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AN ANALYSIS OF THE MEDICAL AND LEGAL ASPECTS RELATED TO
THE EDUCATIONAL PLACEMENT IN THE PUBLIC SCHOOLS OF
CHILDREN WITH HUMAN IMMUNODEFICIENCY VIRUS INFECTION

by

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(ABSTRACT)

The purpose of this study has been to examine and analyze the salient medical and legal aspects related to the educational placement of children in the public schools with the human immunodeficiency virus (HIV) infection. The study attempts to provide information that will serve as a resource to public school personnel who are among the professionals that must make informed decisions on public school attendance policies for children with a lethal, complex, and controversial disease.

New developments in medicine and in the courts have crucial implications for existing policies and for the development of new policies related to the issue. By examining precedents and patterns in the emerging area of AIDS litigation and legislation, the study serves as a resource for school officials enabling them to make informed proactive decisions.

The methodology used in the study was legal research. Primary and secondary sources of law were utilized. Nonlegal research materials included medical research and data that might serve as evidence in legal disputes concerning the educational placement of children with the HIV infection.

In addition to medical evidence related to educational placement issues, the information gathered for the study included an examination of the state antidiscrimination disease laws, state special education laws, state communicable disease laws, and state and selected local policy statements for sixteen states; an analysis of the relevant legal issues of the Education of the Handicapped Act (EHA) and Section 504 of the Rehabilitation Act of 1973; and an examination of the constitutional issues pertinent to educational placement of children with AIDS. Case law "in point" or "analogous" to the issue was presented. The concluding chapter summarizes the findings from Chapters Two, Three, Four and includes recommendations for decision-making and policy based on the medical and legal information presented.

There is no medical evidence to support the exclusion of children from regular school attendance based on the suspicion of or identification of HIV infection. Awareness of sound medical evidence to support educational decision-making provides a means of projecting a solid grounded policy to the school population and community at large. Health care precautions should be taken and routine procedures established

for the removal of blood and/or body fluids in cases of accident or injury. Routine precautions should be followed by all school personnel regardless of whether a HIV-infected individual is present.

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TABLE OF CONTENTS

CHAPTER ONE	1
INTRODUCTION	1
Purpose of the Study	7
Research Questions	9
Need for the Study	10
Research Method	11
Source of Data	19
Federal Statutory Authority and Administrative Agencies	
Courts and the Fourteenth Amendment	23
Medical Evidence	25
Limitations	26
Organization of the Study	27
CHAPTER TWO	29
MEDICAL ASPECTS RELATED TO THE EDUCATIONAL PLACEMENT OF CHILDREN IN THE PUBLIC SCHOOLS WITH THE HIV INFECTION	29
Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV)	32
Acquired Immunodeficiency Syndrome (AIDS)	34
The History of the HIV Infection And Its Mode of Transmission	41
Mode of Transmission	44

AIDS and Its Relationship to Other Communicable Diseases	47
Mycobacterium Infections	51
Pediatric AIDS	52
Health Care and Precautions for HIV Infection	57
Recommendations for the School Attendance of Children With the HIV Infection	58
Recommendations	59
CDC Recommendations	61
Summary	69
CHAPTER THREE	72
LEGAL ASPECTS RELATED TO THE EDUCATIONAL PLACEMENT OF CHILDREN IN THE PUBLIC SCHOOLS WITH THE HIV INFECTION	72
District 27 Community School Board v. the Board of Education of New York City	76
Board of Education of Plainfield v. Cooperman	79
Epidemiological Evidence	82
Legality of Admission	84
Legality of Exclusion	87
Precautions, review procedures, and confidentiality	94
Section 504 and Arline	99
Constitutional Issues Related to Educational Placement of HIV-Infected Children	105
The Education of The Handicapped Act	109
Summary and Conclusions	117

CHAPTER FOUR	123
SELECTED STATE PROFILES OF ADMINISTRATIVE POLICY RELATED TO THE EDUCATIONAL PLACEMENT OF HIV-INFECTED STUDENTS IN THE PUBLIC SCHOOLS	123
Conclusions	188
CHAPTER FIVE	201
CONCLUSIONS AND RECOMMENDATIONS	201
Recommendations	213
References	217
Table of Cases	224
Glossary of AIDS-Related Terms	226
Appendix A. Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome	236
Appendix B. Montgomery County, Maryland, Screening Process for Hepatitis B	244
Appendix C. Sample Request for Information	247
Appendix D. Program Advisory, California State Department of Education	257
Table of Contents	ix

Appendix E. State of Connecticut	263
Appendix F. Hillsborough County, Florida, Public Schools, Protocol for Interdisciplinary Teams Reviewing Cases of Students with Acquired Immunodeficiency Syndrome (AIDS)	271
Appendix G. State of Illinois, Illinois State Board of Education/Illinois Department of Public Health	275
Appendix H. State of Maryland	284
Appendix I. Commonwealth of Massachusetts	293
Appendix J. State of New Jersey Regulations Regarding the Right of School Admission of Children with AIDS	307
Appendix K. New York City Procedures for Review of School Children with AIDS or Other Related Conditions	317
Appendix L. North Carolina	321
Appendix M. Virginia Department of Health, Acquired Immunodeficiency Syndrome (AIDS), Recommendations for School Attendance	331

LIST OF TABLES

Table 1. Guidelines/Positions Related to Policy in Educational Placement of HIV-Infected Students	190
Table 2. A Description of Guidelines/Positions Related to Policy in Educational Placement of HIV-Infected Students	193
Table 3. State Administrative Recommendations and Guidelines on Educational Placement of HIV-Infected Students--Policy Components . .	197

CHAPTER ONE

INTRODUCTION

In recent years with the passage of the 1975 amendments to the Education of the Handicapped Act (EHA) public schools have greatly expanded programs for children with special educational needs. However, educational programs and policies have not yet met the particular health and educational needs of children with chronic illnesses (Hobbs, 1985). The comprehensive study of problems, services, and policies for the chronically ill child completed by the Vanderbilt Institute for Public Policy Studies at Vanderbilt University in 1984 addressed the concerns of parents, educators, health care personnel, and others interested in the optimal services and educational opportunities for this unique and diverse group. Identification and protection of chronically ill children as a "group" with guarantees and protections of the EHA has been difficult and continues to be controversial. The issues that are specific policy questions for the chronically ill child encompass specific issues that are as controversial for the child with the human immunodeficiency virus (HIV) infection. Due to the additional concerns of health and safety to others the educational placement of HIV-infected children involves a myriad of issues facing regular education and special edu-

cation administrators and educators, and public health officials.

The HIV infection, which envelopes Acquired Immunodeficiency virus (AIDS) and AIDS-Related Complex (ARC) conditions, has emerged as a serious public health problem in this country. It is an issue of social, political, medical, economic, and legal controversy. Mass media coverage and the growing complexity of scientific information present a confusing picture to the public at large. Issues surrounding the educational placement of public school children who are identified with the virus are equally controversial, complex, and confusing to educators and school officials who are responsible to the communities that support the local education agencies (LEAs). School officials are placed in a position of balancing the duty to protect the health and safety of students and the duty to protect the school system from litigation alleging violation of individual rights. National and state education associations have been equally concerned about the steps to be taken in assuring the rights of the infected individual and the health and safety protections of all. The National Education Association (NEA) and the American Federation of Teachers (AFT) are among national education groups that have issued policies on the HIV-infection and educational placement issues. The NEA and AFT guidelines parallel the National Centers for Disease

Control (CDC) recommendations of case-by-case decision-making on attendance issues (Weiner, 1986).

Acquired immunodeficiency syndrome (AIDS) is a lethal disease that inactivates the immune system leaving victims defenseless against infections that the body can normally suppress. AIDS is contagious but, unlike ordinary infectious diseases, cannot be spread in the same manner or as easily as the common cold, influenza, measles, or chicken pox (Koop, 1986). AIDS is a bloodborne virus, as is the hepatitis B virus (HBV). However, the mode of transmission of the two viruses differs, at least to some degree (Schwartz, 1987; Weiner, 1986). Documented transmission of AIDS has been reported through exchange of body fluids via sexual contact with an infected person; through the sharing of needles by intravenous drug users; and perinatally to a child by an infected mother. A fourth mode of transmission is infection contracted through the use of contaminated blood products used for treatment and/or transfusion. Screening for the human immunodeficiency virus (HIV) has virtually eliminated transmission via this route (CDC, 1986; Koop, 1986).

Transfusion-associated and perinatal transmission cases of AIDS account for a small percentage of overall cases in this country. As of March 1988, the 57,575 patients identified under the revised CDC case definition and criteria include 913 children (\leq 13 years of age). Nevertheless, the appearance of the HIV infection in children is of concern to

health and school officials faced with educational placement decisions on an issue that has attracted community interest and concern.

Medical experts in the field of AIDS research support the assumption that the HIV infection is not transmitted easily or casually. However, controversy continues as to the solidity of this assumption causing a potential for continual misunderstandings in dealing with the disease and the individuals infected. Public schools are among those subjected to this controversy. In developing policies on procedures for educational placement of children with the virus, some school systems have been resistant in accepting the assurances of the medical profession when there is controversy among the professionals on the issues of "casual" transmission (Weiner, 1986).

Local community constraints and political controls complicate the decision-making process. Although many school districts have developed policies based on immediate need, such as the New York City School District, many communities have acted in a proactive manner, anticipating that inevitably a child or children with the HIV infection will be attending their schools. The "inevitability" continues to become more apparent, in part due to the movement of the virus into the heterosexual community, increasing the numbers of those infected with the virus; thus, increasing the num-

bers of children born with the AIDS virus infected through perinatal transmission.

The HIV infection is not known or suspected of being transmitted from one child to another in schools, day-care, or foster-care settings. Transmission would necessitate exposure of the virus from open cuts to the blood or other body fluids of an infected child, a highly unlikely occurrence in the school environment. Routine safety procedures for handling blood or other body fluids are effective in preventing transmission from children with AIDS or the HIV-infection to other children in the classroom setting (Koop, 1986).

The National Centers for Disease Control (CDC) guidelines first issued in August of 1985 recommend that, in most cases, school-age children with the AIDS virus be allowed to enter and/or remain in school. CDC recommendations suggest restrictive environments as appropriate for pre-school children, children with open lesions, or children lacking control of body secretions or behavior who are HIV-infected. In addition to the health and safety guidelines, the CDC recommendations recognize that there are legal issues to be considered in forming guidelines for the education of infected children, including the constitutional rights of the individual; the protections of handicapped children under the EHA and Section 504 of the Rehabilitation Act of 1973; and the confidentiality of student's school records under the Family Education Rights and Privacy Act (FERPA) of 1974 and

the regulations for EHA. (See Chapter Two for CDC recommendations).

Legal actions that approximately parallel the publications of the CDC guidelines were brought in Indiana, New York, and New Jersey by parents and others concerned with the school attendance of children diagnosed with AIDS (White v. Western School Corp., 1985; District 27 v. Board of Education of the City of New York, 1985; Board of Education of the City of Plainfield v. Cooperman, 1985).

To date the courts have generally held that children with AIDS should be permitted to attend school unless attendance of the child is contrary to reasonable medical judgments of the child's physician and/or public health officials. Analogous cases involving school attendance of children with herpes simplex virus (HSV) and hepatitis B virus (HBV) had been previously resolved in favor of infected children who were seeking entrance to classrooms (Council Bluffs Education Association v. Council Bluffs Community School District, 1984; New York Association for Retarded Children v. Carey, 1979; Community High School District #155 v. Denz, 1984).

In November of 1986, the first decision of a case "in point" concerning school attendance was decided by a federal court in California. The court held that AIDS is a protective handicap under Section 504 of the Rehabilitation Act of 1973, thus the school district involved in the suit was re-

quired to "reasonably accommodate" the child's handicap. Additionally, the court held that the school district failed to show that the child presented a risk to others rejecting 1985 CDC guidelines that suggest biting as high risk behavior which may require a more restrictive environment (Thomas v. Atascadero, 1986).

Emerging issues in AIDS litigation and legislation that may have impact on school attendance decisions include the exclusion of children not identified with AIDS or the HIV infection, but living with a family member or in household contact with the virus (Matthews & Neslund, 1987; Weiner, 1986), and/or cases of children who as asymptomatic carriers of the HIV infection encounter difficulties in attending school (Phipps v. Saddleback, 1986).

AIDS has already had a profound effect on the United States medical community. The growing array of cases and legislation indicates that AIDS-related legal issues in the public health and education sectors will have significant influence on public school policy and decision-making related to placement of children with AIDS, ARC, or the HIV infection in public school classrooms.

Purpose of the Study

The purpose of the study is to examine and analyze the salient medical and legal aspects related to the educational

placement of children in the public schools with the HIV infection.

Public school personnel, including educators, ancillary support staff, public school administrators, and school board members are among those individuals that must address the bombardment of medical and legal information that has surfaced related to the HIV infection and AIDS, in order to make informed decisions on the public school attendance policies for HIV-infected children. Contradictory medical information on subjects, such as mode of transmission, has made the issue additionally confusing and controversial.

The study will attempt to provide information that will serve as a resource to those involved in decision-making issues of attendance and placements and to those involved in the dissemination of information to others, such as administrative staff and faculty involved in the education of children with the virus. The study will address the need to provide medical and legal aspects of the educational placement of children with the HIV infection by examining federal and state statutes and regulations, policy statements, and judicial decisions pertinent to the topic. The administrative and policy-making recommendations will be provided as medical and legal parameters for dissemination of information and decision-making.

Research Questions

The proposed study has been designed to answer the following primary research questions:

1. What are the medical considerations that should be made when considering the educational placement in the public schools of students with the HIV infection?

2. What are the legal considerations that should be made when considering the educational placement in the public schools of students with the HIV infection?

Secondary research questions the study has attempted to answer include the following:

1. Is a student with AIDS or the HIV infection considered "handicapped" under the Education of the Handicapped Act (EHA) and its implementing regulations?

2. Is a student with AIDS, or the HIV infection considered "handicapped" under Section 504 of the Rehabilitation Act of 1973 and its implementing regulations?

3. Is AIDS or the HIV infection a "communicable disease" in any way meaningful to the medical and legal issue of the educational placement in the public schools of those students infected?

4. What are the current court rulings or judicial opinions on the educational placement of students with AIDS or the HIV infection?

Need for the Study

The controversy that surrounds the educational placement in the public schools of children with AIDS, ARC, or asymptomatic virus continues, as medical and legal issues unfold. New developments in medicine and in the courts may have crucial implications for existing policies and for the development of new policies related to the issue.

School officials are often unaware of court decisions and the implications of those decisions on problem-solving, decision-making, and policy issues. Some school officials have been faced with the additional burden of decision-making and policy recommendations for an issue in which there has been no previous policy and no conclusive information on the medical and legal aspects of the concern.

A widely publicized example of a potential dilemma facing school systems related to the emerging issue of AIDS and its broader counterpart, "communicable disease," is the Kokomo, Indiana case of White v. Western School Corp. (1985). In defending the policy of excluding the fourteen-year old from the classroom, school officials supported a position that was consistent with communicable disease law in the state, "although the state had issued guidelines directing schools to admit most students with the AIDS virus" (Weiner, 1986). (See Chapter Three for further discussion of White v. Western School Corporation.)

There is the need to clarify existing laws and to anticipate emerging laws that impact upon the determination of educational placement of children with the HIV infection. A study that examines emerging precedents and patterns in a previously uncharted area of law, such as AIDS litigation and legislation, will provide information that will enable school officials to discern the basis for the decisions rendered or the possible course of action that might be anticipated in future disputes. In delineating precedents and patterns, school officials will be able to make informed proactive decisions that will promote preventative law and policy, both cost-effective and time-efficient to the educational system.

Research Method

. . . the inquirer's mind responds with a tendency to arrange the scattered iron filings of fact into the neat patterning of a magnetic field . . . patterning is a hypothesis, a line of relationship which may or may not prove true but which is plausible enough to serve as a basis for further investigation. (Altick, 1986)

Legal research/analysis is the methodology to be used to conduct the proposed study. The researcher's task is to determine "what the current rules of law are on a given subject and then apply that law to the facts" (Lloyd, 1974, p. 3) of a particular question. The laws are in constant flux, "either through new statutes and regulations, or court decisions interpreting statutes and regulations" (Lloyd, 1974,

p. 3). The quest of the researcher is for the authority, that is, something that will convince one that the law should be as it is (Bander, 1978; Lloyd, 1974).

Mandatory authority is found within the obligation of the courts to be guided by statutes passed by a legislative body sovereign of that jurisdiction, and second, consider as binding the rulings made on similar issues by other courts of that jurisdiction. A court will continue to follow the rule under the principle of stare decisis, which means that the court will follow the rules/decisions of prior cases in later similar cases unless there are compelling reasons for changing the rules (Lloyd, 1974).

Persuasive authority is as implied, in that it is merely persuasive. The persuasive authority may influence the court though it is not binding on the court. The authority is persuasive because of the soundness of the reasoning; the status of the court rendering the decision in that jurisdiction; or the ability or recognized expertise of the author(s) of the treatise or law review article. Therefore, persuasive authority includes judicial opinions and/or statutes from other jurisdictions, federal statutes, law review articles, legal treatises, legal encyclopedias, restatement of law, as well as other commentary dependent on the status of the author (Lloyd, 1974).

Legal research consists of techniques and methodologies for using legal bibliographic information efficiently and

effectively (Bander, 1978; Cohen, 1976). Legal bibliography can be divided into four categories of sources (a) primary, (b) secondary, (c) finding tools, and (4) nonlegal materials.

Primary sources of law include mandatory and persuasive authority serving as rules of behavior which will be enforced by the state or jurisdiction. Federal and state statutes, judicial opinions, and administrative regulations are considered to be primary sources (Bander, 1978). (It is interesting to note that administrative regulations have made an impact so significant on the legal system in recent years, that though once considered secondary sources of law, they are now considered as primary sources (Cohen; cited in Purcell, 1983).)

Secondary sources of law include commentaries on primary sources of the law. Secondary materials include treatises, law review articles, restatements of the law and social science studies (Bander, 1978; Cohen, 1974). As persuasive authority, if the secondary source is brought to the attention of the court, the court is under no obligation to accept it as binding.

According to Bander (1978) secondary sources are not significant in distinction from finding tools. Finding tools are generally characterized as encyclopedias, law dictionaries, and loose-leaf services, such as the Index to Legal Periodicals and a companion index, Index to Periodical Articles Related to the Law. This source of legal bibliography

is beneficial to the researcher as a means of locating primary sources of authority, in addition to other materials related to the topic under research.

In attempting to research and analyze the medical and legal aspects involved in the educational placement of children with HIV infection, an effort will be made to utilize the following secondary sources and finding tools (in alphabetical order):

1. AIDS Policy and Law is "the bi-weekly newsletter on legislation, regulation and litigation concerning AIDS" (AIDS Policy and the Law, 1986). The publication began reporting on the issues in the rapidly expanding area of AIDS litigation in January of 1986. "While most cases are not yet found in the traditional legal reports, it would appear that a substantial body of AIDS law is developing very rapidly and is significantly influencing trends in public health law" (Matthews & Neslund, 1987). In reviewing AIDS related litigation and legislation appearing to date the Journal of the American Medical Association referenced AIDS Policy and Law extensively in a comprehensive bibliography.
2. The American Digest System "employs over 450 general subject headings" and is described as "the only method of insuring that all relevant American cases are searched (Lloyd, 1974). Published by the West Publishing Company

the American Digest System uses the copyrighted West key number system to refer to points of law or factual situations discussed in a case (Bander, 1978). The digest is divided into subtopics with each general area under the main topic given an assigned key number. Each general topic begins with an outline analysis of the scope of the topic. Lloyd (1974) and Bander (1978) suggest the use of the state and regional digests versus the American Digest System because of the time investment involved in going through the multivolume compilation of the General Digest, as well as the separate pamphlets and decennials.

3. American Jurisprudence and Corpus Juris Secundum are legal encyclopedias containing definitions, judicial interpretations of words, phrases, and legal maxims. Lloyd (1974) states that efficient legal research is accomplished by narrowing the search to avoid irrelevant materials. The purpose of utilizing legal encyclopedias is to locate the broad interest area and then narrow to find cases "in point" or "analogous," thus reliable as precedent.
4. American Law Reports is "the most comprehensive set of annotations" available to the legal researcher. An annotation "in point" can save the researcher a good deal of work. It will not only provide an overview of a narrow legal topic but cite one to precedents in all jurisdictions . . ." (Bander, 1978).

5. Education for the Handicapped Law Report (EHLR) is "the only authoritative source of special education law and policy" providing (1) in-depth coverage of Federal statutes and regulations; (2) significant Federal and state court decisions; (3) State Education Association (SEA) appeals and decisions; and (4) Office of Special Education Programs (OSEP) and Office of Civil Rights (OCR) policy rulings summarized and indexed. The EHLR is tri-sectioned by Topical, Statutory, and Regulatory Indexes with each indexed item headed by italicized descriptive headings. The set of loose-leaf notebooks has been developed and organized for convenient accessibility as a current source of documents in the field of education for the handicapped. The legislative and regulatory history of the Education of the Handicapped Act (EHA) and Section 504 of the Rehabilitation Act of 1973 are contained, as well as periodic "Special Reports" and "Analyses" providing such topical perspectives as the impact of AIDS in the schools (EHLR, 1986).
6. The National Reporter System published by West Publishing Company prints/reprints the highest court decision in all fifty states. The system serves as the official reporter in some states and the unofficial reporter for others. Most states publish official reports of their cases, including the highest court decisions, as well as its intermediate appellate court decisions. Arranged by

topics the cross-referenced system can be identified in the American Digest System and the entire case located in the National Reporter System.

The National Reporter System contains: The Atlantic Reporter (Conn., Del., Me., Md., N.H., N.J., Pa., R.I., Vt.); The North Eastern Reporter (Ill., Ind., Mass., N.Y., Ohio); the North Western Reporter (Iowa, Mich., Minn., Neb., N. Dak., S. Dak., Wis.); The Pacific Reporter (Alaska, Ariz., Calif., Colo., Hawaii, Idaho, Kan., Mont., Nev., N.M., Okla., Ore., Utah, Wash., Wyo.); the South Eastern Reporter (Ga., N.C., S.C., Va., W.Va.); the South Western Reporter (Ark., Ky., Mo., Tenn., Tex.); the Southern Reporter (Ala., Fla., La., Miss.); the California Reporter; and the New York Supplement. The federal units of the National Reporter System are: the Supreme Court Reporter, the Federal Reporter, the Federal Supplement, and Federal Rules Decisions (Bander, 1978).

7. Shepard's Citations are used to update case law. This procedure of searching for conflicting decisions and updating case law is known as "shepardizing." Shepardizing enables the researcher to determine if an opinion stated has subsequently been overruled, distinguished, followed, or characterized in any way. Shepard Citations include state and regional citators, federal citators for the United States Supreme Court, a law review citator, and statutory citators informing the researcher if the

- "statute cited has been amended by the legislature or cited by a court" (Bander, 1978).
8. West's Education Law Reporter includes cases taken from the National Reporter System directly related to education. Commentaries and analyses on cases and articles written by noted legal experts are included in the volumes.
 9. Words and Phrases is a multi-volumed set that converts laymen language into legal terms/terminology. Volumes such as West's General Digest system also contain a words and phrases volume.

Nonlegal sources in legal research provide the researcher a broader base from which to observe a given legal issue. Social, political, environmental, medical issues are among the external forces that shape the law. Bander (1978) illustrates the use of nonlegal research sources in an example of a submitted brief by Louis Brandeis in Muller v. Oregon, 208 U.S. 412 (1908). The "Brandeis brief" included a two-page legal argument and 100 pages of sociological data. The historical and psychological issues of segregation are illustrated in the opinion of the Court delivered by Justice Earl Warren in Brown v. Board of Education, 347 U.S. 483 (1954).

Medico-legal references/texts are available exploring significant areas of interaction between the legal and the

medical fields. Bander (1978) provides an extensive bibliography of sources for researching proof/medical evidence. The nonlegal sources for the proposed study include general reference works in the medical field, such as Principles and Practice of Clinical Pediatrics (1987); medical periodicals, including the Journal of the American Medical Association and the Mortality and Morbidity Weekly Report; and general periodicals and newspapers that focus on the topic under investigation.

Source of Data

Since the recognition of acquired immunodeficiency syndrome (AIDS) in the summer of 1981, the virus has had a profound impact on the United States medical community. Within the legal context, it is only now that the impact of AIDS has begun to surface. Although most cases have not yet appeared in the traditional legal reports "a substantial body of AIDS law is developing very rapidly" (Matthews & Neslund, 1987). AIDS litigation and legislation is rapidly evolving with the public education and public health sectors actively involved in the expansion (Weiner, 1986). Matthews and Neslund (1987) suggest three observations that parallel the impact of AIDS medically and legally:

1. The time lag between scientific discoveries and their absorption into the law is significant. In the legal context the reported formal court deci-

sions recently emerging and the less formal new accounts of cases to come will translate into a substantial body of opinions and precedents related to AIDS.

2. Developments and advances in both medical and legal contexts are likely to occur at varying rates within many different AIDS speciality areas. The resolution of the complex assortment of legal issues associated with AIDS are expected to proceed at different rates for different issues.
3. The interdisciplinary skills needed to resolve scientific questions on AIDS require the same careful involvement of many different disciplines that the resolution of legal questions on AIDS will require. (p. 350)

Although AIDS litigation is in its infancy, AIDS and AIDS-related cases have begun to emerge, primarily at the state court level. Case law serves as a source of data for this study. The judicial decisions of the United States court system provide the foundation for the establishment of legal precedents. Case law "in point" and/or "analogous" is utilized in the analysis of the issues.

State statutes and regulations, including antidiscrimination laws, public health laws, and special education laws related to the educational placement issues of children with HIV infection are an additional source of data. The statutes, regulations, and policy statements of sixteen states have been investigated. New York, California, Colorado, Florida, New Jersey, Connecticut, Indiana, Texas, Illinois, Tennessee, South Carolina, Maryland, Massachusetts, Pennsylvania, Virginia, and North Carolina were selected for

purposes of this study based on criteria that may include the following: (1) high state prevalence rate ($\geq 5\%$) of Pediatric AIDS cases based on total number of reported pediatric AIDS cases identified by current figures from the Centers for Disease Control (CDC); (2) issue of state/local policy statements for educational placement of children with AIDS developed prior to December of 1985; (3) state antidiscrimination laws and/or state special education laws that reflect broad or narrow interpretation of federal statutory authority identified in the research for potential legal interest (Matthews & Neslund, 1987; Parry, 1986; Weiner, 1986); (4) geographic proximity of state to researcher to allow for regional comparisons; and/or (5) state court decisions of cases involving communicable diseases/sexually-transmitted diseases that may hold findings analogous to issues involved in the proposed study. A descriptive cross-site analysis presented as an "unordered meta-matrix" has been used to determine similarities and differences among the states and among the categories of state statutes, regulations, and policies (Miles & Huberman, 1984).

Federal Statutory Authority and Administrative Agencies

The guidelines first published by the CDC in August 1985 made general suggestions as to the placement of school-age children with AIDS. The guidelines "did not directly resolve

the varying ancillary legal questions, but did recognize that among the legal issues to be considered 'are 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, the confidentiality of a student's record under state laws and under 20 U.S.C. 11232g, and employee right-to-know statutes. . . .'" (CDC, 1985; Matthews & Neslund, 1987).

The Education of the Handicapped Act (EHA), Section 504 of the Rehabilitation Act of 1973, and the Family Educational Rights and Privacy Act (FERPA) of 1974 include statutory and regulatory provisions that may be pertinent to the issue of educational placement of school-age children with AIDS and the HIV infection. The study attempts to analyze the cogent sections of the laws utilizing secondary legal sources to aid in the interpretations.

Administrative agencies are an additional source of data to aid in the interpretations of federal statutory authority. Administrative agencies are established to monitor the implementation of statutory and regulatory requirements and to settle disputes that arise between or among parties. Administrative or public agencies function in a quasi-judicial manner. Judgments made on issues by the public agencies are written and referred to as administrative decisions. Decisions rendered by the administrative agencies can be appealed, if in opposition to a citizen or another agency.

Administrative decisions are not binding to the agency and may be changed; however, administrative decisions do hold precedent within that agency and may be utilized in conflict resolution. Courts generally "refuse to interfere with decisions rendered by an administrative agency unless the agency has 'acted arbitrarily, used inadequate evidence in coming to its conclusion, improperly interpreted a statute, or lack jurisdiction over the matter'" (Purcell, 1983).

Administrative decisions of the Office of Special Education Programs (OSEP) and the Office for Civil Rights (OCR) were reviewed, as well as major state and local educational agency administrative decisions related to the proposed topic.

Courts and the Fourteenth Amendment

A constitutional right is a legal right based on provisions of the U.S. Constitution or a state constitution. The 14th Amendment of the U.S. Constitution states that no state shall "deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." Equal protection and due process are the federal constitutional rights most relevant to the right to education and "hold respectively, (that) governments may not treat essen-

tially similar people differently or arbitrarily" (Turnbull, 1986).

