

appropriate, although it must be approached cautiously and professionally.³¹² Increasingly, states are addressing this issue to avoid the anomalous situation where no one is available to assist a child who is ill, injured, or needs care.³¹³

[iv] Accommodating Individual Needs

Regardless of the disability status of a student, schools must be increasingly flexible to accommodate the individual needs of students requiring medication. This may involve some tempering of a school's usual "no drugs" policies.³¹⁴ With a suitable protocol, the legitimate interests of the school may be achieved while sensitive to the needs—sometimes lifesaving—of the child.

Those children who require medications at school, by and large, need them only temporarily. Medications for these students are now being designed so that they need not be taken at school and, instead, may be administered at home before and after school. There are, however, some students who require access to medications at school. These are students with chronic conditions.³¹⁵ In some cases, medication may be required routinely or on an emergency basis. Schools need to consider the individual needs of students in developing appropriate protocols and plans to address the reasonable requirements of these children.

[e] Diabetes Care

[i] Nature of Diabetes

Diabetes is a non-contagious disease characterized by high levels of blood glucose or sugar. Under its various forms, diabetes results from defects in insulin secretion because the body has destroyed insulin-producing beta cells in the pancreas, problems exist with the action of insulin in the body, or a combination of these conditions. Insulin is needed to use glucose, the basic sugar resulting from the digestion of most foods. Without insulin, the body will starve regardless of how much food is consumed because the body lacks insulin or is unable to use insulin to turn food into energy.

³¹² See, e.g., National Council of State Boards of Nursing, Delegation: Concepts and Decision-Making Process National Council Position Paper, 1995, available at: http://www.ncsbn.org/regulation/uap_delegation_documents_delegation.asp.

³¹³ *Ramsy Teachers Ass'n v. Board of Educ.*, 382 N.J. Super. 241, 888 A.2d 499, 205 Educ. L. R. 770 (2005) (state law allowed non-school nurse to provide care even where school nurse was not present; state law did not require certified school nurse to be physically present in school building complex and other non-school nurse could supplement services provided by school nurse).

³¹⁴ See, e.g., *Alvarez v. Fountainhead, Inc.*, 55 F. Supp. 2d 1048, 137 Educ. L. R. 592 (N.D. Cal. 1999) (ADA violated where child was not permitted to have inhaler medication at preschool under no medication policy).

³¹⁵ Some examples of these are children with diabetes, asthma or allergies. These are discussed, by way of example, in the succeeding discussion. Other situations may similarly arise, however, and a similar approach would be warranted.

With the discovery of insulin,³¹⁶ diabetes is a treatable but presently non-curable condition with proper care and management.³¹⁷ According to the Center for Disease Control and Prevention, about six percent of Americans—15.7 million people—have diabetes. Of these, roughly 123,000 are under the age of twenty.³¹⁸ It is estimated that around one in every 400 to 500 children have diabetes.³¹⁹ By virtue of the nature of diabetes, proper care and management must occur every day and throughout the day. Necessarily, schools attended by children with diabetes will need to provide for or accommodate the care and management of the disease.

There are two common categories of diabetes. Type 1 diabetics are insulin-dependent because with this form of the disease the pancreas is unable to produce any insulin. Type 1 diabetes is sometimes referred to as juvenile diabetes because it ordinarily occurs in the young. School aged children will be Type 1 diabetics. They must take insulin daily. Type 2 diabetics produce some level of insulin but are unable to properly use insulin and, thereby, glucose. Type 2 diabetes often may be treated with oral medications, but also may require insulin. Type 2 diabetes has been called "adult onset" because individuals are typically diagnosed over 30 years of age, but it is increasingly found in children and teenagers, apparently as a consequence of an epidemic of childhood obesity in the United States.³²⁰

Care of Type 1 diabetes requires that glucose levels be regularly monitored. Four tests daily are typical, one prior to each meal and another at bedtime. An electronic monitor is used. Although the types of monitors vary, most utilize a test strip inserted in the device. The child pricks a finger with a lancet and a drop of blood is then placed on the test strip. Other means to test blood glucose levels are being developed but presently a blood droplet is required.

Because Type 1 diabetics are insulin-dependent, they are required to take injections daily. There are efforts to administer insulin in other ways, such as by

³¹⁶ Frederick G. Banting, Charles A. Best, James B. Collip, and John J.R. MacLeod are credited with the discovery of insulin in 1921. See Michael Bliss, *The Discovery of Insulin* (U. Chi. Press 1982).

³¹⁷ See, e.g., American Diabetes Association, *Complete Guide to Diabetes* 2nd Edition (Am. Diabetes Ass'n); Richard S. Beaser & Joan V.C. Hill, *The Joslin Guide to Diabetes* (Simon & Schuster); Christopher D. Saudek, Richard R. Rubin & Cynthia S. Shump, *The Johns Hopkins Guide to Diabetes For Today and Tomorrow* (The Johns Hopkins Univ. Press).

