician, the student's parents or guardian, and appropriate school personnel, which shall include the infected student's primary teacher(s). In making this determination, the team shall consider: (1) the behavior, neurological development, and physical condition of the student; (2) the expected type of interaction with others in the school setting; and (3) the impact on both the infected student and others in that setting.

(c) The determination of whether an infected school employee should be permitted to remain employed in a capacity that involves contact

with students or other school employees shall be made on a case-by-case basis by a team composed of public health personnel, the school employee's physician, the school employee and/or his/her representative, and appropriate school personnel. In making this determination, the team shall consider: (1) the physical condition of the school employee; (2) the expected type of interaction with others in the school setting; and (3) the impact on both the infected school employee and others in that setting.

2. (a) If a school employer has reasonable cause to believe that a student or school employee is an infected individual, the school employer may require said individual to submit to an appropriate medical evaluation.

(b) The sexual orientation of a student or school employee shall not consitute reasonable cause to believe that he or she is an infected individual. No student, school employee or potential school employee shall be required to provide information as to his or her sexual orientation.

3. (a) If an infected student in grades K through 12 is not permitted to attend classes or participate in school activities with other students, the school employer shall make every

reasonable effort to provide said student with an adequate alternative education. To the extent that this requires personal contact between the student and school employees, only those school employees who volunteer shall be utilized.

(b) If the employment of an infected school employee is discontinued, said school employee shall be entitled to use any available medical leave and receive any available medical disability benefits.

4. A school employee shall not be required to teach or provide other personal contact services to an infected student, or to work with an infected school employee, unless a determination has been made pursuant to Section 1 above to permit said individual to remain in the school setting. NEA and its affiliates shall provide appropriate legal assistance to any school employee who is subjected to adverse action by a school employer because he or she refuses to teach, provide personal contact services to, or work with an infected individual, or an individual who there is reasonable cause to believe is an infected individual; unless a determination has been made pursuant to Section 1 above to permit said individual to remain in the school setting.

5. The identity of an infected individual or an individual who there is reasonable cause to believe is an infected individual shall not be publicly revealed. If an infected individual is permitted to remain in the school setting after a determination has been made pursuant to Section 1 above, school employees who are likely to have regular personal contact with said individual shall be informed of his or her identity by the school employer, and provided with appropriate information as to said individual's medical condition, including information as to any factors that might warrant a reconsideration of whether he or she should be permitted to remain in the school setting.

October 9, 1985

Appendix E

AIDS/Acquired Immune Deficiency Syndrome

Iowa Guidelines for School Policy

Epidemiological studies show that AIDS is a viral infection transmitted via intimate sexual contact or blood to blood contact. To date, there is no recorded transmission to AIDS to family members through non-sexual contacts. There has also been no transmission observed with medical personnel who directly care for and are exposed to AIDS cases. Since there is no evidence of casual transmission by sitting near, living in the same household, or playing together with an individual with AIDS, the following guidelines are recommended for implementation in school systems throughout Iowa.

1. Routine screening of students for AIDS associated virus (HTLV-III/LAV) is not recommended. Screening should not be a requirement for school entry.

2. Children diagnosed as having AIDS, or with laboratory evidence of infection with the AIDS associated virus (HTLV-III/LAV), and receiving medical attention are able to attend classes in an unrestricted eduational setting. Siblings of infected children are able to attend school without

restrictions.

3. An appropriate alternative educational plan which may include a more resistricted envionment should be provided for the child diagnosed as having the AIDS or laboratory evidence of infection with the HTLV-III/LAV virus if:

a) Cutaneous (skin) eruptions or weeping lesions that cannot be covered are present.

b) Inappropriate behavior which increases the likelihood of transmission (i.e., biting or incontinency) is exhibited.

c) The child is too ill to attend school.

4. Decisions as to educational management should be shared utilizing expertise of the physician, parent or guardian, public health personnel and those associated with the educational setting.

a) Notification of the school should be through the school nurse or person responsible for school health who will notify only those necessary to assure optimal management.

b) Notification should be by a process that would maximally provide patient confidentiality. Ideally, this should be direct person to person contact.

c) If school authorities believe that a

child diagnosed as having Aids or with laboratory evidence of infection with the AIDS associated Virus (HTLV-III/LAV) has evidence of conditions described in 3) then the school authorities can dismiss the child from the class and request authorization from the child's personal physician so that the class attendance is within compliance with the school policy.

d) If a conflict arises as to the child's management, they should be referred to the State Department of Health for review to determine the permissibility of attendance.

5. Since the child diagnosed as having AIDS or with laboratory evidence of infection with the AIDS associated virus (HTLV-III/LAV) has a somewhat greater risk of encountering infections in the school setting, the child should be excluded from school if these is an outbreak of threatening communicable disease such as chickenpox or measles until he/she is properly treated and/or the outbreak is no longer a threat to the child.

6. Blood or any other body fluids including vomitus and fecal or urinary incontinence in ANY child should be treated appropriately. It is recommended that gloves be worn when cleaning up any body fluids.

a) Spills should be cleaned up, the affected areas washed with soap and water and disinfected with bleach using one part bleach to ten parts water, or another disinfectant.

b) All disposable materials, including gloves and diapers, should be discarded into a plastic bag before discarding in a conventional trash system. The mop should be disinfected with the bleach solution described in 6.a.

c) Toys and other personal non-disposable items should be cleaned with soap and water followed by disinfection in the bleach solution before passing to another person. A normal laundry cycle in adequate for other non-disposable items.

d) Persons involved in the clean-up should wash their hands afterward.

7. In-service education of appropriate school personnel should ensure that proper medical and current information about AIDS is available.

Appendix F

Montana State Guidelines

Schools and Day Care Centers

Background

As of December 16, 1985, 226 children in the U.S. under the age of 11 have been diagnosed with AIDS/HTLV-III. Most of these children became ill very early in life (at less than one year of age), having contracted the infection either congenitally or from blood transfusions. No family members of these children have become ill from contact with the children. However, until we know more about AIDS/HTLV-III, day care workers, school teachers, and others should exercise the same precautions they would take with an adult with AIDS/HTLV-III.

The recommendations which follow apply to all children known to be infected with human T-lymphotronic virus type III (HTLV-III). This includes children with AIDS/HTLV-III, children who are diagnosed by their physicians as having an illness due to infection with HTLV-III but who do not meet the case definition, and children who are asymptomatic but have virologic or serologic evidence of infection with HTLV-III.

The CDC provisional case definition of

AIDS/HTLV-III is reproduced in Appendix b.

School Attendance Guidelines

The question of children with AIDS/HTLV-III attending day care or school is not strictly a medical matter. The following recommendations and infection control procedures are intended to provide the initial framework for development of subsequent guidelines by all parties concerned. Each child infected with HTLV-III should be considered individually.

1. A child with AIDS/HTLV-III should be allowed to attend day care and school in a regular classroom setting with the approval of the student's physician.

2. Day care centers and schools should attempt to use the least restrictive means to accommodate the child's needs and the infection control recommendations.

3. Infected children should be allowed to attend day care or school as long as they are toilet trained, have no uncoverable open sores or skin eruptions, and do not bite. Students (K-12) who are excluded should receive adequate alternative education through homebound or other programs.

4. Children with AIDS/HTLV-III should be temporarily removed from day care or school if

measles or chickenpox is occurring in the school population (e.g., cases occurring in classroom or close non-classroom contacts). This also applies to other children with immune system abnormalities.

5. Children with AIDS/HTLV-III should be temporarily removed from day care or school when they are acutely ill, as should any child.

6. The day care center of school should respect the right to privacy of the individual; therefore, knowledge that a child has AIDS/HTLV-III should be confined to those selected persons with a direct need to know (e.g., principal, school nurse, child's teacher or day care director). Those persons should be provided with appropriate information concerning such precautions as may be necessary and should be aware of confidentiality requirements.