In one of the few cases to date on the educational placement of children with AIDS, Judge Harold Hyman upheld the New York City policy of school attendance by children with AIDS. The ruling in District 27 v. Board of Education of the City of New York (1985) by the Queens County Supreme Court judge was based on federal antibias laws. Applied broadly, many legal professionals feel that the 14th Amendment, like, Section 504, could be applied with interpretation outlawing distinctions between those with AIDS and those without AIDS (Weiner, 1986).

Absent any rational basis for . . . exclusion of only known AIDS cases or carriers to the virus, without imposing such exclusion in the case of ARC patients or asymptomatic carriers who . . . present a risk of contagion . . . must be deemed a denial of the equal protection of the laws. (District 27, 1985)

For the purposes of the study case law that applies the constitutional rights of the individual under the equal protection clause of the 14th Amendment is a source of data. Specifically, the study researches the District 27 case and the cases that are considered analogous to the issue, such as the New York Association of Retarded Children v. Carey (466 F.Supp. 479; aff'd 612 F.2d 644, 1979). In Carey the court held that separating handicapped carriers of hepatitis B virus (HBV) from their classmates was in violation of the 14th Amendment because no attempt was made to locate and ex-

clude others who were likely to present an equal risk of contagion.

Medical Evidence

The understanding of the medical issues surrounding the educational placement of children with AIDS, ARC, and asymptomatic virus is essential to the educator and the public school personnel involved in the interpretation of the legal issues for the development and monitoring of effective policy. The study attempted to utilize nonlegal sources, such as the Council for Exceptional Children's Task Force Report on Communicable Diseases; the Journal of the American Medical Association; and the Journal of Health, Politics, Policy, and Law to summarize medical issues related to the topic. The primary focus of the data is on the (1) history of the virus; (2) epidemiology; (3) mode of transmission; (4) confusion between AIDS and "other" communicable and sexually-transmitted diseases; and (5) health care concerns/precautions for children with Pediatric AIDS.

Information gleaned from this review was aggregated by the researcher. In addition to the dissertation committee the information was critiqued in review by individuals designated as scientific medical advisors of the AIDS Task Force at Virginia Polytechnic Institute and State University.

Limitations

The initial impact of AIDS on the United States legal system has been explosive. For the purposes of the study, AIDS litigation and legislation is restricted to issues that directly apply to the educational placement of children with the HIV infection.

The educational placement issues that bind the study include: (1) "denial of/access to" educational services; (2) education in the least restrictive environment; and (3) confidentiality of medical records. Cases selected for the study will be primarily confined to court decisions rendered from 1979 to March, 1988. The 1979 date was selected to include New York Association for Retarded Children v. Carey (612 F.2d 644), the landmark hepatitis B case that parallels the legal issues of educational placement for children with the HIV infection (Rothman & Rothman, 1984).

The study is directed towards public school personnel, including educators; ancillary support staff; public school administrators; and school board members in public educational agencies, with primary focus directed to those who have decision-making responsibilities related to the topic. Any conclusions and recommendations drawn from the study are based upon the aforementioned literature.

A variety of existing documents pertinent to the medical and legal aspects of the educational placement of children

in the public schools with the HIV infection have been referenced in the text or included in the Appendices. They are time-bound and not necessarily representative of model policy and/or best practice.

Organization of the Study

The study is organized in a five chapter format.

Chapter One includes the introduction, purpose of the study, need for study, research questions, research methodology and source of data, limitations of the study, and proposed organizational format.

Chapter Two summarizes the current medical research that is relevant to the issue of educational placement of children with AIDS. The chapter includes medical evidence that should be considered in the formation of school attendance policies concerning HIV-infected students in public school systems. Medical evidence presented includes: (1) history of the virus; (2) the causes (epidemiology) of the syndrome; (3) the mode of transmission; (4) the confusion between AIDS and "other" communicable diseases, such as hepatitis B (HBV) and herpes simplex (HSV); and (5) the health care concerns and precautions necessary for safeguarding the health of HIV-infected children and those that come into contact with such children.

Chapter Three of the study examines the legal issues that surround the provision of educational services to HIV-infected students. Case law that has developed and is developing in the area of AIDS litigation is reviewed. Analyses of the legal issues emerging under constitutional law, civil rights law, and the EHA are included.

Chapter Four examines the state antidiscrimination laws, state special education laws, state communicable disease laws, and state and selected local policy statements for sixteen states. Criteria for the selection of the states are included. Individual descriptions of the states are presented and the similarities and differences among the states' administrative guidelines on educational placement of HIV-infected students are summarized.

The concluding chapter summarizes the findings from Chapters Two, Three, and Four. Recommendations for decision-making and policy based on the medical and legal information are presented.

CHAPTER TWO

MEDICAL ASPECTS RELATED TO THE EDUCATIONAL PLACEMENT OF CHILDREN IN THE PUBLIC SCHOOLS WITH THE HIV INFECTION

The emergence of the medical condition, now familiarly known as AIDS, has extended beyond the scope of medicine to involve a myriad of factors and issues not limited to politics, sociology, psychology, economics, public health, and sex. In the medical field alone AIDS extends across general medicine, microbiology, virology and immunology, involving physicians, scientists, and researchers interested in the complexities of degenerative diseases (Brown, 1986).

As a dominant social and political issue the complexity of AIDS and the human immunodeficiency virus (HIV) crisis continues to unfold. In the United States as of March 1988 over 57,500 cases of AIDS have been reported to the National Centers for Disease Control (CDC). Cases have been reported in all 50 states with representation highest in the large urban areas of the country, e.g., New York, Los Angeles, San Francisco, and Miami. It is estimated that two to four million individuals are currently infected with the HIV infection and that, by 1991, 54,000 new cases of AIDS per year will occur in the United States. Approximately 1.5% of the CDC reported cases of AIDS are among infants, children, and

adolescents. Although the percentage is small when looking at overall numbers of reported AIDS cases, the numbers are expected to increase dramatically with estimates of ten times the current numbers within five years (Baltimore and Wolff, 1986; Phair, 1987).

The appearance of AIDS cases in children and the well-publicized issue of school attendance for several of these children is of concern to public health, school health and school officials faced with the educational placement decisions of an issue that has attracted community interest and concern. In the foreword of a text published by the Gay Men's Health Crisis, Daniel William, President of New York Physicians for Human Rights, stated that:

For persons with AIDS and those who witness its course, no epidemic disease since polio has generated such fear and anguish. But the fear AIDS provokes has two very different components. First, there is the reality of what we see. AIDS is a devastating illness that has already sapped the strength and lives of thousands of individuals, as the number of reported cases continues to double approximately every twelve months The second component of our fear is fear of the unknown Staying informed can help us cope with the reality, however difficult, however painful, of AIDS, and reality can never be as frightening as the unknown. (Mass, 1985)

The fear of the unknown can have serious ramifications legally, ethically, and socially. The public schools are in a unique position to assume a role in providing to staff, pupils, parents, and the community both an awareness to and interest in one of the most complex issues of the decade.

In a 1986 Leadership Report, the National School Board Association (NSBA) stressed the need for education concerning the prevention and transmission of the virus that causes AIDS. NSBA directed the schools to serve as role models by first developing reasoned policies for staff and students based on sound medical evidence; and secondly, by establishing awareness of the pertinent issues surrounding the topic to prevent and/or diminish the panic surrounding AIDS through educational efforts targeted to staff, parents, and students.

The purpose of this chapter is to address the medical aspects that surround the HIV infection with emphasis on the presentation of medical evidence that may be useful to individuals involved in decision-making for educational placement of children in the public school setting.

In presenting medical evidence for the establishment of policy in educational decision-making, it must be stressed that the nature of the information gathered thus far concerning HIV and AIDS is dynamic. Individuals involved in policy and public information must keep abreast of new developments as they are reported, in order to provide accurate information and knowledgeable leadership.

The National Academy of Sciences (NAS) and the Institute of Medicine (IOM) undertook a study in 1986 to "assess the current understanding of the virus that causes acquired immunodeficiency syndrome (AIDS), its transmission, the natural history of the infection and associated diseases, the

epidemiology of conditions associated with the virus, and the likely trends in these" (Baltimore, et al, pp. v-vi). Similarly, the information presented here will focus on (1) the history of the virus; (2) epidemiology; (3) mode of transmission; (4) confusion between AIDS and other communicable and sexually-transmitted diseases (STD); and (5) health care concerns and precautions for Pediatric AIDS and HIV infected individuals.

Acquired Immunodeficiency Syndrome (AIDS) and Human
Immunodeficiency Virus (HIV)

AIDS is the commonly known acronym for the medical condition, acquired immunodeficiency syndrome. AIDS is one of the varying, often progressively severe series of conditions caused by the human immunodeficiency virus (HIV). HIV was the name proposed for the causative agent of AIDS by the International Committee on Taxonomy of Viruses. HIV was previously known as the HTLV-III/LAV virus, representing both United States and French claims to the discovery of the agent. Both the HTLV-III virus (human T-cell lymphotropic virus type III) discovery credited to Robert Gallo's research group at the National Cancer Institute in 1984 and LAV (lymphadenopathy-associated virus) isolated in France in 1983 are retroviruses, and only recently discovered and rarely

seen in man. The HTLV-III and the LAV are thought to be variants of the same virus (Gong, 1986).

The HIV infection damages the body's immune system through invading the T-lymphocytes in the system and reproducing. T-lymphocytes are cells that mature in the thymus gland and are found primarily in the blood, lymph and lymphoid organs. Known as T-cells, they are responsible for protection against a range of infectious agents, particularly agents that replicate inside cells, e.g., viruses, parasites, and fungi. After reproduction, the T-cells are eventually destroyed leaving the host immune deficient and vulnerable to attack by other replicating agents that the immune system is normally capable of combatting (Baltimore, et al, 1986; Fettner, 1985; Gallo, 1987; Gong, 1986; Mass, 1985). The infections that are fought easily by those with intact immune systems are called "opportunistic infections/diseases" because they invade the body at an opportunity of susceptibility.

The term AIDS was established as a surveillance term by CDC for epidemiologic purposes. In 1987 CDC published a revision of the case definition for AIDS. The definition now includes the spectrum of conditions known to be associated with HIV. The epidemiology of AIDS, in its full context includes individuals with AIDS, as well as less severe manifestations of disease, such as those earlier identified as AIDS-related complex (ARC). The original surveillance defi-

nition provided data on severe HIV disease. After HIV was discovered as the cause agent of AIDS the spectrum of manifestations of the HIV infection became better defined. The CDC revision adds to the definitional criteria of AIDS severe non-infectious, non-cancerous HIV-associated conditions. For reporting purposes the revised definition of AIDS is an illness characterized by one or more "indicator" diseases which include previously-termed "opportunistic" diseases as described in the section on AIDS later in this chapter. Additional "indicator" diseases include definitively diagnosed cytomegalovirus of a specific type, herpes simplex, bronchitis or pneumonitis for any duration, mycobacterium avium specific, or toxoplasmosis of the brain. (See Appendix A for Revised CDC Surveillance Case Definition.)

A limitation of the old definition was 10-15% of AIDS-indicative diseases presumptively diagnosed. Without confirmation by methods required in the old definition this appreciable proportion of AIDS cases were missed for reporting purposes (CDC, 1987).

Acquired Immunodeficiency Syndrome (AIDS)

AIDS, often called "full-blown" AIDS, is a lethal medical condition that is now associated with over 30,000 deaths in the United States since 1981. Unlike inherited immunodeficiencies, AIDS is an **acquired** medical condition,

not due to heredity or to medical treatment. The HIV infection causes a diminished cellular immune system rendering the system ineffective against the protection from disease, due to the suppression or deficiency. The diagnosis or characterization of AIDS is determined by a set of signs, symptoms, and maladies that are collectively the syndrome of AIDS (NSBA, 1986; Weiner, 1986).

The AIDS syndrome is characterized most commonly by the presence of one or more repeated "opportunistic infections" within the individual. (See also revision of case definition to include "indicator" diseases, Appendix A.) In addition to or separate from these often multiple "opportunistic infections" (OI), individuals with AIDS may develop severe rare forms of cancer. Two of the most prevalent conditions within the scope of the disease are Pneumocystis carinii pneumonia, an opportunistic infection and Kaposi's sarcoma, a previously rare, benign cancer seen in the United States typically in men over the age of 50 (Weiner, 1986). Some researchers suggest that AIDS and the HIV infection can only be understood by studying the individual diseases of Kaposi's sarcoma and Pneumocystis carinii pneumonia (Cantwell, 1986).

Pneumocystis carinii pneumonia (PCP). PCP was first reported in Germany in the late 1930s where it was occurring in children, often fatally. In the 1940s and 1950s PCP was common in central Europe, usually striking low birth weight and premature infants during the first year of life. In the

United States the pneumonia was rarely seen prior to 1981 unless the individual had an immunosuppression, which is often the case among inherited immunodeficiencies and/or persons who have undergone medical treatments, e.g., organ transplants and/or chemotherapy.

PCP is often a latent infection common in childhood. Children with cancer are particularly at high-risk for PCP due to chemotherapy and an immature immune system. Considered to be a protozoan parasite, there are contradictory studies to suggest that PCP is a disease, e.g., malaria and toxoplasmosis, that may possibly be "infections and probably viral origin" (Cantwell, 1986, p. 37). The inability of microbiologists to grow PCP in pure culture further limits investigations and treatment options as to mode of transmission and the actual disease agent (Cantwell, 1986).

Kaposi's sarcoma (KS). Kaposi's sarcoma is a cancer or a tumor of the blood and/or the lymphatic vessel walls. Prior to the appearance of AIDS, KS was rare in the United States and Europe. When seen KS occurred primarily in older men, usually of Mediterranean origin. AIDS-associated KS is a more aggressive form of the disease than seen earlier (Baltimore, 1986).

Discovered in 1872 by Moriz Kaposi the cause of KS is a mystery with some suggestion that it is an infection rather than a cancer or a sarcoma (Brown, 1986). Frequently fatal in Africa the disease is most often seen in young men and

children. African KS is considered to be more closely related to AIDS-associated KS than the earlier form seen in the United States. Organ transplant patients have been especially susceptible to KS with a four to five hundred times greater chance of contracting the cancer (Cantwell, 1986). Recent research suggests a possible link to cytomegalovirus and Epstein-Barr virus, viruses of the herpes group (Brown, 1986).

The AIDS Retrovirus

An elegant organism [the virus] is a stripped-down biological package that carries nothing but the essentials: a strand of genetic information--either RNA or DNA surrounded and protected by a thin shell of protein. Models of efficiency, viruses drift aimlessly until they contact a living organism. Once inside a cell, they use that cell's energy and machinery to replicate (Fettner, 1985, p. 85).

Of the several hundred viruses that affect human beings, most cause no apparent illness. This is fortunate because man has been remarkably unsuccessful in treating viral infections. The first human retrovirus (HTLV-I) was isolated by Robert Gallo and his research group in 1978. HTLV-I can be transmitted by blood, intimate contact and congenital infection. The chief effect of HTLV-I is leukemia, the virus also causing a mild immune deficiency in some individuals (Gallo, 1987). Prior to the HTLV-I discovery, retroviruses were known in animals infecting them with persistent, often

life-long infections; it is thought that there is little doubt this also applies to humans (Brown, 1986).

The retrovirus is among a class of viruses that contain the genetic material RNA. The viruses have the capability of producing an enzyme that allows the virus to copy this RNA into DNA inside an infected cell. This is the first step in the natural cycle of reproduction for the virus. The process, known as reverse transcription, allows the resulting DNA to integrate into the genetic material of the cell (Baltimore, et al, 1986; Brown, 1986; Gallo, 1987). The latent provirus can be activated when the cell replicates, killing the cell, i.e., destroying the valuable T-cells of the immune system. No virus until now has been known to attack specific cells of the immune system (Fettner, 1985).

The HIV attack on the human immune system is illustrated in the following steps:

1. When the AIDS virus enters the body and the bloodstream it attaches itself "most often" to the T-helper (lymphocyte). The "helper" cell is the white blood cell that controls the immune cells by helping to stimulate the B-cells, also white blood cells, to produce antibodies to fight germs.
2. The virus penetrates the cell wall of the "helper" cell and integrates into its genetic structure through a process known as reverse transcription, then allowing the reproduction of HIV.
3. The converted helper cell, which may remain dormant indefinitely, replicates itself copying the provirus to produce new HIV-infected cells.
4. Newly produced HIV attacks other helper cells, thus weakening the immune system. As the process is repeated, the original host "helper cell" dies. (Re-

cent research indicates that HIV may attack other cells of the immune system as well.)

5. Without the helper cells that stimulate the B-cells to produce antibodies to fight germs, the B-cells are not triggered to produce antibodies. "The helper cell can be described as sort of an orchestra leader. They direct the rest of the symphony. When the helper cells are gone, you are left with instruments playing on their own" (Rogers in Weiner, 1986, p. 14).

The virus can insert itself into the genetic material and remain inactive. In this stage of inactivity the infected individual is an asymptomatic carrier of the virus. The CDC estimates that one to two million individuals are asymptomatic carriers of the virus and the primary transmitters of the infection. The asymptomatic carrier is often unaware of his/her status, unwittingly spreading the virus. It is estimated that as many as 60%+ of those asymptomatic carriers may go on to develop AIDS or other "milder forms" of HIV disease previously identified as AIDS-Related Complex (ARC), but now under the case definition of AIDS.

AIDS-Related Complex (ARC)

AIDS-Related Complex or ARC was previously recognized as the wide spectrum between "full-blown" AIDS and the asymptomatic or carrier stage of the HIV infection. The condition now reported under the new case definition for AIDS was defined as a serious AIDS-associated infection that manifested a variety of chronic symptoms that occur in some in-

dividuals infected with HIV, but not meeting the CDC case definition of AIDS. ARC was often known as a precursor to AIDS; however, most of those with ARC and other milder forms of immune deficiency (60-80%) were not developed KS, PCP or other complications identified by the CDC definition (Brown, 1986; Gostin, 1986). The degree and duration of the HIV infection in ARC was not known. The infection in some subsides, perhaps remaining inactive awaiting favorable conditions for reactivation, as in bacterial infections such as tuberculosis. Asymptomatic HIV infection and symptoms/manifestations previously identified as ARC may be stages of an irreversible progression to AIDS. Many investigators suspect that, at least in a certain percentage of the population, that this is the case (Baltimore, et al, 1986). Symptoms of the previously defined ARC included many of the same symptoms as "full-blown" AIDS with the degree, duration, and intensity differentiating the two conditions, although KS and PCP frequent in AIDS was absent in ARC. The symptoms included, but were not limited to:

- unexplained and increasing tiredness;
- unexplained and increasing fever, chills lasting over several weeks;
- night sweats lasting over several weeks;
- swollen glands lasting over several weeks (most common symptom of ARC);
- sudden and extreme weight loss;
- white patches and/or spots on tongue or mouth;

- persistent diarrhea;
- persistent unexplained dry cough; and
- pink or purple flat or raised blotches on or under skin, inside the mouth, nose, eyelids, or anus (Mass, 1985).

These symptoms are now identified as "indicator" diseases for AIDS, depending on the status of laboratory evidence of HIV infection (CDC, 1987).

The History of the HIV Infection And Its Mode of Transmission

Between 1979 and 1981 physicians in New York and California were beginning to see infections in previously healthy individuals that were unexplained, rarely seen, and difficult to treat. The first reports of what was to soon be termed "AIDS" were reported to CDC in June of 1981, although evidence supports cases as early as 1969.

Theories abound from multiple disciplines as to the originating source of HIV. The importance of the source is informative for epidemiologists and other researchers, but may prove to serve no more importance than the question of the origination of other communicable diseases, e.g., tuberculosis, syphilis, polio and influenza (Mass, 1985).

Although the AIDS epidemic officially began in America in June 1981, there are case reports in the medical literature, which suggest that some people in other parts of the world had acquired AIDS-like illnesses before that time To suggest that AIDS started in Africa or Europe, on the contrary, it is far more likely

that AIDS has been, and will prove to be a world-wide disease. The recognition of AIDS is undoubtedly a "new" phenomenon (Cantwell, 1986, p. 49).

A potential source of origination that has brought much speculation is the link to the AIDS virus from Africa, specifically sub-Saharan areas. AIDS was recognized in central Africa at about the same time as its recognition on the East and West coasts of the United States, although some researchers propose that African-AIDS represents a more advanced stage of disease with a longer incubation time than in the United States and European populations (Fettner, 1985).

AIDS is endemic in central Africa where unhealthy living conditions and malnutrition are prevalent. The sensitivity of the immune system to protein deprivation is an added factor in both Africa and Haiti, where protein deprivation is widely spread. Malnutrition provides conditions in which the AIDS virus flourishes (Brown, 1986).

Estimates are conservative as to the epidemic in central Africa, although figures suggest no less than an estimated 10 million people infected with the virus, 1/10 of the central African population. The "deterioration of African health from the crumbling of colonial health structures, extensive population dislocations, and wide-spread environmental and ecological disintegration" (Hasseltine in Brown, 1986, p. 33) has compounded an already devastating situation. Epidemiology on AIDS in Africa is in its infancy with eco-

nomics being the major factor in inadequate data collection (Norland, 1986).

The tourist trade has resulted in a downplay of the epidemic in many of the African countries affected by the epidemic. Additionally, African-AIDS has affected upper and middle income groups producing "severe dislocations of the more competent, highly trained people" of the involved areas (Brown, 1986, p. 33).

An interesting parallel can be drawn in comparing living conditions in much of central Africa and the puzzling town of Belle Glades, Florida, where the highest incidence per capita of AIDS cases have been reported in this country. Living conditions in the area outside of urban Miami closely resemble African conditions of poverty, tuberculosis, venereal disease, parasites, and viruses (Brown, 1986).

The full spectrum of signs and symptoms of this relatively new phenomenon are unknown. "Manifestations of the HIV infections and immunodeficiency reflect, at least in part, the environmental pathogens to which individuals are exposed; manifestations, therefore may appear to vary in different population groups in different parts of the world, but still reflect basic underlying HIV infection" (Baltimore, et al, 1986, p. viii).

Mode of Transmission

Transmission of the AIDS virus has been documented in humans via:

- intimate sexual contact with an infected person that allows for blood and/or bodily fluids, e.g., the presence of the virus in semen allowing the cell to cell transmission through entry into the bloodstream of a non-infected person. Documentation of transmission has occurred in male to male, female to female, male to female contacts involving vaginal and rectal intercourse.
- intravenous injection of drugs through shared hypodermic needles contaminated with the virus.
- injection of blood or blood products contaminated with the virus, e.g., blood transfusions and blood-clotting products, Factor VII used by hemophiliacs.
- pre-natal or perinatal transmission to fetus or newborn child by infected mother. One research study documents transmission via breast milk (Ziegler, 1985).

Although HIV has been isolated in body fluids, e.g., saliva, tears, breast milk, and urine, the CDC recommendations for prevention of AIDS states that the epidemiologic evidence suggests the virus can only be transmitted via blood or semen. There is no scientific evidence of transmission not involving parenteral or sexual exposure or maternal-infant routes, although unsubstantiated reports of transmission through kissing and biting have been made. Observations and studies with spouses, siblings, children, and household contacts support the assumption that casual contacts, regardless of settings, e.g., school, are not

likely to transmit HIV (Friedland, et al, 1987; Fisch, et al, 1987; Scott, et al, 1985).

Because of the specific modes of transmission of the AIDS virus certain individuals and groups of individuals have been identified as high-risk for contracting the virus if the individuals engage in high-risk behaviors. Identifiable groups potentially at risk for contracting HIV include:

1. Males who engage in homosexual or bisexual sexual relationships with partners who may be infected with HIV. Multiple partners increase the risk of exposure to infection.
2. Females who engage in sexual relationships with infected males. Multiple partners or "monogamous" relationships with bisexual males increase the risk of infectivity.
3. Males or females who engage in sexual relationships with intravenous drug users who share drug equipment.
4. Males or females who have had blood transfusions or used blood products, e.g., Factor for hemophilia, prior to 1983. As of mid-1985 blood screening for the AIDS virus has virtually eliminated contamination via this mode.
5. Infants or newborns of infected mothers. Pregnancy and childbirth may be predisposing factors for activation of the previous dormant HIV infection.

Parenteral transmission. Exposure from transfusion-associated HIV infections occurred primarily from late 1970s until mid-1985. Blood components or products can transmit HIV, including packed red cells, frozen plasma, clotting factors, whole blood, and platelets. Screening does not guarantee complete safety of blood supply because blood and

blood products may be obtained from HIV-infected individuals before the appearance of HIV antibodies and because sensitivity of the test for detecting antibodies is less than 100% (Baltimore, et al, 1986). While blood and blood product transmission of HIV is a medical problem, the health factors connected to the lifestyles and poor hygiene of many illegal IV drug users play a prominent role in the spread of the AIDS virus.

The fastest growing risk factor associated with AIDS is the illicit IV drug use prominent in urban areas where the majority of AIDS cases are now identified. The most common source of HIV infection among women is in this group. In New York City AIDS is the leading cause of death among females 25-29 (Fettner, 1985; MMWR, 1986). An additional factor in the spread of the virus is the almost universal infections related to IV drug use, including hepatitis B, cytomegalovirus, and Epstein-Barr virus, all of which suppress the immune system in varying degrees (Fettner, 1985; Gong, 1986).

Intravenous drug use is the primary source of heterosexual and prenatal/perinatal transmission with numbers rapidly increasing. Blacks and Hispanics are widely represented in this group. The proportion of blacks and Hispanics meeting the AIDS case definition for national reporting is disproportionately high.

Ramifications for AIDS and minorities are staggering. CDC figures at the end of 1987 were reporting 25% of the total number of reported cases were in blacks and 14% were Hispanic. The overall cumulative incidences for black and Hispanic adults were 3.4 times that for whites (CDC, 1986). Inner city ghettos have become breeding grounds of infection adding to the already serious health conditions of poverty, crime, and teenage pregnancy. Educational efforts are slow in these areas where information is not easily accessible or solicited and where family structures and cultures do not respond to mainstream media campaigns (Bakeman, Lumb, Jackson, Smith, 1986).

AIDS and Its Relationship to Other Communicable Diseases

Hepatitis B virus and the herpes family of viruses that includes herpes simplex, herpes varicella-zoster (i.e., chickenpox or shingles), cytomegalovirus, and the Epstein-Barr virus are viruses closely associated with the HIV infection (Brown, 1986). Hepatitis B virus (HBV) is a viral infection manifesting either acute or chronic illness and is often associated with liver cancer. A blood borne virus, HBV induces a carrier state in about 10% of the individuals who contract the virus. The HBV transmission patterns are all but identical to those of the HIV infection. The virus can be transmitted by asymptomatic carriers, as well as those

with acute or chronic illness by blood and/or body fluid contact, blood transfusions, contaminated needles, maternal-infant routes, saliva, breast milk, and/or genital secretions. There is an approximate incidence of 800,000 cases of HBV in this country with an estimated 200,000 new cases each year (Fettner, 1985).

HBV spread rapidly in the 1970s with an infectivity rate far exceeding that of HIV. Health care professionals, homosexuals and intravenous drug users are among the groups of individuals that are often carriers and/or considered high risk due to exposure to contaminated blood or health and safety practices. The clinical manifestations of HBV are difficult to separate from the features of the herpes virus family, due to the production of a viral hepatitis-like illness seen in both Epstein-Barr virus and cytomegalovirus (Boyle, 1987; Brown, 1986).

Because of the similarities in risk group populations for HBV and HIV, researchers are not surprised that liver damage by HBV or cytomegalovirus is present in a large number of AIDS cases (Cantwell, 1986).

Health care precautions established for the identification, placement, and management of Hepatitis B carriers have been established by many public health departments, hospitals, and school systems (see Appendix B--Montgomery County, Maryland, Screening Process for Hepatitis B). Policies in

many school systems on placement of children with HIV infection have utilized HBV guidelines and procedures.

Herpes Virus

The herpes viral group includes the herpes virus, types I and II; the herpes varicella-zoster virus (the cause of chicken pox and shingles); cytomegalovirus; and the Epstein-Barr virus (Baltimore, et al, 1986).

Herpes Simplex. The herpes simplex virus (HSV) is a wide-spread viral infection that is present in estimates of as high as 90% in the general population. Transmission of HSV occurs through contact with infected persons with a primary or a recurrent infection, or from asymptomatic carriers of the virus. Exposure occurs through direct skin contact with infected secretions. Intact skin is a barrier for HSV with infections occurring due to skin insults, e.g., cuts, abrasions, burns, and dermatitis.

HSV is increasingly recognized as a cause of viral meningitis and encephalitis. Prenatal HSV can result in brain damage and/or blindness or death for the newborn.

Type I and II HSV can be differentiated by isolation on the body. Type I virus usually infects skin or mucous membranes above the waist, although oral genital sex is changing the representation for both Type I and II; most common HSV of this type is fever blisters. Type II occurs from lesions

below the waist (Brown, 1986; Council of Exceptional Children, 1986; Scott, 1987).

Cytomegalovirus. Cytomegalovirus (CMV) is a commonly contracted virus contracted by both adults and children through transmission by close person-to-person contact with an infected person. CMV has been isolated in body secretions, e.g., urine, saliva, feces, breast milk, semen, and cervical secretions, blood and blood products (Cantwell, 1986).