³¹⁸ Centers for Disease Control and Prevention, *National Diabetes Fact Sheet: National Estimates and General Information on Diabetes in the United States*, Revised Edition (1998).

³¹⁹ See James A. Rapp, *Students with Diabetes in Schools*, Inquiry & Analysis at 1 (NSBA Council of School Attorneys, June 2005).

³²⁰ American Diabetes Association, *First Report 6* (June 9-13, 2000) (quoting Sonia Caprio, M.D., of the Department of Pediatric Endocrinology at Yale University School of Medicine).

inhalation, but none is generally available. Oral medications are ineffective to treat Type 1 diabetics. Injections using syringes are required. Most children taken a regimen of at least two shots daily, but some may take three or four shots daily. Insulin acts at different rates and, therefore, children with diabetes are required to eat at regular means and also have snacks or juice during the day. Insulin pumps are becoming more common and involve a continuous injection system, thus giving somewhat greater flexibility to a diabetic person.

Children with diabetes face the possibility of two significant challenges daily: Hyperglycemia and hypoglycemia. Hyperglycemia results when blood glucose levels are too high; hypoglycemia results when these levels are too low. Either is serious.

Hyperglycemia usually results in hunger, thirst, headache, blurry vision, frequent urination, itchy and dry skin, but where extreme may cause breathing difficulties, electrolyte imbalance, coma, shock, and even death. Hyperglycemia is usually dealt with by taking additional insulin to lower blood glucose levels. Where blood glucose levels are high, diabetics will test for ketones, which are the chemical by-products of fat breakdown (akin to ashes being the by-product of burned wood). Ketones may lead to diabetic ketoacidosis, which may lead to flu-like symptoms and more serious conditions. Ketones are testing by using urine test strips.

Hypoglycemia—again, low blood glucose—results from too much insulin. This results in tremors, palpitations and sweating, confusion, drowsiness, mood changes, unresponsiveness, unconsciousness, convulsions, and if left untreated, death. Where a diabetic is “low” the usual treatment is a ingesting a snack, juice, or fast-acting glucose tablets. If consciousness is lost, a substance known as glucagon is injected by syringe to revive the child.

Diabetes is a serious illness. But with properly insulin injections, blood glucose monitoring, proper diet and exercise, children with diabetes enjoy substantially normal lives including a full and vigorous educational experience.

[ii] Disability Protections of Children with Diabetes

Students with diabetes are said to “constitute an overlooked and disadvantaged group within the public and private schools systems.”³²¹ Quite frequently children are not suspected as having diabetes and are diagnosed only after a life threatening episode of ketoacidosis.³²² Nonetheless, it is clear diabetes constitutes a disability and, accordingly, children with diabetes may not be denied equal educational opportunities, safe educational environments, and full access to the education process.³²³ The U.S.

³²¹ Michael K. Vennum, *Students with Diabetes: Is There Legal Protection?*, 24 *J. of Law & Educ.* 33, 66 (1995).

³²² See *Hinkle v. Shepherd Sch. Dist. #37*, 2004 MT 175, 93 P.3d 1239 (2004) (although holding that student did not have claim for causing, accelerating or exacerbating diabetes condition, providing an unfortunate example where a student had a traumatic experience of teasing and disregard where he was apparently suffering undiagnosed ketoacidosis).

³²³ Vennum, *Students with Diabetes: Is There Legal Protection?*, 24 *J. of Law & Educ.* at 66.

See also *Lawson v. CSX Transportation, Inc.*, 245 F.3d 916 (7th Cir. 2001) (in employment case, held

Department of Education's Office for Civil Rights has characterized diabetes as one of the "hidden disabilities," meaning that it is a physical impairment that is not readily apparent to others.³²⁴

Protection of those with disabilities arises from federal law³²⁵ and, typically, state counterparts.³²⁶ The Americans with Disabilities Act (ADA), for example, defines "disability" to include "a physical or mental impairment that substantially limits one or more of the major life activities of such individual."³²⁷ A physical impairment, by regulation, expressly includes diabetes.³²⁸ Learning is a major life activity.³²⁹ Section 504 of the Rehabilitation Act, although not as specific, has been similarly interpreted.³³⁰ Under the Individuals with Disabilities Education Act (IDEA), diabetes constitutes an "other health impairment,"³³¹ but the condition is seldom so severe as to invoke most IDEA protections.³³²

Type I insulin-dependent diabetic was disabled under ADA; noting that diabetic "must endure the discomfort of multiple blood tests to monitor his blood glucose levels," "must adjust his food intake and level of exertion to take into account fluctuations in blood sugar," and "[w]hen his blood sugar drops, he 'must stop all other activities and find the kinds of food that will bring his levels back to normal or he will experience disabling episodes of dizziness, weakness, loss of mentation and concentration, and a deterioration of bodily functions' ").

