

No. 68. An act relating to health and schools.

(S.4)

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. FINDINGS

The General Assembly finds:

(1) According to the Centers for Disease Control and Prevention:

(A) Each year, emergency departments (EDs) in the United States treat an estimated 173,285 persons 19 years of age and younger for sports- and recreation-related traumatic brain injuries (TBI), including concussions, 70 percent of which were suffered by young people 10–19 years of age.

(B) From 2001 to 2009, the number of annual sports- and recreation-related ED visits for TBI among persons 19 years of age and younger increased 62 percent, from 153,375 per year to 248,418 per year.

(C) For males 10–19 years of age, TBIs most commonly occur while playing football. For females 10–19 years of age, TBIs most commonly occur while playing soccer or bicycling.

(2) According to a study in the American Journal of Sports Medicine, many high school athletes do not report when they suffer concussions despite the increased awareness of and focus on the seriousness of such injuries and the potential for catastrophic outcomes, particularly from multiple concussions.

(3) Without a clear action plan describing the steps a youth athlete must take in order to return to play after suffering a concussion, the youth is more likely to hide the concussion and continue to play without receiving the necessary treatment.

Sec. 2. 16 V.S.A. § 1431 is amended to read:

§ 1431. CONCUSSIONS AND OTHER HEAD INJURIES

(a) Definitions. ~~For purposes of~~ As used in this subchapter:

(1) ~~“School athletic team” means an interscholastic athletic team or club sponsored by a public or approved independent school for elementary or secondary students.~~

~~(2) “Coach” means a person who instructs or trains students on a school athletic team.~~

(2) “Collision sport” means football, hockey, lacrosse, or wrestling.

(3) “Contact sport” means a sport, other than football, hockey, lacrosse, or wrestling, defined as a contact sport by the American Academy of Pediatrics.

(4) “Health care provider” means an athletic trainer, or other health care provider, licensed pursuant to Title 26, who has within the preceding five years been specifically trained in the evaluation and management of concussions and other head injuries. Training pursuant to this subdivision shall include training materials and guidelines for practicing physicians provided by the Centers for Disease Control and Prevention, if available.

(5) “School athletic team” means an interscholastic athletic team or club sponsored by a public or approved independent school for elementary or secondary students.

(6) “Youth athlete” means an elementary or secondary student who is a member of a school athletic team.

(b) Guidelines and other information. The ~~commissioner of education~~ Secretary of Education or designee, assisted by members of the Vermont Principals’ Association selected by that association, members of the Vermont School Boards Insurance Trust, and others as the Secretary deems appropriate, shall develop statewide guidelines, forms, and other materials, and update them when necessary, that are designed to educate coaches, youth athletes, and the parents and guardians of youth athletes regarding:

(1) the nature and risks of concussions and other head injuries;

(2) the risks of premature participation in athletic activities after receiving a concussion or other head injury; ~~and~~

(3) the importance of obtaining a medical evaluation of a suspected concussion or other head injury and receiving treatment when necessary;

(4) effective methods to reduce the risk of concussions occurring during athletic activities; and

(5) protocols and standards for clearing a youth athlete to return to play following a concussion or other head injury, including treatment plans for such athletes.

(c) Notice and training. The principal or headmaster of each public and approved independent school in the ~~state~~ State, or a designee, shall ensure that:

(1) the information developed pursuant to subsection (b) of this section is provided annually to each youth athlete and the athlete's parents or guardians;

(2) each youth athlete and a parent or guardian of the athlete annually sign a form acknowledging receipt of the information provided pursuant to subdivision (1) of this subsection and return it to the school prior to the athlete's participation in training or competition associated with a school athletic team;

(3)(A) each coach of a school athletic team receive training no less frequently than every two years on how to recognize the symptoms of a concussion or other head injury, how to reduce the risk of concussions during athletic activities, and how to teach athletes the proper techniques for avoiding concussions; and

(B) each coach who is new to coaching at the school receive training prior to beginning his or her first coaching assignment for the school; and

(4) each referee of a contest involving a high school athletic team participating in a collision sport receive training not less than every two years on how to recognize concussions when they occur during athletic activities.