The pathologic effects of CMV were first noted in 1904 in a stillborn infant who had acquired syphilis from the mother. CMV, meaning "giant cell" virus, is most commonly asymptomatic; but in some children whose mothers are exposed to the virus for the first time during pregnancy, disabilities may occur including hearing loss, mental retardation, and developmental delays (CEC, 1986; Hanshaw, 1983).

At the beginning of the AIDS epidemic CMV was strongly suspected as the causative agent of AIDS. The close relationship of cytomegalovirus to the HIV infection may be one of a co-factor that is influential to the development of the virus. Exposure to CMV is prevalent in high-risk group populations for HIV infection. Active CMV infection is immunodepressive and along with the AIDS virus may be "an additional implicating and catalytic co-factor precipitating clinical disease only in those whose body defenses are already compromised or defective" (Brown, 1986, p. 1).

Epstein-Barr virus. The Epstein-Barr virus (EBV) has additionally been linked to the HIV infection and AIDS with the probability existing that EBV, CMV, and/or other multiple or recurrent communicable diseases including HIV play critical roles in the development of more serious forms of AIDS (Brown, 1986; Mass, 1985). Epstein-Barr, more commonly known as infectious mononucleosis, is a classic disease found in older children and young adults, although a high incidence of infection is evidenced among children from low socioeconomic levels (Scott, 1986). Symptoms of EBV are similar to CMV and tuberculosis and differentiation is often difficult. Early symptoms of the infection include fever, malaise, sore throat, chills, and fever. Transmission occurs through close personal contact as in CMV and HSV Type I.

Current research of EBV and a chronic form of the virus, CEBV, suggest a link between the virus and cancer (Kosterman, 1987; Brown, 1986). Further research of EBV and other herpes group viruses may support theories that suggest HIV may be at least one of the viral agents that cause both AIDS and cancer (Brown, 1986; Cantwell, 1986; Kosterman, 1987).

Mycobacterium Infections

Tuberculosis (*mycobacterium tuberculosis*) is an immunosuppressive disease evidenced in increasing numbers in those individuals identified with AIDS. Scientists know very

little about how mycobacterium (MAC) is acquired, but there is now reason to suspect that tuberculosis or other MAC infections may be early manifestations of the HIV infection in a large number of individuals (Cantwell, 1986).

Pediatric AIDS

Until recently AIDS seemed to be limited to adults, predominantly those with aberrant lifestyles or exposure to blood products. It seems, however, that the epidemiology of AIDS may now have taken an ominous new turn, with otherwise "normal" infants and children as additional victims (Oleske in Cantwell, 1986, p. 66).

In December 1981 the first report of an acquisition of AIDS in an infant was made. The infant acquired the infection after a blood transfusion, blood contaminated with HIV. Since 1982 over 425 cases of AIDS in children have been reported to CDC, 1.5% of all reported AIDS cases. Oleske (1983) studied the first cases of AIDS. Eight children in Newark, New Jersey, born into families with one or more parents with known risk factors for contracting the infection were studied. All infants had "unexpected immunodeficiencies," some of whom had opportunistic infections and fit the working definition of AIDS developed by CDC. Eighty percent of the cases of Pediatric AIDS (PAIDS) in children continue to be seen in those under 6 years of age (Ammann, 1987; Baltimore, et al, 1986).

The clinical manifestations of PAIDS differ significantly from those of adults. Recurrent bacterial, viral, and candidal infections; failure to thrive; lymphoid interstitial pneumonitis; and encephalitis are among common characteristics of the PAIDS condition. Because of differential diagnosis of PAIDS versus the adult AIDS condition, the earlier CDC surveillance definition of AIDS was not useful or sensitive to the pediatric cases, therefore, CDC developed a new case definition for epidemiologic surveillance. The primary differentiation between the clinical and case definitions of PAIDS was the exclusion of opportunistic infections (OI) and Kaposi's sarcoma (KS) from the criteria for AIDS in clinical definitions (Ammann, 1987). PAIDS most closely resembles manifestations earlier defined in the adult population as ARC (Brown, 1986) (see Appendix A for revised CDC definition).

Additionally, in infants and children the determiners are more complex because a differentiation must be made between PAIDS and other congenital immunodeficiency diseases (Anderson, 1986). The common denominator of pediatric categories of AIDS is the developmental immaturity of the newborn and of early childhood (Brown, 1986).

A mortality rate of 65% has been reported in those children meeting the restricted criteria of CDC (i.e., inclusion of opportunistic infections). Children who are at risk for the virus, have developed an ARC or AIDS-associated

illness, or who test positive for HIV antibodies is conservatively estimated at two to three times those reported by CDC (Ammann, 1987; Baltimore, 1986).

The two primary means of acquiring the HIV infection in children are through maternal-infants routes, accounting for approximately 80% of cases, and transmission of the virus through blood and blood products.

Studies suggest that infants born of mothers with previously affected infants acquire the virus in utero, although perinatal transmission is also suggested. Data on post-natal transmission via breast milk is still being investigated (Ammann, 1987; Baltimore, et al, 1986; Ziegler, 1985). Rate of infection from mother to infant is unknown, although recent studies show incidences of as high as 65% (Scott, 1985). Ammann (1987) suggests current estimates to be at about 20% for rate of infection to infant.

Six risk groups for PAIDS have been identified by Ammann (1987). The groups include:

- infants of infected mothers,
- recipients of blood transfusions 1979-1985 (rare cases expected after 1985),
- hemophiliacs,
- sexually abused children,
- child and adolescent intravenous drug abusers, and
- sexually active children and adolescents (homosexual/heterosexual).

In the most frequently affected group, infants of infected mothers, the majority of mothers (90%) are intravenous drug users with a smaller percentage infected by bisexual or heterosexual partners.

HIV infection is difficult to recognize in infants. From the time of infection to the development into AIDS, ARC, or seropositivity is variable depending on the condition of the immune system (i.e., presence of underlying immunodepression), route of transmission, and dose of virus. Children who are seropositive may remain asymptomatic or develop symptoms after as many as 4 or more years. For infants who test seropositive the median interval prior to onset of symptoms is 8 months (Rogers, 1985).

Minority groups have been heavily hit not only by adult AIDS. Eighty-one percent of children with PAIDS are black or Hispanic, sixty percent and twenty-one percent, respectively. Three-fourths of PAIDS cases have occurred in the high incidence states of New York, California, Florida, and New Jersey. Conservative figures indicate that 54% of the children infected are children of intravenous drug users, though those figures are expected to go much higher (Baltimore, et al, 1986).

Opportunistic infections are frequent in children with PAIDS, but in general more bacterial infections are experienced. PCP is seen in approximately 70% of the PAIDS cases. Lymphoid interstitial pneumonitis, suggested to be associated

with EBV, is seen in from 30-60% of PAIDS cases (Ammann, 1987).

PAIDS numbers are expected to continue to increase with projections of 3000-4000 reported cases by 1991 (Baltimore, et al, 1986). As previously indicated the major route of transmission will be via maternal-infants routes. The 1986 National Academy of Sciences/Institute of Medicine report on AIDS indicated primary research needs in the area of maternal-infants routes and seroconversion (see Glossary) in children.

A subset of particular interest in total cases of PAIDS is that group between the ages of 13-19. Approximately 20% of all PAIDS cases are reported in this group. Unlike the majority of 0-13 cases, 52% of the 13-19 group acquired the virus through either heterosexual or homosexual contact with an infected person. As of mid-1986, in addition to the approximately 1/2 infected through sexual contact; 21% were known to be infected through a contaminated blood clotting product, e.g., Factor VIII; 9% of the individuals had a history of intravenous drug abuse; and 5% acquired the virus through a blood transfusion; 13% of the age-group acquired the disease through "unknown" or "other" means, e.g., several who were born or lived outside the United States in areas with a high incidence of AIDS (NSBA, 1986).

Health Care and Precautions for HIV Infection

It is unfortunate that children with AIDS are usually chronically ill and unlikely to attend school. However, medical research strongly supports the premise that AIDS/PAIDS is not transmitted through casual or household contact and, likewise, does not support the probability that AIDS or the HIV infection can be transmitted to the classroom through normal day to day casual contact.

Because children like adults can only become infected with the human immunodeficiency virus through sexual, parenteral, or maternal-infant routes, schools do not need special precautions to protect other children with the exception of routine procedures for cleaning up body fluids after accidents or injury.

Eighty percent of all reported cases of PAIDS are in children so young that there is little chance of survival to day care or public school entrance. Infants testing seropositive to HIV at birth usually develop symptoms of the infection prior to one year of age.

As in AIDS the numbers of children suspected of carrying the HIV infection are conservatively three times that of those already identified with PAIDS. These children represent cases that may be asymptomatic or the individuals may be suffering from an AIDS-associated illness, e.g., ARC.

ARC has a wide spectrum of illnesses, often periodic and episodic. Some cases of the illness as in full-blown PAIDS may require special medical consideration, e.g., reduced class size to decrease exposure to infectious agents common to childhood (e.g., measles, chicken pox, mumps). Elimination from immunization to such diseases required for school attendance may also be necessary.

Educational efforts by school districts may also be considered precautionary, especially in the age groups of 13-19 where drug and sexual experimentation may begin to take place. Additionally, educational efforts may be suggested for younger groups of children and/or those individuals who have been sexually abused or who are suspected of being high-risk for abuse.

Recommendations for the School Attendance of Children With the HIV Infection

In October of 1985 the American Academy of Pediatrics' Committees on School Health and Infectious Diseases made recommendations on the school attendance of children and adolescents with the HIV infection, at that time known as HTLV-III/LAV. The recommendations were based on

- 1) a review of the available data related to potential transmission of HTLV-III by school-aged children and
- 2) the Centers for Disease Control (CDC) statement of August 30, 1985.*

The recommendations apply to all children known to be infected with HTLV-III/LAV including (1) children with AIDS as defined for reporting purposes; (2) children determined to have an illness due to infection with HTLV-III/LAV but who do not meet the case definition, which has been called AIDS-related complex (ARC; symptoms may include chronic lymphadenopathy, weight loss, fever, chronic diarrhea, anemia, thrombocytopenia, and mild signs of opportunistic infections); (3) children who are asymptomatic but have virologic or serological evidence of HTLV-III/LAV infection. (AAP, 1986, p. 430)

Recommendations

1. Most school-aged children and adolescents infected with HTLV-III should be allowed to attend school in an unrestricted manner with the approval of their personal physician. HTLV-III infection, in these recommendations, includes cases of AIDS, ARC, or seropositivity, in as much as the potential for transmission of the virus is present in any of these three clinical conditions. Based on present data, the benefits of unrestricted school attendance to these students outweigh the remote possibility that such students will transmit the infection in the school environment.

2. Some infected students may pose a greater risk than others. Students who lack control of their body secretions, who display behavior such as biting, or who have open skin sores that cannot be covered require a more restricted school

* issue of guidelines on the education and foster care of children with AIDS.

environment until more is known about the transmission of the virus under these conditions.

3. School districts should designate individuals, including the student's physician, who have the qualifications to evaluate whether an infected student poses a risk to others. Evaluations to assess the need for alternatives to continuing in school should be performed regularly. Hygienic practices of an infected student may improve with maturation or deteriorate if the condition worsens. If it is determined that a risk exists, the student must be removed from the classroom, and an appropriate alternative education program must be established until a subsequent review determines that the risk has abated. A plan for periodic review should be established at the time a decision has been made to exclude a child from attending classes.

4. The number of personnel aware of the child's condition should be kept to the minimum needed to assure proper care of the child and to detect situations in which the potential for transmission may increase. It is essential that persons involved in the care and education of an infected student respect the student's right to privacy. Confidential records should be maintained.

5. All schools should adopt routine procedures for handling blood or body fluids, regardless of whether students with HTLV-III infection are known to be in attendance. School health care workers, teachers, administrators, and

other employees should be educated about procedures that may be or may have been established by local codes.

6. The physician of the student with HTLV-III infection should regularly assess the risk of school attendance. Students with HTLV-III may develop immunodeficiency, which places them at increased risk of experiencing severe complications from infections such as chickenpox, tuberculosis, measles, cytomegalovirus, and herpes simplex.

7. Routine screening of children for HTLV-III is not recommended.

CDC Recommendations

The Center for Disease Control guidelines published in August of 1985 two months prior to AAP recommendations were also based on the premise that casual contact is not a contributing factor in contracting the HIV infection. The CDC recommendations for education and foster care of children are:

1. Decisions regarding the type of educational and care setting for HTLV-III/LAV-infected children should be based on the behavior, neurologic 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 parent or guardian, and personnel associated with the proposed care or educational setting. In each case, risks and benefits to both the infected child and to others in the setting should be weighted.
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 nonexistent risk of transmission of HTLV-III/LAV. These children should be allowed to attend school and after-school day-care and to be placed in a foster home in an unrestricted setting.
 3. For the infected preschool-aged 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 hands. Any open lesions on the infected person should also be covered.

5. **Because other infections in addition to HTLV-III/LAV 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 the 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 a 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 of 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 educational 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.

Both the CDC and AAP guidelines are being used extensively in day care and public school settings in the development of policy for school attendance. The policies stress case-by-case individualization and the need of regular re-evaluation.

A child may be so immunosuppressed at one time that he does not belong in class, and another time it is quite appropriate to be in class. And that is one of the criteria for being in school: is a child under adequate medical supervision, in a responsible family setting, so that his whereabouts can be monitored properly? (Cooper in NSBA, 1986, p. 19).

The AAP and CDC guidelines differ in the issue of responsibility for evaluation. While the CDC does not indicate the responsible agent for assembling an evaluative committee, the AAP recommendations determine that the school has the role of responsibility for determination of those individ-

uals, including the child's physician, "who have the qualifications to evaluate whether an infected student poses a risk to others." The AAP also stresses that the child's physician should be the individual that regularly assesses the risk of school attendance to the HIV infected child. The risks of attendance may be determined to be higher when there is an increased risk of contraction of infectious childhood diseases, which cause severe complications in already immunosuppressed children. Likewise, children with HIV infections should not be exposed to live virus vaccines as in normal school entrance immunization. AAP guidelines use stronger language in not recommending immunization than does CDC which states that live virus vaccines "may be hazardous" (NSBA, 1986).

In a report issued by the United States Department of Health and Human Resources, the Surgeon General echoed both AAP and CDC recommendations for school attendance:

No blanket rules can be made for all school boards to cover all possible cases of children with AIDS and each case should be considered separately and individualized to the child and setting, as would be done with any child with a special problem, such as cerebral palsy or asthma . . . Casual social contact between children and persons infected with the AIDS virus is not dangerous. (Surgeon General Koop, 1986, p. 24)

Koop does add that the schools are likely to have special problems in the future fostering a need both in the area of sex education and the education of the handicapped.

Children with HIV infections may develop neurological impairments due to the virus that produce changes in mental capacity and emotional behavior. School boards and administrative staffs should be in an informed position to make determinations, if it becomes necessary to assess and/or reassess an HIV-infected child to determine the need of special education services.

In April of 1986 the Council for Exceptional Children adopted a set of policies and procedures for the management of communicable and contagious diseases. The increased prevalence of chronic communicable diseases such as hepatitis B, cytomegalovirus, herpes simplex virus, and acquired immune deficiency syndrome "necessitated the reassessment of existing school policies and procedures. The Council for Exceptional Children believes that having a communicable/contagious disease does not in itself result in a need for special education." Recommendations that stress inclusion and case-by-case management are noted:

1. **Do not exclude the affected child from the receipt of an appropriate education even when circumstances require the temporary removal of the child from contact with other children.**
2. **Provide that determination of a non-temporary, alteration of a child's educational placement should be done on an individual basis, utilizing an interdisciplinary/ inter-**

agency approach including the child's physician, public health personnel, the child's parents and appropriate educational personnel.

3. Provide that decisions involving exceptional children non-temporary alternatives of educational placements or services constitute a change in the child's Individualized Educational Program and should thus follow the procedures and protections required under Federal and state laws.
4. Recognize that children vary in the degree and manner in which they come into contact with other children and school staff.
5. Provide education staff with the necessary information, training, and hygienic resources to provide for a safe environment for students and educational staff.
6. Provide students with appropriate education about communicable diseases and hygienic measures to prevent the spread of such diseases.
7. Provide, where appropriate, carrier children with education about the additional control measures that they can practice to prevent the transmission of the disease.
8. Enable educational personnel who are medically at high risk in regard to certain diseases to work in environments which minimize such risk.

9. Provide educational personnel with adequate protections for such personnel and their families if they are exposed to such diseases through their employment.

Summary

The purpose of this chapter was to review medical aspects related to the HIV infection, both in the adult population and in infants and children with PAIDS.

Although only a small percentage of children are now identified with PAIDS, and a much smaller percentage of school-age children, three to four times the number are presumed to be infected with either manifestations of ARC or as asymptomatic carriers.

There is no medical evidence to support the exclusion of children from regular school attendance based on suspicion of or identification of HIV infection. CDC and AAP guidelines suggest that some infected students may pose a greater risk than others and a more restrictive school environment may be warranted. AIDS virus has been documented in transmission through sexual, parenteral, and maternal-to-infant routes. All indications to date are that AIDS is a blood-borne, virus that is not spread by casual contact.

The HIV infection is often present with other communicable diseases, such as the herpes virus group that includes herpes simplex virus (HSV), cytomegalovirus (CMV),

and Epstein-Barr virus (EBV). The majority of children who have developed PAIDS are chronically ill and usually unable to attend school. Many children with AIDS-associated illnesses may attend school during periods of wellness.

Health care precautions should be taken for the child with HIV infection, as well as other children, teachers, and staff. Ordinary health precautions established for the removal of blood and/or body fluids should be followed in cases of accident or injury. Infected children should be protected from possible infectious agents of childhood including chickenpox, measles, and mumps. Regular immunization programs should exclude HIV infected children from exposure to live virus vaccines. Children with HIV infections should be regularly assessed on a case-by-case basis by the child's physician to determine the appropriate educational environment. Sex and drug education may be a precautionary device to prevent the spread of HIV in the adolescent population, 13-19 years of age.

AIDS (and the HIV infection) is a topic of medical, social, political, economic, and educational speculation and concern. Well-informed school officials responsible for policies and procedures on educational placement of children with the HIV infection are in the best of positions to educate and inform parents, children, and staff on an issue that is dynamic and often misunderstood. Awareness of sound medical evidence to support educational decision-making provides

a means of projecting solid grounded information to the school population and community at large.

CHAPTER THREE

LEGAL ASPECTS RELATED TO THE EDUCATIONAL PLACEMENT OF CHILDREN IN THE PUBLIC SCHOOLS WITH THE HIV INFECTION

The legal issues that surround the provision of educational services to children with human immunodeficiency virus (HIV) infection are complex and, as yet, primarily unresolved. Allegations of discrimination against children with the HIV infection have begun to surface. Sources of law emerging in the rapidly expanding area of legislation and litigation related to AIDS and the HIV infection include the equal protection clause of the Fourteenth Amendment, Section 504 of the Rehabilitation Act, and the Education for the Handicapped Act (EHA). Additional sources include state administrative laws, state special education laws, and state communicable disease laws (Weiner, 1986). Although there has been no binding precedent thus far established in AIDS litigation, several cases have emerged that may set precedent for accommodation of those with the HIV infection, including a Supreme Court decision of Spring 1987 that addressed issues considered by many to be analogous with AIDS (Arline, 1987).

The purpose of this chapter is to introduce emerging legal issues presented by the AIDS controversy with a primary focus related to the aspects of educational placement and

provision of services for children in the public schools with the HIV infection.

Case law that has developed and is developing in the area of AIDS litigation will be reviewed. Case law analogous to the issues of the HIV infection will be presented, and an analysis of the legal issues emerging under constitutional law, civil rights law, and the EHA will be included.

The National Centers for Disease Control (CDC) guidelines issued in August of 1985 recommending that most school-age children with AIDS be allowed to attend school, did not attempt to resolve the subsidiary legal questions related to public school attendance; but did note the recognition of legal issues that should be considered including "the civil rights aspects of public school attendance, the protection of handicapped children under 20 U.S.C. 1401 *et seq* and 29 U.S.C. 794, the confidentiality of a student's record under state laws and under 20 U.S.C. 11232g, and employment right-to-know statutes for public employment in some states" (CDC, 1985, p. 55).

Almost simultaneous to the publication of the CDC recommendations legal actions were being brought by parents and others to exclude children diagnosed with AIDS from attending schools in Indiana, New York, and New Jersey (Matthews & Neslund, 1987). The Indiana White v. Western School Corporation (1985) case, the District 27 Community School Board v. Board of Education of the City of New York (1986), and the

Board of Education of Plainfield v. Cooperman (1987) cases now stand as indicators of what is expected to continue as rulings in favor of the inclusion of HIV-infected children in the public schools.

The courts are generally holding that children with AIDS or who test positive for the HIV antibodies should be permitted access to public schools unless public school attendance is against medical advice. Case by case determination of the attendance of children in question has clearly been indicated as paramount to the decision-making process.

Analogous case law supports the recent rulings in the AIDS litigation that has come to trial. The District 27 case relied heavily on case law presented in New York Association of Retarded Children v. Carey (1979), a hepatitis B (HBV) case that denied exclusion of children from public schools solely due to carrier-status of children. Later rulings in HBV, as in Community High School v. Denz (1984), continue to support the no automatic exclusion stance for HIV-infected children. Herpes simplex virus (HSV) was the focus of Council Bluffs Education Association v. Council Bluffs Community School District (1984), that held in favor of public school inclusion for a student with HSV.

In November of 1986 the first decision by a federal court ruled AIDS as a handicapping condition under Section 504 of the Rehabilitation Act in a school attendance case involving the readmittance of a kindergarten student removed

from school due to biting a classmate. In Thomas v. Atascadero Unified School District (1986) a federal district judge found that AIDS is a protected handicap under 504 and that the school district is required to "reasonably accommodate" the child. The court also found the school district to be remiss in failing to show that the child in question presented a risk in the classroom to staff or to classmates (Matthews & Neslund, 1987; The Bureau of National Affairs, 1987).

The Thomas v. Atascadero case is only one of a growing number of school attendance cases to have emerged in this time frame. In another 1986 decision an Orange County, California child testing positive to HIV antibodies was ordered returned to school after several months suspension. The court held that the child, a hemophiliac, who had contracted the HIV infection via a contaminated blood product posed no risk to others in the classroom setting (Phipps v. Saddleback Unified School District, 1986; see Chapter Four--Selected State Profiles--California).

In the fall of 1985 after the recommendations of CDC had been issued a Georgia child was barred from school due to a perceived threat to others after the death of the child's sister from perinatally-acquired AIDS. Only after a threat of a lawsuit by NAACP did the school board in question reverse the decision allowing the child to return to school. Although school attendance was allowed, the Irwin City School

Board stipulated that the child's attendance was acceptable only if the child was not living with the mother, an AIDS victim (Matthews & Neslund, 1987).

As of this writing the primary cases related to the educational placement of HIV-infected students in the public schools have been in the high incidence states of New York, New Jersey, and California. The New Jersey Cooperman case and the much cited New York District 27 case will be discussed in an attempt to illustrate the direction taken by the courts of supporting an educational placement policy for HIV-infected children that allows exclusion to be considered only as an option for HIV-infected students when reasonable medical evidence suggests removal from the normal classroom setting is necessary due to risk to the infected student or to others in the school environment.

District 27 Community School Board v. the Board of Education
of New York City

The decision of the court in the District 27 Community School Board v. the Board of Education of New York City (1986) was the first to address in depth many of the legal and medical issues surrounding the HIV infection and AIDS. Prior to the opinion of Judge Harold Hyman of the Supreme Court of Queens County the legal issues surrounding the HIV infection and AIDS had been addressed only in limited treat-

ment related to issues surrounding the segregation of prisoners in New York State correctional facilities (Schwartz & Schaffer, 1985). Hyman's ruling has served as guidance for other lawsuits (see Board of Education of the City of Plainfield v. Cooperman, 1987) with the degree of comprehensive medical data and thorough legal analysis making exclusionary policy difficult to defend (Weiner, 1986). The comprehensiveness of the data presented and the legal issues addressed in District 27 serve as an illustration of what AIDS in the schools litigation may entail.

Two local community school boards under jurisdiction of the New York City Board of Education applied for a temporary restraining order and permanent injunction prohibiting attendance of children with AIDS in their boroughs. The controversy developed over a New York City policy established in the fall of 1985 that recommended a "no automatic exclusion" policy for children with AIDS in the public schools with review of determination of such children on a case-by-case basis. The New York City policy relied heavily on the CDC guidelines issued at the same time. The case-by-case panel review of such children was "to determine if their health, development, and behavior permitted them to attend school in an unrestricted setting" (Schwartz & Schaffer, 1985, p. 165).

A five member review panel was established reviewing seven cases for the 1985-86 school year. Of the seven cases

three were considered ineligible because they were not New York City residents, two were excluded due to hospitalization. A sixth child was excluded after consideration for attendance, but because of a breach of confidentiality was considered for alternative programming. The seventh and only child placed was permitted to attend and became the focus of the plaintiff's complaint. (The child was later determined to be HIV infected, but not considered under CDC surveillance definition for AIDS. The court chose to hear the issues because of the likelihood of recurrence and due to public importance and interest.)

Prior to the New York City Board of Education announcement and in absence of any known guidelines forthcoming, two community school boards in Queens passed a resolution "that no child who had AIDS or who lived in a household with someone who had AIDS could attend school in those districts" (Schwartz & Schaffer, 1985, p. 165). On the opening day of school after the New York City policy was announced and during a parental boycott a lawsuit was brought "seeking to enjoin the admission of the child with AIDS or, in the alternative, to have the child's identity revealed to the school board members and school officials" (Schwartz & Schaffer, 1985, p. 166).

The threshold issue of the District 27 case was the admission vs. exclusion of children with AIDS in the public schools. Additional issues surrounding precautions against

transmission, review procedures, and confidentiality of obtaining information were also decided.

The court upheld the policy of no automatic exclusion of children with AIDS from the public schools in that the policy did not violate any New York City or state communicable and/or contagious disease law (see Chapter Four--New York). In addition, the overwhelming medical evidence presented supported the New York City policy as being neither arbitrary nor capricious, nor an abuse of discretion. The court further ruled that a policy that was exclusionary would violate the law under the equal protection clause of the Fourteenth Amendment and Section 504 of the Rehabilitation Act.

In a 1985 article in Hofstra Law Review, F.A.O. Schwartz, corporation counsel of the City of New York, and Frederick Schaffer analyzed the District 27 case and the implications of its conclusions to the educational setting. In the analysis the threshold issue of admission vs. exclusion was viewed as resting on three points: (1) epidemiological evidence, (2) legality of admission, and (3) legality of exclusion.

Board of Education of Plainfield v. Cooperman

On April 15, 1987, the New Jersey Supreme Court upheld state regulations that require schools to admit students with

HIV. The New Jersey regulations require public schools to admit HIV-infected students to regular classroom programs under most circumstances. The regulations based on epidemiological studies, including recommendations by the National Centers for Disease Control (CDC), state that the HIV infection is not transmitted by casual contact normally occurring in the public school setting. However, CDC recommendations and the New Jersey regulations do include references to special considerations for alternative placements that might be made in cases of students with the HIV infection who are unable to control drooling, are incontinent, are "unusually physically aggressive" or have a history of biting or harming others due to the theoretical risk of transmitting the virus that can cause AIDS.

In the 7-0 decision the court in Board of Education of Plainfield v. Cooperman and Board of Education of the Borough of Washington v. Cooperman noted that the regulations were "thoughtful efforts intended to protect both school children's health and school children's right to a public education." The court findings included a discussion of "contagiousness" limiting the contagious state to an individual case-by-case determination and not to the disease.

The court interpreted the New Jersey regulations to give schools and parents the right to a hearing before a state medical panel in disputed cases. The state had preferred discretion over hearings be up to the state medical panel

rather than the requirement of "mandatory live testimony" in all cases. The education department had argued, in appeal, that the medical review process in the regulations satisfied legal due process requirements. In 1986 a lower court ruled that the New Jersey regulations were invalid because they were adopted without formal proceedings for rule making. While a state medical panel adjudicates in disputes between schools and families the lower court stated that the rules were in violation of due process standards because neither side had the right to be heard in person, to be present, or to cross-examine witnesses. Decisions by the panel were based solely on written documents presented to panel.

After the lower court ruling New Jersey adopted rules in formal rulemaking proceedings which the high court upheld and interpreted in the April rulings. While the new regulations do not require presence at the testimony or cross-examination, the medical panel is allowed to invite schools and parents to present such testimony. The court decision concerning examination and cross-examination stressed the "importance of the rights at stake as well as the dire consequences that could result from an erroneous decision" and stated that "the right to call witnesses with the attendant right of cross-examination must be provided automatically upon the request of the parties." Judge Alan Handler's written decision stated that the authority the regulations

give the medical panel "expressly" carries the obligation of due process standards.

The court also rejected the argument by the plaintiffs that the SEAs are not in the position to adopt regulations on contagious diseases because the local districts have control of health-related admissions questions. The power to promulgate such regulations "can be inferred from the broad powers that are granted to the department" by state law. The Borough of Washington had argued that the local districts should make individual determinations in all cases with no regulations.