7. The school nurse or other knowledgeable person should be appointed as the child's advocate to assist in problems that arise, provide educational materials, answer questions, and act as liaison with the child's physician.

General Precautions

1. Good personal hygiene is probably the best protection against infection wioth HTLV-III virus, with careful handwashing being the single most

important personal hygiene practice. Handwashing, combined with a common-sense avoidance, removal or reduction of possible sources of infection is important in all communicable disease control, including HTLV-III/AIDS. Handwashing applies even if gloves are worn.

2. Disposable gloves should be used any time there will be contact with blood, urine, feces, semen or saliva. Hands shold be thoroughly washed after gloves are discarded.

3. Through cleaning of surfaces contaminated with blood and other body fluids, followed by use of disinfectants, must be maintained.

a) Environmental surfaces are generally adequately cleaned by housekeeping procedures commonly used. Surfaces exposed to blood and body fluids should be cleaned with a detergent followed by decontamination using an EPA-approved hospital disinfectant that is mycrobactericidal. Individuals cleaning up such spills should wear disposable gloves.

b) Laundry and diswashing cycles commonly used in public facilities are adequate to decontaminate linens, dishes, glassware and utensils.

c) Chemical germicides registered with and

approved by the U.S. Environmental Protection Agency (EPA) should be used. Information on specific label claims of commercial germicides can be obtained by writing: Disinfectants Branch;, Office of Pesticides, Environmental Protection Agency, 401 M Street, S.W., Washington D.C. 20460. The manufacturer's instructions should be followed, and the instrument or device to be sterilized or disinfected should be cleaned thoroughly before exposure to the germicide.

Personal Contact

1. Direct mouth-to-mouth or genital contact should be avoided with persons with AIDS/HTLV-III. Activities such as mouth-to-mouth kissing should be discouraged.

2. Mouth-to-mouth sharing of food and other objects (e.g., pencils, gum, toys) between children should be discouraged.

3. Personal toiletry items (e.g., towels, toothbrushes, razors) and tools (e.g., scissors, nail files, woodworking tools) which may potentially cause cutting injuries should not be shared by persons with AIDS/HTLV-III and others. Toothbrushes should not be available in day care or pre-school situations.

Contact With Blood or Other Body Fluids

1. Care should be taken to minimize breaks in the skin (for example, hand lotion can be used to minimize chapping). If the person with AIDFS/HTLV-III has breaks in the skin, the care provider should use gloves when touching those areas.

2. Bleeding or oozing cuts or abrasions (in either the care giver or a person with AIDS/HTLV-III) should be covered (gauze, bandaids, etc.) whenever possible. The care provider's fingernails should be kept trimmed and clean.

3. Care providers should avoid direct skin contact with blood while caring for nose bleeds, bleeding or oozing wounds, or menstrual accidents in a person with AIDS/HTLV-III. Disposable gloves should be used in these situations.

4. Gloves, sanitary napkins, gauze pads or any other materials which are soiled should be carefully and promptly discarded in leakproof, sealed plastic bags or containers. Ultimate disposal is by incineration or placement in a properly supervised and maintained sanitary landfill.

5. Environmental surfaces soiled with blood should be thoroughly cleaned as recommended previously.

Soiled Items

1. Items soiled by blood, saliva or other body fluids from a person with AIDS/HTLV-III should not be used by others; these items should be discarded or thoroughly cleaned with soap and water and disinfected with appropriate disinfectant before reuse.

2. Dishes -- Washing of dishes with plenty of hot, soapy water, followed by thorough rinsing, is recommended. An electric dishwasher can also be utlized for dishwashing. Separate dishwashing is not needed for dishes or utensils used by someone with AIDS/HTLV-III.

3. Laundry -- Blood-contaminated items should be handled with appropriate precautions (gloves, apron and any other cover-up needed to prevent direct exposure to blood). Washing with soap, HOT water and bleach, followed by thorough rinsing is suggested. A washing machine and dryer can be utilized. Separate laundering is NOT necessary for items used by a child with AIDS/HTLV-III. It is of importance to thoroughly scrape and clean adherent materials from objects and surfaces before laundering.

Employees with AIDS/HTLV-III

The determination of whether an infected school employee should be permitted to remain employed in a

capacity that involves contact with students or other school employees should be made on a case-by-case basis. In making this determination, consideration should be given: (1) the physical condition of the school employee; (2) the expected type of interaction with others in the school setting, and (3) the impact on both the infected school employee and others in that setting.

The sexual orientation of a school employee is not cause to believe that he or she is an infected individual. No school employee or potential school employee should be required to provide information as to his/her sexual orientation.

School districts who have employees with reactive HTLV-III tests are urged to solicit advice from their legal counsel and the state epidemiologist (444-4740).

Other Issues In the Workplace

The information and recommendations contained in this document do not address all the potential issues that may have to be considered when making specific employment decisions for persons with HTLV-III infection. The diagnosis of HTLV-III infection may evoke unwarranted fear and suspicion in some co-workers. Other issues that may be considered include the need for confidentiality,

applicable federal, state, or local laws governing occupational safety and health, civil rights of employees, workers' compensation laws, provisions of collective bargaining agreements, confidentiality of medical records, informed consent, employee and patient privacy rights, and employee right-to-know statutes.

Appendix G

Connecticut Administrative Guidelines

For providing Education To Students With AIDS/ARC

1. All children in Connecticut have a consitutional right to a free, suitable program of educational experiences.

2. As a general rule, a child with AIDS/ARC should be allowed to attend school in a regular classroom setting, with the approval of the child's physician, and should be considered eligible for all rights, privileges and services provided by law and local policy of each school district.

3. The school nurse should function as (a) liaison with the child's physician, (b) the AIDS/ARC child's advocate in the school (i.e., assist in problem resolution, answer questions) and (c) the coordinator of services provided by other staff.

4. The school should respect the right to privacy of the individual; therefore, knowledge that a child has AIDS/ARC should be confined to those persons with a direct need to know (e.g., principal, school nurse, child's teacher). Those persons should be provided with appropriate information concerning such precautions as may be necessary and should be aware of confidentiality requirements.

5. Based upon individual circumstances, including those discussed below, special programming may be warranted. Special education should be provided if it is determined to be necessary by the Planning and Placement Team.

6. Under the following circumstances, a child with AIDS/ARC might pose a risk of transmission to others: if the child lacks toilet training, has open sores that cannot be covered or demonstrates behavior (e.g., biting) that could result in direct innoculation of potentially infected body fluids into the bloodstream. If any of these circumstances exist, the school nurse and the child's physician, must determine whether a risk of transmission exists. If it is determined that a risk exists, the student shall be removed from the classroom.

7. A child with AIDS/ARC may be temporarily removed from the classroom for the reasons stated in No. 6 until either an appropriate alternative education program can be established or the medical advisor determines that the risk has abated and the child can return to the classroom.

a) A child removed from the classroom for biting or lack of toilet training should be immediately referred to the Planning and Placement Team for assessment and, thereafter, for the

development of an appropriate program if warranted.

b) A child temporarily removed from the classroom for open sores or skin eruptions that cannot be covered should be placed on homebound instruction and readmitted only with medical documentation that the risk no longer exists.

c) Removal from the classroom under sections (a) and (b) above should not be construed as the only responses to reduce risk of transmission. The school district should be flexible in its response and attempt to use the least restrictive means to accomodate the child's needs.

d) In any case of temporary removal of the student from the school settting, state regulations and school policy regarding homebound instruction must apply.

8. Each removal of a child with AIDS/ARC from normal school attendance should be reviewed by the school medical advisor in consultation with the student's physician at least once every month to determine whether the condition precipitating the removal has changed.

9. A child with AIDS/ARC, as with any other immune deficient child, may need to be removed from the classroom for his/her own protection when cases

of measles or chicken pox are occurring in the school population. This decision should be made by the child's physician and parent/guardian in consultation with the school nurse and/or the school medical advisor.