But cf. *Orr v. Wal-Mart Stores, Inc.*, 297 F.3d 720 (8th Cir. 2002) (holding in employment case that insulin dependent diabetic failed to establish that he was disabled under ADA and could be terminated for closing single-pharmacist Wal-Mart facility to take a mid-day lunch break during his ten-hour work shift; declining to follow or consider the *Lawson* case and claim that eating is a major life activity that was substantially limited due to his diabetes because precise argument was not raised at the district court level).

³²⁴ See U.S. Dep't of Educ., Office for Civil Rights, *The Civil Rights of Students with Hidden Disabilities Under Section 504 of the Rehabilitation Act of 1973* (1995).

³²⁵ See generally § 10.15 (regarding educational opportunities and discrimination on the basis of disability).

³²⁶ See, e.g., *Ellison v. Creative Learning Center*, 383 N.J. Super. 581, 893 A.2d 12, 207 Educ. L. R. 273 (2006) (non-sectarian private pre-school was a "public accommodation" under state discrimination law; remanded to consider whether school failed to afford child with Type I diabetes reasonable accommodations by, among other things, failing to have medically trained personnel on staff, obtaining training in the use of the insulin pump, etc.).

³²⁷ 42 U.S.C. § 12102.

³²⁸ 28 C.F.R. § 35.103 (for purposes of Title II of ADA, physical impairment includes diabetes); 28 C.F.R. § 36.104 (for purposes of Title III of ADA, physical impairment includes diabetes).

³²⁹ 28 C.F.R. § 35.104.

³³⁰ Michael K. Vennum, *Students with Diabetes: Is There Legal Protection?*, 24 J. of Law & Educ. 33, 41-42 (1995).

³³¹ IDEA Proposed Regulations, 70 Fed. Reg. 35782, 35836 (June 21, 2005) (to be codified at 34 C.F.R. § 300.8(c)(9)(i)) (specifically listing diabetes).

³³² An "other health impairment" must result in "limited strength, vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that . . . (i) is due to chronic or acute health problems such as . . . diabetes . . . ; and (ii) Adversely affects a child's educational performance." IDEA Proposed Regulations, 70 Fed. Reg. 35782, 35836 (June 21, 2005) (to be codified at 34 C.F.R. § 300.8(c)(9)).

In the school setting, there is usually little disagreement that children with diabetes suffer a disability and some level of protection exists.³³³ However, the argument is sometimes made that because diabetes may be controlled by the regular use of insulin, a major life activity is not substantially limited and, therefore, a diabetic under control is not disabled. This is based on the *Sutton* case³³⁴ decided by the Supreme Court in which it was held that, in some contexts, the availability and use of a mitigating measure precludes classification as disabled.³³⁵ The Department of Education's Office for Civil Rights subsequently issued a Guidance in which it emphasized that the Supreme Court requires an individualized assessment including consideration of any negative affects from mitigating measures.³³⁶ In the school setting, according to OCR, schools must distinguish between those mitigating measures which a student may use without any action or assistance by the school from those reasonable modifications, academic adjustments, auxiliary aids and services, or related aids and services that schools are required to provide under Section 504 or the ADA. Only those independently available to the student are considered and not those when some action or permission of the part of the school would be required.³³⁷ Accordingly, school officials must consider the manner in which mitigations are available³³⁸ and when.³³⁹

³³³ See generally James A. Rapp, *Students with Diabetes in Schools*, Inquiry & Analysis (NSBA Council of School Attorneys, June 2005).

See also *AP ex rel. Peterson v. Anoka-Hennepin Indep. Sch. Dist. No. 11*, 538 F. Supp. 2d 1125, 230 Educ. L. R. 627 (D. Minn. 2008) ("The parties do not dispute that AP's diabetes is a disability.").

³³⁴ *Sutton v. United Air Lines, Inc.*, 527 U.S. 471, 119 S. Ct. 2139, 144 L. Ed. 2d 450 (1999) (severely myopic individuals denied employment as airline pilots held not disabled under ADA where corrective lenses allowed individuals to function identically to people without impairment).

³³⁵ With respect to diabetes in particular this statement is based on the Supreme Court's observation that "courts would almost certainly find all diabetics to be disabled, because if they failed to monitor their blood sugar levels and administer insulin, they would almost certainly be substantially limited in one or more major life activities." Therefore, it continued, a "diabetic whose illness does not impair his or her daily activities would therefore be considered disabled simply because he or she has diabetes." 527 U.S. 483.

³³⁶ *Sutton Investigative Guidance: Consideration of "Mitigating Measures" in OCR Disability Cases*, U.S. Department of Education Office for Civil Rights (September 29, 2000), available at: http://www.diabetes.org/uedocuments/Sutton_Investigative_Guidance.pdf.