The New Jersey Department of Education policy states that admissions are confidential and that children may be admitted without the knowledge of anyone except the parents and school officials with the challenge of admission only if the child experiences incontinence, drools, or exhibits aggressive behavior. Cases are reviewed by a medical panel if there is a dispute between the child's doctor and a school physician over admission status of a child.

Epidemiological Evidence

Central to the epidemiological evidence were two crucial facts unanimously agreed upon by the medical experts based on the current available data at that time.

1. HIV can be transmitted by sexual intercourse with an infected partner, by injection of infected blood and blood products (especially by drug addicts who share needles and syringes), and by transmission from an infected mother to her child in utero or during the birth process. There is also one reported case via breast feeding.
2. HIV is not transmitted as a result of a casual or routine contact, such as breathing, sneezing, coughing, shaking hands, hugging, or sharing toilets, food, water, or utensils (Schwartz & Schaffer, 1985, p. 168).

Surveillance data obtained from CDC demonstrated that AIDS patients continue to fall into well-recognized risk groups (see Chapter Two for detailed discussed of medical aspects).

Considerable testimony by medical experts focused on transmission issues through two routes: (a) biting, and (b) blood from an injured child. Schwartz and Schaffer (1985) summarize opinion testimony demonstrating a majority view that there was no finding to suggest that the HIV infection had been transmitted in either way with a preponderance of medical evidence suggesting that this mode of transmission was unlikely for several reasons:

1. Although the human immunodeficiency virus has been isolated in saliva, there is no evidence of transmission via this route. Family studies of close daily contact support this finding.
2. Frequently, the HIV infection is not found in the saliva of HIV infected persons.
3. Serious biting is uncommon in school-aged children.

4. The human immunodeficiency virus is easily destroyed through normal first-aid techniques for the treatment of bites.
5. The natural healing process for a cut or wound is a preventative from the virus reaching lymphocytes in the bloodstream.

According to the medical evidence presented to the court, the existence of a minimal theoretical risk can be obviated by simple, routine precautions. Based on epidemiological evidence that suggests apparent nonexistent risk of HIV-transmission, the court could find no factual or legal basis for an automatic exclusion policy, despite the understandable parental fears that exist.

Legality of Admission

Under New York state law to challenge a non-adjudicatory administrative decision made by a state agency the only questions that may be raised are whether (1) "the body or officer failed to perform a duty enjoined by it by law" and/or whether (2) "a determination was made in violation of lawful procedure, was affected by an error of law or was arbitrary and capricious or an abuse of discretion"

The court in holding that the decision not to exclude children with the HIV infection did not violate any substantive or procedural duty imposed by law reasoned that "substantively . . . the state and local laws providing for

the control of communicable disease were not applicable since AIDS has never been defined or designated as a communicable disease by the New York State Public Health Law, the New York State Sanitary Code, or the New York City Health Code" (Schwartz & Schaffer, 1985, p. 174). Therefore, the Department of Health and the Board of Education had no statutory duty to exclude children with AIDS from school (see further discussion of New York State/City laws in Chapter Four--Selected State Descriptions--New York).

Procedurally, although the decision of the Board of Education was not invalid or improper, it was the court's opinion that the policy should have been reached at a public meeting rather than an executive session. While Judge Hyman was critical of the method of developing policy, the court would not require opening meetings to be rescheduled because the Board of Education recommendations were nothing more than an endorsement of a policy of the Commissioner of Health, not requiring rule setting procedure followed by the Board of Education.

In the commentary of the District 27 case Hyman elaborates:

From the outset, it was clear that the respondents operated with a notion that they knew what was best and would make all the necessary decisions for everyone's good. Believing this, they acted in an imperious fashion, accepted little by way of inquiry, and no criticism.

This court cannot resist making some observations with regard to this situation. Fundamental to our system of government is the notion that officials govern with the

consent of the people and that the people have the right to know what these officials are doing. In order to strengthen this flow of information, the legislation of this state has created a Freedom of Information Law and enacted other public access statutes. The respondents have taken great pains to establish that the letter of this legislation does not apply to this case. They have, however, missed the spirit of the law.

The court recognized that under the test to the issue of whether the policy was arbitrary and capricious or an abuse of discretion, the appropriate standard of review "relates to whether a particular action should have been taken or is justified . . . and whether the administrative action is without foundation in fact" (Matter of Pell v. Board of Education quoted in District 27); and, that, "it is not within the scope of the court's review to weigh conflicting evidence and substitute its judgment for that of the agency."

In light of medical evidence presented and guidelines and policy recommendations of the CDC, New York and Connecticut, the court held that the New York City policy was well within the agency's discretionary policy and was neither arbitrary, nor capricious nor an abuse of discretion. The court in rejecting the petitioner's argument based on the reluctance of medical experts to guarantee non-transmission stated that: "It is not the nature of medical science to be governed by a no-risk standard" and further concluded that:

Since "the apparent nonexistent risk of transmission of HTLV-III/LAV" in the school setting finds strong support in the epidemiological data accumulated over the five years experience with this disease . . . and because the "automatic" exclusion of children with AIDS from the regular classroom would effect a purpose having no ade-

quate connection with the public health, safety, or welfare, it would usurp the function of the Commissioner of Health if this court adjudged . . . that the nonexclusion policy was arbitrary and capricious or an abuse of discretion simply because in the court of public opinion, that the particular policy was--perhaps, or possibly--not the best choice. Although this court certainly emphasizes with the fears and concerns of parents . . . it is duty bound to objectively evaluate the issue of automatic exclusion according to the evidence gathered and not be influenced by unsubstantiated fears of catastrophe.

Legality of Exclusion

The court held that in upholding the New York City policy of no automatic exclusion a contrary policy would violate rights under Section 504 of the Rehabilitation Act (29 U.S.C. 794) and the equal protection clause of the Fourteenth Amendment. For this analysis the court drew extensively from two analogous federal appellate decisions concerning other communicable diseases, the hepatitis-B virus (HBV) and tuberculosis.

The court in New York State Association for Retarded Children, Inc. v. Carey (1979) held that exclusion or isolation of students merely because of a medical condition that may pose a potential theoretical risk of transmission violates Section 504 of the Rehabilitation Act. The New York City Board of Education had refused admittance of a group of mentally retarded students identified as carriers of the hepatitis-B virus (HBV) on the grounds that movement from a

residential facility into the school population would result in other children acquiring HBV. In two separate opinions the court held that excluding children as was intended in the Board's original plan or isolating in separate classroom settings would violate the student's rights under 504, the Education of the Handicapped Act (EHA), and the equal protection clause of the Fourteenth Amendment. In the final decision the 2nd Circuit affirmed the holding "since the students were handicapped within the meaning of the act, were being excluded from participation in a federally assisted activity on the basis of that handicap, and there was no substantial justification for that exclusion" (Schwartz & Schaffer, 1985, p. 178; Carey, 1979, at 649-50).

The court in District 27 following the reasoning of the Carey decision concluded that the exclusion of children with AIDS from public school would also violate Section 504. The three critical elements of a Section 504 violation present in the District 27 case were:

1. Students with AIDS are handicapped within the meaning of the act;
2. Exclusion of students with AIDS from public schools would deprive them of the benefits of a public education; and
3. Exclusion of such children would be without substantial justification.

As the HIV infection inactivates the immune system allowing susceptibility to certain illnesses, including can-

cers, persons with AIDS can be defined as handicapped within the meaning of the Rehabilitation Act as:

Any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such impairment, or (iii) is regarded as having such an impairment (29 U.S.C. §706(7)(B)(1982)).

Regulations under the act define (1) physical or mental impairment as "any physiological disorder or condition . . . affecting one or more of the following body systems . . . hemic and lymphatic . . ." 34 C.F.R. §104.3(i)(A)(1985).

Automatic exclusion from school of a student with AIDS would treat the said individual as having a

physical or mental impairments that does not substantially limit major life activities but that is treated by a recipient as constituting such a limitation . . . that substantially limits major life activities only as a result of the attitudes of others toward such impairment . . . has none of the impairments as defined . . . but is treated by a recipient" of federal funds "as having such an impairment" 34 C.F.R. §104.3(i)(A)(1985).

The second element necessary to establish a Section 504 violation is that of exclusion of students from public programs thus denying them the benefits of public education. As held in Carey the court reasoned that severe detrimental effects on educational and emotional development would take place if students were excluded from participation in school programs. The District 27 court concluded that, as in the case of HBV carriers, students with AIDS who were excluded from school would have little benefit to "the extent to which they can participate in school activities . . . and will re-

inforce stigma to which . . . children have already been subjected."

The final element to test Section 504 violation was satisfied in that the court found medical data sufficient to provide that a "substantial justification" for automatic exclusion was not valid.

The court noted several parallels between the factual issues in District 27 and Carey. First, transmission by saliva was central to the Carey issue in that HBV had been isolated in saliva, but not documented as a route of transmission. Additionally, there was no evidence to suggest that the children being isolated in Carey engaged in behaviors that might pose a theoretical risk of transmission of HBV through saliva in the classroom. (Later studies of HBV have documented nonparenteral routes, and although risks are substantially increased in the classroom the risk is still slight in comparison to risk of infection in the general population. Furthermore, exclusion and/or isolation is not an issue in HBV due to development of a safe and effective vaccine now presently available (Denz, 1984).)

The District 27 case demonstrates a similar lack of proof, but as concluded in Carey found that "there are prophylactic measures . . . to reduce the risks. . . . It is not necessary to close the schoolhouse to these children."

Third, District 27 and Carey provide evidence that establishes a substantial number of students infected with the

virus are not being excluded or isolated. In Carey the court found that the Rehabilitation Act requires that handicapped students be given the same opportunities as those afforded to others. "Segregation of retarded hepatitis-B carriers without imposing a similar restriction on non-handicapped persons would constitute unlawful discrimination within the meaning of the Rehabilitation Act." Likewise, there is recognition that HIV-infected children are present in the public schools who have not been identified or do not have AIDS but are as capable of transmitting the virus as those in more active stages. The court in District 27, therefore, concluded that based on the reasoning in Carey a policy of automatic exclusion of children with AIDS without similar exclusion of other HIV-infected students "would constitute discrimination under Section 504 of the Rehabilitation Act."

Arguments that distinguish Carey from the District 27 case and/or defend the plaintiffs' claims in District 27 include the nature of the HIV infection vs. the nature of HBV and that some weight should be taken in determining a policy that includes children in public school settings with a potentially fatal disease. "Nevertheless, the gravity of the illness does not change the rule that exclusion must be supported by concrete evidence that AIDS may be transmitted in the classroom setting" (Schwartz & Schaffer, 1985, p. 182) rather than guided by unsubstantiated fears of what might be

(see Arline; see also Fannie Mae Jackson v. New York State Urban Development Corporation).

Courts must decide on cases based on the record before them. The majority of medical experts, including those at CDC, are of the opinion that within a reasonable degree of certainty the risk of transmission of HIV is so slight or nonexistent that exclusion is not necessary. To argue that there are insufficient data on transmissibility is to ignore the impressive amount of epidemiological data collected that supports no significant changes in route of transmission over the periods studied. While there can be no guarantee to transmissibility it is both "unrealistic and impractical to measure public health decisions by a no-risk standard. . . . Unsubstantiated fears based on demand for absolute certainty are not sufficient to justify a policy of exclusion" (Schwartz & Schaffer, 1985, p 183).

Unlike District 27, Carey involved a decision by the Board of Education to exclude children who were HBV carriers in an education policy that was contradictory to recommendation of the Department of Health. In the subsequent decision to isolate children in special classes based on Department of Health guidelines in seeking to enforce a federal right in a federal court proceeding, the recommendations were given little weight because they were not issued as formal regulations. Where the facts presented a prima facie case of discrimination the board was required to demonstrate at least

a "substantial showing" that the plan of exclusion or isolation was justified.

The court in District 27 considered and rejected the arguments on the nature of the illness, the deadliness of the illness, and the insufficiency of data on transmissibility. The argument involving the relevancy of the expertise utilized in the policy development was not at issue because in District 27 the Commissioner of Health's recommendations were not in conflict with New York City policy.

The court's determination that the exclusion of children with AIDS from public schools is considered a violation of Section 504 may be too broad (Schwartz & Schaffer, 1985). In the Carey decision the possibility was left open that a decision to exclude children with a communicable disease from school may be made if adopted by a health department through formal regulations, upon notice and an opportunity for comment. Thus, decision for exclusion may be valid and enforceable under the Rehabilitation Act, if proper procedures are followed and determinations made on a case-by-case basis.

Schwartz and Schaffer (1985) questioned the court's declaration that a policy of excluding children known to have AIDS, AIDS-Related Complex (ARC) or who test positive for the HIV antibodies would deny them equal protection under the laws. The court's decision was based on a conclusion in Carey that noted there were large numbers of children who were HBV carriers capable of transmitting the virus who were

not being identified or excluded from public school programs. The fact that for various medical/policy reasons "no one is recommending a mandatory screening program for all school children does not make it an unconstitutional discrimination to exclude children who are known to be infected with HIV." The court's statement in Carey "that it is constitutionally permissible for the government to deal with a problem in a step-by-step manner, strongly suggests that the court in the District 27 case erred in stating that it would violate the equal protection clause to exclude 'known carriers of HTLV-III/LAV while untested and unidentified carriers still remain in the classroom where they pose the same theoretical (though undocumented) risks of transmitting the virus to normal children'" (Schwartz & Schaffer, 1986, p. 185).

Precautions, review procedures, and confidentiality

District 27 also addressed the related issues of (1) precautions, (2) review procedures, and (3) confidentiality as related to the educational placement in the public schools of children with HIV infection. The petitioners in District 27 questioned the preparedness of New York City school system to deal with the presence of children with the HIV infection in the schools. The preponderance of medical evidence presented at the trial suggested that there was substantial agreement as to the precautions necessary to guard against

any theoretical risk of transmission. The court found that the policies in effect at the beginning of the 1985-86 school year were acceptable practices that included (1) the distribution of alcohol swabs for disinfecting bites, (2) the revision of first aid manuals and charts to include more detailed information on bites and blood spills, (3) the usage and availability of gloves and disinfectant, and (4) a two-hour educational forum on AIDS for all school employees.

Case-by-case review as recommended by CDC is to determine if there is anything in the child's neurological, physical, or emotional behavior that would make an unrestricted setting inappropriate. Although CDC is not clear on precise criteria that can be applied for this determination, Schwartz and Schaffer (1985) suggest that a review might entail two aspects:

- (1) a determination that the child is well enough to attend school without undue risk to his/her own health and
- (2) a determination that the child's behavior does not pose any increased risk of transmission of HIV to others within the classroom.

The CDC recommendations focus on the latter concern suggesting that the case-by-case review by a multi-disciplinary panel consider whether the child is neurologically handicapped and/or lacks control of his/her bodily secretions or displays behavior such as biting.

The plaintiff's claim that case-by-case review should be handled by the local school district's Committee on the

Handicapped (COM) established to implement the Education for the Handicapped Act (EHA) was rejected by the court. For purposes of the programs under EHA the District 27 court held that children with AIDS are not educationally handicapped merely because of the illness; but that the status of the child in regard to special programs depends upon the ability to function in an ordinary educational setting (see EHA heading for further discussion).

The court also rejected a claim questioning the composition of the panel and the procedures that were followed. In its findings the court found that the divergency of the panel from suggested make-up by CDC was not significant since CDC recommendations were advisory in nature. And although the court was critical of certain practices it perceived in the panel's method of evaluation, the "mere displeasure" with panel members on the procedures employed "cannot be translated into arbitrary or capricious" conduct. The New York City information on children with AIDS was collected from surveillance reports that are prohibited from disclosure outside the Commissioner of Health's office. While no breach of confidentiality occurred in that the identities of the children were not known outside the Department of Health, the court was critical of the Commissioner of Health for using surveillance reports to identify children to be reviewed. The court was clear to point out that if the panel had recommended revealing the identity of any child reviewed, the

recommendation could not be made without violating the requirement of confidentiality within the law.

State guidelines differ as to disclosure of information and the use of surveillance reports (see Chapter Four). The District 27 ruling on disclosure was based entirely on the legal provision of New York State and local laws on government surveillance reports that prohibited disclosure. The court noted that "the use of the surveillance data was inconsistent with the purpose for which it was collected and risked breaching the confidentiality guaranteed by law" (Schwartz & Schaffer, 1985, p. 189).

The court's ruling on confidentiality was based on the issue of the legal provision regarding surveillance reports. The court did not reach the issue of who, if anyone, should be informed of the identity of an HIV-infected child. The court, however, noted that CDC recommendations provide little guidance on the issue of whether anyone within the school system should be informed of the identity of AIDS children recommending only that:

Persons . . . should respect the child's right to privacy, including maintaining confidential records. The number of personnel . . . 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.

School policies and school personnel arguments for disclosure as a precautionary safeguard are not necessarily consistent with medical evidence that suggest routine safety

procedures as effective in preventing transmission of HIV. Disclosure may, indeed, be counterproductive due to the public stigma attached to AIDS and the HIV infection. School personnel should be trained in simple first aid techniques for handling injuries in the school setting. Procedures for handling bites or bleeding should be a matter of routine policy, regardless of the presence of a child with AIDS or the HIV infection. Non-identified asymptomatic carriers may be present in a classroom, as well as children with other infections that may be transmitted through blood or saliva, e.g. HBV. **There is no guarantee that knowledge of the identity of an infected child will increase precaution.** Unfortunately, knowledge of the absence or presence of HIV-infected children in the classroom or school setting may cause the classroom teacher or other school personnel from acting wisely in an emergency due to fear or due to a false sense of security.

Likewise, disclosure of identity to protect the health of the child with the HIV infection may not be necessary. A system of notification wherein the treating physician is informed of an outbreak of infectious disease in the school or district may enable the child with the HIV infection to be removed from the school environment, if necessary, and given appropriate treatment without disclosing the identity of the child. The decision of whether or not to disclose the identity of the child is most appropriately placed with those

most responsible for the protection of the child's health, the parents and the treating physician (Schwartz & Schaffer, 1985).

At the present time, disclosure of identity of children with the HIV-infection holds questionable benefits. The stigma attached to AIDS and the HIV-infection continues, and it may be unrealistic to expect school personnel to adhere to a policy of strict confidentiality. Additionally, there is concern in the public health sector that breaches in confidentiality will inhibit physicians from reporting cases, as well as discourage HIV-infected persons from seeking medical attention. The potential harm resulting from the disclosure of the identities of children with the HIV-infection to school personnel, at the present time, continues to outweigh the possible benefits the disclosure of identities may have. As one of the leading cases in AIDS and the schools District 27, though not binding on other jurisdictions, has served as a representative case, primarily due to the unprecedented medical evidence presented by medical experts in the field of AIDS and communicable diseases.

Section 504 and Arline

The District 27 case, although a district court decision binding only on the parties in the case, illustrates a legal analysis that demonstrates a judicial stance recognizing AIDS

as a handicap under Section 504 of the Rehabilitation Act. "In holding that exclusion of the AIDS-infected child from school would violate Section 504, the court determined that AIDS does qualify as a 'physical impairment' for purposes of the Rehabilitation Act" (Schumaker, 1986, p. 292). Although the immune system is not included in the definition of "physical impairment" AIDS affects the "hemic and lymphatic" systems determining the infection as a "disorder or condition, cosmetic disfigurement, or anatomical loss" to affect "one or more of the following body systems: neurological; musculoskeletal; special sense of organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito- urinary; hemic and lymphatic; skin; and endocrine" (34 C.F.R. §104.3(j)(2)(i)(1985)). When adopting the "physical impairment" definition the Department of Health and Human Services (HHS) did not "set forth a list of specific diseases and conditions . . . because of the difficulty of ensuring the comprehensiveness of any such list" (Schumaker, 1986; 34 C.F.R. §104, app. A (1985)).

The definitional determination of AIDS as a protected handicap rests on the restriction of the handicap as to "substantially limiting one or more major life activities." Little direction is given in the 504 regulations for defining "substantially limiting"; however, there is little to refute a "substantially limiting" restriction in the case of AIDS and the HIV infection due to the devastating disabling ef-

fects and public stigma attached to the condition. Moreover, according to Schumaker (1986) the limiting of any activity relating to the maintenance of good health lends itself as definitional support to the interpretation of "limiting major life activities" (Schumaker, 1986).

Federal judicial interpretations support the contention that AIDS does qualify as a protected handicap under Section 504. Risk of contagion had been a major obstacle in the attainment of protected status for AIDS until the Spring 1987 ruling on contagious diseases by the United States Supreme Court in Arline v. The School Board of Nassau County. Arline supported the Department of Health and Human Services regulations "that it has no flexibility within the statutory definition to limit the term to persons who have those severe, permanent, or progressive conditions that are most commonly regarded as handicaps" (34 C.F.R. §104, app. A (1985)). In the Eleventh Circuit decision on Arline the court stated that:

Though the district court apparently thought it illogical to conclude that Congress would have placed contagious diseases within the definition of "handicaps," there is no objective evidence to support this conclusion. Neither the regulations nor the statutory language give any indication that chronic contagious diseases are to be excluded from the definition of "handicap" (Arline in Schumaker, p. 589).

On appeal the Supreme Court in Arline upheld the Eleventh Circuit decision ruling that individuals with contagious diseases are considered "handicapped" under Section 504 of

the Rehabilitation Act. The ruling has been considered by many to be precedent setting in discrimination cases of those with HIV infection. In specific reference to HIV-carrier status the court in a footnote stated that:

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 . . .

In declaring AIDS a handicap Schumaker (1986) suggests that persons perceived as having AIDS, in addition to those with the actual disease, could find legal refuge in the antidiscrimination law. Those perceived as having AIDS could include those who exhibit AIDS-related illnesses, as well as those who test positive for the HIV antibodies. Legal opinion is mixed (Gianelli, 1987) as to what line of reasoning the courts will take, although the decision in Arline broadens the "scope of Section 504 and advances the view that impairment can arise under circumstances in which . . . treatment of and toward the individual . . . can have a substantial impact" (Beckham, 1986).

The Court was specific in not addressing the carriers issue because the Arline case facts involve a disease that produces both physical impairment and contagiousness--tuberculosis.

In the opinion the Court dismissed the reasoning of the Department of Justice in its memorandum issued in the summer

of 1986. The Justice Department memorandum concluded that the Department of Health and Human Services (HHS) was to be advised that while Section 504 prohibits discrimination based on the disabling effects of the HIV infection it holds no such restriction in any measures utilized to prevent the communication of any communicable disease, including AIDS (EHLR, 1986). Justice William Brennan writing for the Arline decision noted that:

The fact that some persons who have contagious diseases may pose a serious health threat to others under certain circumstances does not justify excluding from the coverage of the act all persons with actual or perceived contagious diseases. Such exclusion would mean that those accused of being contagious would never have the opportunity to have their condition evaluated in light of medical evidence and a determination made as to whether they were 'otherwise qualified'. Rather they would be vulnerable to discrimination on the basis of mythology precisely the type of injury Congress sought to prevent.

The Supreme Court decision in Arline was concerned with the determination of whether tuberculosis was a "handicapping condition." (The question of whether the individual in question was "otherwise qualified" for employment was remanded to the district court for decision.) The general counsel for the American Medical Association, Kirk B. Johnson, said that the major significance of the ruling was its "balancing of the competing interests of the rights of people handicapped by the disease and the rights of their co-workers and others to be protected from communicable disease" (Johnson, in Gianelli, 1987, p. 50).

In the amicus brief presented to the court by the AMA, it is noted that inquiry into the employment of a person handicapped with a contagious disease should include

[Findings of] facts, based on reasonable medical judgments given the state of medical knowledge, about the nature of the risk [how the disease is transmitted], the duration of the risk [how long is the carrier infectious], the severity of the risk [what is the harm to others], and the probabilities the disease will be transmitted and will cause varying degrees of harm.

The guidelines suggested for the inquiry into the determination of "otherwise qualified" for employment include recommendations that may be useful in determining educational placement and policy procedures for children in the public schools with the HIV infection, including fact-finding concerning the nature of the risk to others, duration of the risk, severity of the risk and the probabilities of transmission. The Arlene court established a framework for case-by-case determination "permitting individual analysis based on reasonable medical judgment and reasonable . . . accommodation" (Johnson, in Gianelli, 1987, p. 50).

Voluntary exposure to the risk of acquiring the HIV infection through drug abuse or sexual activities is an issue used by critics opposed to the protected handicap status for AIDS (Schumaker, 1986). While "volunteerism" may or may not be a factor in a proportion of transmission cases, acquisition of AIDS perinatally or via blood/blood product transfusion in no way suggests a discussion of exclusion of the disease as a protected handicap and does little to support

automatic exclusion of children with AIDS. Case law is clearly indicating that an automatic exclusion policy of children with AIDS in the public schools would be viewed unequivocally as a violation of Section 504.

Constitutional Issues Related to Educational Placement of
HIV-Infected Children

The constitutional issues related to the educational placement of children with the HIV infection in the public schools underscore regulations that affect interests fundamental to liberty, privacy, equal protection, freedom of association, and the right to be educated (Harvard Law Review, 1986).

Restrictions on liberty may be imposed if a government's power and need to protect public health are imposed, such as in treatment issues. At the most extreme, restrictions on liberty could involve quarantine of HIV-infected persons. Along the continuum of restrictions, HIV-infected persons could be denied access to public places, including schools.

The individual's right to privacy may or may not be affected by state responses to AIDS and the HIV-infection. Governmental responses fall on a continuum which may include requirements of testing in certain contexts and not in others. State reporting systems may also be at issue depending upon the level of confidentiality that is applied to test

results (Dolgin, 1985). (See further discussion on state responses in Chapter Four.)

In the decision of the court in District 27, the equal protection clause of the 14th Amendment was applied, much the same as in the earlier analogous hepatitis B case of New York Association of Retarded Children v. Carey, to contrast the treatment of individuals with AIDS with the treatment of those with other related conditions of the HIV infection (Weiner, 1986):

Absent any rational basis for . . . exclusion of only known AIDS cases or carriers to the virus, without imposing such exclusion in the case of ARC patients or asymptomatic carriers who are as likely to present a risk of contagion because they too are infected . . . must be . . . a denial of the equal protection of the laws.

(Although medical evidence in the Carey case was later found to be inaccurate, at the time there was nothing to suggest that the risk of injury to others outweighed the harm of exclusion to the students (Weiner, 1986)).

In an analysis of the constitutional issue of equal protection Parry (1986) concluded that the District 27 ruling was correct in applying the rational relationship test to the question of HIV infection, but that it was doubtful that the court's reasoning would "lead the way" for other courts primarily due to the facts of the District 27 case in which the government was supporting the student's interests versus the more difficult cases that involve a government agency opposing the child's inclusion. (Alleged equal protection clause

violations were included in the White v. Western School Corporation suit filed in the summer of 1985.) Application of constitutional rights to situations involving HIV-infectious persons is dependent upon the factual situation presented in each case (Jones, 1987; Dolgin, 1985; Olgin & Wise, 1985).

Medical evidence at the present time strongly suggests that policies of blanket exclusion would not hold up constitutionally since no rational basis for excluding children from public school settings exists, at the present time, unless individual circumstances warrant the exclusion (Harvard Law Review, 1986). Additionally, implementation of an exclusionary policy would probably be "more intrusive than necessary" even "if testing could isolate those who are AIDS carriers" (Parry, 1986, p. 83).

Although the courts have ruled that education is not a fundamental right under the federal constitution (San Antonio Independent School District v. Rodriguez, 1973) the importance of education has been noted in the courts; and following the logic of Brown v. Board of Education, "irrational prejudice" is not a permissible basis on which to rest restrictive state action (Harvard Law Review, 1986).

If a child is excluded from school attendance and relegated to home-bound teaching, then there is no opportunity for association with peers. If a HIV-infected child is handicapped and removal from the classroom takes place, then

a possible violation of least restrictive environment (LRE) may exist.

As noted in District 27 a court may not weigh conflicting opinions and simply substitute its judgment for that of the policy maker. A regulation excluding children from public school when medical and scientific evidence suggests only the most remote of possibilities for transmission in that setting is absent any rational basis for exclusion and would in all probability be deemed a denial of the equal protection of the laws (Harvard Law Review, 1986, p. 1291).

The possible uncertainty of the medical and scientific knowledge concerning the transmission of HIV infection complicates a constitutional analysis of the issues (Orland & Wise, 1986). Responses to the balancing of rights of an HIV infected student to an education against the rights of other students to attend school in an environment free of the risk of transmission of a life threatening disease often represent "a hysterical social reaction, unrelated to the reality of the underlying risk" (Orland & Wise, 1986, p. 151). As noted in the analysis of the District 27 case "it is the real, not the perceived, health hazard that courts must consider" (Harvard Law Review, 1986). The Constitution requires that policies be grounded on decisions based on conceived reasonableness and it is perhaps in no other instance that children in public schools with the HIV infection would be considered less blameworthy. "At the same time, perhaps no other con-

cerns of those calling for restrictions are more understandable than the worries of parents" (Harvard Law Review, 1986, p. 1292).