10. Routine and standard procedures should be used to clean up after a child has an accident or injury at school. Blood or other body fluids emanating from ANY child, including ones known to have AIDS/ARC, should be treated cautiously. Gloves should be worn when cleaning up blood spills. These spills should be disinfected with either bleach or another disinfectant, and persons coming in contact with them should wash their hands afterwards. Blood soaked items should be placed in leakproof bags for washing or further disposition. Similar procedures are recommended for dealing with vomitus and fecal or urinary incontinence in ANY child. Handwashing after contact with a school child is routinely recommended only if physical contact has been made with the child's blood or body fluids, including saliva.

Appendix H

Rockford, Illinois

DRAFT

Policy for Management of Students and District Employees Having HIV Infection

- Findings -

The U.S. Public Health Service's Centers for Disease Control, the American Academy of Pediatrics and other medical groups have developed recommended guidelines regarding attendance at school for children with HIV infection.

These guidelines include:

1. Most HIV infected children should be allowed to attend school.
2. Some infected children could pose an increased risk to themselves and others and must be alternately placed.
3. Periodic medical review by qualified physicians shall be made in each case.
4. The number of personnel aware of the child's condition must be kept to the minimum necessary to assure proper care and identify situations where potential of transmission

and/or risk to the infected child may be increased.

5. Procedures for hygienically handling blood or body fluids of all persons in schools whether or not HIV infected students are known to be present.

6. Routine screening of students for HIV infection is not recommended.

No medical evidence supports the spread of HIV infections through casual contact such as that which occurs in the school setting.

An employee having HiV infection will be allowed to remain in his/her regular work assignment until it is medically determined that allowing him/her to do so is outweighed by potential of transmission of HIV infection to other staff members or students and/or increased likelihood of damage to the infected employee.

The Board will develop procedures for the management of students and employees having HIV infections consistent with the foregoing findings.

(JNS 9/23/87)

Rockford, Illinois

DRAFT (Alternate - AIDS Specific)

Procedure For

Management of Students and District Employees

Having HIV Infection

A student diagnosed as being infected with human immuno-deficient virus (HIV), the virus causing acquired immune deficiency syndrome (AIDS), herein "HIV infection", will be allowed to remain in the regular classroom setting until such time as it may be determined that the benefit to such student of delivering the educational product in a regular classroom setting is outweighed by the potential of transmission of HIV infection to other students and/or staff or by increased likelihood of damage to the infected student's physical condition.

A student known to have or reasonably suspected of having HIV infection, will be evaluated by a specially constituted review team. The Review Team which will include:

1. The student's teacher
2. The student and/or parent/guardian (Nothing shall prohibit the student having legal representation)
3. Student's physician

4. School District medical advisor

5. Chief school nurse

6. Appropriate building administrator (who will determine which one of the student's teachers to include on the team)

7. Superintendent or designee

8. School District Attorney

will convene to determine if the student's behavior or physical condition poses a risk of spread of HIV infection and, if so, the least restrictive educational environment that is appropriate to the student's physical condition.

A student found to have HIV infection will not be removed from the regular classroom setting unless it is determined by the Review Team that such removal is necessary because of:

1. The risk of transmission of HIV infection to other students and/or staff; or

2. There is a health risk to the infected student such as an outbreak of a communicable disease (e.g., chicken pox, measles), which could be threatening to a child with HIV infection.

The Review Team will convene on a timely basis and render its decision promptly. As soon as it is known or reasonably believed that a student has HIV

infection, the Chief School Nurse will be advised and he/she will then promptly notify the Superintendent who will identify the Team members and convene the first meeting. This first Review Team meeting will be held within five (5) days of the date the Chief School Nurse is so informed.

A student reasonably suspected of having HIV infection will be examined by the student's own physician or in the absence of a student's own physician, at Board expense by a physician selected by the Board. Students refusing such examination will be excluded from regular classroom attendance pending the results of such medical examination. An appropriate educational program will be provided to the student while temporarily excluded from regular classroom work pending such medical examination. Teachers directly involved in the educational process during this period will be advised that reasonable suspicion exists as to the health condition of the student and that he/she may have HIV infection.

Once a student is found to have HIV infection through the initial evaluation by the Review Team, the Review Team will continue to monitor the student's physical condition and the appropriateness of the educational program provided as frequently as

medical advice deems it necessary to continue such monitoring.

Each student will have the right to a due process hearing before a hearing officer appointed by the Board of Education if the parent or guardian disagrees with the student's educational placement or change of placement due to a finding that a student has HIV infection. Parents or guardians shall have the opportunity to appeal such determinations to the Board of Education within ten days of making a request for such appeal.

All school personnel will respect the right to privacy of any student found to have HIV infection. Knowledge that a student has such HIV infection will be confined to those persons with a direct need to have such information, e.g. the building principal, the school nurse, and the student's teacher. Those persons having a need to know will be provided with appropriate information concerning precautions as may be necessary and will be made aware of these confidentiality requirements.

The Chief School Nurse will routinely monitor all students identified as having HIV infection and report in an appropriate manner to the Review Team convened for each student. A student found to have HIV infection who remains in regular classroom

attendance should be monitored continuously in order to determine if his/her behavior or medical condition has altered in such a way as to affect the transmissibility of the HIV infection. When a student is removed from normal classroom attendance, the student should be placed on a monitoring schedule appropriate to the HIV infection and the condition precipitating the removal or change for the purpose of alternative educational programing or reintegrating the student into the regular classroom setting. A student with HIV infection should be educated in the least restrictive environment possible. Those students whose behavior or physical condition precludes school attendance should be continually evaluated for return to the classroom.

All school district employees will be instructed regarding hygienic procedures necessary to maintain a safe, clean school environment and particularly with respect to those procedures used to clean up after any person who has an accident or injury at school. Blood or other body fluids (saliva, vomitus, feces, urine) emmanating from any person should be treated cautiously. The Chief School Nurse will consult with the Winnebago County Public Health Officials, officials of the Illinois Department of Public Health and other appropriate

public health officials and medical advisors to the Board of Education in developing hygienic procedures necessary to implement this procedure.

Decisions regarding the educational and care setting for a student with HIV infection should be developed on an individual case by case method and be based on the behavioral, neurological and physical condition of that particular student and the expected type of interaction with others in that setting. For students with HIV infection, including pre-school and neurologically handicapped students who lack control of body secretions or display behavior such as biting and students who have uncoverable oozing lesions, the Review Team shall consider recommending a more restricted environment.

Any district employee when diagnosed as having or reasonably suspected of having HIV infection will notify the Superintendent and then be monitored by a review team whose composition is similar to the review team convened for students with HIV infection except that inapplicable members of the student team such as parents and teachers will be replaced by the building principal and the senior administrative manager.

Appendix I

Peoria, Illinois

Article 5 Students - Board Policy 5141.14

Chronic Infectious Disease - Students

The Administration shall immediately investigate the health status of any student suspected of having a chronic contagious or infectious disease. Upon confirmation of the presence of a chronic infectious disease, the student shall be referred to the chronic infectious review team for evaluation and determination of an appropriate course of action. The findings of the chronic infectious review team shall be forwarded to the District Superintendent for consideration.

The School District reserves the right to temporarily remove for up to ten school days the infected student from the normal educational environment until the chronic infectious review team can make a determination as to the appropriate course of action. After the ten school day period, an alternative educational environment shall be provided during periods when the infectious disease condition interferes with the student's ability to

learn or the risk of infection of other individuals in the school environment is heightened. Individuals in the school environment shall be informed of the presence of a contagious or communicable disease on the basis of need to know and all decisions regarding the infected student shall be made in a non-discriminatory manner.