³³⁷ OCR concluded, for example, that "permission to monitor diabetes or inject insulin" falls into the category that requires school action or assistance.

³³⁸ OCR provided these directions:

If there is a mitigating measure involved, determine if the student can use the mitigating measure independently in the school setting.

Does the student need the school to take some action (such as provide a related aid or service, or modify a policy, including giving permission to use the mitigating measure during school hours, on school grounds) in order to use the mitigating measure?

If the student needs the school to take some action, do not consider the effect of the measure (positive or negative) in determining if the student has an impairment that substantially limits him or her in any major life activity.

³³⁹ Another factor considered by OCR is whether a mitigating measure is effective all the time even

Even with mitigation children with diabetes will most always be considered to have a disability.

[iii] Providing and Accommodating a Diabetic Care Plan

The care and management of diabetes in the school setting is complicated by the fact that children of all ages may have the disease. Varying approaches and accommodations or modifications are necessarily required.³⁴⁰ Stated generally, any reasonable accommodation or modification is required unless doing so would fundamentally alter the affected program.^{340.1}

Diabetes is largely a self-treated disease. Children with diabetes are often singularly self-sufficient in this task, but others require help. The length of a child's diagnosis is significant; a younger child diagnosed as an infant may be much better able to provide for the child's own care than an older, newly diagnosed, child. Care and management is also complicated by the fact that the ability of children to control the condition may vary. Some are able to keep blood glucose levels in relative tight ranges while others are unable to do so even with great diligence. How children will be treated usually must be considered individually.³⁴¹

Where a child with diabetes attends a school, it is advisable and, under disability protections, the school may be required to develop a diabetic care plan for the child. This plan would be developed through the cooperative effort of school officials and staff, parents, the child, and the child's health care professionals. Where disagreements exist over the plan, various remedies may apply to resolve those differences. While not always required, administrative remedies generally should be exhausted before

if available. It observed, for example, that "a student with diabetes who injects insulin at home may still need an insulin injection, on an emergency basis, at school."

³⁴⁰ Resources for addressing the needs of children with diabetes are available on the Internet. See Ch. R3, Vol. 7. The American Diabetes Association, in particular, has materials to assist in the development of a diabetes care plan in the school setting. See www.diabetes.org. Many of the issues that arise in the education setting are covered in the ADA's publication, *Legal Rights of Students with Diabetes*, prepared by James A. Rapp, Shereen Arent, Brian L. Dimmick, and Crystal Jackson. Some states agencies, also, have published helpful publications. The New York State Department of Health, for example, has published two helpful guides: *Children with Diabetes: A Resource Guide for Families of Children with Diabetes* and *Children with Diabetes: A Resource Guide for Schools*.

^{340.1} AP *ex rel.* Peterson v. Anoka-Hennepin Indep. Sch. Dist. No. 11, 538 F. Supp. 2d 1125, 230 Educ. L. R. 627 (D. Minn. 2008) (declining summary judgment in favor of school and holding that it was reasonable to ask that child care staff be trained and willing to operate child's blood-glucose meter and his insulin pump if he was unable to do so and that it was unlikely district could establish to a jury's satisfaction that granting either accommodation would have been an undue burden upon it or would have fundamentally altered the program; although declining to determine whether request that staff be trained and authorized to administer glucagon is unreasonable and would place an undue burden on the district or would fundamentally alter the program claim rejected because child could not establish the requisite intent for compensatory damages.)

³⁴¹ See generally James A. Rapp, *Students with Diabetes in Schools*, Inquiry & Analysis (NSBA Council of School Attorneys, June 2005) (noting that if a single theme permeates decisions concerning children with diabetes in school, it is that they must be based on individualized determinations).

attempting litigation.³⁴²

There are a number of issues that may be addressed in a diabetic care plan.³⁴³ Among them:

- Will the child's teachers and other appropriate school personnel be informed of the child's diabetic condition?
- Are teachers and school personnel able to recognize the symptoms of and respond appropriately to diabetic emergencies, including hypoglycemia and hyperglycemia?
- Where a child is unable to fully self-monitor and self-treat, what services or assistance will be provided, when, by whom, and where?
- When and where will a child be able to self-monitor blood glucose levels?
- What will the child's meal schedule be and will the child be permitted to carry and consume a snack or juice in class?
- How will testing for ketones be handled and will appropriate action be taken to deal with abnormal ketone levels?
- Will the child be permitted to keep a supply of insulin and glucagon at school?
- How will the administration of insulin and glucagon be handled?

³⁴² See, e.g., *Eads ex rel. Eads v. Unified School Dist. No. 289*, 184 F. Supp. 2d 1122, 162 Educ. L. R. 223 (D. Kan. 2002) (where administrative remedies had not been exhausted, IDEA and ADA claims dismissed alleging a failure to accommodate a diabetic child's educational needs; a Section 504 claim was not included).