Accurate medical knowledge should become prerequisite to all government and agency policies and regulations concerning the HIV infection. Timely medical evidence should be at easy access for policy and regulatory reevaluation (Dolgin, 1986). As medical knowledge continues to unfold, justification for infringement upon the fundamental rights of the individual may shift. In the school environment the balance must be made between the rights of property and freedom of association of the individual to participate in school programs weighed against the potential of harm to others in the same environment.

The Education of The Handicapped Act

The application of the Education of the Handicapped Act (EHA) to the educational placement of children with HIV infection has not to this date been judicially addressed in detail (Jones, 1987). As a funding statute EHA grants federal monies to states in return for a requirement of a "free appropriate public education" (20 U.S.C. §1401). Together with the civil rights statute, Section 504 of the Rehabilitation Act, the EHA has been described as "the culmination

of the civil rights movement for handicapped children in the United States" (Stark in Jones, 1986, p. 198).

The purpose of the EHA as stated in the law is:

to assure . . . a free appropriate public education which emphasizes special education and related services designed to meet . . . unique needs, to assure that the rights of handicapped children and their parents and guardians are protected to assist states and localities to provide for the education of all handicapped children, and to assess and assure the effectiveness of efforts to educate handicapped children. 20 U.S.C. §1401.

The EHA while requiring individualized education programs tailored to the needs of the handicapped child encourages placement of children in the least restrictive environment (LRE) to accommodate those needs. The LRE principle in education is the right to placement in an integrated environment not as an absolute right but secondary to the primary purpose of providing an education appropriate to the handicapped child's unique needs (Turnbull, 1986). Mainstreaming is the cornerstone of the LRE provision requiring that to the maximum extent possible handicapped children are to be educated with nonhandicapped children (20 U.S.C. §§1412(5)(B), 1414(a)(1)(C)(iv)). Also contained in the EHA are detailed procedural requirements that include, but are not limited to, provisions for notification of educational change of placement and provisions for administrative hearings and judicial actions by aggrieved parties in matters of dispute in identification, evaluation, or educational placement (20 U.S.C. §1415).

Opinion is mixed as to the application of the EHA to children with HIV infection with determination primarily dependent upon inclusion of HIV infection or AIDS under the "handicapping condition" classification of "other health impaired" 20 U.S.C. §1401(a)(1). The EHA regulations define "other health impaired" as . . . "(ii) having limited strength, vitality, or alertness, due to chronic or acute health problems, e.g., heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes, which adversely affects a child's educational performance" 30 C.F.R. §300.5(b)(7) (1985).

In a 1984 statement, the Assistant Secretary for Special Education and Rehabilitative Services Madeline Will, indicated that: "children with AIDS would be eligible for coverage under the EHA-B if they are evaluated as having one of the handicapping conditions listed in the statute, and in need of special education and related services. Children with AIDS or the HIV-infection could be eligible for special education programs under the category of 'other health impaired'" (Jones, 1987). Not all children, however, would necessarily fall within the EHA definition of "other health impaired," even if special education programming was warranted. Coverage of HIV-infected children is dependent upon state interpretation of the category.

Complicating the issue of eligibility for services under "other health impaired" is the limited attention school programming for chronically ill children has received. Unlike other disabilities covered under EHA, the severity of the condition is applied to eligibility as an "adverse effect test." EHA gives little direction as to how the "adverse effect" test is to measure functional impairment or to what degree the functional impairment must adversely effect the student's learning before special education programming may be warranted (Walker & Jacobs in Hobbs, 1985).

In the District 27 case the court made the decision that EHA was not necessarily relevant:

The pivotal question is whether a child diagnosed as having AIDS would fall within the definition of a 'handicapped child' . . . the term includes those children evaluated as being health impaired who, because of those impairments, need special education and related services. Health impaired is defined as 'having limited strength, vitality or alertness due to chronic or acute health problems . . . which adversely affect a child's educational performance.' Thus, while a child with AIDS could become handicapped as a result of deterioration in his or her condition, the evidence clearly supports the determination that such children are not handicapped for purposes of referral . . . merely because they have AIDS/ARC or are infected with the virus.

The EHA defines "handicap" more narrowly than Section 504 and not all children deemed "handicapped" for purposes of Section 504 will necessarily qualify as "other health impaired" under EHA. A series of questions that may guide determinations for inclusion of a child with AIDS or the HIV infection under the umbrella of EHA include:

- (1) Does the child have a physical condition? The obvious answer to this is yes, although HIV-infected individuals may be asymptomatic.
- (2) Does the physical condition have an adverse effect on the child's education? The answer may be yes or no dependent upon the functional impairment the condition may or may not cause. Additionally, the HIV-infection, while chronic, may cause adverse effects on the child's learning only from time to time and in an inconsistent pattern.
- (3) Does the child need special education? Again, the answer may be yes or no depending upon the severity of the infection, frequency, and intensity of the infection and the accompanying symptoms (Weiner, 1986).

In White v. Western School Corporation the United States district court in Indianapolis ruled in the first of several suits involving Ryan White that the adolescent was to be treated as handicapped under EHA. However, the ruling of the court did not state the specifics as to how it applied to White (Weiner, 1986). Indiana special education law defines "other health impaired" more broadly than the federal definition and in the 1986 decision In Re Ryan White the student was found to have a handicapping condition because he is both a hemophiliac and has AIDS (1985-1986 EHRL Dec. 507:342).

In a 1986 analysis of issues related to the EHA coverage of children with AIDS, Jones discusses the balancing of interests that must take place if children are covered under the Act. While EHA mandates a free appropriate public education requiring mainstreaming where appropriate a balancing of interests must take place between the desire or need of a child with AIDS who is physically capable of attending school

and the potential health risk to others. Jones (1986) suggests that a balancing approach of interests is easily applicable to the educational placement of students with the HIV infection. The difficulty in decision-making is in the parameters of potential harm to others. The question concerning admission to the classroom continues to center on the unconfirmed possibility of transmission. The CDC (1985) provides guidelines on actions that might be considered by a school board or in policy development for certain students that may be at greater risk for transferring the infection: "the infected school-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. . . ."

In McKay v. Board of Education of Anne Arundel County (1985) the court concluded that a child with herpes simplex virus was eligible to attend school when he had no active lesions, the lesions were crusted over or they were covered by clothing. As in Carey, Community High School District 155 v. Denz (1984), and Council Bluffs Education Association v. Council Bluffs Community School District (1984) the court in McKay found that when medical evidence indicates slight to minimal risk of transmission, segregation of a handicapped child is not permitted. Consequently, an automatic exclusion policy for a child with AIDS or HIV infection would be difficult to support. Under the regulations of EHA an examina-

tion of a child's status should be completed on a case-by-case basis with a determination to be made as to a particular child's threat to others. If danger to others appears to be present based on competent medical evidence, it is likely that the threat may be sufficient to override the Act's mainstreaming requirements. In a finding of the State of Florida, Division of Administrative Hearings a six year old child infected with HIV and with evidence of AIDS-Related Complex (ARC) was found to be appropriately placed in homebound instruction. Among the determining issues was the child's lack of toilet training potentially increasing the possibility of transmission of the HIV infection to other children as indicated by recommendations of the Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP). The decision was based on the determination of a risk with removal of the child to an appropriate alternative education program (Rosa E. Martinez v. School Board of Hillsborough County). The Martinez case may be one of the first to suggest the increasing significance of the EHA to children with AIDS. Many of the children now infected are very young and the recent Education of the Handicapped Act Amendments of 1986, P.L. 99-457, has earmarked increased authorized federal assistance to states to develop and deliver educational and related services to handicapped children 0-5 years of age.

While the issues raised by the application of the EHA to children with the HIV infection are unresolved, the statutory and regulatory requirements under the Act and the existing judicial interpretations provide guidance for policy and decision-making concerning educational placement issues (Jones, 1987). Children with the HIV infection may have repeated absences from school. Common childhood illnesses may cause complications due to the weakened immunity caused by the virus. Contagious diseases, such as hepatitis or tuberculosis, also compromise the health of the HIV-infected child. Determination as to appropriate placement is essential, especially if the child's health status is in question as to the likelihood of risk to others. Placement decisions under both the EHA and Section 504 must be made by a multidisciplinary team knowledgeable about the child's condition based on varied sources of data concerning the child. Decisions based on education needs and reasonable medical judgments should provide for a setting that is least restrictive to the child and of non-apparent risk to others. For most school-age children the benefits of regular classroom programming outweigh the "apparent nonexistent risk of transmission" to others (Jones, 1987).

Under the EHA an individualized educational program is designed that may include home tutoring in the continuum of services to the child. The educational program must be reviewed regularly to determine the appropriateness of the

placement and whether a change-in-placement may be necessitated depending on the condition of the child (U.S. Department of Education, 1987).

Although state laws may differ as to interpretation on whether the HIV-infected child should be covered by EHA, it is suggested that schools should include in policy determinations information on the responsible agent for the education of these students within the school, be it regular or special education. Recommendations for developing policy suggest that the use of EHA procedures for case-by-case evaluations may provide clarity in the decision-making process. However, in utilizing EHA procedures it is advised to specify whether the use is for convenience or because there is a consideration being made as to the eligibility of the student for special education services (Weiner, 1986).

Summary and Conclusions

AIDS litigation and legislation continues to emerge as a rapidly expanding area of the law. The characteristics of the HIV infection that include the populations at higher risk for the infection have raised a multitude of legal issues. The educational placement of children in the public schools with the HIV infection is only one of many surfacing arenas that include constitutional issues and other federal and state and common law. Of significance to educational place-

ment are the constitutional issues of the equal protection clause of the 14th Amendment, the determination of qualifying handicap under Section 504 of the Rehabilitation Act, and application of the Education for Handicapped Act to children with AIDS or the HIV infection. Not included in this chapter, but of possible significance to admission of children in the public schools are public health laws that determine policy within a state (see Chapter Four). Privacy law must also be considered when framing policy. Disclosure of information on identities of HIV-infected children may constitute a breach of confidentiality (see District 27 discussion).

Students are also protected under the 1974 Buckley Amendments (the Family Education Rights and Privacy Act of 1974). The regulations of the act provide for written parental consent before release of a student's educational and school medical records. Under the stipulations of the Act parents may ask for corrections to be made on misleading records.

AIDS litigation is a high intensity vs. a high volume legal problem (Weiner, 1986). In developing and administering policy, school administrators should develop and maintain open communication with the major policy and rule-makers in the state. AIDS policy direction under state and local laws may be under the jurisdiction of education officials or public health officials. Interagency collaboration is crucial

to concise and accurately administered policy recommendations. A network for resources should be developed for disseminating and implementing new information as it develops.

Sound medical evidence provides the basis for strong supportable policy. CDC guidelines, the American Academy of Pediatrics recommendations, National Education Association, and the Council for Exceptional Children policies represent a number of guidelines and recommendations that provide a basis for arguing that there is minimal risk of exposure to HIV infection in casual settings, such as the classroom.

Report of the Surgeon General's Workshop on Children with HIV Infection and Their Families (1987) recommendations concerning educational issues include suggestions as to placement considerations, suggested criteria for admission to school, team participation, use of testing results, safety precautions, and curricular options. The recommendations are included with emphasis added in areas that concern legal and policy implications:

- 1) There is no evidence that HIV is transmitted by normal casual and nonsexual contact in home, school, day care, or foster care settings. Screening of children for the presence of HIV antibodies for the purpose of attendance at day care centers or school is neither warranted nor recommended. Routine common sense procedures for handling blood and body fluids should be adopted for everyone. The decision to inform others of HIV infection should only be made with the consent of the parent and/or guardian. Although it is ideal that someone in day care or school know that a child is ill, that should not be

a prerequisite for attendance and may not be practical at this time in many communities.

- 2) Existing Centers for Disease Control (CDC) and American Academy of Pediatrics (AAP) guidelines are well done and serve as an adequate resource in most respects. However, the group recommends the following modifications:
 - a) If infected toddlers can safely mingle with peers, that should be so stated. If there is evidence they can transmit HIV infection to each other, that evidence must be clearly presented. We have not seen any data that toddlers can transmit HIV infection. CDC comments on the preschool population are somewhat ambiguous. CDC should reanalyze data or design new studies if existing data cannot be brought to support clearer recommendations one way or the other.
 - b) We do not agree with the Academy's suggestion that an expert panel review toddler admissions to day care. The child's own physician and parents can make a reasonable decision. Community school boards and departments of health may make a panel available if physicians, parents, or teachers request expert advice. The child does have the right of privacy. Doctors should share data on HIV infection with others only upon careful consideration of likely community reaction and with parental consent. This right to privacy extends to a child attending preschool or day care.
- 3) The following are our suggested criteria for admission to school. For children of developmental age three years and up, there is no need for special school admission criteria. HIV-infected children should be permitted to attend school unless prevented from doing so by weakness or poor health. For preschoolers less than age three and for older children developmentally less than an age three equivalent, we suggest a more positive national position. Hedging at the national level may lead to fear at the local level. Again, CDC should reexamine the accumulated data and either make a more positive statement or quickly gather data about transmission between toddlers.
- 4) Under ideal circumstances, the teacher or someone in the school should know the diagnosis and be an

active participant in the team caring for the child. In many communities, however, it may not be possible for the child to attend school in an unrestricted manner if the diagnosis is known. The child has the right, therefore, to have the information withheld from the school. The decision as to whether an immunocompromised child can attend school safely, with the unavoidable exposures to enteric and respiratory ailments, is best left to his own physician and caretaker. Schools need to notify all parents about outbreaks of illnesses such as measles and varicella, which pose a particular threat to immunocompromised children.

- 5) Whenever possible, school systems should be prepared ahead of time by education of staff, parents, and social workers, to accept an HIV-infected child should one be identified. Current hygienic measures are sufficient in most schools and preschool settings, and handwashing facilities always should be accessible. If soap and water are sufficient to clear up blood spills, this should be stated in published guidelines which currently tend to emphasize the need for bleach. Positive hygienic measures should be clearly stated and adhered to consistently.
- 6) Children with HIV infection should share the same curricula as their uninfected schoolmates, including age-appropriate health and sex education. Counseling regarding sexual behavior for HIV-infected adolescents should focus on risk reduction and modes of transmission. There must be age-appropriate education about AIDS for all children: common sense information about body functions in preschool years; counseling about decision making and developing self esteem in elementary school; specifics about risk reduction and transmission before the age when a child begins to experiment with sex and drugs.
- 7) Use of the antibody test in children must be done with prudence and for reasonable clinical cause. The group opposes mandatory testing prior to school attendance.
- 8) Ultimately, it should become possible for AIDS to be considered with neither more nor less emotion than other severe illnesses of infancy and childhood. Key issues of AIDS epidemiology are poorly understood by most segments of society. A concerted

community educational effort should be undertaken. Guidance and education programs developed with Federal support should be directed from national groups to their memberships, including health-care groups, education and parent groups, and social work groups. (U.S. Department of Health & Human Services, 1987)

Determination for inclusion or exclusion of a particular child due to the HIV infection must be made with reasonableness and medical support. Sensible and realistic guidelines based on accurate, current information are necessary.

At the present time there is no evidence that HIV is transmitted by casual contact in the home, school, or day care settings. As noted in the Surgeon General's Report HIV-infected children should be permitted school attendance unless an individual child's health status prevents participation. Policy considerations should include current research and discussions concerning admission criteria for children less than age three or for children developmentally less than an age three equivalent. Additionally, policy development must address the issue of confidentiality for the identified child. Decision-makers should concern themselves with effective policy recommendations that protect the identity of an infected child without compromising the safety of the child and the persons involved with the child's education and primary care in the public school setting.

CHAPTER FOUR

SELECTED STATE PROFILES OF ADMINISTRATIVE POLICY RELATED TO THE EDUCATIONAL PLACEMENT OF HIV-INFECTED STUDENTS IN THE PUBLIC SCHOOLS

The judicial decisions of the United States court system provide the foundation for the establishment of legal precedents. AIDS litigation and legislation has rapidly emerged, primarily at the state level. An excess of 450 bills specifically related to the human immunodeficiency virus (HIV) were introduced in state legislatures in 1987 alone (Lewis, 1987). The legislative activity surrounding the HIV infection and those infected reflects the serious public health concern raised by the virus. State statutes were enacted relating to AIDS as early as 1983. The laws primarily addressed the creation of statewide task forces to provide information and education to the public. Later statutes have addressed AIDS-related topics that include, but are not limited to (1) antibody testing, (2) blood and blood products, (3) confidentiality, (4) employment, (5) housing, (6) informed consent, (7) insurance, (8) marriage, (9) prison population, and (10) reporting (Lewis, 1987; Matthews & Neslund, 1986).

State regulations provide a vehicle by which policymakers may respond to the considerations brought forward by the HIV infection. Regulations, such as state public health department requirements, may carry the force of law and must be considered if relevant to such guidelines and recommendations as educational placement policies for children with the HIV infection.

Decision-makers should be familiar with legislation that may both directly and indirectly affect policy. Informed school personnel provide the impetus for the establishment and continuance of positive, well-developed dialogue among staff, students, parents, and the community.

A majority of AIDS-related legislation such as housing, prison population, and marriage do not directly affect decision-making on educational issues surrounding the child with the HIV infection. Other categories of legislation, such as antibody testing and reporting, may only indirectly affect considerations for the development of policy on educational placement of students with the HIV infection.

Confidentiality issues and legislation related to confidentiality may be relevant and may directly affect public school decisions concerning development of guidelines, recommendations and/or policy. The issue of confidentiality has been raised in state statutes of at least seventeen states prohibiting the release of information contained in (1) confidential research files (California and New York);

(2) public health records containing personally identifying information (California, Hawaii, Indiana); and (3) medical and epidemiological information, including disclosure of test results, maintained by a state agency, health care provider or facility, physician, blood bank, or third-party payee regarding information indicating that a person is HIV-infected (California, Colorado, Florida, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, North Dakota, Oregon, Rhode Island, Texas, and Wisconsin) (Lewis, 1987). Policy considerations concerning the identification of HIV-infected students and disclosure of student identity within the school system must be addressed with pertinent legislation and litigation entertained. (For further discussion, see Chapter Three, District 27 Community School Board v. the Board of Education of New York City.)

A diagnosis of AIDS is a reportable condition in all 50 states, either by statute or administrative regulation. AIDS-related conditions, such as ARC or the presence of the AIDS antibody are reportable under specific conditions in California, Colorado, Florida, Maryland, North Carolina, Rhode Island, Texas, and Wisconsin (Staver, 1988; Lewis, 1987).

The purpose of this chapter is to present descriptive information on the HIV infection compiled from data collected on sixteen states. The descriptions focus on legislation, policies, recommendations, and/or guidelines related to the

educational placement of HIV-infected students in the public schools and are intended to provide information to those decision-makers who are responsible for the development and/or revision of policy on the HIV infection.

The National Association of State Boards of Education (NASBE) (1987) in a preliminary study of fifty states and the District of Columbia noted that, as of the summer of 1987, thirty-nine states had developed policies or position statements on the educational placement of HIV-infected students in the public schools. Recommendations at the state level for the admission of HIV-infected students may be formal or informal guidelines developed to serve as regulation or as a model for district and/or local levels.

State policies or guidelines established within a state may be developed by state health departments, such as the New York State Department of Health policy, or as a collaborative effort between state health and state education departments.

Policy or position statements may be specific to the HIV infection, or may be the expansion of an existing state policy on communicable diseases. Medical and legal issues must be addressed in an attempt to (1) protect the rights of the infected person; (2) protect other students and school personnel in the classroom environment; (3) maintain the individual's right to privacy and medical confidentiality; and (4) provide current, accurate information to students, staff, parents, and the community.

The NSBA (1986) summarizes common components of many of the existing policies, including six elements:

- (1) definition of the disease under consideration and policy response to infected persons;
- (2) identification of the medical and other personnel responsible for the evaluation of infected persons;
- (3) description of the administrative process by which infected students are evaluated for entry, removal, readmission, or contained status in the classroom setting;
- (4) determination of educational arrangements for students with the HIV infection;
- (5) maintaining respect for the infected student's right to privacy; and
- (6) development of procedures for the appropriate hygienic measures to protect against the transmission of the HIV infection. (p. 43)

California, Colorado, Connecticut, Florida, Illinois, Indiana, Maryland, Massachusetts, New Jersey, New York, North Carolina, Pennsylvania, South Carolina, Tennessee, Texas and Virginia were selected for purposes of the study based on criteria that included: (1) high state prevalence rate ($> 5\%$) of Pediatric AIDS (PAIDS) cases based on the total number of reported PAIDS cases identified by current figures from the National Centers for Disease Control (CDC); (2) issue of state and/or local policy statements for educational placement of children with AIDS developed prior to the December 1985 publication of CDC recommendations for the education of children infected with HIV; (3) state antidiscrimination laws and/or state special education laws that reflect broad or

narrow interpretation of federal statutory authority identified in the research for potential legal interest (Matthews & Neslund, 1986; Parry, 1986; Werner, 1986); (4) geographic proximity of the state to researcher to allow for regional comparisons; and/or (5) state court decisions of cases involving communicable diseases and/or sexually-transmitted diseases that held findings analogous to issues involved in the educational placement of HIV-infected students.

Policy statements, state statutes and regulations including antidiscrimination laws, public health laws, and special education laws related to the educational placement issues of children with the HIV infection were investigated. The information utilized in the descriptions was obtained through written request to the (1) Office of the Attorney General; (2) Office of Civil Rights or Human Relations Council; (3) Department of Public Health; (4) Department of Education; (5) Director/Individual(s) responsible for Special Education services; and (6) State Chapter of the American Academy of Pediatrics (AAP) within each of the designated states. Each agency received correspondence specifically related to the expertise of that office. (As an example, a request was made to the Director of Public Health for information related to public health laws pertinent to the educational placement of HIV-infected students in the public schools.) A general request for all available information on the topic within a designated state was sent to the Of-

fices of the Attorney General and the State Chapter Chairpersons for the AAP (see Appendix C).

State descriptions are presented in alphabetical order. Information submitted from each state is delineated with data pertinent to educational placement issues highlighted. The chapter is concluded with a discussion of similarities and differences among the states and an overview of policy recommendations for components related to the educational placement of HIV-infected students in the public schools.

California

While there are no laws or administrative regulations related to educational placement of HIV-infected students in California, a program advisory was distributed by the State Department of Education in May of 1986. The Program Advisory, reviewed for medical accuracy by the California Department of Health Services, contains guidelines that include

- information on the HIV infection and its transmission;
- precautions for the handling of blood and body fluids; and
- suggestions for schooling of students with the HIV infection.

The guidelines were prepared in accordance with recommendations of the CDC and the American Academy of Pediatrics (AAP) which emphasize that

Decisions regarding the type of education and care setting for students diagnosed as having AIDS should be made on a **case-by-case basis depending on the age, be-**

havior, neurological development, and physical condition of the child and the expected type of interaction with others in that setting. These decisions should be made by a team composed of the student's physician, public health personnel, the student's parents or guardian, and a school representative. In each case the rights and benefits of the infected student must be weighed against those of the rest of the school population. (Emphasis added).

The Program Advisory states that the Governing Board of a school district has the legal responsibility of determining placement decisions regarding regular school classes. It is the position of the California Department of Education that due to this responsibility, the Governing Board should be given information that would impact on this responsibility. Procedures for obtaining the information are not suggested. However, it is noted that while having general authority over control of communicable diseases, the local public health officials have no obligation to inform school authorities of the incidence of students infected with HIV. Moreover, state law prohibits the disclosure of the AIDS antibody test results without written authorization of the individual tested.

Guidelines suggest that routine precautions for prevention of transmission should be observed by all school personnel. Schools should not wait until . . . an identified student or adult [is] infected with the AIDS virus before updating their infectious disease prevention techniques. All schools should consider periodically informing parents, students, and school personnel regarding infectious disease

prevention techniques in an attempt to protect the school environment without segregation, discrimination, or stigma.

Through the School Health Programs Unit of the State Department of Education the document, Techniques for Preventing the Spread of Infectious Diseases was updated with an addendum entitled "Guidelines for Educational Services to Children with AIDS." The information was developed with input of the State Health Department Infectious Disease Section and the California Task Force on AIDS to provide information specific to routine precautions to be utilized in the public school setting when injury or accident occurs involving blood or body fluid spills.

School districts in California are encouraged to contact the Department of Education for assistance in developing policy. The Department recommends a team approach with co-operation from state and local medical, health, legal, and educational agencies (see Appendix D).

The California School Boards Association (CSBA) issued an information packet to board presidents and superintendents in the Fall of 1985 in response to immediate needs that schools districts may have encountered related to the issue of AIDS in the schools. Included in the materials were guidelines issued by CDC, materials distributed in the Saddleback Valley Unified School District describing a proactive effort developed in the state, and two sample policy options limited specifically to the issue of admitting stu-

dents with the HIV infection to public school programs. The policy options include procedures for inclusion and exclusion of HIV infected students.

It is the policy of the CSBA to coordinate its efforts with the state education and state health departments. The CSBA Board Policy Services Unit provides information to local school districts on policies, regulations, and other materials related to the topic on an on-going basis.

Sample policy options for Governing Boards to consider were field tested with superintendents in Sacramento County. Separate policy dealing specifically with the HIV infection was not recommended. Incorporating policy language into existing policy was suggested with continuous monitoring of definitive information as it becomes available. Information pertinent to policy concerns included:

- 1) legal rights of students and employees;
- 2) appropriate measures and procedures to minimize risk of transmission;
- 3) curriculum and other materials and resources designed to instruct and inform students, school personnel, and the community; and
- 4) medical updates and/or current research findings on the topic.

California Education Code Section 48211 regarding contagious or infectious diseases excludes children from regular classroom admission if identified as having a contagious or infectious disease. A student excluded from the regular instructional program shall be provided with home instruction in all cases where instruction would benefit the child. San

Diego Unified School District and the School District in Carmel were among the districts that utilized the exclusionary policy educating all HIV-infected children in a non-classroom setting. It is the responsibility of the district "for providing an education to all of the students of the district pursuant to the requirements of the Education Code" (NSBA, 1985, p. 45). When the district was informed of a HIV diagnosis the student in question was removed from the regular classroom and provided an appropriate education in a non-classroom setting. The San Diego policy, as well as the Carmel, California policy, was recently revised to follow a policy of determination on a case-by-case basis reflecting an educated, reasoned approach to the issue.

There is no standardized vehicle for identification of infectious or communicable diseases. In April of 1985 the California Health and Safety Code was amended under Assembly Bill 403 to maintain the confidentiality of blood testing for HIV. Fines for disclosure of information provide between \$1000 and \$5000 for negligently or willfully disclosing information without written authorization. Local district practices of Saddleback Unified School District require that a child with an infectious or communicable disease be exempt from school until a physician verification that the child's condition is not contagious to others. Schools are responsible for notifying the Pupil Personnel Office, and the Assistant Superintendent for Pupil Personnel Services, in turn,

is responsible for notification to the county health department of all confirmed or suspected cases of infectious diseases, including AIDS.

Special Education Law (Education Code Part 30), including California early childhood legislation, may be relevant to educational placements issues of the HIV-infected child if the said child is "adversely affected" due to the onset of AIDS or AIDS-Related Complex (ARC). California Special Education Law does not recognize "other health impaired" as an eligibility category for special services. HIV-infected students unless otherwise qualified are not considered eligible for special education services.

Colorado

The Colorado Board of Education adopted a resolution in October of 1985 concurring with the Colorado State Department of Health and the Colorado Medical Society that school related issues concerning the HIV infection be determined by local school districts on a case-by-case basis. The State Board of Education in instructing the Commissioner to prepare a set of guidelines suggested that the rights of privacy and confidentiality and the welfare of the people of the state be best served by private review. A review of the current medical status and behavioral condition of the student should be made by a panel of individuals, including the attending physician, parents, a district school official, and a public

health official. The local school board is considered the appropriate decision-making body for the actions.

The resolution instructed the Board of Education to explore the legal, medical, and constitutional implications of inclusion in the guidelines of (1) long or short term exclusion of HIV-infected students, (2) the medical evidence on HIV-infected students remaining in the regular classroom setting, (3) AIDS as a handicapping condition to be treated with appropriate staffing and IEP, and (4) local school district liability questions as they relate to the inclusion of HIV-infected students in the regular classroom setting and the safety and welfare of other students.

Recommendations on the education of HIV-infected students adopted by the Colorado State Board of Health are based primarily on CDC guidelines issued in August of 1985. Persons involved in the education of HIV-infected children should respect the child's right to privacy, including maintaining the confidentiality of school records and medical information. Colorado guidelines stress the potential for social isolation that might occur if the child's condition is common knowledge. Persons knowledgeable of the child's condition should be kept at a minimum with a "need to know" status given only to assure precautions in handling accidents or injuries.

While Colorado has no state public health laws that determine the legal boundaries on the educational placements

of public school students with HIV according to Fred Wolf, Director of Sexually Transmitted Diseases (STD)/AIDS Control for the Colorado Department of Health "school board attorneys around the state have argued that these children would be protected under Section 504 of the Rehabilitation Act of 1973 . . . and have counseled their respective school boards to respond accordingly."