Adopted: September 8, 1987

Article 5 Students - Administrative Procedure 5141.14

Chronic Infectious Disease Procedures

1. The chronic, communicable, contagious and/or infectious diseases addressed by these procedures include congenital rubella syndrome (CRS), hepatitis B, cytomegalovirus (MV) infections, acquired immunodeficiency syndrome (AIDS), aids-related complex (ARC), herpes simplex or other disease as designated by the public health department. The policy and procedures do not apply to the common, acute, short-term childhood diseases such as chicken pox, impetigo, strep throat, or scarlet fever.
2. For a student with a chronic infectious disease, the determination whether the behavior or physical condition poses a high risk to the

individual student or others in the school environment shall be made on a case by case basis by a team of individuals including but not limited to the school principal, classroom teacher, school nurse, parents or other representative (i.e., family physician), Director of Pupil Health Services and a medical representative from the Peoria County Health Department. A report of the team's findings shall be filed with the District Superintendent for consideration within ten days of notification of the presence of an infectious disease in the schools.

3. On a case by case basis, the determination of the appropriate educational environment shall be made by the infectious disease review team. Depending upon the age, behavioral characteristics, control of bodily functions and stage of development of the infectious disease of the infected student, an alternative educational environment may be necessary for the benefit of the infected student as well as for the well-being of others in the educational environment. A student's removal from and/or readmission to the normal school environment shall be based on the recommendation of the chronic infectious review team.

4. The condition of the student with a chronic infectious disease should be monitored on a schedule

appropriate to the individual characteristics of the student and the infectious disease.

5. Procedures of cleanliness and hygiene for handling saliva, vomitus, feces, urine or other bodily fluids emanating from students with a chronic infectious disease shall be disseminated to all district personnel.

September, 1987.

Appendix J

Danville, Illinois

5.14 Students With Chronic Communicable Diseases

Any student who has a chronic communicable disease or is a carrier of a communicable disease shall be provided a free and appropriate education in the least restrictive placement. A student who has a chronic communicable disease or is a carrier of a communicable disease may attend school in the regular classroom setting whenever, through reasonable accomodation, the risk of transmission of the disease and/or the risk of further injury to the student is sufficiently remote in such setting so as to be outweighed by the detrimental effects of the student's placement in a more restrictive setting. If a student is required to be placed in a non-school setting, an appropriate educational program shall be developed and provided to the student. The determination of whether such student may attend school in the regular classroom setting shall be based upon the following factors:

(1) the risk of transmission of the disease to others;

(2) the health risk to the particular student;

(3) reasonable accomodations which can be made without hardship to reduce the health risk to the student and others; and

(4) the educational benefits of a less restrictive placement versus the educational deteriments of a more restrictive placement.

The Superintendent is authorized to establish rules and regulations that are designed to implement this policy and that are consistent with the State and Federal rules and regulations.

Legal References: Ill. Rev. Stat. ch. 122, Art. 14
Ill. Rev. Stat. ch. 122, par. 27-8.1
P.L. 94-142

Board Adoption Date: ....

Effective Date: ....

Rules and Regulations Implementing Board Policy No. 5.14 Students with Chronic Communicable Diseases

A. Temporary Exclusion

Pending determination of Placement, a student who has a chronic communcable disease or is a carrier of a communicable disease, or a student who is reasonably suspected of having a chronic

communicable disease or being a carrier may be temporarily excluded from school. During the period of temporary exclusion, this student shall be provided with an appropriate educational program.

B. Initial Evaluation

Each student shall be evaluated by a team that may consist of appropriate district personnel and a physician or other consultants selected by the Superintendent or his designee, the student's physician, public health personnel, the student and the student's parents or guardians.

C. Placement Decision

Upon completion of a case study evaluation, one or more conferences shall be convened for the purpose of formulating program and service options. Recommendations concerning the student's placement and the individual education program shall be made at these multidisciplinary conferences by consensus of the participating public school personnel and shall be determined in accordance with the standards set forth in Board Policy.

D. Appeal

A decision on a student's placement or

individualized educational program may be appealed in accordance with The School Code and the Rules and Regulations to Govern the Administration and Operation of Special Education.

E. Subsequent Evaluations

The student shall be periodically reevaluated by the placement team to determine whether the student's placement continues to be appropriate. The frequency of the reevaluations shall be determined by the team, but in no event shall the student be reevaluated less frequently than once per school year.

F. Confidentiality

The student's medical condition shall be disclosed only to the extent necessary to minimize the health risks to the student and others.

4.76 Employees with Chronic Communicable Diseases

An employee who has a chronic communicable disease or is a carrier of a communicable disease shall be permitted to retain his or her position whenever, through reasonable accomodation, there is no significant risk of transmission of the disease to

others. An employee who cannot retain his or her position shall remain subject to the Board's employment policies, including but not limited to sick leave, physical examinations, temporary and permanent disability and termination. If a dispute arises as to the ability of an employee to remain in his or her position, such employee may be temporarily excluded from work or transferred to another position by the Superintendent or his/her designee pending determination of the employee's continued employment status. During any period of temporary exclusion, the employee shall be entitled to utilize sick leave and other related benefits. In the event it is determined that the employee could have been at work during the temporary exclusion, no deduction from sick leave shall be made for such excluded time. An employee who has a chronic communicable disease or is a carrier of a communicable disease or who is reasonably suspected of having a chronic communicable disease or being a carrier of a communicable disease may be required from time to time to undergo an examination by a physician licensed in Illinois to practice medicine and surgery in all its branches. The Board shall pay the expenses of any required medical examination. The Superintendent is authorized to

establish rules and regulations designed to implement this policy.

Legal Reference: Ill. Rev. Stat. ch. 122, par. 10-22.4

Ill. Rev. Stat. ch. 122, par. 24-5

Ill. Rev. Stat. ch. 122, par. 24-6

Section 504 of the Rehabilitation Act of 1973.

Board Adoption Date:....................

Effective Date:........................

Rules and Regulations Implementing Board Policy No. 4.76 Employees with Chronic Communicable Diseases

A. Medical Examinations

In the Event the Board requires a medical examination of any employee, the employee shall be allowed to select the physician from a list supplied by the Superintendent. In the event the employee unreasonably delays in selecting the physician or making an appointment for an examination, the Superintendent will select the physician and/or make the appointment on behalf of the employee.

B. Initial Evaluation

The employee shall be evaluated by a team that may consist of appropriate district personnel, and a physician or other consultants selected by the Superintendent or his/her designee, the employee's physician, public health personnel and the employee. The team's report and recommendations including an dissenting opinions shall be forwarded to the Superintendent or his/her designee. Every effort shall be made to complete the evaluation in a timely and prompt manner.

C. Subsequent Evaluations

The employee shall be periodically reevaluated by the evaluation team to determine whether the employee's placement continues to be appropriate. The frequency of the reevaluations shall be determined by the team.

D. Confidentiality

The employee's medical condition shall be disclosed only to the extend necesssary to minimize the health risks to the employee and others.

Appendix K

Belleville Public School District #118

Policy Regarding Students

With Chronic Communicable Diseases

I. Board Policy

It is the policy of the Board of Education to provide a safe learning environment for its students and to provide a free, appropriate education for each of its students.

II. Placement Procedures

Upon being informed that a student has, or is reasonably believed to have, a chronic communicable disease, an employee of the school district must inform the Superintendent or the Superintendent's designee immediately.

In the event that the Superintendent or the Superintendent's designee is of the opinion that the situation warrants temporary exclusion, the Superintendent or the Superintendent's designee shall immediately notify the student's parents or guardians, by certified mail and by telephone, that the student will be temporarily excluded from the classroom pending a determination as to placement, and that among the placement options being considered are placement in the classroom setting or

an alternative education outside the normal classroom. The Superintendent shall then convene a Placement Evaluation Committee, which shall consist of the Superintendent, a physician designated by the school district, the school district psychologist, the school district nurse, the principal of the school or schools in wich the student would be placed, the teacher who would be primarily responsible for teaching the student, the President of the Board of Education, and the school district's attorney, and such other persons as the Board President may designate. The Secretary of the Board of Education shall be present at meetings of the Placement Evaluation Committee to take and prepare minutes.