But cf. AP ex rel. Peterson v. Anoka-Hennepin Indep. Sch. Dist. No. 11, 538 F. Supp. 2d 1125, 230 Educ. L. R. 627 (D. Minn. 2008) (where child's claims related to day-care program sponsored by school district rather than his education program, exhaustion requirement did not apply; ADA and Section 504 claims would not be treated as IDEA-type claims because the claims relate only tangentially to his education).

See generally § 10.27[3] (regarding the exhaustion requirement for ADA, Section 504, and IDEA claims).

³⁴³ The American Diabetes Association suggests that a plan consider:

1. Blood glucose monitoring, including the frequency and circumstances requiring testing.
2. Insulin administration (if necessary), including doses/injection times prescribed for specific blood glucose values and the storage of insulin.
3. Meals and snacks, including food content, amounts, and timing.
4. Symptoms and treatment of hypoglycemia (low blood glucose), including the administration of glucagon if recommended by the student's treating physician.
5. Symptoms and treatment of hyperglycemia (high blood glucose).
6. Testing for ketones and appropriate actions to take for abnormal ketone levels, if requested by the student's health care provider.

See American Diabetes Association, *Care of Children With Diabetes in the School and Day Care Setting*, Diabetes Care, Vol. 24, Supp. 1, American Diabetes Association: Clinical Practice Recommendations 2001. This publication is available on the ADA's web site at: www.diabetes.org.

- Will personnel be available and sufficiently trained to provide assistance to the child and act in the event of emergency?

Just how to provide for children with diabetes must be determined on an individualized basis. A child's parents, the child, and the school each have responsibilities that should be addressed.

The American Diabetes Association has advised that parents should be prepared to provide the following in connection with their child's care:³⁴⁴

- All materials and equipment necessary for diabetes care tasks, including blood glucose testing, insulin administration (if needed), and urine ketone testing.³⁴⁵
- Supplies to treat hypoglycemia, including a source of glucose and a glucagon emergency kit, if indicated in the Diabetes Health Care Plan.
- Information about diabetes and the performance of diabetes-related tasks.
- Emergency phone numbers for the parent/guardian and the diabetes care team so that the school can contact these individuals with diabetes-related questions and/or during emergencies.
- Information about the student's meal/snack schedule. The parent should work with the school to coordinate this schedule with that of the other students as closely as possible. For young children, instructions should be given for when food is provided during school parties and other activities.

State law may address some of these issues.³⁴⁶ Diabetes-specific legislation has

(Text continued on page 11-289)

³⁴⁴ American Diabetes Association, *Care of Children With Diabetes in the School and Day Care Setting*, Diabetes Care, Vol. 24, Supp. 1, American Diabetes Association: Clinical Practice Recommendations 2001.

³⁴⁵ The ADA also recommends:

The parent/guardian is responsible for the maintenance of the blood glucose testing equipment (*i.e.*, cleaning and performing controlled testing per the manufacturer's instructions) and must provide materials necessary to ensure proper disposal of materials. A separate logbook should be kept at school with the diabetes supplies for the staff or student to record test results; blood glucose values should be transmitted to the parent/guardian for review as often as requested.

³⁴⁶ Information on these laws is available on the American Diabetes Association web site at: www.diabetes.org.

been recommended to protect students with diabetes.³⁴⁷

The diabetic child should be expected to participate in the plan. The extent of the child's participation or involvement would be determined taking into account the child's ability and willingness to perform self-care tasks.³⁴⁸ The American Diabetes Association has advised that a school should be expected to provide the following:³⁴⁹

- Training to all adults who provide education/care for the student on the symptoms and treatment of hypoglycemia and hyperglycemia and other emergency procedures.³⁵⁰
- Immediate accessibility to the treatment of hypoglycemia by a knowledgeable adult. The student should remain supervised until appropriate treatment has been administered, and the treatment should be available as close to where the student is as possible.
- If indicated by the child's developmental capabilities and the Diabetes

³⁴⁷ Christopher W. Goddard, *Children with Diabetes: Are State Statutes Needed to Protect Students' Rights?*, 34 *J. of Law & Educ.* 497 (2005).

³⁴⁸ The American Diabetes Association has summarized these expectations of a child in diabetes care:

Preschool and day care. The preschool child is usually unable to perform diabetes tasks independently. By four years of age, children may be expected generally to cooperate in diabetes tasks.

Elementary school. The child should be expected to cooperate in all diabetes tasks at school. By age 8 years, most children are able to perform their own fingerstick blood glucose tests with supervision. By age ten, some children can administer insulin with supervision.

Middle school or junior high school. The student should be able to administer insulin with supervision and perform self-monitoring of blood glucose under usual circumstances when not experiencing a low blood glucose level.