Denver Public School policy supports the Colorado State Board of Health and the Denver Department of Health and Hospitals policies which are based on CDC recommendations suggesting case-by-case review. It is the opinion of the City and County of Denver Disease Control Service that medical grounds for barring someone with the HIV infection from attending public school is unlikely under most circumstances.

The Colorado Civil Rights Commission issued a position on AIDS in March of 1986 declaring that AIDS fits the definition of a physical handicap under Civil Rights Statute 1973, Title 24-Article 34-Part 801 (C.R.S. 1973, 24-34-801). The Civil Rights Division was directed to accept charges based on having, or being perceived as having, AIDS as charges of handicap discrimination.

In reviewing the definition of "handicap" the Colorado Civil Rights Commission specifically notes:

- a. AIDS is a serious illness for which there is no known cure, and
- b. that it is debilitating for some period of time, limiting a person's ability to perform major life functions (Rule 60.1 B (1)).

Additionally, the Colorado Civil Rights Commission acknowledges the relationship of AIDS-Related Complex (ARC) to AIDS and considers ARC in the same manner as AIDS.

Connecticut

The State of Connecticut was one of the first states to recognize the need to establish guidelines for the educational placement of children with AIDS and AIDS-Related Complex (ARC). The Department of Education, in conjunction with the Department of Health Services convened a joint task force to explore the legal, social, education, and health issues associated with the provision of educational services. The task force recommended the use of the most up-to-date factual information to be distributed with the guidelines to assist school administrators faced with the problems associated with placement of students and provision of services for students with AIDS and/or ARC.

In 1984 the Connecticut State Board of Education and the Department of Health Services in a combined effort produced two significant policies regarding AIDS: "Prevention of Disease Transmission in Schools" and a "Curriculum Resources Packet: AIDS, Secondary Level." Admission guidelines to determine school placement issues were first published in April of 1985 and revised in May of 1986. The Department of Education brought together thirty-five experts including pediatricians, neurologists, nurses, psychologists, attorneys,

educators, social workers, and parents. Open hearings were announced with community participation encouraged. The task force was concerned primarily with (1) the problems associated with providing education to children with diagnosis of AIDS and/or ARC; (2) legal, social, educational, and health issues; (3) distribution of recommendations that utilize the most recent factual information to assist school administrators faced with the problem of providing education for students with AIDS, ARC; and (4) issues regarding risks of exposure to potential infectious diseases balanced with the prevention of transmitting a number of contagious and/or communicable diseases. The Connecticut guidelines stress the balance between risk of exposure to "opportunistic" diseases with the prevention of transmission of communicable diseases, including the hepatitis-B (HBV) virus.

The guidelines are intended to provide districts with a suggested frame-work on which to develop programs which meet the needs of all children for whom the public schools are responsible. Guidelines for handling body fluids in schools prepared in consultation with the State Department of Health Services are comprehensive and often referenced for use in other locales. New Jersey and North Carolina are among the states that have adopted Connecticut "Guidelines for Handling of Body Fluids in the School" (see Appendix E).

The Department of Education includes in its booklet, Information and Guidelines: Prevention of Disease Trans-

mission in Schools (1986), a model policy for educating students with chronic infectious diseases for local boards of education. "As a general rule, a child with a chronic infectious disease will be allowed, with the approval of the child's physician, to attend school in a regular classroom setting and will be eligible for all rights, privileges, and services provided by law and existing policy . . ." The policy is based on administrative guidelines for providing education to students with AIDS or ARC and addresses conditions including herpes and cytomegalovirus (see Appendix E).

Knowledge of a child's condition should be limited to those with a direct need to know. Those persons (e.g., principal, school nurse, child's teacher) should be provided with appropriate information concerning confidentiality and routine precautions for handling injuries and accidents. Routine and standard procedures for handling accidents or injury at school should be followed by all staff. Blood or other body fluids from any staff or child, including ones known to have chronic infectious disease, should be treated cautiously.

Special education may be warranted based on individual circumstances. Referrals for assessment should be made to the local school district Planning and Placement Team.

Ironically, while Connecticut was one of the first states to publish guidelines recommending admitting children with AIDS the New Haven school system came under attack by

the Connecticut Civil Liberties Union in the fall of 1987 for being the only school system in the state to exclude children with AIDS from the public schools. The superintendent of the New Haven system, despite federal rulings on AIDS as a handicap, has argued that AIDS is a communicable disease and under Connecticut communicable disease law students may be exempt from school attendance (Reed, 1988).

Florida

There are currently no Florida statutes or Florida State Board of Education rules that specifically address the issue of appropriate placement of HIV-infected students. Florida statutes and the State Board of Education give responsibility of educating eligible exceptional students to local school districts. The term eligible exceptional students refers to students who are eligible for special programs. Criteria for eligibility for special programs is defined in State Board of Education Rules. Florida currently has two due process hearings on the issue of the appropriate placement of students with AIDS (Goff, S., Program Specialist, Procedural Safeguards, Bureau of Education for Exceptional Students, personal correspondence, August 4, 1987) (see Chapter Three).

Section 230.23(6)(a), Florida Statutes provide that each school district set admission policies for students entering school. Thus, each school district determines its own policy for the admission of students with the AIDS virus.

The Department of Health and Rehabilitative Services (HRS) has a policy manual containing guidelines for children with HIV infection with regard to general care (Scott, G., Associate Professor of Pediatrics, Division of Infectious Disease and Immunology, University of Miami School of Medicine, personal correspondence, June 30, 1987). School districts may choose to utilize the manual in the development of policy.

The Pinellas County School Board adopted a policy in January of 1987 that calls for the referral of any student who is suspected of having a communicable disease to the parent and/or community health school nurse. The student shall not be allowed to return to school without a written authorization from the Pinellas County Health Department or the treating physician. In the case of a suspected communicable disease which has no known vaccine (such as AIDS or AIDS-Related Complex) a panel of educational and medical professionals shall recommend to the Superintendent on an individual basis the appropriate educational placement and program. The Board reserves the right to determine final placement, including those decisions on appeal from the Superintendent.

Hillsborough County Public School policy includes a protocol for the interdisciplinary team for reviewing cases for HIV-infected students. The interdisciplinary team consisting of representatives from the local health department;

a specialist in infectious disease; representatives from the local school district, including the Director of Exceptional Students; and other participants, e.g., parents, attending physician, and school principal is charged with making appropriate decisions concerning the educational environment for HIV-infected students. The procedures for reviewing cases and the role responsibilities of permanent team members are outlined in the protocol (see Appendix F). Meeting format and post-meeting activities are also included.

The Florida Commission on Human Relations is charged with the primary responsibility of resolving complaints of discrimination. Florida was the first such commission to determine that AIDS met the definition of handicap as defined in the Florida Human Rights Act, Chapter 760, Florida Statutes. The Commission has issued several determinations in both housing and employment complaints.

Dade County, DeSoto County, and Hillsborough County are among those county school districts that have been in legal disputes over segregation and/or exclusion of students from the regular classroom setting (see Chapter Three).

Illinois

The Illinois State Board of Education and the Illinois Department of Public Health issued recommendations concerning the "Management of Chronic Infectious Diseases in School Children" in September of 1986. The administrative guide-

lines were designed to assist local school boards and school personnel in establishing policies and procedures that protect the child's right to an education and the rights of other students to be educated in a safe environment.

The Task Force on School Management of Infectious Disease organized by the Illinois State Board of Education was charged with developing policy concerning the provision of educational services to students with the following chronic forms of infectious disease:

1. Herpes Simplex (HSV)
2. Human Immunodeficiency Virus (HIV)
3. Cytomegalovirus (CMV)
4. Hepatitis B (HBV)
5. Congenital Rubella Syndrome

The school management policy stresses the need to develop a plan before it is needed. In many instances, school districts will be informed of a student with a chronic infectious disease. However some students will be enrolled in schools unaware of their carrier-status. The State Board of Education strongly recommends that school districts establish policies and procedures to reduce the risk of spreading disease, regardless of the presence or absence of a student known to have an infectious disease.

The Illinois State Department of Education Infectious Disease Program (1986) includes 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 consisting of a school medical advisor, school nurse, and school administrator;
- 3) maintenance of routine hygienic procedures; and
- 4) a health education/health counseling program to educate school staff, students, and parents (p. 3).

Legal considerations related to chronic infectious diseases are outlined in the policy noting that children affected with chronic infectious diseases are entitled to a free, appropriate public education in the least restrictive environment. Students who may have chronic infectious diseases do not necessarily require special programming. Each student will be individually evaluated to determine appropriate placements.

Chronic infectious disease policy as developed in Illinois was determined primarily from policy guidelines from other states with policies specific to the HIV infection (see Appendix G).

The maintenance of confidentiality should be assured with information confined to those with a direct "need to know" (e.g., principal, school nurse, and student's teacher). School board meetings to discuss individual students should be closed in accord with the Open Meetings Act of Illinois Revised Statutes (Ill. Rev. Stat.), Chapter 102, par 41 et seq.

Individual evaluation of students known to have chronic infectious diseases will be determined by the school infec-

tious disease team who in conjunction with local, regional, or state health officials, the attending physician, the student, the student's teacher, and the student's parent should convene to establish the most appropriate education program for the identified student.

Special education services or adaptive programming may be considered if the program is necessary to meet the special needs of the individual child (e.g., temporary services in the home or hospital). Each student should be individually evaluated to determine the most appropriate educational placement.

Exclusion from regular attendance may occur if a temporary condition poses a risk of transmission or if the student lacks toilet training, has open sores, or demonstrates at-risk behavior (e.g., biting). "Exclusion from 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." (Illinois Department of Education and Illinois Department of Health, 1986, 5.c.).

State health regulations concerning the removal of children with chronic infectious diseases from school are not clearly defined. The length of time for removal should be determined on a case-by-case basis. Recommended policy requires each student the right to due process in cases of placement disputes between the school system and the parents.

Students who are expected to be out of the classroom for more than 10 school days are eligible for home and hospital programs under 23 Illinois Administrative Code (Sections 226.115 and 226.350 et seq.).

Routine monitoring of all students with chronic infectious disease is the responsibility of the school nurse. The school nurse is considered the most appropriate person to coordinate the school's infectious disease program. Routine and standard procedures for handling accidents and injury should be employed. Procedures for the school management of infectious disease **should be employed at all times when providing care for all students, regardless of infectious status.**

Senate Bill 651 passed by the Illinois General Assembly provides for the designation of AIDS as a reportable condition to the Department of Public Health. It additionally provides that confidentiality of information to assure knowledge of transmissible diseases will remain private and confidential with disclosure restricted under the Illinois Sexually Transmissible Disease Control Act. The Department of Public Health adopted amendments under Title 77 of the Illinois Administrative Code pertaining to communicable diseases, including the reporting of AIDS as a reportable condition (section 690.290).

According to information provided by the Illinois Department of Human Rights, the Illinois Human Rights Act (Ill. Rev. Stat. Chapter 68, Section 1-101 et seq.) gives the

Illinois Department of Human Rights the authority to accept and investigate charges of unlawful discrimination as defined by the Act. Section 1-103(Q) of the Act defines unlawful discrimination to include discrimination against a person because of the handicap. The Department's Interpretative Rules on Handicap Discrimination state, in part, that a physical handicap is a physical characteristic of a person, the history of such characteristic, or the perception of such characteristic by the person complained against that is unrelated to the person's ability to perform the duties of a particular job or position. The handicapping condition must not be transitory or unsubstantial and it must be significantly debilitating.

The Department has determined that AIDS falls within the meaning of "physical handicap" under the Act and the Interpretative Rules.

The Act prohibits discrimination based on "handicap" or "perceived handicap" in four areas: employment, housing, financial credit, and public accommodations. The public accommodations section prohibits discrimination in places of public accommodations and by public officials. In Section 5-101(C) of the Act, a public official is defined as "any officer or employee of the state or any agency thereof including . . . educational institutions and schools."

Officials in public schools are public officials under the Act, and may not discriminate in the provision of services to a physically handicapped student if the student's handicap is unrelated to the ability to utilize and benefit from the services provided. Thus, the denial of entry into a public school because of AIDS, or the perception that a student has AIDS, is unlawful discrimination actionable under the Act if the student is capable of attending school (Molinary, R., Staff Attorney, Department of Human Rights, personal correspondence, July 7, 1987).

Indiana

The first issue of guidelines for HIV-infected students attending school in Indiana was released by the Indiana State

Board of Health in July of 1985. The guidelines were based on Connecticut and Florida recommendations issued by health officials of those states.

Indiana School Board of Health guidelines recommend school attendance of AIDS and ARC children unless exceptional conditions prevail (e.g., biting, open sores, lack of toilet training). Monitoring of childhood diseases occurring in the school should determine necessity of removal of the HIV-infected child when such outbreaks occur. Routine and standard procedures should be followed by staff who may have contact with the HIV-infected child.

The Indiana State Board of Health Executive Board has formed an Advisory Committee on AIDS/ARC. Guidelines concerning educational placement issues will be reviewed and revised by an Advisory subcommittee periodically.

The policy suggests that the school be informed of the presence of the HIV-infected student. Selected school persons (e.g., principal, school nurse, child's classroom teacher) knowledgeable of the child's condition in conjunction with the child's physician, local health officials, and the child's parents should work as a team in determining issues regarding the child's attendance. A child advocate (e.g., school nurse, medical social worker) should be appointed to serve as a liaison with the child's physician, provide educational materials, and be a focal point for questions concerning the HIV infection. School personnel

should be aware of confidentiality requirements. It is essential that the schools and persons involved in the care and education of an infected student respect the student's right to privacy.

Periodic review should occur if a child is removed from the classroom setting. The review should take place as a consultation between the school medical advisor and the child's physician at least once every other month to determine whether change of placement is necessary.

House Enrolled Act 1010 was passed by the Indiana legislature in the summer of 1987. As an amendment to the Indiana Code concerning communicable diseases, 16-1-95 is added as a chapter. Section 6(a) states that

the local health officer may exclude from school a student . . . [with] a communicable disease that poses a threat to the healthy and safety of the school community. The student after exclusion may be readmitted if the local health officer issues a certificate to admit or readmit the student to school. A child may also be readmitted under IC 20-8.1-7-8 section 4(c) if upon the certification of a physician that the child has a communicable disease, but the disease is not transmissible through normal school contacts.

In reference to exclusion of a child from school due to a communicable disease the language regarding removal suggests that a court would rule that the state's significant, if not, compelling, interest in preserving public health would outweigh the student's property interest in attending school. It is the policy of the Indiana School Boards Association (ISBA) that school authorities consider, with advice

of counsel, establishing a formal procedure for suspension (and expulsion) of student with health-related problems. The principal of a local school may consider the health condition as a suspension of 5 days or less and follow due process procedures.

Pursuant to the student exclusion statute (IC 29-8.1-5.5), as amended, a student may be excluded if the student's immediate removal is necessary to restore order or to protect persons on school property. Therefore, it is the opinion of the ISBA that a student with a health problem, that so endangers other students that it calls for immediate removal, could be excluded providing that full statutory due process is afforded, even after the removal has occurred.

It is the policy of the Indianapolis Board of School Commissioners that if a student can profit from attendance, and does not pose a health threat either to himself/herself or the other students and school personnel the student shall be entitled to attend school with the approval of the appropriate public health officer pursuant to applicable Indiana law and to receive educational services appropriate to the individual needs of the student.

The Board of School Commissioners direct local school officials in the Indianapolis district to notify the superintendent or his designee of a student with the HIV infection. A series of specific procedures follow as to

verification of the medical diagnosis, notification of the local health officer and the parents of the infected student.

- a. The parent shall be requested to remove the child with HIV infection until such time that a written certificate to permit school attendance (IC 16-1-9-8) is obtained.
- b. If a parent refuses to agree to remove the child from school, the school principal is directed to initiate exclusion proceedings (IC 20-8.1-5) and suspend the student (IC 20-8.1-5-12).
- c. It may be determined that homebound instruction or other appropriate educational services on a temporary basis be implemented pending determination of school attendance.
- d. If it is determined that the student's condition poses needs which may indicate a change of placement or programming from the regular classroom setting, the committee to review the educational determination will refer the student to the Indianapolis Public Schools (IPS) Special Education Division for evaluation pursuant to Rule 5-1 of the Indiana Department of Education.
- e. In compliance with the Federal Education Rights and Privacy Act (FERPA) the superintendent is to ensure that confidentiality is maintained and only those school officials and teachers with a need to know status be notified of the identity of the HIV-infected child.
- f. Inservice education programs for all school employees should provide information related to routine precautions

for handling accidents and injuries and the general management of body fluid spills.

Maryland

The Maryland Governor's Task Force on AIDS endorsed Department of Health and Mental Hygiene Preventive Medicine Administration recommendations for the education of HIV students in Maryland Public Schools in the fall of 1987. The recommendations were developed with input from state and national authorities in infectious diseases, local and state educators, and other interested parties and adapted from CDC guidelines published in Morbidity and Mortality Weekly Report (MMWR) in August of 1985 (see Appendix H). Maryland Code Annotated, Health-General Article, §18-209 requiring that a health officer within a county give notice of an infectious or contagious disease that "affects or is likely to endanger the health of school children within the county" to the County Board of Education resulted in the development of Department of Education policy (Fink, V., Assistant Attorney General, Deputy Counsel, Department of Health and Mental Hygiene, personal correspondence, August 5, 1987).

There are no statutes or regulations which explicitly prevent children with AIDS from attending school. If a child has a confirmed case of AIDS, the child's condition must be reported to the deputy state health officer (Code of Maryland Regulations (COMAR) 10.06.01.01). The deputy state health

officer is responsible for preventing the spread of communicable disease (COMAR 10.06.01.04A.) To date, Maryland officials have chosen not to classify AIDS as a communicable disease for the purposes of COMAR 10.06.01.04E. This regulation instructs "the principal or other person in charge of any school to exclude from the school any child or other person affected with a communicable disease."

In general, the State Board of Education guidelines recommend that the decision to admit children infected with the AIDS virus to the school setting be made on a case-by-case basis. The policy states that the decision-making team should include the child's physician, the child's parent or guardian, and school personnel from the local education agency and local health department. Three categories of school-age children with the HIV-infection should be considered for exclusion from attending school (1) those who lack control of body secretions; (2) those who exhibit behavioral problems, such as biting; and (3) those with uncoverable, oozing lesions (Fink, V., Acting Principal Counsel, & Klein, Staff Attorney, Office of Attorney General, Department of Health and Mental Hygiene, personal correspondence, December 30, 1987).

The policy also makes provisions for safeguarding the child's right to privacy. **Notification of HIV infected children in the school environment should be done to maximally assist patient confidentiality. It is not necessary**

to notify parents of other school children regarding the HIV status of any child. Routine precautions for the management of accidents and injuries should be a public health priority. As a coordinated activity between the local education agency and the local health department, regardless of whether HIV-infected children are involved, steps should be taken to educate parents, students, and school employees regarding the HIV infection and its transmission.

The Department of Health and Mental Hygiene's (DHMH) Preventive Medicine Administration has additional recommendations regarding chronic carriers of hepatitis B (HBV), herpes simplex (HSV), and cytomegalovirus (CMV) in the school settings. The policies outline general information on the virus, and include procedures for precautions against transmission of communicable diseases that should be implemented in the school setting, where applicable.

An example of local adaptations of Maryland recommended policy is a policy developed by a consortium of nine Eastern Shore counties. The purpose of the establishment of policy is to insure necessary regulations and procedures that (1) identify students; (2) make decisions concerning placement of students; and (3) provide information regarding communicable diseases and modes of transmission.

Recommendations for the Education of Children in Child Day Care and the Public Schools with HIV-Infection in Maryland, the policy developed by the Eastern Shore consor-

tium, and the general policy, information on communicable diseases issued by DHMH are included in Appendix H.

Massachusetts

The Massachusetts Governor's Task Force on AIDS was established in 1983. The Task Force recommended policies consistent with CDC guidelines and the American Academy of Pediatrics (AAP) recommendations based on medical, epidemiological, and scientific evidence to assure that social interaction with people with AIDS is guided by scientific and medical knowledge of the disease and its transmission and is not predicated on fear and ignorance (Massachusetts Department of Health [MDH], 1987).

Among the policies recommended by the Task Force and the Department of Health is a school attendance policy for implementation in school systems through the Commonwealth. Both the Departments of Education and Public Health adopted the Task Force recommendations and jointly issued them for implementation to local school districts (see Appendix I).

Children with the HIV infection should not be excluded from regular classroom settings unless exceptional circumstances prevail (e.g., skin eruptions or weeping lesions). Exclusion may also occur if an outbreak of any illness is in the school setting.

The primary manager of the child with the HIV infection is the child's personal physician. Management includes act-

ing as the "gatekeeper" for the child's attendance in the public school setting. It is the responsibility of the personal physician to report a case of AIDS to the Massachusetts Department of Public Health's Division of Communicable Disease after consultation with the child's family. The school superintendent will be notified by the child's personal physician and will provide assistance in identifying those educational or health care agents with an absolute need to know.

The principal, school nurse, and teacher may be included as persons with an absolute need to know. Notification should be by a process that would maximally assist patient confidentiality. If school authorities and the child's physician are in conflict, the case will be referred to the Department of Public Health for review to determine the permissibility of attendance.

Routine precautions for handling blood or body spills are outlined in the Massachusetts recommendations. Inservice education of school personnel should be made available to ensure the availability of current medical information.

The educational placement of students with AIDS, ARC, or Asymptomatic virus is not recognized as a special education issue by the Commonwealth, unless home tutoring is necessary. If home tutoring is required, the provisions of section 502.7 of Chapter 766 Regulations apply (Biffar, M., Legislative Liaison, Division of Special Education, personal correspondence, July 24, 1987). Under regulations for a home

or hospital program the child's physician specifies the terms of the child's placement and educational program.

Among the local school districts to implement the recommended Commonwealth policy is the Boston Public Schools. The policy provides inclusion in regular classrooms unless the HIV-infected student (1) has open sores that cannot be covered, (2) exhibits inappropriate behaviors, e.g., biting, or (3) has an acute infection that does not allow attendance. In cases where children are unable to attend school, alternative education plans will be developed by the school principal of the school where the infected child attends.

A continuing series of AIDS Fact Sheets developed by the Massachusetts Department of Public Health answering frequently asked questions about AIDS are included in distribution of the policy statements and other AIDS related materials to each Boston Public School, the city-wide Parent Council, and the Home and School Association (see Appendix I).

Under the confidentiality and informed consent requirements of Massachusetts, it is a violation to disclose HIV test results or the identity of test subjects without written informed consent by the parties in question.

New Jersey

In November of 1987, the New Jersey Department of Education adopted a rule regarding the placement of HIV-infected

students in the public schools. The rule provides that children shall not be excluded from school solely due to the HIV infection, unless exceptional conditions warrant such exclusion (New Jersey Administration Code [N.J.A.C.] 6:29-4.4(b)). The conditions which could lead to exclusion include those previously recognized in guidelines issued by CDC. The regulations that specific conditions for exclusion located at N.J.A.C. 8.61-1.1(b) were developed by the Department of Health for the Department of Education (see Appendix J). The rules describe procedures to be followed only in the event of a conflicting opinion on admission status between the child's personal physician and the school's physician relative to the existence of any condition which would lead to a child's exclusion from school. In a 1987 decision the New Jersey Supreme Court upheld state regulations as "thoughtful efforts intended to protect both school children's health and school children's right to an education" (Board of Education of Plainfield v. Cooperman and Board of Education of Washington v. Cooperman 105 N.J. 587 (1987)).

In cases of dispute the district board of education is directed to submit a request to the State Medical Advisory Panel for an admissions ruling. It is the responsibility of the district board of education to demonstrate that the pupil exhibits the behavior or manifests the symptoms deemed justifiable for exclusion contained in N.J.A.C. 8:61-11(b). Pending decisions at either district or local levels the

student in question will be excluded from regular programming. Home instruction is provided from onset of the district's decision to exclude.

School age children in New Jersey are afforded the right to privacy. New Jersey does not require pupils or school personnel to report their conditions to local school districts. If information concerning educational placement is communicated to the school physician of the district that information is to remain confidential. It is not necessary that anyone in the school be notified that an HIV-infected student is present (N.J.A.C. 8:61-1.1(k)). Department of Health regulations concerning the handling of blood and body fluids supports this position in that

All school and day care facilities, regardless of whether pupils or adults with the HIV infection are present, should adopt routine procedures for handling blood and body fluids (8.61-1.1(j)). Additional regulations include a provision for the removal of anyone in the school setting when the individual has weeping lesions or skin eruptions that cannot be covered.

In providing procedures for precautions when handling blood and body fluids the Department of Education in conjunction with the Department of Health distributed guidelines adapted from the State of Connecticut Departments of Education and Health Services "Guidelines for Handling Body Fluids in Schools" (see Appendix E).

While the New Jersey regulations on educational placement of HIV-infected students do not specifically address special education classification due solely to the

HIV-infection, N.J.A.C. 6:28-3.5 determination of eligibility criteria defines "chronically ill" as a health condition which makes it impractical to receive adequate instruction through a regular school program. Chronic illness is defined as a condition such as tuberculosis, leukemia, or other medical disability. The definition for chronic illness may be sufficiently broad as to allow classification of the excluded HIV-infected student as eligible for special education services. If classification as eligibility for special education services is made a stricter standard for "least restrictive environment" may be warranted.

The New Jersey School Boards Association (NJSBA) in a position statement in the Fall of 1985 advocated a policy that removed local boards of education from the decision-making process for policy on HIV-infected students. The NJSBA reasoned that the sheer volume of information on a highly technical issue may overwhelm the non-specialist in the field when the decisions involve a potentially life-threatening illness.

The New Jersey Law Against Discrimination prohibits discrimination at N.J.S.A. 10:5-4.1. The Division on Civil Rights (DCR) guidelines interpret AIDS as a protected handicap under the law. It is the position of the DCR, "overwhelmingly supported by medical and legal authority" that it is an act of discrimination to deny public accommodations to

any individual suffering from AIDS based on that person's handicap.

New York

The New York State Department of Education issued a recommendation in 1985 developed by the Department of Health based on CDC guidelines to school districts urging local districts to review each student's case individually with the appropriate medical personnel and the child's parents to determine whether the child can be accommodated in a normal educational setting without undue risk to himself/herself or to others. No child should be excluded from school attendance solely because the child has been diagnosed as infected with the AIDS virus (Gloeckler, L., Assistant Commissioner for the Education of Children with Handicapping Conditions, personal correspondence, July 7, 1987).

The need for special education is also determined on an individual basis. Children with AIDS are not handicapped under the Education of the Handicapped Act (EHA) merely because they have AIDS or are infected with HIV and do not necessarily require referral to the Committee on Special Education. Only when the education of the child is adversely affected is a referral necessary (District 27 Community School Board et al v. Board of Education of the City of New York 130 Misc. 2d 398; 502 N.Y.S.2d 325 Supreme Court, Queens County, 1986).

In the State of New York a child between the ages of 5 and 21 who has not received a high school diploma has a right to attend the public school in which he or she resides. Nevertheless, New York Education Law §906 provides that a pupil who has symptoms of any contagious or infectious disease be excluded from school. Public Health Law §2101 requires physicians to report communicable diseases. A list of communicable diseases set forth in 10 NYCRR 2.1 does not include AIDS. Nevertheless, a child whose physical condition endangers the health of others may be excluded from public school under the provisions of section 3214(e) of the New York Education Law. Moreover, 10 NYCRR 24.1 requires all cases or suspected cases of AIDS be reported to the Commissioner of Health (Whitney, J. H., Acting Counsel, Counsel and Deputy Commissioner for Legal Affairs, personal correspondence, July 13, 1987).

In an opinion from the Counsel for Legal Affairs of the Department of Education the fact that a student has AIDS is not per se a basis for his exclusion from school pursuant to Education Law §906. Additionally, exemption from attendance as set forth in 8 NYCRR 101 for a student with AIDS would appear inappropriate without sufficient evidence that the student was too ill to benefit from instruction.

The New York State Department of Law was approached by the City Commission on Human Rights for the City of New York on a potential AIDS-related discrimination suit concerning

the removal of a second grader from a private school setting because the child's primary care-taker was dying of AIDS. In a legal analysis of the placement issues the Office of the Attorney General reasoned that Civil Rights Law (CRL) §40 prohibits discrimination in public accommodations and includes schools in its enumeration of covered entities, but does not extend it to disability discrimination. CRL §40-C prohibits discrimination against disabled persons in the exercise of "civil rights" but does not define the civil rights covered. It is the opinion of the Attorney General's office that the wording of §40-C "civil rights" could easily be interpreted to extend to basic activities such as access to education.

The Attorney General can assert authority to challenge removal of child under both Executive Law §63.12 and under the state's parens patriae authority. Although a New York court ruled that automatic exclusion of children with AIDS in public schools may constitute discrimination (see District 27) under the federal Rehabilitation Act, no case has emerged in the context of private schools or under New York's human rights and civil rights laws (Lynn, S., Arriola, E., & Dubin, J., Civil Rights Bureau, Offices of the Attorney General, Department of Law, personal correspondence, July 21, 1987).