III. Medical Examination

The Superintendent may require the student to submit to a physical examination, including a blood test, where appropriate, conducted by a physician selected by the district, at school district expense. In the event that a student refuses to submit to such an examination, that student may be excluded pending a medical examination and submission of the results of said medical examination, including a blood test where appropriate, to the Placement Evaluation Committee.

The Superintendent shall have the discretion to accept written findings of a qualified medical doctor, including the results of a blood test, where appropriate, in lieu of requiring the aforementioned medical examination.

IV. Placement Evaluation

The Placement Evaluation Committee shall then conduct an evaluation of the student's medical condition, including the student's physical, mental, and emotional condition. The Committee shall also inquire into the student's prior conduct to determine if the student has a history of behavior which may present a risk as well as any other factors which the Committee considers relevant. The parents or guardians of the student shall be given an opportunity to be heard before the Placement Evaluation Committee, and shall be given writtten notice of the time and place at which they will be heard. The Committee shall also inquire into the placement options available to the school district, and the resources available to the district. The President of the Board of Education, or designee, shall chair each meeting of the Placement Evaluation Committee. All meetings of the Placement Evaluation Committee shall be held in executive session.

V. Placement Decision

The Placement Evaluation Committee shall issue a written report of its findings to the Board of Education, which, as soon as possible, shall meet in executive session to review the findings of the Placement Evaluation Committee. The Board of Education shall then determine the appropriate placement for the student. The student's parents or guardians shall be notified by certified mail of the time and place of the meeting, and the purpose of the meeting, and that they will be afforded an opportunity to be heard before the Board of Education. In selecting the appropriate placement for the student, the Board of Education shall, among other factors consider the following:

A. The risk of transmission of the disease to others;

B. The health risk to the particular student;

C. Reasonable accomodations which can be made without undue hardship to reduce the health risk to the student and others;

D. The resources available to the School District.

The decision of the Board of Education shall immediately be sent via certified mail to the parents or guardians of the student. In addition, the Superintendent, building principal, and teacher

shall be notified immediately.

VI. Individualized Education Plan

In the event that a decision is made to place the student in an education environment other than the normal classroom, an Individualized Education Plan will be developed with the precedures employed by this district in developing an Individualized Education Plan for handicapped children or children needing special education, except that any appeal procedures stated therein, to the extent that they conflict with the terms of this Policy, need not apply.

VII. Subsequent Evaluation

The condition of the student shall be monitored on a monthly basis by the school district nurse to determine whether the student's placement continues to be appropriate. In addition, the Placement Evaluation Committee shall regularly reevaluate the student. In no event shall the student be reevaluated by the Placement Evaluation Committee less frequently than once every twelve months. The Placement Evaluation Committee shall immediately report its findings to the Board of Education, which shall determine if a change in placement is necessary. In the event of an emergency, however, the Superintendent shall have the right to take

appropriate action which shall be reviewed by the Board of Education as soon as possible.

VIII. Confidentiality

The student's medical condition shall be disclosed only to the extent necessary to minimize the health risks to the student and others. Only those persons deemed to have a direct need to know this information will be so informed, and these persons shall not further disclose such information. The Board of Education shall determine who shall be so informed. In no event shall the name of the student appear in any minutes of any meeting which are accessible to the public and in no event shall the name of the student be referred to in any public meeting of the Board of Education.

IX. Notification to Parents

The Board of Education recognizes that parents and guardians of its students have a real and legitimate concern regarding the welfare of its students. For that reason, in the event that a student with a chronic communicable disease is admitted to the classroom, parents and guardians of students attending classes in the same building will be notified that a student with a chronic communicable disease is attending school in that building. However, no other identifying information

regarding that students shall be so released.

Procedures for school management of infectious disease are those from the Illinois State Department of Public Health (see Appendix B) plus the ISBE.

Approved 7/21/87

Reaffirmed 8/18/87

Appendix L

Charleston, Illinois

Policy Regarding Students

With Chronic Communicable Diseases

I. Policy

The Charleston Community Unit No. 1 School Board recognizes that students or employees with chronic infectious disease are entitled to all rights and privileges provided by law and the District's policies. The District shall balance those rights with the District's obligation to protect the health of all District students and staff.

We will provide information about chronic infectious diseases to students, staff, parents, and the public in general so that the best decisions can be made for all concerned and they can be made in a calm, responsible manner.

II. Procedures for students with Chronic Infectious Diseases.

A. The school district reserves the right to remove a student with a chronic infectious disease from the normal educational environment for up to ten school days until the chronic infectious review team can make a determination as to the appropriate

action to be taken.

B. A student identified through medical examination as having a chronic infectious disease shall be evaluated by a review team to determine if physical condition or behavior poses a risk of spread of the disease.

The review team may include but is not limited to:

A. Superintendent

B. Building Principal

C. School Nurse

D. Classroom Teacher

Whenever possible, consultation with the student's family physician, local health authorities and/or a specialist in infectious diseases will be made to determine the risk of transmission of the disease and the potential dangers of regular classroom attendance.

C. The review team will develop an individual student plan that will include the student's educational program, the health-related conditions of the program, specific health instructions and other relevant information.

D. A student with a chronic infectious disease will be allowed to attend school in a regular classroom setting or participate in school

activities with other students unless an individual evaluation results in the need for a more restrictive program.

E. A more restrictive program may appropriate when:

1. The student lacks control of bodily secretions.

2. The school environment proves dangerous to the affected student's health or well being.

3. The student has open sores that cannot be covered.

4. The student demonstrates behavior (e.g. biting) which could result in direct innoculation of potentially infected body fluids into the bloodstream.

F. All students with chronic infectious disease regardless of their placement by the review team shall be monitored on a schedule appropriate to the individual characteristics of the student the the infectious disease by the school nurse. Needed changes in the child's program will be referred to the review team.

G. If the parent/guardian disagrees with the student's alternative educational placement or program, they shall be offered the opportunity to an appeal to the School Board within ten days of their

notification of the decision of the review team.

H. The collection and maintenance of the student's medical information shall be done in a manner to ensure the strictest confidentiality and in accordance with federal and state laws regarding student records. The student's medical condition shall be disclosed only to the extent necessary to minimize the health risks to the student and others.

I. The building staff shall be informed of the presence of the disease and information about the precautions to be taken shall be provided.

J. All inquiries from the media shall be directed to the (Superintendent or Building Principal). A standard/appropriate response, developed by the District's legal counsel to inquiries will be made available to all administrators.

III. Procedures for employees with Chronic Infectious Disease.

A. When it comes to the attention of the Superintendent that an employee is reasonably suspected of being ill with or a carrier of a chronic infectious disease and there is a question as to the transmission of the disease to others, the Superintendent may temporarily exclude such employee from work or transfer him/her to another position

until such time as it is determined the employee poses no risk to others.

B. The employee may submit health information from his physician; however, the Superintendent may require a physical exam from a physician of the board's choosing, preferably a specialist in infectious diseases, so as to obtain a prompt and reliable diagnosis. This exam should be done as soon as possible. The Superintendent may also request of any such physician an opinion as to the means and risk of transmission of any disease diagnosed. All costs related to such examination, including the cost of reasonable reimbursement for transportation, shall be borne by the district; and the employee shall suffer no loss of pay or other benefits. The employee may be permitted to take any sick or personal day available to such employee for such examination if, for reasons of privacy, the employee so desires.

C. If the examination by the physician(s) reveals that the employee is not ill with or is not a carrier of an infectious disease, then all records relating to such belief and examination shall be destroyed, except to the extent to which the employee requests that they be retained. If the examination by the physician reveals that the

employee is ill with or is a carrier of an infectious disease, then such information shall be retained by the District.

D. An employee identified through medical examination has having a chronic infectious disease shall be evaluated by a review team to determine the employee's medical condition as it relates to the performance of regular employment duties. The review team may include but not necessarily be limited to:

1. Superintendent
2. Medical Acvisor(s)
3. School Nurse
4. County Health Nurse
5. Employee's Physician
6. Legal Consultant
7. Employee

E. The review team will develop a recommendation regarding the conditions of continued employment based on the employee's medical condition and the risk posed to the employee and to others.