High school. The student should be able to perform self-monitoring of blood glucose under usual circumstances when not experiencing low blood glucose levels. In high school, most adolescents should be able to administer insulin without supervision.

See American Diabetes Association, *Care of Children With Diabetes in the School and Day Care Setting*, *Diabetes Care*, Vol. 24, Supp. 1, American Diabetes Association: Clinical Practice Recommendations 2001.

³⁴⁹ American Diabetes Association, *Care of Children With Diabetes in the School and Day Care Setting*, *Diabetes Care*, Vol. 24, Supp. 1, American Diabetes Association: Clinical Practice Recommendations 2001.

³⁵⁰ The ADA also suggests:

An adult and back-up adult(s) trained to: (1) perform fingerstick blood glucose monitoring and record the results; (2) take appropriate actions for blood glucose levels outside of the target ranges as indicated in the student's Diabetes health Care Plan; and (3) test the urine or blood for ketones, when necessary, and respond to the results of this test.

Health Care Plan, an adult and back-up adult(s) trained in insulin administration.

- An adult and back-up adult(s) trained to administer glucagon, in accordance with the student's Diabetes Health Care Plan.
- A location in the school to provide privacy during testing and insulin administration, if desired by the child and family, or permission for the student to check his or her blood glucose level and to take appropriate action to treat hypoglycemia in the classroom or anywhere the student is in connection with a school activity.
- An adult and back-up adult(s) responsible for the student who will know the schedule of the student's meals and snacks and work with the parents to coordinate this schedule with that of the other children as closely as possible. This individual also will notify the parents in advance of any expected changes in the school schedule that affect the student's meal times or exercise routine. Young children should be reminded of snack times.
- Permission for the student to see school medical personnel upon request.
- Permission for the student to eat a snack anywhere, including the classroom or the school bus, if necessary to prevent or treat hypoglycemia.
- Permission to miss school without consequences for required medical appointments to monitor the student's diabetes management. This should be an excused absence with a doctor's note, if required by usual school policy.
- Permission for the child to use the restroom and access to fluids (*i.e.*, water), as necessary.
- An appropriate location for insulin and/or glucagon storage, if necessary.
- The student with diabetes should have immediate access to diabetes supplies at all times, with supervision as needed. Provisions similar to those described above must be available for field trips, extracurricular activities, other school-sponsored events, and on transportation provided by the school to enable full participation in school activities.
- An adequate number of school personnel should be trained in the necessary diabetes procedures (*e.g.*, blood glucose monitoring, insulin and glucagon administration) and in the appropriate response to high and low blood glucose levels to ensure that at least one adult is present to perform these procedures in a timely manner while the student is at

school, on field trips, and during extracurricular activities or other school-sponsored events. These school personnel need not be health care professionals.

Another aspect of diabetes care involves a proper and controlled diet. Diabetics count carbohydrates. It is necessary to balance food intake, insulin use and physical activity to maintain proper control. This is especially critical for those diabetics on an insulin pump and certain insulin regimens. Under these approaches to diabetes care, a low level of insulin is maintained in the body at all times and additional insulin is taken to correspond to the amount of food consumed. "Carb" counting requires information regarding the nutrient levels in food. A Diabetes Care Plan should provide access to this information to the extent reasonably available. The National School Lunch Program is sensitive to these sorts of needs. Discrimination is prohibited and accommodation of disabilities required.³⁵¹ Adjustments are to be made as necessary for a student with special and dietary needs.³⁵² The National School Lunch Program also requires that nutrition of meals be analyzed.³⁵³ Therefore, information to assist a child to count carbohydrates and other nutrients should be available. The child, of course, should be expected regulate consumption consistent with the child's diet.

Appropriate school personnel must be made aware that a child has diabetes. With this said, the privacy of the student should be respected.³⁵⁴ However, there is a clear need for teachers and others to be able to identify symptoms of hypoglycemia and hyperglycemia.³⁵⁵ They should also be aware of the impact of such conditions of performance. And, importantly, they must be able to deal with the condition or assist the student in doing so.

To provide for proper care, it is essential that school personnel have a basic knowledge of diabetes care. A training program of some sort is often appropri-

³⁵¹ See 7 C.F.R. § 15b.1 *et seq.*

³⁵² See 7 C.F.R. § 210.10(d).

³⁵³ See 7 C.F.R. § 210.10.

³⁵⁴ See *Vernonia Sch. Dist. 47J v. Acton*, 515 U.S. 646, 658, 115 S. Ct. 2386, 132 L. Ed. 2d 564, 101 Educ. L. R. 37 (1995) (observing that it would be inappropriate to give tests to students to determine "whether the student is, for example, epileptic, pregnant, or diabetic"); *Gruenke v. Seip*, 225 F.3d 290 (3d Cir. 2000) (claim stated for invasion of privacy where information disclosed about a student's possible pregnancy); *Eads ex rel. Eads v. Unified School Dist. No. 289*, 184 F. Supp. 2d 1122, 162 Educ. L. R. 223 (D. Kan. 2002) (FERPA claim made for allegedly divulging confidential information regarding diabetic student dismissed on procedural grounds).