New York State School Board Policy

The school board acknowledges lack of expertise in the

issue of educational placement of HIV-infected students. In a policy statement the board supports the Department of Health (DOH) recommendations. It is suggested that decisions as to inclusion/exclusion in regular classroom programs of HIV-infected students be made by the school physician after consultation with the physician who made the diagnosis, the local health officer, and the parents of the student, where applicable. The school board is to determine whether to adopt the recommendation of the school physician. If the school physician recommends that the HIV-infected student be removed from the classroom, a referral should be made to the Committee of Handicaps. The Committee should be responsible for developing an individual educational program and recommending an appropriate placement for the student (New York State School Boards Association, 1986).

New York City Schools Policy

The Office of the Mayor and the Department of Health prepared a Special Report on Acquired Immunodeficiency Syndrome for the New York City Schools. Recommendations from the report include a procedure that suggests physicians for school-aged children with the HIV-infection refer the HIV-infected child for review to a 4-person panel of the New York City Department of Health (NYCDH). The committee will consider the medical, physical, developmental, neurological, behavioral condition of the student and recommend to the

Committee a determination as to placement for the student. A second panel of AIDS experts independently reviewed Department of Health (DOH) procedure and is available for consultation in questions of determination (see Appendix K).

If a student's parent or guardian report that a student may have AIDS, the child should be referred to the school principal and school nurse for medical attention. If, after medical condition, the student is diagnosed as having AIDS, the condition will be reported by the physician to the Department of Health. The child's physician and/or parent may then request the school panel to review the child's status and make a recommendation regarding school attendance and appropriate school placement.

The identity of any student will not be disclosed unless there is a request to the contrary by the parent.

New York City policy outlines four basic reasons for strict confidentiality

- Both state and local laws prohibit the DOH from revealing to anyone the identity of persons with AIDS;
- The more people aware of the identity of the student the greater the likelihood of identification generally becoming known;
- If identity of student with the HIV infection becomes known, he/she may be stigmatized, ostracized and effectively deprived of benefits of a public school education;
- There is no benefit to either the student with AIDS or to other children from revealing his/her identity to anyone within the school system. Any medical supervision needed by the student with AIDS can be effected by his/her treating physician in cooper-

ation with the Department of Health. General precautions should be carried out regardless of whether or not there is a student with AIDS present. [Emphasis added.]

As a result of the 1986 decision in District 27 Community School Board, et al. v. Board of Education of New York City (130 Misc.2d 398; 502 NYS.2d 325 Supreme Court, Queens County) revisions were made in the procedures for review of school children with the HIV infection. Both the review panel and source of referral were questioned in the course of the District 27 case (see Chapter Three for further discussion).

Surveillance data gathered pursuant to the requirements of the State Sanitary Code, 10 NYCRR Part 24, shall remain entirely confidential and shall not be used by the Department of Health to identify school-aged children to be reviewed by the screening panel . . . the panel will review only those children whose parents have notice of the review. . . .

The New York City procedures outline information to be considered by the panel in making placement decisions including social, psychological, developmental, and educational status of the child. It is anticipated that a child presented for review will fall into one of the following categories:

- a. Children who are unable physically to attend school. These children should receive home instruction.
- b. Children with multiple problems (e.g. developmental delay, behavioral disorder, neurological handicaps or inadequate medical care plan). These children should receive:

- i. Specially arranged mainstream educational placement;
 - ii. School-based special education; or
 - iii. In severe cases, home instruction.
- c. Children who have none of the problems specified above. These children should enroll or remain in school in an unrestricted setting (Koch & Joseph, 1986).

Results of the evaluations will be addressed to the Commissioner of Health as recommendations. The Commissioner of Health may accept, modify, or send the case back to the panel for further review. Notification of results to parents and treating physician will be made and a schedule for periodic review arranged at that time.

If the school physician recommends that a student with AIDS be removed from regular instruction, a referral will be made to the Committee on the Handicapped, which will develop an individual education program and recommend an appropriate placement for the student (Koch & Joseph, 1986) (see Appendix K).

North Carolina

In the fall of 1986 the Secretary of Human Resources appointed a 17-member AIDS Task Force to recommend strategies that address AIDS-related issues. The Task Force focus includes AIDS control issues among which are public education, HIV antibody testing, contact tracing, quarantine and isolation, and confidentiality. Legal and ethical implications are emphasized.

Representatives from the North Carolina Division of Health Services, the North Carolina Department of Public Instruction, and the North Carolina School Board Association developed guidelines for managing AIDS in the schools (Department of Human Resources [DHR] & Division of Health Services [DHS], 1987) (see Appendix L).

Temporary removal from the classroom of a child with AIDS or ARC may be made until either (1) an appropriate school program can be made, (2) an appropriate Alternative Education Program approximate to the instruction in the regular classroom can be made, or (3) the child's physician determines that the risk has abated and recommends return to the classroom. An interdisciplinary committee is suggested to best determine placement. The committee composition should include the (1) child's personal physician, (2) teacher who has primary responsibility for the student, (3) school principal or designee, (4) school nurse, and (5) local health director or designee. Additionally, consultation with an infectious disease specialist and the Communicable Disease Control Branch of the North Carolina Division of Health Services is encouraged (DHR, 1987).

Confidentiality must be strictly protected. Division of Health Services guidelines state that "only the principal, school nurse, and teacher should be notified of the child's condition. In this manner confidentiality can be ensured"

(DHS, 1986). (See Chapter Three concerning confidentiality issues contrary to this position.)

North Carolina General Statute 130A-136 requires school officials to report certain diseases, including AIDS (N.C.A.L.-70:07A.0101), to local health departments. Confidentiality is protected by law (G.S. 130A-143), and officials cannot be liable for reporting (G.S. 130A-142). House Bill 458 amendments to the Communicable Disease Law include AIDS as a reportable condition.

The Department of Health Services guidelines for handling body fluids were adapted from "Guidelines for Handling Body Fluids in Schools" published by the Connecticut Department of Education in December of 1984 (see Appendix E).

Children with AIDS may be considered handicapped under special education regulations for "other health impaired" (OHI) in that children with special needs . . . who because of temporary or permanent disability from intellectual, sensory, or physical factors allow for special education services (Walker & Jacobs, 1985, p. 650). (See also North Carolina General Statutes 115C-106 through 150.)

North Carolina General Statutes 168A-1 through 168A-12 delineate the Discrimination of Handicapped Persons-Protection Act and may be considered in policy determinations (Majestic, A., Attorney-At-Law, personal correspondence, August 12, 1987). The Medical Task Force on AIDS at the School of Medicine, University of North Carolina at Chapel Hill and

North Carolina Memorial Hospital issued the general policy guidelines based on the American Hospital Association recommendations on infection control for the management of AIDS (see Appendix L). While the hospital environment theoretically provides conditions at higher risk than the classroom setting the recommendation on confidentiality may be appropriate in considering issues of "need to know" status.

Patient confidentiality and dignity must be preserved at all times. Appropriate precautions can be taken to prevent the spread of disease without compromising patient confidentiality or dignity. The category of Blood and Body Fluid Precautions will be used through out the hospital [and] should never be used to identify those patients.

General guidelines on educational placement of HIV-infected students that encourage education and/or training of all school personnel in routine precautions provides an environment that is conducive to all students and staff safety and provides safeguards against the stigma and the social isolation of students who may or may not carry the HIV antibody.

Pennsylvania

An advisory concerning the provision of education for students with AIDS was prepared by the Department of Education for the Commonwealth of Pennsylvania. The advisory issued in October of 1985 "underscores the rights of the individual to an education and offers ways that an appropriate educational experience may be delivered." Case-by-case

review is stressed with "paramount consideration" given to the health implications of any educational decision.

According to information supplied from the Pennsylvania Department of Education the advisory was the only official communication with local school districts on the educational placement of students with the HIV infection until March of 1987 when the State Board of Education adopted two policies concerning AIDS and ARC. The Board after completing the regulatory process will require school districts, intermediate units and area vocational technical schools to comply with these policies. State Board of Education policy states that it should be the responsibility of each local educational agency to set forth the procedure for the admission and readmission of students who have been diagnosed as having AIDS or ARC.

The advisory (1985) based on CDC recommendations was issued to local districts to provide information on options legally available in making decisions regarding admission and readmission of students with the HIV infection.

Because AIDS has been identified as a communicable disease in limited circumstances, and because children with AIDS are susceptible to infection from other children, local school districts in Pennsylvania should review each individual AIDS case and decide, based on the circumstances of each case, whether the child should be excluded from school and how the educational needs can best be met.

While providing no specific guidelines themselves the Department of Education and the Department of Health provide

assistance concerning policy development on educational placement for local school districts.

The Department of Education advisory outlined three general points for policy consideration, including issues of risk to self and others, followed by a detailed explanation of legal authority relevant to formulating educational policy.

The advisory suggests that the school district identify one administrator as a central contact for handling information related to AIDS policy. This maximizes consistency of policy information and confidentiality requirements. Additionally, the school district is advised to discuss policy considerations with legal counsel. Support of legal basis to policy strengthens the Board's legal claim to having made a good faith decision.

Confidentiality of health records is required under state statute (24 P.S. §14-1409). The administrator responsible for handling information related to the HIV infection should inform only such personnel as is necessary for the student's health and welfare of others. Procedures for determining necessity to inform are not provided.

While acknowledging the right to education for all children the Department of Education summarizes for local school districts the legal educational options concerning decisions about individual students with AIDS.

Excerpts from the Pennsylvania advisory (1985) are included to provide an example of what might be investigated by any local school district in determining policy decisions.

1. Assignment within the school system: Pennsylvania Public School Code (24 P.S. §13-1310) permits authority to the local school district for flexibility in providing that HIV infected students are educated with the regular school population yet in any building or classroom location where the district determine staff, students, and facilities are most sensitive to the well being of the student. Assignment authority is particularly helpful if community reaction to school attendance is more adverse in one area of the district than others.
2. Classification as handicapped students: If an AIDS student is to be handicapped as defined in the Rehabilitation Act of 1973, §504 as amended, 29 U.S.C. §794, but not in need of special education, his or her full participation in the regular education program should be decided based on an evaluation of the reasonable accommodations which the district can make for the student's physical condition.
3. Classification as exceptional and in need of special education: As with any other student, a school district has the authority to determine that an AIDS student should be evaluated for possible classi-

fication as an exceptional student in need of special education. Physical or psychological effects of AIDS in a particular case may be such as to reasonably prompt the parents or district to suggest such evaluation. In this event, the school district has the flexibility of proposing accommodations in the educational program which meet the student's needs while still providing a free appropriate education. Because case by case decision making must be utilized under the special education laws, school officials can propose programs that take into account a wide variety of factual case differences. Additionally, educational programs developed pursuant to such law can be and indeed must be continually reevaluated. Therefore, if the student's physical or psychological condition or behavior changes requiring adaptation or modification changes in the student's educational program, adjustment of the program is possible. Due process protections required by special education laws must be followed (24 P.S. §13-1371, 22 Pa. Code §13.11(d)).

4. Students already classified as exceptional: If a student already classified as exceptional is diagnosed as having AIDS, the district should make its attendance decisions as it would regarding any other

exceptional student (22 Pa. Code §13.4). The district's educational decisions must also be made in the same manner as any other case involving an exceptional student. If a change in educational program is deemed appropriate, due process procedures must be followed (24 P.S. §13-1372, 22 Pa. Code §§13.31, 13.32, 13.32(22), 341.1 et seq.).

5. Creation of special classes or schools for exceptional students: School Districts alone or with other districts, and intermediate units have authority to create special classes or schools to assure that exceptional students receive education. If the psychological or physical conditions of AIDS students warrant, such special classes could be considered (24 P.S. §13-1372).
6. Homebound instruction: Students diagnosed as having AIDS and unable to attend school as determined by a medical examination should be considered for homebound instruction pursuant to local district policies governing homebound instruction.
7. Excusal from school: As with any other disease, school districts can approve a student's absence from school if the parent or guardian seeks such excuse based on the advice of medical or psychological experts treating the student (24 P.S. §§13-1329, 13-1330(2)).

8. Exclusion from school based on health: Exclusions from school based on health reasons are also legally available to school boards. It should be noted that for children with AIDS this could lead to a legal battle between medical experts: the student's experts asserting the disease is nontransmittable in the normal school setting and the school's experts stressing the facts of the particular case and the conflicts and unknowns in current medical theories on AIDS. Although blanket exclusion of all AIDS students based on health reasons does not appear legally sound, the facts in a particular case may still make the exercise of this authority a reasonable approach (24 P.S. §14-1417).
9. Exclusion for reasons other than health: The school board also has authority to exclude a student upon satisfactory evidence of urgent reasons which prevent the student from attending school. The exercise of this authority must be approved by the Department of Education prior to exclusion. In extreme circumstances involving serious threat of bodily injury to an AIDS student or to other students attending the school due to adverse public reaction, this authority might be exercised (24 P.S. §13-1329).

South Carolina

Neither the South Carolina General Assembly nor the State Board of Education has adopted law or policy on the educational placement of children with the AIDS virus. At the present time each local school district in South Carolina has the authority to develop its own policy. The South Carolina Department of Health and Environmental Control (DHEC) has developed "a broadly worded policy statement" concerning admission of HIV-infected students. A copy of the recommendations were sent to each local school superintendent to be used as a guide for school districts in developing a policy position (Shealy, L., Administrative Assistant, Legal Services, Department of Education, personal correspondence, July 15, 1987). The DHEC recommendations follow guidelines developed by the United States Public Health Service, Centers for Disease Control (1985):

The decision to limit the educational setting for any particular child because of medical or behavioral reasons should be made jointly by the child's physician, public health personnel, the child's parent or guardian and personnel associated with the particular school. Decisions should be made on an individual case-by-case basis, weighing risks and benefits to the infected child as well as to others in the school or day care setting.

While identification procedures for HIV-infected students are not suggested, the DHEC notes that information regularly received concerning persons with AIDS or the HIV-infection in South Carolina is maintained with strict confidentiality within the Department, as required by state

law, and will not be communicated to anyone outside the Department, including schools. Personnel aware of the condition of an infected child should be kept at a minimum respecting the child's right to privacy.

South Carolina Code Annotated §44-29-10-210 is the major state statute relative to contagious and infectious diseases. Attendance of pupils with contagious or infectious diseases may be prohibited and may require a health certificate from one or more physicians stating that attendance does not hold a risk to others attending school (S.C.A.C. §44-29-200).

DHEC regulation §61-20 entitled "Communicable Diseases" excludes children with contagious diseases from schools. The term "contagious disease," however, in DHEC regulations refers to any communicable disease that is easily transmitted by direct contact. State regulations do not prevent any city, town, or county from making such health laws as are deemed necessary for preservation of the public health (S.C.A.C. §R61-20).

Richland County School District One (Columbia, South Carolina) developed a policy statement on educational placement of HIV infected students guided by public health recommendations provided by the DHEC and the district's legal counsel. The School Board of Richland County reserves the right to exclude any student from school, if the medical condition of the student represents a significant risk to the physical health of other students or employees. The Board

may choose to provide alternative education for excluded students.

The district policy notes that the administration does not have a system for active identification of an AIDS or HIV-infected student. Information must be voluntary by the child's parent, physician, or both. If identification is made the administration shall:

1. Convene a committee consisting of (a) the district coordinator of health services; (b) a representative of the state DHEC; (c) a physician with expertise in infectious diseases from the district's medical advisory committee; and (d) others, if deemed necessary;
2. Confer with the student's parents and physician;
3. Make a recommendation to the superintendent concerning a placement decision; and
4. After review of material with legal counsel the superintendent shall make a decision on the matter informing the board of the action to be taken by the administration.

Jurisdiction over antidiscrimination complaints are handled by the South Carolina Human Affairs Commission. Section 43-33-520 of the South Carolina Bill of Rights for Handicapped Persons guarantees opportunities to make use of educational facilities. However, the commission is authorized to handle alleged handicap discrimination in employment only.

Definition of "handicapped" person appears in the laws of the state as a person who . . . meets any other definition prescribed by federal law or regulation for use by agencies of state government which serve handicapped persons. In view of the Supreme Court decision in Arline, AIDS would fall un-

der the definition of "handicapped persons" under §2-7-35 of the South Carolina Code of Laws.

DHEC provides no guidelines for routine precautions for handling blood spills or body fluids.

Tennessee

A memorandum entitled Recommended State Guidelines for Dealing with Students with AIDS was issued jointly in April of 1986 by the Commissioner of the Tennessee Departments of Education and the Commissioner of Health and Environment. The guidelines are based on similar recommendations made by the CDC. Local school districts are responsible for drafting their own policies and procedures.

AIDS is a reportable condition in Tennessee. Individuals with AIDS-Related conditions or who test positive for HIV are not reportable. Voluntary reporting to school officials is the only vehicle for knowledge of the child's condition.

While AIDS is a reportable condition the Human Rights Commission (HRC) for the State of Tennessee excluded from the definition of the term "handicap" any disease or condition which is infectious, contagious, or similarly transmittable to other persons; therefore the Commission is not authorized to investigate AIDS related complaints.

School systems in the state have established policies that determine placement decisions be made by a group of in-

dividuals consisting of the child's physician, a public health physician, the school principal, plus various other individuals depending upon the system. The team is to determine if there is any risk to other students or to the student from infections in the classroom setting.

In the foreword to the memorandum (1986) issuing the recommendations the Superintendent for the Department of Education, Robert McElrath notes that

If any school superintendent or director becomes aware that he/she has (or is to have) a student with AIDS, he/she should notify the County Health Department immediately. The County Health Department will notify the Communicable Disease Section of the Tennessee Department of Health and Environment and arrange for an evaluation of the student's hygienic practices and his general condition. . . . After appropriate assessment and consultation, staff from the Department of Health and Environment will meet with appropriate educators and school officials to outline and educate about appropriate precautions and measures to be taken.

Texas

In January of 1985 in a joint administrative letter to Texas school superintendents, the Texas Department of Health and the Texas Education Agency issued recommended guidelines for providing education to students with the HIV infection "intended to provide schools with a framework on which to develop programs to meet the needs of all children. . . ." The recommendations for local school districts were adapted from the State of Connecticut Departments of Education and Health Services "Information and Guidelines" published in

March of 1985 and the Centers for Disease Control (CDC) recommendations issued on August 30 of 1985 (Whitley, 1986).

The guidelines apply to all school-age children known to be infected with the human immunodeficiency virus (HIV), including children diagnosed with PAIDS, AIDS-Related Complex (ARC), or who have tested seropositive for the HIV antibody.

The Communicable Disease Prevention and Control Act (Article 4419b) empowers the Texas Board of Health to establish Rules and Regulations for the Control of Communicable Diseases (25 Texas Administrative Code (TAC)). Section 97.5 refers to diseases that require exclusion from child-care centers and schools:

- a) It shall be the duty of the . . . school administrator, to exclude from attendance any child having or suspected of having a reportable disease [AIDS is a mandated reportable disease under 25 TAC §97.4] until one of the criteria listed in subsection (c) of this section is fulfilled. . . .
- c) All children excluded for the reason of communicable disease may be readmitted . . . as determined by the local health authority . . . attesting to the absence of communicable disease or to their recovery or non-infectiousness.

Thus, the state administrative guidelines addressing admission of HIV-infected students to public schools in the State of Texas state:

As a general rule, the child should be allowed to attend school in a regular classroom setting with the approval of the child's physician. The school nurse should function as (a) the liaison with the child's physician, (b) the child's advocate in the school (i.e., assist in problem resolution, answer questions), and (c) the co-ordinator of services provided by other staff.

The current language of the Communicable Disease Law is considered absolute, as it is directed primarily at preventing diseases spread through respiratory methods, now almost all prevented by vaccination. "The current wording implies that a child with any of the reportable diseases, including AIDS, be excluded but the criteria for the readmission would allow exclusion only in specific situations described in the guidelines" (Alexander, C., Chief, Bureau of Epidemiology, Texas Department of Health, personal correspondence, June 30, 1987).

Under circumstances, as defined by CDC guidelines, where a risk may be posed to the infected student or others consultation between the school nurse and the child's physician should determine whether a risk of transmission exists and the child may temporarily be removed from the classroom until either an appropriate school adjustment can be made, 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. Each removal of the child from normal school attendance should be reviewed by the school medical advisory in consultation with the student's physician at least once every month to determine whether the condition precipitating the removal has changed. Special education programming may be warranted based on individual circumstances with referral made to the Admission, Retention, and Discharge (ARD) Committee within the District.

The Houston Independent School District (HISD) utilized state administrative guidelines in the development of a policy manual for teachers and administrators on Acquired Immunodeficiency Syndrome (AIDS). The document was designed to answer questions related to the history, routes of transmission, epidemiology, risk factors, symptoms of the HIV infection. Additionally, the significance of confidentiality related to HIV issues was addressed.

Under the "Texas Open Records Act" (Article 6252-17a, Vernon's Texas Civil Statutes (VTCS)) certain information is made confidential by state law, including that information which is covered under the Communicable Disease Prevention and Control Act. Physicians and local school authorities are required to report to the local health authority those children attending school who are suspected of having a reportable disease. Procedures for determining exclusion of children from school described previously are followed. However, neither the HISD nor the state administrative guidelines provide a vehicle for disclosure of information to school officials. It is assumed that identified students are reported on a voluntary basis by the joint discussion of the child's parents and the child's attending physician.

While respecting the right to privacy state guidelines recommend that the local health authority serve as intermediary between the parents, child, and attending physician, on the one hand, and school officials and staff on the

other. The recommendations suggest that the identity of the HIV-infected child should be confined to those with a direct need to know. The principal, school nurse, and the child's teacher are suggested individuals that may have a need to be notified. Those persons should be provided with appropriate information concerning such precautions as may be necessary and should be aware of confidentiality requirements. Procedures for communicating information on handling accidents and injury involving body fluids were not included in the material provided.

Routine and standard procedures for clean-up are recommended in the HISD policy based on CDC guidelines as issued in state administrative recommendations.

While information specific to antidiscrimination laws was requested, the Office of the Attorney General and the Department of Human Resources could not supply specifics and referred the request for information to the Texas Education Agency for response.

Virginia

The Virginia Department of Health (VDH) in November of 1985 issued recommendations for attendance in schools and day care settings. While the Virginia Department of Education has not chosen to adopt the Health Department's policy as educational policy it should be noted that the education system in Virginia allows local authorities to be supreme.

"With the exception of those mandated by the State Legislature, almost all education policies are developed by local Boards of Education and are accepted by the state as long as they do not violate Virginia Law or general education requirements" (Zanga, J., Chairman, Committee on School Health, American Academy of Pediatrics, personal correspondence, May 6, 1987).

Contagious or infectious disease is addressed through state law. Virginia Code, Section 22.1-272 requires exclusion from public schools of persons suffering from contagious or infectious disease. Virginia Code, Section 22.1-256 exempts from compulsory school attendance those children suffering from contagious or infectious disease. In an opinion issued by the Attorney General in the Fall of 1985 the responsibility for exclusion of HIV-infected children in public schools is considered a local school decision. School officials are advised, however, that as acknowledged by CDC guidelines admission decisions are best made on a case-by-case basis (Chisick, A., Supervisor of Complaints Management, Department of Education, personal correspondence, August 18, 1987).

In communication with local school superintendents the Superintendent for Public Instruction noted that the Department of Education supports the decisions made by local authority that are "designed to protect the health and safety of students in the public schools, including decisions to

exclude from the general school environment persons who have been properly identified as suffering from AIDS" (Superintendent memos 223,231,19).

Such exclusion should be made pursuant to local school board policy developed after consultation with appropriate medical and legal authorities. In those instances where it is determined that a pupil should not attend a day school program because of a contagious or infectious disease, every reasonable effort should be made to provide homebound instruction for such pupil (Superintendent memorandum 193, September 18, 1985).

As stated in the adoption of CDC guidelines (1985) Virginia Department of Health recommendations for school attendance state:

Decisions regarding the type of educational and care setting for children with HIV infection should be based on the behavior, neurologic development, and physical condition of the child and the expected type of interaction with others in that setting. Decisions should be made using the team approach composed of the child's physician, public health personnel, and the child's parents or guardian. Risks and benefits to both the infected child and to others in the setting should be weighed. For most infected school-aged children, the benefits of an unrestricted setting would outweigh the risks of potentially harmful infections in the setting and the apparent nonexistent risk of transmission.

For some neurologically handicapped children a more restricted environment may be advisable. Eligible handicapped children requiring special education services must be placed in compliance with Virginia Code, Sections 22.1-213 through 221.

A plan for periodic review by the team described above should be established at the time of the initial decision. The periodic review is essential due to the possibility of

change-in-status of a child's behavior and or condition. Hygienic practices may improve as the child matures; likewise, the hygienic practices may deteriorate if child's condition worsens. In both cases reevaluation is necessary to determine admission and/or placement status.

As with procedures for periodic review and maintenance of confidential records, the procedures for handling blood or body fluids as recommended by VDH are outlined from CDC guidelines (see Appendix M).

Conclusions

Administrative guidelines, positions on special education services, civil rights positions, and communicable disease policies related to the educational placement issues of HIV-infected students are illustrated in Table 1. According to information obtained for this study, state administrative guidelines on the education of HIV-infected students are in place in varying degrees in the sixteen states investigated. The administrative recommendations designed to assist local school boards and school personnel in the establishment of policies and procedures that protect the student's right to an education and the rights of other students to be educated in a safe environment were formulated by the (1) State Department of Public Health; (2) State Department of Education; or (3) in conjunction with both Department of Public Health

and Department of Education within each of the designated states.

Nine of the states (Colorado, Florida, Indiana, Maryland, New Jersey, New York, North Carolina, South Carolina, and Virginia) have issued administrative recommendations based on policy directed by State Department of Health efforts. Six of the states (Connecticut, Illinois, Massachusetts, New York, Tennessee, and Texas) issued joint recommendations directed by collaborative efforts of the Department of Education and the Department of Health.

Both California and Pennsylvania issued guidelines in the form of a program advisory prepared by the direct efforts of the State Department of Education within the respective states. Florida has no established recommended procedures for the placement of the HIV-infected student, although the Department of Health and Rehabilitative Services has a policy manual containing guidelines that include general health care procedures that may be utilized in the development of local school policy.

With the exception of New Jersey and Pennsylvania, administrative recommendations for the development of guidelines and/or policy are intended to provide an information source to local school officials as policy concerns are addressed. Local control of policy determinations is stressed. Administrative guidelines in the state of New Jersey carry the force of regulatory law. In 1987 the New Jersey Depart-

Table 1. Guidelines/Positions Related to Policy in Educational Placement of HIV-Infected Students

States Providing Information	Board of Education (BOE)-directed	State Administrative Guidelines Board of Health (BOH)-directed	BOE/BOH cooperative	Civil Rights Position	Communicable Disease Policy	Special Education Position	Other	Curriculum Materials/ AIDS Education
California	X					X		
Colorado		X		X			Denver policy	
Connecticut			X		X	X		X
Florida		X		X		X	Pinellas County Hillsborough County Public School policy	
Illinois			X	X	X	X		
Indiana		X			X	X	Indianapolis Public School policy	X
Maryland		X		X	X			
Massachusetts			X			X		
New Jersey	regulatory status	X		X		X	New Jersey School Board Policy	
New York		X	X	X	X	X	New York City School Board Policy	X
North Carolina		X		X	X	X	Medical Task Force on AIDS School of Medicine, University of North Carolina at Chapel Hill	
Pennsylvania	pending regulatory status							X
South Carolina		X		X	X	X	Richlands County (Columbia)	
Tennessee			X	X				
Texas			X		X	X	Houston	
Virginia		X			X	X		

X = existing document(s)

ment of Education adopted a rule regarding the procedures for placement of HIV-infected students in the schools. The New Jersey School Boards Association (NJSBA) issued a position statement in 1985 advocating state board of education control for policy-making decisions on the education of the HIV-infected student based on the reasoning that the sheer volume of information on a highly technical issue may overwhelm the non-specialist in the field when the decisions involve a potentially life-threatening illness.

The Pennsylvania State Board of Education adopted two policies concerning AIDS and ARC in March of 1987. After completion of the regulatory process the Board will require school districts, intermediate units, and area vocational technical schools to comply with these policies.

CDC recommendations were utilized by all states formulating policy. Eleven of the states (California, Colorado, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, South Carolina, Tennessee, Texas, and Virginia) based policy directly on recommendations published by CDC and/or the AAP. Indiana adopted Connecticut guidelines on the education of the HIV-infected student. The guidelines provide a suggested framework that stresses the balance between the risk of infection from "opportunistic" diseases to the student with the prevention of transmission of a communicable disease. The Connecticut guidelines first published in April of 1985 parallel guidelines published by CDC in August of 1985.

Nine of the states have established civil rights positions on the HIV-infection, AIDS, and/or communicable disease. Table 2 references rules and regulations that apply within each of the states (Colorado, Florida, Illinois, New Jersey, New York, North Carolina, South Carolina, Tennessee, and Texas).