F. All discussion by the board of such employee shall be done in a closed meeting in accord with the Open Meeting Act.

G. At all times, the Superintendent shall endeavor to protect the confidentiality of the

employee. In no event shall information provided by the employee, the employee's physician or the board's physician be revealed to any person except members of the Board of Education, the School District attorney, and any other person who, in the opinion of the Superintendent and the board must be apprised of the health of the employee affected so as to protect the health or welfare of the students or other employees.

H. A monitoring review team consisting of the principal or designee and the school nurse will monitor the condition of the employee known to have a chronic infectious disease to determine if any change in the employee's medical condition requires modification of the employment duties.

IV. Procedures for Maintenance of a Clean School Environment. These should be followed regardless of the presence or absence of a student known to have an infectious disease.

A. Clean the following areas and items daily.

1. Classrooms, bathrooms, and kitchen
2. Floors
3. Sinks and faucet handles
4. Cabinet drawer handles
5. Doorknobs
6. Soap dispenser spigots and/or bar soap

containers.

7. Toilets.

B. Vacuum carpets daily. If a rug or carpet is soiled, it should be disinfected immediately.

C. Clean waste receptacles at least weekly.

D. Empty soap dispensers, wash and air-dry monthly.

E. Steam-clean carpets quarterly.

F. If heavy nondisposable gloves are worn when a disinfectant is being used, they must be washed and air-dried after each use. They must be stored in the room of use in the area reserved for soiled articles.

G. Techniques for Handling Food and Utensils

1. Maintain a clean area of the kitchen for serving food.

2. Maintain a separate area of the kitchen for cleanup.

3. All leftover food, dishes, and utensils should be treated as if they were contaminated.

4. Scrape food from soiled dishes and/or place disposable dishes in plastic-lined, covered waste receptacle.

5. Pour liquids into sink drain.

6. Rinse dishes and utensils with warm

water before placing them in the dishwasher.

7. Clean sinks, counter tops, tables, chairs, trays, and any other areas where foods or liquids have been discarded or spilled; use approved disinfectant.

8. Wash hands prior to removing clean dishes from the dishwasher and storing them in a "clean" area of the kitchen.

V. Procedures for School Management of Infectious Disease.

Prevention of infectious diseases depends on basic principles of cleanliness and hygiene. The transmission of these infectious diseases may be prevented by using standard procedures to maintain both personal and classroom cleanliness and by monitoring the actions of suspected and known infected students. The procedures listed in this chapter should be employed at all times when providing care for all students regardless of their infectious-disease status.

Teaching and supervising staff who perform these preventive measures for the control of infectious diseases is a school nursing function which does not requires a physician authorization. Personnel responsible for carrying out these procedures include the infectious disease review

team, teachers, teachers' aides, care workers, custodial staff, food handlers, volunteers and anyone who may have direct contact with the students, equipment and supplies, including eating utensils and objects. Responsibility also extends to such areas as contaminated floors, walls, toilets, sinks and changing surfaces, as well as contaminated clothing or cleaning equipment such as mops.

I. Infectious Disease Prevention Procedures

A. Transmission of infectious diseases may occur more readily where close personal contact is involved in student care. Preschool and kindergarten settings, as well as special facilities for handicapped students, need special attention for the prevention of infectious diseases.

B. Preventing the spread of infection requires that personal and environmental cleanliness techniques be practiced at all times in every school setting.

C. Prior to the enrollment or continued attendance in the regular or special classroom of an infected student, the school nurse shall develop specific procedures appropriate to the student's age and the stage of development for the specific disease. The school nurse should carry out the

following procedures.

1. Conduct a health and developmental assessment, including a review of the student's medical records. Collaborate with parents and physician to ensure that the records are complete.

2. Identify students and school personnel who may be at risk, such as those who are chronically ill, pregnant, capable of childbearing or taking immunosuppressant medication.

3. Identify appropriate personal and environmental cleanliness techniques in accordance with student and staff needs.

4. If the regular education program cannot be modified and the student is identified as an individual with exceptional needs, write appropriate health objectives for the student's Individualized Educational Program (IEP).

5. Orient and train all staff members, including custodians, substitute teachers, volunteers, and bus drivers. Orientation and training must be ongoing and must be scheduled to include new personnel.

6. Maintain ongoing communication with parents and the primary physician regarding the

student's status.

7. Verify the school district's efforts to prevent the spread of infection and to protect the health of employees and students by documenting the training and superivision of employees.

II. Safe, Healthful School Environment Procedures. Procedures should be followed regardless of the presence or absence of a student known to have an infectious disease.

A. All facilities should make provisions for personal and environmental cleanliness.

1. Allow sufficient time for hand washing after using the toilet and before eating meals and snacks.

2. Provide ready access to hand-washing facilities. These should include hot and cold running water and liquid soap in a workable dispenser.

3. Provide disposable paper towels. The use of cloth towels is discouraged; however, if cloth towels are used, discard them with other contaminated linens after each use.

4. Maintain storeage areas for linens, utensils, equipment, and disposable items. These areas must be separate from areas used for

storage of soiled items.

5. Keep soiled disposable items in covered waste receptacles lined with disposable plastic bags. At the end of each day, the plastic bags are to be resealed and discarded. Do not reuse.

B. Hand washing is the most important technique for preventing the spread of disease and should be done frequently. Proper hand washing requires the use of soap and water and vigorous washing under a stream of running water for at least 10 seconds. Rinse under running water. Use paper towels to thoroughly dry hands.

1. Before drinking, eating, or smoking
2. Before handling clean utensils or equipment.
3. Before and after handling food.
4. Before and after assisting or training the student in toileting and feeding.
5. After going to the bathroom.
6. After contact with body secretions, such as blood (including menstrual flow), urine, feces, mucus, saliva, semen, tears, drainage from wounds, etc.
7. After handling soiled diapers, menstrual pads, garments, or equipment.
8. After removing disposable gloves.

C. All staff members should practice specific hygienic principles designed to protect themselves and others from infection.

1. Maintain optimum health through effective daily health practices such as adequate nutrition, rest, exercise, and appropriate medical supervision.

2. If a careprovider has a cut or an open lesion on his/her hands, disposable gloves must always be worn when providing direct care for any student where there is contact with bodily excretion or secretions.

3. Avoid rubbing or touching eyes.

4. Refrain from kissing or being kissed by students.

5. Wash hands frequently.

6. Avoid the use of jewelry such as rings, dangling bracelets and earrings during working hours.

7. Use one's own personal care items such as combs, fingernail files, nail clippers, lipsticks, and toothbrushes.

8. Keep fingernails clean and trimmed short.

III. Procedures for Cleaning Up Bodily Fluid Spills (blood, feces, urine, semen, vaginal secretions, vomitus). These procedures should be used for all

students regardless of their infectious disease-status.

A. Wear disposable gloves. When disposable gloves are not available or unanticipated contact occurs, hands and other affecterd areas should be washed with soap and water immediately after contact.

B. Clean and disinfect all soiled hard, washable surfaces immediately, removing soil before applying a disinfectant.

1. Use paper towels or tissues to wipe up small, soiled areas. After soil is removed, use clean paper towels and soap and water to clean area.
2. Disinfect area with a dilution of 1:10 household bleach solution or another disinfectant (see Section VI for selection of a disinfectant).
3. Apply sanitary absorbent agent for larger soiled areas. After soil is absorbed, vacuum or sweep up all material.
4. Disinfect area with a clean mop (See Section VI for selection of a disinfectant).

C. Clean and disinfect soiled rugs and carpets immediately.

1. Apply sanitary absorbent agent, let dry and

vacuum

2. Apply rug shampoo (a germicidal detergent) with a brush and revacuum.

D. Clean equipment and dispose of all disposable materials.

1. Soiled tissue and flushable waste can be flushed in toilet. Discard paper towels, vacuum bag, or sweepings in a waste receptacle lined with a plastic bag.