³⁵⁵ Parents of children with diabetes and the children themselves usually make certain those with whom they will have regular contact are aware of their condition. In this way, teachers, friends, and others, will not only be able to provide some level of assistance or at least know to seek help. Diabetic children are uniformly expected to wear a bracelet or some other item to inform others in case of emergency that they are diabetic.

ate.³⁵⁶ Some states now require schools to have employees who are trained to administer insulin and glucagon³⁵⁷ and it has been suggested that such legislation be widely adopted.³⁵⁸ Where not otherwise required, some schools have agreed to have such personnel available and assure that they receive training.³⁵⁹ Apart from the civil rights aspects of this obligation, schools have an obligation to respond appropriately to emergency medical needs of students.³⁶⁰

A knowledgeable staff is especially important because a child suffering a hypoglycemic reaction simply may not be able to delay dealing with the situation or even be able clearly to communicate the nature of the problem. Without some training a teacher may not appreciate the seriousness of the situation and might unwittingly delay matters, questioning whether the student's situation is genuine.³⁶¹

³⁵⁶ American Diabetes Association, *Care of Children With Diabetes in the School and Day Care Setting*, Diabetes Care, Vol. 23, Supp. 1, American Diabetes Association: Clinical Practice Recommendations 2000 (recommending that there be an adequate number of school personnel trained in the necessary diabetes procedures, e.g., blood glucose monitoring, insulin and glucagon administration, to ensure that at least one adult is available to perform these procedures while the child is at school or on a field trip); Michael K. Vennum, *Students with Diabetes: Is There Legal Protection?*, 24 J. of Law & Educ. 33, 54-59 (1995) (providing a Model Diabetes Education Program).

³⁵⁷ The State of Virginia adopted legislation in 1999 to provide various provisions relating to the care of public school students diagnosed with Type 1 diabetes. If a student is diagnosed with diabetes, at least two instructional or administrative or other employees, among others, must have been trained in the administration of insulin, glucagon, and intravenous glucose solution. Virginia Code Ann. § 22.1-274 (amended by Senate Bill 889).

³⁵⁸ Christopher W. Goddard, *Children with Diabetes: Are State Statutes Needed to Protect Students' Rights?*, 34 J. of Law & Educ. 497, 517-18 (2005).

³⁵⁹ This was the case at Loudoun County Public Schools in Virginia. After complaints from parents were made to the U.S. Department of Education Office for Civil Rights over a policy that provided for calling "911" rather than have non-medical personnel administer glucagon, the district entered into a settlement to administer insulin and glucagon shots. The agreement also required staff to be trained in the care of children with diabetes. See OCR Complaint Nos. 11-99-1003, 11-99-1064 and 11-99-1069. Further information on this case is available from the American Diabetes Association at its web site at: www.diabetes.org.

³⁶⁰ See generally § 12.09 (regarding tort claims arising from medical care issues).

³⁶¹ An example of this is *DeFalco v. Deer Lake Sch. Dist.*, 663 F. Supp. 1108, 40 Educ. L. R. 1186 (W.D. Pa. 1987). A nine-year old diabetic student asked her teacher for permission to go to the nurse's office because she was having a hypoglycemic reaction. The teacher refused to allow her to leave the room until after the reading class, nearly 45 minutes later. By the time the student arrived at the nurse's office, she was intermittently losing consciousness and was unable to inform the school nurse that she needed food. For nearly two hours, she received no medical care. The school phoned the child's grandmother who came to school and instructed the school to get her to the hospital. The child was hospitalized for six days. Although the court rejected federal claims, in part because a failure to train claim could not be based on a single incident of this sort, the court

Of all aspects of a diabetic care plan, glucose monitoring is the most debated. Glucose monitoring is essential to the proper management of diabetes. Students should be encouraged regularly to monitor glucose levels as directed by their physicians. Most children, except the very young, quickly learn to self-monitor. Schools should not do anything that would dissuade a child from performing the tests.