(d) Participation in athletic activity.

(1) ~~A~~ Neither a coach nor a health care provider shall not permit a youth athlete to continue to participate in any training session or competition associated with a school athletic team if the coach ~~has reason to believe or~~

health care provider knows or should know that the athlete has sustained a concussion or other head injury during the training session or competition.

(2) ~~A Neither a coach nor health care provider shall ~~not~~ permit a youth athlete who has been prohibited from training or competing pursuant to subdivision (1) of this subsection to train or compete with a school athletic team until the athlete has been examined by and received written permission to participate in athletic activities from a health care provider ~~licensed pursuant to Title 26 and trained in the evaluation and management of concussions and other head injuries.~~~~

(e) Action plan.

(1) The principal or headmaster of each public and approved independent school in the State or a designee shall ensure that each school has a concussion management action plan that describes the procedures the school shall take when a student athlete suffers a concussion. The action plan shall include policies on:

(A) who makes the initial decision to remove a student athlete from play when it is suspected that the athlete has suffered a concussion;

(B) what steps the student athlete must take in order to return to any athletic or learning activity;

(C) who makes the final decision that a student athlete may return to athletic activity; and

(D) who has the responsibility to inform a parent or guardian when a student on that school's athletic team suffers a concussion.

(2) The action plan required by subdivision (1) of this subsection shall be provided annually to each youth athlete and the athlete's parents or guardians.

(3) Each youth athlete and a parent or guardian of the athlete shall annually sign a form acknowledging receipt of the information provided pursuant to subdivision (2) of this subsection and return it to the school prior to the athlete's participation in training or competition associated with a school athletic team.

(f) Health care providers; presence at athletic events.

(1) The home team shall ensure that a health care provider is present at any athletic event in which a high school athletic team participates in a collision sport. If an athlete on the visiting team suffers a concussion during the athletic event, the health care provider shall notify the visiting team's athletic director within 48 hours after the injury occurs.

(2) Home teams are strongly encouraged to ensure that a health care provider is present at any athletic event in which a high school athletic team participates in a contact sport.

(3) A school shall notify a parent or guardian within 24 hours of when a student participating on that school's athletic team suffers a concussion.

Sec. 3. REPORT

To the extent permitted by applicable state and federal law, the Vermont Traumatic Brain Injury Advisory Board (the Board) shall obtain information necessary to create an annual report on the incidences of concussions sustained by student athletes in Vermont in the previous school year. To the extent such information is available, the report shall include the number of concussions sustained by student athletes in Vermont, the sport the student athlete was playing when he or she sustained the concussion, the number of Vermont student athletes treated in emergency rooms for concussions received while participating in school athletics, and who made the decision that a student athlete was able to return to play. For purposes of the report, the Board shall consult with the Vermont Principals' Association and the Vermont Association of Athletic Trainers. If the Board obtains information sufficient to create the report, it shall report on or before December 15 of each year starting in 2014 to the Senate and House Committees on Judiciary and on Education.

Sec. 4. 16 V.S.A. § 1388 is added to read:

§ 1388. STOCK SUPPLY AND EMERGENCY ADMINISTRATION OF
EPINEPHRINE AUTO-INJECTORS

(a) As used in this section:

(1) "Designated personnel" means a school employee, agent, or volunteer who has been authorized by the school administrator to provide and

administer epinephrine auto-injectors under this section and who has completed the training required by State Board policy.

(2) “Epinephrine auto-injector” means a single-use device that delivers a premeasured dose of epinephrine.

(3) “Health care professional” means a physician licensed pursuant to 26 V.S.A. chapter 23 or 33, an advanced practice registered nurse licensed to prescribe drugs and medical devices pursuant to 26 V.S.A. chapter 28, or a physician assistant licensed to prescribe drugs and medical devices pursuant to 26 V.S.A. chapter 31.