2. Rinse broom and dust pan in disinfectant solution.

3. Soak mop in disinfectant solution and rinse thoroughly or wash in hot-water-cycle after soaking in disinfectant.

4. Disinfectnat solution should be promtply disposed of down a drain.

E. Clothing and other nondisposable items (e.g. sheets, towels) soaked with body fluids should be rinsed and placed in a plastic bag to be sent home or laundered.

F. Remove disposable gloves and discard in waste receptacle.

G. Wash hands.

H. Plastic bags holding contaminated waste should be secured and disposed of daily.

I. Large waste containers (dumpsters or other

containers which are impervious to animals) containing protentially contaminated waste should be located in a safe area away from the playground or other areas used by students.

VI. Selecting an Appropriate Disinfectant

A. Any liquid or bar soap is acceptable for routine hand washing.

B. Select and stock a sanitary absorbent agent for cleaning body fluid spills.

C. Select an intermediate-level disinfectant which will kill vegetative bacteria, fungi, tubercle bacillus and virus. Aerosol sprays are not recommended because of possible inhalant problems and flammability.

1. Select an agent that is registered by the U.S. Environmental Protection Agency (EPA) for use as a disinfectant in schools.

2. Select an agent that belongs to one of the following classes of disinfectants:

a. Ethyl or isopropyl alcohol (70-90 percent).

b. Quaternary ammonium germicidal detergent solution (2 percent aqueous solution).

c. Iodophor germicidal detergent solution (500 ppm available iodine).

d. Phenolic germicidal detergent solution (1 percent aqueous solution).

e. Sodium hypochlorite (1:10 dilution of household bleach). This solution must be made fresh daily.

3. Use all products according to the manufacturer's instructions.

4. Store all disinfectants in a safe area inaccessible to students.

Appendix M

Palatine Policy

Communicable Disease -- Students

In recognition that certain communicable diseases may constitute serious health problems for students of this school district, the Board has established the following policy:

- A student known to have a chronic infectious disease will be individually evaluated to determine if behavior or physical condition poses a high risk of spreading disease. The most appropriate educational program for the student will be determined by the Superintendent and his staff after consultation with a team consisting of a medical advisor(s), school nurse, school administrator(s), health officials, the family physician, the student, the student's teachers and the student's parents.

- An individual evaluation of a student known to have a chronic infectious disease will result in the development of a specific educational plan for the student. The individual student plan will identify the student's educational program, the health-related conditions of the placement, specific health instructions and other relevant information.

- A student with a chronic infectious disease

will be allowed to attend school in a regular classroom setting unless an individual evaluation results in the need to place specific limitations on attendance. A student will be excluded from school for the period in which there is any risk of transmitting the disease to other students or employees. A more restrictive environment would be appropriate for some students such as those who cannot control their bodily functions or behavior.

- The review team will monitor the condition of each student known to have a chronic infectious disease to determine the need for a more restrictive environment (i.e., hospital or homebound instruction).

- The privacy of a student known to have a chronic infectious disease will be respected by maintaining confidential records in accordance with federal and state privacy laws.

- The Superintendent shall notify students and parents or guardians of the District's policy and of any other relevant information concerning communicable diseases where there has been possible exposure with a student known to have a chronic infectious disease.

Adopted: March 12, 1987

Student

Procedures for Implementing Policy on

Communicable Disease -- Student, File JHCC

1) A student identified through medical examination as having a communicable disease shall be evaluated by a review team to determine the student's medical condition as it relates to continuing their education. The review team may include, but not be limited to:

a) Medical advisor(s)

b) Building Principal

c) County Health Official

d) Student Services Director

e) School Nurse

f) Student's Physician

g) Legal Consultant

h) Student's Parents

f) Student

2) The review team will develop an individual student plan that will include the student's educational program, the health-related conditions of the program, specific health instructions and other relevant information.

3) If the disease is life-threatening or poses a risk of tansmittal as determined by the review tesam, the following actions shall be taken:

a) Maintain the confidentiality of the medical record and the student's name and class.

b) Inform the building staff of the presence of the disease and provide information about the precautions to be taken.

c) Inform students and parents about the nature of the disease and the steps that have been taken to minimize the risk to others.

d) Direct all inquiries from the media to the building principal. A standard/appropriate response, developed by the District's legal counsel, to inquiries will be made available to all administrators.

e) Schedule meetings for parents to present facts and myths about the disease and to answer questions. Appropriate informational materials will be distributed to parents.

f) Implement an education program for staff and students developed by the school nurse and health education teachers with the assistance of a medical advisor(s).

4) A building review team consisting of the principal, the student services director and the school nurse will monitor the condition of each student known to have a chronic infectious disease to determine if any change in the student's medical

condition requires modification of the educational program.

WCB

8-27-87

Communicable Disease -- Personnel

In recognition that certain communicable diseases may constitute serious health problems for students or employees of this school district, the Board has established the following policy:

- Any employee infected with a communicable disease shall immediately notify his or her supervisor of the employee's medical condition. Immediately upon such notification, a determination of the status of the employee's medical condition as it relates to the performance of regular employment duties will be made by the Superintendent and his staff after consultation with a review team consisting of a medical advisor(s), school nurse, health officials, an administrator(s), the employee's physician and the employee.

- When the employee's medical condition prohibits the employee from performing regular duties, the employee may take sick leave pursuant to applicable School District policies.

- Notwithstanding the employee's ability to work, if the review team in consultation with health

officials and the employee's physician determines that the employee's medical condition may create a serious health risk to students and employees, the employee may be required to submit to a medical examination by a physician(s) as designated by the Superintendent. In addition, subject to a hearing as may be required by law, the employee will be required to take a leave of absence for the period of time that the employee's health poses such a risk.

- The review team will monitor the condition of an employee known to have a chronic infectious disease to determine reasonable employment accomodation based on the requirements of the employee's position and the status of the employee's medical condition.

- The privacy of an employee known to have a chronic infectious disease will be respected by maintaining confidential records in accordance with federal and state laws.

- Any action to review the status of an employee infected with a communicable disease will be undertaken only after proper legal consultation.

- The Superintendent shall notify employees of the District's policy on communicable diseases.

Adopted: March 12, 1987

Employee

Procedures for Implementing Policy on

Communicable Disease -- Personnel, File GBEC

1) An employee identified through medical examination as having a communicable disease shall be evaluated by a review team to determine the employee's medical condition as it relates to the performance of regular employment duties. The review team will include, but not be limited to:

a) Medical advisor(s)

b) Building Principal

c) County Health Official

d) School Nurse

e) Employee's Physician

f) Legal Consultant

g) Employee

2) The review team will develop a recommendation regarding the conditions of continued employment based on the employee's medical condition and the risk posed to the employee and to others.

3) If the disease is life-threatening or poses a risk of transmittal as determined by the reveiw team, the following actions shall be taken:

a) Maintain the confidentiality of the medical record and the name of the employee.

b) Inform the building staff of the presence

of the disease and provide information about the precautions to be taken.

c) Inform students and parents about the nature of the disease and the steps that have been taken to minimize the risk to others.

d) Direct all inquiries from the media to the building principal. A standard response, developed by the District's legal counsel, to any inquiries will be made available to all administrators.

e) Schedule meetings for parents to present the facts and myths about the disease and to answer questions.

f) Implement an education program for staff and students developed by the school nurse and health education teachers with the assistance of a medical advisor(s).

4) A building review team consisting of the principal and the school nurse will monitor the condition of each employee known to have a chronic infectious disease to determine if any change in the employee's medical condition requires modification of the employment duties.