At some schools, students are required to go to a nurse's office or other location between classes or they are excluded briefly from class to perform tests. There are different reasons for this position, including concerns over whether the test is performed, disruption of class, lack of sterile conditions, blood borne pathogens, disposal of the lancet or test strip which contain blood, and concern that other students might play or experiment with the testing equipment, among others. These reasons may have merit in some cases, particularly with younger children, but seem to be unreasonable, unrealistic, and entirely inappropriate with older students.³⁶² Children with diabetes are generally quite responsible and take their responsibilities quite seriously.³⁶³ A better practice would be to allow self-monitoring when and where desired, including the classroom, after confirming that the child is mature and responsible enough to monitor blood glucose properly and without posing a risk to others.³⁶⁴

Most schools find children with diabetes to be very involved in their treatment. Of course, age and maturity will impact this. It should be recognized, of course, that at any age an individual with diabetes may require help where experiencing hypoglycemia or a "low" and any school-age child may need a reminder to eat, drink, or test.³⁶⁵ This can be especially important a field trips or times when the school routine is broken. In more extreme situations, school personnel may be called upon to administer insulin or even glucagon.³⁶⁶

noted that traditional common-law remedies may be available.

³⁶² The concern over blood receives the greatest attention. However, in practice, most schools do not show a similar concern regarding blood incidents during physical education class and athletic programs, paper-cuts in class, or the disposal of feminine hygiene products. Some schools provide suitable containers in restrooms for all blood-related items which could include test strips and lancets. Some students carry a baggie to hold items until they may be disposed of in a manner desired by the school. In point of fact, however, concerns about blood are seldom justified.

³⁶³ Anecdotal stories involve situations such as a student being suspended for violating a school's drug policy by giving a glucose tablet to another student and another student taking a diabetic child's lancet and pricking his own finger. It may be appropriate to caution a child with diabetes about these concerns if they exist.

³⁶⁴ School personnel might confirm either directly or through parental or physician certification that the student demonstrates correct use of the blood glucose meter, knows the time for monitoring, and knows how properly to dispose of testing materials.

³⁶⁵ See American Diabetes Association, *Care of Children With Diabetes in the School and Day Care Setting*, Diabetes Care, Vol. 24, Supp. 1, American Diabetes Association: Clinical Practice Recommendations 2001.

³⁶⁶ A number of states specifically authorize school personnel, even those who are not nurses or health care providers, to administer insulin or glucagon. Where not authorized, the usual debate is whether

Many parents of children with diabetes report problems related to diabetes management at their children's schools. The development of a diabetic care plan will assist in lessening these problems.

[f] Asthma Care

Asthma is a chronic lung condition which is characterized by difficulty in breathing. Those with asthma have highly sensitive or hyperresponsive airways. When the airways become irritated, they narrow or obstruct making it difficult for the air to move in and out. In extreme situations, a child with asthma may have a life threatening or anaphylactic reaction resulting in faintness, collapse, or even death if left untreated. Those with asthma have inhalers containing medication that relieves the effects of chronic asthma.

A school is required to permit children to have this medication available.³⁶⁷ Of course, the requirements associated with bringing medicine into the school would be subject to the school's usual rules.³⁶⁸

Parents may request that a child be permitted to carry the child's inhaler or nebulizer. Whether a school must allow a child personally to carry an asthma inhaler or nebulizer is subject to greater debate and depends on the circumstances of the individual child.³⁶⁹ In some instances, whether medication is immediately available to a child is a matter of life or death.³⁷⁰ Quite clearly, school officials should not preclude a child from having access to medical care.^{370.1}

Where a child is determined to be disabled for purposes of Section 504 of the

(Text continued on page 11-295)

non-health care providers should undertake this responsibility. The reason for this concern is that a prescription medication is involved. Insulin generally is not a prescription medication in the United States. Syringes may or may not be, depending on the individual state. Glucagon is ordinarily a prescription medication. Most schools are comfortable with undertaking this responsibility should the need arise where a non-health care provider receives some training and is authorized by the child's parent to administer medication.

³⁶⁷ See also *Alvarez v. Fountainhead, Inc.*, 55 F. Supp. 2d 1048, 137 Educ. L. R. 592 (N.D. Cal. 1999) (ADA violated where child was not permitted to have inhaler medication at preschool under no medication policy).

³⁶⁸ See § 11.04[5][d].

³⁶⁹ See generally Linda Magruder, *Asthma Inhalers in the Classroom, or Not?*, 30 J. of Law & Educ. 171 (2001).

³⁷⁰ See *Gonzalez v. Handord Elementary Sch. Dist.*, 2002 Cal. App. Unpub. LEXIS 1341 (2002) (multi-million-dollar judgment upheld, with remittitur, for wrongful death of asthmatic child who was not permitted to carry nebulizer; although school's written medication policy had an unwritten exception to allow children to carry inhalers or nebulizers with a physician's approval, parent was never informed of it).

^{370.1} *Taylor v. Altoona Area Sch. Dist.*, 513 F. Supp. 2d 540, 225 Educ. L. R. 778 (W.D. Pa. 2007) (although rejecting various claims, held that due process claim alleged based on allegations that school personnel affirmatively prevented asthmatic child from seeking medical attention on his own, contacting his Mother, and prevented him from carrying his own medication or administering the medication on his own; child died after acute bronchial asthma attack).