(4) “School” means a public or approved independent school and extends to school grounds, school-sponsored activities, school-provided transportation, and school-related programs.

(5) “School administrator” means a school’s principal or headmaster.

(b)(1) A health care professional may prescribe an epinephrine auto-injector in a school’s name, which may be maintained by the school for use as described in subsection (d) of this section. The health care professional shall issue to the school a standing order for the use of an epinephrine auto-injector prescribed under this section, including protocols for:

(A) assessing whether an individual is experiencing a potentially life-threatening allergic reaction;

(B) administering an epinephrine auto-injector to an individual experiencing a potentially life-threatening allergic reaction;

(C) caring for an individual after administering an epinephrine auto-injector to him or her, including contacting emergency services personnel and documenting the incident; and

(D) disposing of used or expired epinephrine auto-injectors.

(2) A pharmacist licensed pursuant to 26 V.S.A. chapter 36 or a health care professional may dispense epinephrine auto-injectors prescribed to a school.

(c) A school may maintain a stock supply of epinephrine auto-injectors. A school may enter into arrangements with epinephrine auto-injector manufacturers or suppliers to acquire epinephrine auto-injectors for free or at reduced or fair market prices.

(d) The school administrator may authorize a school nurse or designated personnel, or both, to:

(1) provide an epinephrine auto-injector to a student for self-administration according to a plan of action for managing the student's life-threatening allergy maintained in the student's school health records pursuant to section 1387 of this title;

(2) administer a prescribed epinephrine auto-injector to a student according to a plan of action maintained in the student's school health records; and

(3) administer an epinephrine auto-injector, in accordance with the protocol issued under subsection (b) of this section, to a student or other

individual at a school if the nurse or designated personnel believe in good faith that the student or individual is experiencing anaphylaxis, regardless of whether the student or individual has a prescription for an epinephrine auto-injector.

(e) Designated personnel, a school, and a health care professional prescribing an epinephrine auto-injector to a school shall be immune from any civil or criminal liability arising from the administration or self-administration of an epinephrine auto-injector under this section unless the person's conduct constituted intentional misconduct. Providing or administering an epinephrine auto-injector under this section does not constitute the practice of medicine.

(f) On or before January 1, 2014, the State Board, in consultation with the Department of Health, shall adopt policies for managing students with life-threatening allergies and other individuals with life-threatening allergies who may be present at a school. The policies shall:

(1) establish protocols to prevent exposure to allergens in schools;

(2) establish procedures for responding to life-threatening allergic reactions in schools, including postemergency procedures;

(3) implement a process for schools and the parents or guardians of students with a life-threatening allergy to jointly develop a written individualized allergy management plan of action that:

(A) incorporates instructions from a student's physician regarding the student's life-threatening allergy and prescribed treatment;

(B) includes the requirements of section 1387 of this title, if a student is authorized to possess and self-administer emergency medication at school;

(C) becomes part of the student's health records maintained by the school; and

(D) is updated each school year;

(4) require education and training for school nurses and designated personnel, including training related to storing and administering an epinephrine auto-injector and recognizing and responding to a life-threatening allergic reaction; and

(5) require each school to make publicly available protocols and procedures developed in accordance with the policies adopted by the State Board under this section.

Sec. 5. SCHOOL-BASED MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

(a) It is estimated that 10 percent of children need mental health or substance abuse services nationally, but that only 20 percent of this 10 percent receive treatment.

(b) Children who need mental health or substance abuse services are at a higher risk of dropping out of school than those who do not have mental health or substance abuse needs.

(c) Untreated mental health and substance abuse conditions have been linked to higher rates of juvenile incarceration, drug abuse, and unemployment.

(d) Early intervention decreases subsequent expenditures for special education and increases the likelihood of academic success.