WCB; 8-27-87

Appendix N

Robinson Policy

Contagious Diseases--Employees

Findings

The Board of Education finds that from time to time employees of the District may suffer from or may be carriers of infectious diseases. Because of the nature of the education process whereby large numbers of students are confined in close quarters with teachers, aides, clerical personnel, custodians, and other school employees, the risk of transmission of communicable diseases is higher than for noneducational settings. The Board of Education further finds that because school attendance is mandatory for students between the ages of 7 and 16 years, it is in the best interest of students that the District adopt a policy which will ensure that all reasonable steps are taken so as to protect the health of those who must mandatorily attend school. Furthermore, because of the nature of the educational process, employees must also work in close proximity to each other and students. Adequate steps should be taken to ensure the health of District employees and to prevent, to the extent feasible, the transmission of infectious diseases

from employees to students, from employee to employee, and from students to employees.

The Board finds that risk of transmission of disease cannot be known with scientific certainty. Such risk must be determined on a case by case basis, and may rest upon information which is unknowable. Such determination is, therefore, ultimately a matter of discretion and judgment.

Purpose and policy

It is the policy of School District that employees who are ill or who are carriers of infectious diseases and who, as a result of such disease, might transmit dangerous infectious diseases to other persons should not be present in school or in contact with other school employees or students.

It is further the policy of School District that employees who are not ill with or who are not carriers of dangerous infectious diseases should perform their duties as employees.

It is further the policy of School District that any employee reasonably suspected of being a carrier or, or being ill with a dangerous infectious disease should be examined at District expense, by a physician licensed to practice medicine in all of its branches, of the District's choosing, to

determine if such employee is ill with or is a carrier of a dangerous infectious disease. In order to effectuate this policy, the superintendent is directed as follows:

1. When it comes to the attention of the Superintendent that an employee is or may be ill with or a carrier of a dangerous infectious disease, the Superintendent shall bring the matter to the attention of the employee, and provide the employee with an opportunity to provide whatever information the employee may desire concerning the situation. If on the basis of all information obtained by the Superintendent from the employee or elsewhere it appears reasonable to the Superintendent that the employee is or may be ill with or the carrier of a dangerous infectious disease, then the Superintendent shall direct such employee to be examined by a physician licensed to practice medicine in all of its branches. The Superintendent, without further Board approval, may select such physician(s) as he feels most appropriate, including specialist physicians, so as to obtain a prompt and reliable diagnosis. The Superintendent, may also request of any physician an opinion as to the means and risk of transmission of any disease diagnosed.

2. At all times, the Superintendent shall endeavor to protect the confidences of the employee. In no event shall information provided by the employee or revealed or determined by a physician be revealed to any person except members of the Board of Education, the School District attorney, the physician selected by the employee, and any other person who, in the opinion of the Superintendent, must be apprised of the health of the employee affected so as to protect the health or welfare of the students or other employees.

3. The employee shall forthwith submit to the examination by the physician(s) as selected by the Superintendent. All costs related to such examination, including the cost of reasonable reimbursement for transportation, shall be borne by the District; and the employee shall suffer no loss of pay or other benefit. However, the employee may be permitted to take any sick or personal day available to such employee for such examination if, for reasons of privacy, the employee so desires.

4. If the examination by the physician(s) reveals that the employee is not ill with or is not a carrier of an infectious disease, then all records relating to such belief and examination shall be destroyed, except to the extent to which the

employee requests that they be retained. If the examination by the physician reveals that the employee is ill with or is a carrier of an infectious disease, then such information shall be retained by the District. However, the Superintendent shall take all steps reasonably necessary to prevent dissemination of such information to persons who, in order to perform their duties, do not need access to such information.

5. Upon receiving such information from the physician(s), the Superintendent shall make a determination, subject to review upon demand of the employee by the Board of Education. The Superintendent shall notify the employee promptly of his determination.

6. The Superintendent's determination may include:

a) removal of the employee from work, and placement on leave in accordance with any applicable leave provisions.

b) removal of the employee from work with pay, with the employee's duties to be performed elsewhere, including home.

c) the addition of conditions under which the employee shall work, including as appropriate,

the discontinuation of direct student contact, or contact with other employees.

d) any combination of the foregoing.

e) any other change in work status consistent with Board policy, including arrangements made by agreement with the employee and/or representative.

7. In making such a determination, the Superintendent shall consider the risk of contagion and of the potential severity of illness to others, as well as procedures which might be utilized to prevent the transmission of diseases to others. The decision of the Superintendent shall be subject to review by the Board of Education. The decision of the Board of Education shall be final.

8. The Superintendent may, in any case necessary, continue any of the options set forth above, until the employee is well or no longer capable of transmitting the disease to others.

9. The Superintendent may, in any case necessary, modify any of the options set forth above when there is an change in the status of the employee, including, but not limited to deterioration or improvement of the employee's condition, change in information available to the Superintendent which in the discretion of the

Superintendent justifies a change in status, or otherwise when in his judgment the interests of the District, its students or other employees so requires.

10. Refusal to:

a) submit to a physical examination in accordance herewith,

b) cooperate fully in such examination, or

c) permit such examination to be completed

shall be cause for immediate discipline.

Appendix O

Participating Districts and 1986-87 Enrollments

District	Enrollment
Bethany	509
Casey-Westfield	1070
Charleston	3153
Chrisman	476
Cowden-Herrick	351
Crestwood	717
Cumberland	1145
Findlay	323
Kansas	314
Lovington	385
Marshall	1364
Martinsville	456
Mattoon	4099
Moweaqua	614
Neoga	865

Oakland		487
Paris = 95		1949
Shelbyville		1445
Shiloh		397
Stewardson-Strasburg		448
Sullivan		1102
Tower Hill (Dual)	161	85
Windsor		410

Appendix P

Superintendent's Questionnaire on Aids

Many of the following questions are adapted from a new survey of superintendents done by Phi Delta Kappa. Other questions were generated that were more local in nature. Most of the questions or statements used the following scale: Strongly Agree (SA), Agree (A), Neutral (N), Disagree (D), and Strongly Disagree (SD). Please circle your response.

1. Education about AIDS should be part of the regular school curriculum.

   SA A N D SD

2. Schools and outside health agencies should coordinate their efforts to better meet the needs of students with AIDS.

   SA A N D SD

3. School districts should have a policy for dealing with AIDS.

   SA A N D SD

4. Students with AIDS should be excluded from contact sports.

   SA A N D SD

5. Individuals with AIDS should be protected by federal anti-discrimination laws.

SA A N D SD

6. School district policies should treat AIDS differently from other communicable diseases.

SA A N D SD

7. The curriculum should specifically address the moral issues and values related to AIDS.

SA A N D SD

8. Employees should undergo mandatory testing for AIDS.

SA A N D SD

9. Students should undergo mandatory testing for AIDS.

SA A N D SD

10. Contracts should make testing for AIDS a condition of employment.

SA A N D SD

11. Concerning a policy for dealing with a student with AIDS:

A. My district has a policy.

B. My district is developing a policy.

C. My district has not addressed the issue.

12. Concerning a policy for dealing with an employee with AIDS:

A. My district has a policy.

B. My district is developing a policy.

C. My district has not addressed the issue.

13. In developing district policy for dealing with AIDS, who should be involved:

A. Administration, board, and legal counsel

B. The above plus health officials

C. All the above plus staff

D. All the above plus community representatives.

14. If you were developing AIDS policies, which of the following sources would you trust most? Please rank in order.

...A. Guidelines from the Center for Disease Control.

...B. Model policies form the IASB and NSBA

...C. Recommendations from the State Board of Education.

...D. Policies from other Illinois school districts.

...E. Paid legal consultants.

15. In my school district, concern about AIDS is:

A. High

B. Moderate

C. Low

16. What is your personal opinion as to the grade level at which AIDS education should begin?

A. K-3

B. 4-5

C. 6-8

D. 9-12

E. Not at all.

17. AIDS curriculum is presently being taught in my district at the following level or levels:

A. K-3

B. 4-5

C. 6-8

D. 9-12

E. Not at all

18. What is your opinion of the legislation mandating the teaching of AIDS information and abstinence at the 6-12 grade levels?

SA A N D SD

THANK YOU FOR YOUR TIME AND TROUBLE!

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