(e) School-based mental health and substance abuse services increase access to and use of mental health and substance abuse services and improve coordination of services.

(f) School-based mental health services increase student and parental awareness of available services.

Sec. 6. SCHOOL-BASED MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES; STUDY

(a) The Secretaries of Education and of Human Services, in consultation with the Green Mountain Care Board, the Department of State's Attorneys, the Juvenile Division of the Office of the Defender General, and other interested parties, shall:

(1) catalogue the type and scope of mental health and substance abuse services provided in or through collaboration with Vermont public schools;

(2) determine the number of students who are currently receiving mental health or substance abuse services through Vermont public schools and identify the sources of payment for these services;

(3) estimate the number of students enrolled in Vermont public schools who are not receiving the mental health or substance abuse services they need and, in particular, the number of students who were referred for services but

are not receiving them, identifying whenever possible the barriers to the receipt of services;

(4) identify successful programs and practices related to providing mental health and substance abuse services through Vermont public schools and nationally, and determine which, if any, could be replicated in other areas of the State;

(5) determine how the provision of health insurance in Vermont may affect the availability of mental health or substance abuse services to Vermont students;

(6) detail the costs and sources of funding for mental health and substance abuse services provided by or through Vermont public schools during the two most recent fiscal years for which data is available; and

(7) develop a proposal based on the information collected pursuant to this subsection to ensure that clinically appropriate and sufficient school-based mental health and substance abuse services are available to students through Vermont public schools.

(b) On or before January 15, 2014, the Secretaries shall present their research, findings, and proposals to the House Committees on Education and on Human Services and the Senate Committees on Education and on Health and Welfare.

Sec. 7. CONCUSSION TASK FORCE

(a) Creation. There is created a Concussion Task Force to study concussions resulting from school athletic activities and to provide recommendations for further action.

(b) Membership. The Concussion Task Force shall be composed of the following members:

- (1) the Secretary of Education or designee;
- (2) the Commissioner of Health or designee;
- (3) a representative of the Vermont Principals' Association;
- (4) a representative of the Vermont Athletic Trainers' Association;
- (5) a representative of the Vermont Traumatic Brain Injury Advisory

Board:

- (6) a representative of the School Nurses Division of the Department of

Health;

- (7) a student athlete appointed by the Vermont Athletic Trainers'

Association;

- (8) a representative of the Vermont School Boards Insurance Trust; and

- (9) a coach of a high school athletic team appointed by the Vermont

Principals' Association.

(c) Powers and duties. The Concussion Task Force shall study issues related to concussions resulting from school athletic activities and make recommendations, including:

(1) what sports necessitate on-site trained medical personnel at athletic events based on data from public high schools and independent schools participating in interscholastic sports;

(2) the availability of trained medical personnel and whether school athletic events could be adequately covered; and

(3) the financial impact on schools of requiring medical personnel to be present at some athletic activities.

(d) Assistance. The Concussion Task Force shall have the administrative and technical assistance of the Agency of Education.

(e) Report. On or before December 15, the Concussion Task Force shall report to the House and Senate Committees on Education, the House Committee on Health Care, the Senate Committee on Health and Welfare, and the House and Senate Committees on Judiciary its findings and any recommendations for legislative action.

(f) Meetings.

(1) The Secretary of Education or designee shall call the first meeting of the Concussion Task Force to occur on or before July 15, 2013.

(2) The Secretary of Education or designee shall be the chair.

(3) A majority of the members of the Concussion Task Force shall be physically present at the same location to constitute a quorum.

(4) Action shall be taken only if there is both a quorum and a majority vote of all members of the Concussion Task Force.

(5) The Concussion task Force shall cease to exist on December 31, 2013.

Sec. 8. EFFECTIVE DATES

This act shall take effect on July 1, 2013, except that in Sec. 2, subsection 16 V.S.A. § 1431(f) (presence of health care provider at school sports activities) shall take effect on July 1, 2015.

Date the Governor signed the bill: June 4, 2013