Communicable disease policy and/or laws are in place in eleven of the states investigated (California, Illinois, Indiana, Maryland, Massachusetts, New York, North Carolina, Pennsylvania, South Carolina, Texas, and Virginia). As is noted in the individual state descriptions, communicable disease policy is often reflected in policy statements on educational placement issues of HIV-infected students. The state policies and/or laws represent varying positions related to the definition of AIDS or the HIV-infection as a communicable disease. While exclusion of teachers and students with communicable diseases is required under specific state public health regulations, a state may choose to exclude AIDS or HIV-infection from definition as a communicable disease (see New York State regulations (10 NYCRR 2.1) excluding AIDS from the list of communicable diseases).

Information gathered on the special education positions within a state related to the educational placement issues of HIV-infected students indicates that, in general, HIV-infection is not a special education issue unless the nature of the infection adversely affects educational per-

Table 2. A Description of Guidelines/Positions Related to Policy in Educational Placement of HIV-Infected Students

	Administrative Guidelines	Civil Rights Position	Communicable Disease	Special Education Position
California	Program Advisory issue by Department of Education with review by Department of Health	.	California Education Code 48211 excludes children from regular classroom admission if identified as having a contagious or infectious disease.	California Special Education law does not recognize "other health impaired" as an eligibility category for special services. California Early Childhood legislation (Education Code Part 30-Chapter 4.4) may apply if HIV-infected child "adversely affected" due to onset of AIDS or ARC.
Colorado	Board of Education resolution concurring with State Department of Health recommendations	Colorado Civil Rights Commission position 1973 24-34-801 Rules 60.1 notes that AIDS fits under definition of a physical handicap in that it is debilitating and limits the person's ability to perform major life activities.		
Connecticut	Joint Task Force of Department of Education and the Department of Health Services			Special education may be warranted based on individual circumstance with referral to local Planning and Placement Team.
Florida	Department of Health and Rehabilitative Services policy manual	Florida Commission on Human Rights determined that AIDS meets the definition of handicapped as defined by Florida Human Rights Act Chapter 760, Florida Statutes.		Education of exceptional students under local authority as defined by State Board of Education rules.
Illinois	Department of Education/Department of Health joint issue of chronic infectious disease policy.	Illinois Human Rights Act (Ill. Revised Statute Chapter 68, Sec. 1-101 et seq. gives the Illinois Department of Human Rights (DHR) authority to investigate unlawful discrimination. Sec. 1-103(Q) defines unlawful discrimination to include discrimination because of a handicap. DHE has determined AIDS falls within the meaning of "physical handicap" under the Illinois Human Rights Act.	Senate Bill 651, Illinois Administrative Code, Title 77 Sec. 690-290 pertains to reporting confidentiality of information under Illinois Sexually Transmitted Disease (STD) Act.	Special Education may be considered if temporary service in the home or hospital are considered under 23 Illinois Administrative Code 226.115 and 226.350 et seq. Students who may have chronic infectious diseases do not necessarily require special programming.
Indiana			Indiana Code (IC) 16-1-95 Chapter 16-83 Section 6 excludes student with a communicable disease that poses a health threat to others. A child may be readmitted under I.C. 20-8.1-7-8 section 4(c) if communicable disease is not transmissible through normal school contacts.	If it is determined that the student's condition poses needs requiring a change of placement or programming, the student should be reviewed or review for special education under Rule 5-1 of the Indiana Department of Education.

	Administrative Guidelines	Civil Rights Position	Communicable Disease	Special Education Position
Maryland	Maryland State Department of Health and Mental Hygiene Preventive Medicine Administration recommendations were endorsed by Maryland State AIDS Task Force for the education of HIV-infected students in the Fall of 1985 and include recommendations that present procedures to the transmission of Communicable Diseases in Groups in Developmentally Delayed Children/Youth in the School Settings.	Maryland Code Annotated Health-General Article, §18-209 requires that a county health officer give notice to the presence of an individual with an infectious or contagious disease that "affects or is likely to endanger the health of school children. Code of Maryland Regulations (COMAR) 10.06.01.02 requires the reporting of AIDS to county health officers. COMAR 10.06.01.04E instructs "the principal or other person in charge to exclude . . . any child with communicable disease. To date, AIDS has not been classified as a communicable disease for purposes of reporting.		
Massachusetts	Joint issue of Department of Education and the Department of Health recommendations based on Governor's Task Force on AIDS recommendations-- local adoption strongly recommended.	Confidentiality and informed consent requirements required under Massachusetts law G.L.C. III §707 (1986 ed.)	Special education services required if home tutoring is necessary under provisions of Chapter 766 Regulations §5027 of Commonwealth Code.	
New Jersey	New Jersey School Board Association (NJSBA) position statement advocated policy of removal of local controls in the decision-making process for HIV-infected students.	New Jersey Law Against Discrimination prohibits discrimination under N.J.S.A. 10:5-4.1.	determination of eligibility defines "chronically ill" as a	N.J.A.C. 6.28-3.5 health condition which makes regular classroom placement inadequate.
New York	New York School Boards Association policy.	Civil Rights Law §40 prohibits discrimination in public accommodations; §40C prohibits discrimination against "disabled persons" in the exercise of "civil rights" (may be interpreted to extend to basic activities such as access to education).	New York Education Law §906 excludes students with communicable diseases from public school settings; 10 N.Y.C.R.R. 2.1 does not include AIDS as a communicable disease; 10 N.Y.C.R.R. 24.1 requires reporting of AIDS to Commission of Health; N.Y. Education Law 3214(3) excludes from attendance a student whose physical condition is of danger to others.	School Board policy recommendations suggest that if a child is excluded from classroom based on recommendations of student's physician, a referral should be made to Committee of Handicapped for development of IEP and appropriate placement.
North Carolina	North Carolina Division Health Services recommendations developed by Task Force representatives from Division of Health Services, North Carolina Department of Public Instruction; North Carolina School Board Association Guidelines for Day Care; established guidelines from Connecticut Department of Education.	Discrimination of Handicapped Persons Protection Act N.C. 6.5.168A-1 through 168A-12 prohibits discrimination of protected persons.	North Carolina General Statutes Chapter 130A/House Bill 458 requires the inclusion of AIDS as a reportable condition. Confidentiality is protected by General Statutes 130A-143.	North Carolina Special Education General Statutes 115C-106 through 150 may apply to children with AIDS who may be handicapped under special education classification for "other health impaired."

	Administrative Guidelines	Civil Rights Position	Communicable Disease	Special Education Position
Pennsylvania	State advisory program pending regulatory status.		24 Pennsylvania Public School Code §14-1409 requires confidentiality of health records.	Case-by-case determination of special education need is outlined in Pennsylvania Public School Code outlined in advisory.
South Carolina	South Carolina Department of Health Environmental Control (DHEC) recommendations issued a policy statement concerning admission of HIV-infected students.	Bill of rights for Handicapped Persons §43-33-520 et seq. South Carolina Code of Laws of Laws of 1976, as amended §2-7-35 defines handicapped person any individual who meets the definition prescribed by federal law or regulation. In view of Supreme Court decision in <i>Arline AIDS</i> falls under definition of handicapped person.	DHEC regulation §61-20 §15-24 Rules/Regulation DHEC Control (Communicable disease) and 1976 S.C. Code of Laws §44-29-200 exclude teachers/ students with contagious diseases from public school setting and may require certification from 1 or more physicians that attendance is no longer a risk to others.	No inclusion of "other health impaired" as "handicapping condition" under Special Education regulations §1976 S.C. Code §5-9-33-20.
Tennessee	Joint administrative memorandum of the Department of Education and the Department of Health and Environment entitled <i>Recommended State Guidelines for Dealing with Students with AIDS</i>	Tennessee Human Rights Commission (HRC) excludes contagious, infectious, or communicable conditions from definition of handicap.	Not considered/recommended.	
Texas	Joint administrative letter to Texas school Superintendents issued by the Texas Department of Health and the Texas Education Agency.	Office of Attorney General and Department of Human Resources referred request for information to Texas Education Agency.	State guidelines on HIV-infection patterned after guidelines HBV infection issued under Communicable Disease Prevention and Control Act (Article 4419b) §3.06. AIDS is a mandated reportable disease under 25 Texas Administrative Code §97.4.	Referral to Administrative Review and Dismissal Committee (ARD), if warranted. No separate provision for special education service.
Virginia			Code of Virginia Sections 22.1-256[1], 22.1-272 excludes pupils with a contagious or infectious disease from school attendance	Virginia Code Sections 22.1-213 through 22.1 require special education services to eligible handicapped children.

formance. Seven states (Massachusetts, New York, North Carolina, Pennsylvania, South Carolina, Texas, and Virginia) provided specific information related to the state special education positions. The remainder of the information gathered from state responses indicated that no special education position was deemed necessary in the case of HIV-infected students. Table 2 notes positions specific to special education programming, as in the Commonwealth of Massachusetts where home tutoring is considered a special education service. In New York State the school board policy recommends that if an HIV-infected child is excluded from the classroom based on a recommendation by the attending physician, the student must be referred to the Committee on the Handicapped for development of an individual education program and an appropriate placement for the student.

Common components of the state administrative policy recommendations investigated are illustrated in Table 3 and parallel components summarized by NSBA previously referenced in this chapter. State admission policies on educational placement of HIV-infected students utilize CDC recommendations that state

Decisions regarding the type of educational and care setting for HIV-infected children should be based on the neurological development, and physical condition of the child and the expected type of interaction with others in that setting.

Composition of review panels differs minimally among states with representation generally following CDC recommen-

Table 3. State Administrative Recommendations and Guidelines on Educational Placement of HIV-Infected Students--Policy Components

States providing Information	Admission policy a. policy response to infected persons b. eligibility criteria	Review Panel	Confidentiality	Routine Precautions
California	CDC/AAP based criteria	*CDC recommendations include representation to include the child's physician, public health personnel, and the child's parent or guardian. *CDC recommendations on confidentiality note that the child's right to privacy should be maintained, including confidentiality of school records and medical information.	Schools are responsible for notifying the Public Personnel Office of confirmed or suspected cases of infectious disease. Knowledge of child's condition should be limited to those with a direct need to know (e.g., principal, school nurse, child's teacher)	Usage of procedures for handling blood and body fluids should be followed by all staff (open usage policy).
Colorado	CDC-based criteria	Attending physician, parents, public health official, a district school official.	Persons knowledgeable of the child's condition should be kept at minimum to ensure the child's right to privacy.	
Connecticut	Criteria parallels CDC recommendations.			Open usage policy on routine precautions.
Florida	No state policy.			
Illinois	Chronic Infectious Disease policy based on CDC/AAP recommendations based on Connecticut policy.	Infectious Disease Review Team consisting of a school medical advisor, school nurse, and school administrator.	School board meetings to discuss individual students must be in accordance with the Open Meetings Act (Illinois Revised Statutes, Chapter 102, par. 41 et seq.); "need to know" basis.	Open usage policy on routine precautions.
Indiana	Adoption of Connecticut guidelines.	Periodic review (once a month). Team composition to include principal, school nurse, child's classroom teacher, child's physician, and local health officer.	Appointment of child advocate to serve as a liaison for parents, school, and others. "Need to know" status.	

States providing Information	Admission policy a. policy response to infected persons b. eligibility criteria	Review Panel	Confidentiality	Routine Precautions
Maryland	State of Connecticut/ CDC based criteria	Child's physician, parent, CDC guidelines with approval of local education agency (LEA) personnel, superintendent.	Local health department notification to maximally assist patient confidentiality.	Public health priority regardless of whether HIV-infected children are involved--Open Usage policy (see General Guidelines for Minimizing the Transmission of Communicable Diseases on Groups of Developmentally Delayed Children/Youth in School Settings policy for HSV/HSV/CMV).
	As a general rule, the child 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.	Review by school medical advisor once a month to determine appropriateness of placement if a precipitating change of condition. School nurse as liaison.	Direct "need to know" status (e.g., principal, school nurse, child's teacher).	Removal of child, if necessary (e.g., cases of chicken pox within school population).
Massachusetts	CDC/AAP-based criteria	Personal physician as case manager for HIV-infected student. Management includes acting as "gatekeeper" for the child's attendance in accordance with recommended policy.	'Need to know' status (e.g., principal, school nurse, teacher).	Inservice of school personnel as availability of information occurs.
New Jersey	New Jersey Administrative Code 8:61-1.1(b)/CDC-based criteria.	Referral *State Medical Advisory Panel if conflicting opinions of school physician/treating physician on child's placement.	N.J.S.A. 26:4-2 information reported to Department of Health (DOH) to access subjected by DOH for public health purposes only. N.J.A.C. 8:61-1.1(R).	Connecticut guidelines--open usage policy.

States providing Information	Admission policy a. policy response to infected persons b. eligibility criteria	Review Panel	Confidentiality	Routine Precautions
New York	CDC-based criteria	"Blind" panel consisting of child's physician, local health officer, child's parents, if applicable; requires only the principal, school nurse, teacher).	Strict confidentiality--No "need to know" status available; requires suspected cases of AIDS reported to Department of Health.	Open usage policy (see N.Y.C. policy).
North Carolina		child's physician, child's teacher, school principal, school nurse, local health director, communicable disease specialist/Department of Health Services representative.	Guidelines to insure confidentiality	Adoption of Connecticut guidelines on routine precautions.
Pennsylvania	CDC-based criteria		Confidentiality of health records is required under 24 P.S. §14-1409.	
South Carolina	CDC-based criteria	Child's physician, public health personnel, child's parent or guardian, building personnel.	Department of Health and Environmental Control (DHEC) does not release information reportable to DHEC.	No specific guidelines for precautions/handling of blood spills.
Tennessee	CDC-based criteria	*		
Texas	... includes children with AIDS as defined by CDC for reporting purposes, ch. who are diagnosed by their physicians as having an illness because of infection with HTLV-III/LAV but do not meet the case definition, and children who are asymptomatic but have virologic or serologic evidence of infection with HTLV-III/LAV.	School nurse as (a) liaison with child's physician, (b) the child's advocate in in school, (c) coordinator of services provided by other staff.	"Need to know" status (e.g., principal, school nurse, teacher).	No procedures outlined.
Virginia	CDC-based criteria	*	*	*Adoption of Connecticut guidelines

dations that suggest including the child's physician, public health personnel, and the child's parent or guardian.

State policies differ as to the issue of "need to know" status for school personnel. While confidentiality and the individual's right to privacy is stressed in state policy, determination of those with a direct need to know may differ at local levels, as in New York where both state and New York City policy and law prohibit the Department of Health (DOH) from disclosing to anyone the identity of persons with AIDS noting that "there is no benefit to either the student with AIDS or to other children from revealing his/her identity within the school system" (see New York City Policy).

California, Connecticut, Illinois, and New York policy recommendations advise that routine precautions for prevention of transmission of infectious disease be observed by all school personnel, regardless of infectious status.

Local education agencies have the primary responsibility for establishing policies and procedures for educational placement of HIV-infected students. Individuals responsible for policy decisions should be familiar with state and national trends that may both directly and indirectly affect policy. Informed school personnel provide the basis for strong, sound policy decisions that reflect the needs of students, staff, parents, and the community.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to examine medical and legal aspects pertinent to the educational placement of children in the public schools with human immunodeficiency virus (HIV) infection. The study attempts to provide information that will serve as a resource to public school personnel who are among the professionals that must make informed decisions on public school attendance policies for students with a lethal, complex, and controversial disease. School officials are placed in a position of balancing the duty to protect the health and safety of the students and the duty to protect the school system from litigation based on alleged violation of individual student rights.

New developments in medicine and in the courts have crucial implications for existing policies and for the development of new policies related to the issue. By examining precedents and patterns in the emerging area of AIDS litigation and legislation, the study provides an information source for school officials enabling them to make informed proactive decisions.

Decision-makers should be familiar with medical evidence and legal issues that may both directly and indirectly affect

policy. Informed school personnel provide the impetus for the establishment and continuance of positive, well-developed dialogue among staff, students, parents, and the community.

Primary and secondary sources of law were utilized in the legal research. Nonlegal research materials were employed including medical research and data that might serve as evidence in legal disputes concerning the educational placement of children with the HIV infection.

The study was designed to answer the following primary research questions:

1. What are the medical aspects that should be considered concerning the educational placement of students in the public schools with the HIV infection?
2. What are the legal aspects that should be considered concerning the educational placement of students in the public schools with the HIV infection?

Secondary research questions attempt to answer the following:

1. Is a student with the HIV infection considered "handicapped" under the Education of the Handicapped Act (EHA) and its implementing regulations?
2. Is a student with the HIV infection considered "handicapped" under Section 504 of the Rehabilitation Act of 1973 and its implementing regulations?

3. Is AIDS a "communicable disease" in any way meaningful to the medical and legal issue of the educational placement of HIV-infected students?

4. What are the current court rulings on the educational placements of HIV-infected students?

The study was organized to include (1) medical evidence that supports decision-making policies on admission or exclusion of HIV-infected students in the public schools; (2) an examination of state antidiscrimination laws, state special education laws, state communicable disease laws, and state and selected local policy statements in sixteen states; (3) an analysis of the relevant legal issues of the Education of the Handicapped Act (EHA), Section 504 of the Rehabilitation Act of 1973, and constitutional issues pertinent to educational placement of HIV-infected children; and (4) case law "in point" or "analogous" to the issue addressed.

The purpose of Chapter Two was to address the medical aspects related to the HIV infection in the adult population and in infants, children, and adolescents with emphasis on the medical considerations pertinent to educational placement of HIV-infected students in the public schools.

According to this research there is no medical evidence to support the exclusion of children from regular school attendance based on suspicion of or identification of the HIV infection. However, in presenting medical evidence for the establishment of policy in educational decision-making, it

must be stressed that the nature of the information is dynamic. Individuals involved in and responsible for policy decisions must keep abreast of new developments as they are reported, in order to provide accurate information and knowledgeable leadership. The Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP) recommendations on school attendance provide guidelines that suggest that some HIV-infected students may pose a greater risk than others and a more restrictive environment may be warranted for those students. Sound medical evidence provides the basis for strong, supportable policy. CDC and AAP guidelines and recommendations provide a basis for arguing that there is minimal risk of transmission of the HIV infection in casual settings, such as the classroom.

In 1987, the Report of the Surgeon General's Workshop on Children with HIV Infection and Their Families issued recommendations that support the existing CDC and AAP guidelines as adequate resources in most respects. Modifications are suggested as they relate to the preschool population. The recommendations are reproduced in Chapter Three of this study. In the Report it is noted that:

It should become possible for AIDS to be considered with neither more or less emotion than other severe illnesses of infancy and childhood. Key issues of epidemiology are poorly understood by most segments of society. A concerted community effort should be undertaken. (Recommendation 8)

Well-informed school officials responsible for policies and procedures on educational placement are in the best position to educate and inform parents, children, and staff on this issue that is often misunderstood. Awareness of sound medical evidence to support educational decision-making provides a means of projecting solid grounded information to the school population and community at large.

Schools need no special precautions to protect others in the environment from possible transmission of the virus with the exception of the adoption of routine precautions for handling blood and body fluids in cases of accident or injury. State of Connecticut guidelines are included in Appendix E as an example of health care procedures that are necessary to provide effective precautions against transmission.

The need for further study in the area of medical aspects related to educational placement issues of HIV-infected students include efforts to isolate the unique needs of the high risk groups specific to childhood and adolescence, such as the sexually abused and/or the substance abuser. Adolescents represent a unique subset of individuals whose specific needs must be addressed in communicating the circumstances surrounding transmission and contraction of the virus. Additional needs for study include the implications of the disproportionate numbers of urban and minority children and adolescents infected with or at-risk for transmission of the

HIV infection and the impact the spread of the virus will have on these groups, medically and educationally.

AIDS (and the HIV infection) is a topic of medical, legal, social, economic, and educational speculation and concern. The educational decision-maker must be knowledgeable in communicating strong reasoned policy in educational issues concerning this issue. A network of resources should be developed and a vehicle in place for disseminating and implementing new information as it develops.

Chapter Three introduces emerging legal issues presented by the AIDS controversy with primary focus on the aspects of educational placement and provision of services for children in the public schools with the HIV infection. Of significance are the constitutional issues of equal protection and right to association, the determination of qualifying handicap under Section 504, and the application of the Education for Handicapped Act (EHA) to children with AIDS or the HIV infection.

To date the courts have generally held that children with the HIV infection should be permitted access to public school unless public school attendance is contrary to medical advice. Case-by-case determination on attendance issues has been clearly indicated as paramount to the decision-making process. As a singular handicapping condition HIV-infection is a medical, not an educational issue. Decisions to place must be based on medical evidence that balances the risk to

the infected student with the health and safety of others. Exclusion may only be considered as an option for HIV-infected students when reasonable medical evidence suggests removal from the normal classroom setting is necessary due to risk to the infected student or to others in the school environment.

The issue of confidentiality has been addressed in the courts. However, as in the District 27 case the court has not reached the issue of who, if anyone, should be informed of the identity of an HIV-infected child. Additionally, in District 27 the court noted that CDC recommendations provided little guidance on the issue of whether anyone within the school should be informed. School policies and school personnel arguments for disclosure as a precautionary safeguard are not consistent with medical evidence that suggests routine safety procedures as effective in preventing transmission of HIV infection. The decision of whether or not to disclose the identity of the child is most appropriately placed with those responsible for the protection of the child's health, the parents and the treating physician. The potential harm resulting from the disclosure of the identities of children with the HIV infection to school personnel, at the present time, continues to outweigh the possible benefits the disclosure may have. Future study to address confidentiality is warranted. A comparison of attitudes and perceptions between school personnel in districts that have

direct need to know policies for all individuals responsible for the education of the HIV-infected student and those who have strict confidentiality with complete anonymity is suggested as one measure to evaluate the degree of stigma and fear that may be associated with the issue.

Federal judicial interpretations support the content that AIDS and the continuum of illnesses known as the HIV infection qualify as a protected handicap under Section 504 of the Rehabilitation Act (see Arlene discussion in Chapter Three) indicating that an automatic exclusion policy of children with the HIV infection from public schools would be viewed as a violation of Section 504 and its implementing regulations.

The EHA defines "handicap" more narrowly than Section 504 and not all children deemed "handicapped" for purposes of Section 504 will necessarily qualify as "other health impaired" (OHI). AIDS (and the HIV infection) may or may not be considered as a "communicable disease" under state law; and may or may not be considered "OHI", dependent upon state definitional criteria.

For most purposes of the programming under the Education of the Handicapped Act (EHA), children with AIDS or with the HIV infection are not educationally handicapped merely because of the illness. The status of the child in regard to special programs depends upon the ability to perform in the regular classroom without adverse effects. If it is deter-

mined that the HIV-infected child requires special education services, EHA regulations apply. Although the EHA recognizes that not all children can be placed in a normal school environment, the statute does require that a decision not to mainstream be justified by evidence that reflects the child's special needs.

School personnel should be advised that while an HIV-infected student may not necessarily be identified as "handicapped" under EHA, the HIV-infected student is deemed as "handicapped" for purposes of protection under Section 504.

Chapter Four provides a description of administrative guidelines, positions on special education services, civil rights positions, and communicable diseases policies related to the educational placement issues of HIV-infected students in sixteen states. State administrative guidelines with the exception of the regulatory status of procedures in Pennsylvania and New Jersey are advisory in nature. Local education agencies have the primary responsibility for establishing educational policies and procedures on the issue. Individuals responsible for policy decisions should be familiar with state and national trends that may directly and/or indirectly affect policy.

Medical evidence at the present time strongly suggests that policies of exclusion would not hold up constitutionally under the equal protection clause of the Fourteenth Amendment

since no rational basis for excluding children from public school settings exists unless individual circumstances warrant the exclusion. Additionally, implementation of an exclusionary policy would probably be considered more intrusive than necessary and may be considered an infringement of property and freedom of association rights. As medical knowledge continues to emerge, justification for infringement upon the fundamental rights of the individual may shift. In the school environment the balance must be made between the rights of the individual to participate in school programs weighed against the potential of harm to others in the same environment.

Selected state descriptions indicate that CDC recommendations were utilized by all states formulating policy and are the sole basis for eligibility criteria in the admission policies for HIV-infected students in eleven of the sixteen states investigated. The guidelines provide a suggested framework that stress the balance between the risk of infection from "indicator" diseases to the infected student with the prevention of transmission of a communicable disease.

The major findings of the study are summarized as follows:

1. The human immunodeficiency virus (HIV) infection is a complex, often lethal, disease that inactivates the immune system leaving victims defenseless against infections that

the body can normally suppress. Unlike ordinary infectious diseases, the HIV infection is not easily transmissible. The mode of transmission has been reported through exchange of body fluids via sexual contact with an infected person; through the sharing of needles by intravenous drug users; perinatally to a child by an infected mother; and through contraction through the use of contaminated blood products used for treatment and/or transfusion.

2. There is no medical evidence to support the assumption that the HIV infection is easily transmitted through casual contacts found in the normal school environment. Exclusion of HIV-infected children from regular school attendance is not warranted unless supported by medical recommendation.

3. The preponderance of medical evidence of the HIV infection suggests that there is substantial agreement as to the precautions necessary to guard against any theoretical risk of transmission. Health care precautions should be taken and routine procedures established for the removal of blood and/or body fluids, in cases of accident or injury.

4. For most purposes of the programming under the Education of the Handicapped Act (EHA), children with AIDS or with the HIV infection are not educationally handicapped merely because of the illness. The status of the child in regard to special programs depends upon the ability to perform in the regular classroom without adverse effects. If

it is determined that the HIV-infected child requires special education services, EHA regulations apply. Although the EHA recognizes that not all children can be placed in a normal school environment, the statute does require that a decision not to mainstream be justified by evidence that reflects the child's special needs.

5. Federal judicial interpretation supports the contention that AIDS is a protected handicap under Section 504 of the Rehabilitation Act. The Arline ruling is considered precedent setting for cases of communicable diseases, including the HIV infection under Section 504, there must be a medically proven justification for policy for exclusion.

6. Medical evidence at the present time strongly suggests that policies of exclusion would not hold up constitutionally since no rational basis for excluding children from public school settings exists unless individual circumstances warrant the exclusion.

7. Responses to the balancing of rights of an HIV-infected student to an education against the rights of other students to attend school in an environment free of the risk of transmission of a life-threatening disease can be a social reaction unrelated to the reality of underlying risk. The Constitution requires that policies be grounded on decisions based in reality. As medical knowledge unfolds justification for infringement upon fundamental rights may shift.

Recommendations

1. In developing and administering policy, school administrators should establish and maintain open communication with the major policy and rule-makers in the state. Knowledge of existing public agency policies at the national, state, and local levels supports educational policy that is sound and reasonable. AIDS policy direction may be under the jurisdiction of education officials, public health officials, or both. Interagency collaboration is crucial to efficient, concise, and accurately administered policy recommendations.

2. The National Center for Disease Control (CDC) recommendations on the educational placement of HIV-infected student provide a guide when developing eligibility criteria for admission and/or exclusion of HIV-infected students in the public schools. In the school environment the balance must be made between the rights of the individual to participate in school programs weighed against the potential of harm to others in the school environment.

3. Although state laws may differ as to the interpretation on whether the HIV-infected child should be covered by EHA, it is suggested that schools include in policy determination information on the responsible agent for education of these children within the schools, be it regular or special education.

4. Statutory and regulatory requirements of the EHA and Section 504 of the Rehabilitation Act provide guidance for policy and decision-making concerning educational placement issues. The use of EHA procedures for case-by-case determination to provide clarity in decision-making is suggested. However, in utilization of EHA procedures it is advisable to specify whether the use is for convenience or because eligibility for special education services is being considered.

5. Routine precautions should be followed by all school personnel regardless of the presence or absence of a HIV-infected individual. There is no guarantee that knowledge of the infected child will increase precaution. An open usage policy where all school personnel are trained in precautionary procedures provides a vehicle for a safe school environment and allows for strict confidentiality to be maintained in an attempt to respect the child's right to privacy, if a HIV-infected student is present in the local public schools or district.

6. Case-by-case review, as recommended in CDC guidelines is suggested to determine if there is anything in the child's neurological, physical, or emotional behavior that would make an unrestricted environment inappropriate. Suggested panel review might entail two aspects: (a) determination that the child is well enough to attend school without undue risk to self, and (b) determination that the child's behavior does not pose an increased risk of transmission of

the HIV infection to others in the classroom. Composition of the panel should include representatives of medical, public health, and educational agencies within the community. There is no evidence to support that identification of the infected child is necessary for determination of placement status. A procedure should be in place for periodic review.

7. Special education referral is suggested, only after panel review, if there is a determination that the physical condition of the child may have or has had an adverse effect on the child's learning.

8. The number of persons knowledgeable of an infected child's condition should be kept at a minimum with disclosure only to those with a direct need to know. School policies and procedures that argue for disclosure of identity as a precautionary safeguard are not necessarily consistent with medical evidence that suggests routine safety procedures are effective in preventing the transmission of HIV. The decision of whether or not to disclose information regarding the HIV-infected student is most appropriately placed with those responsible for the protection of the HIV-infected child's health (e.g., the parents and the child's physician).

9. Awareness of sound medical evidence to support educational decision-making provides a means of projecting solid grounded policy to the school and community at large. Dependent upon district size a means of information-gathering should be in place to provide continuous up-dating of both

medical and legal issues related to the educational placement of HIV-infected students. A network of resources should be developed for disseminating and implementing new information as it develops.

A variety of existing documents pertinent to the medical and legal aspects of the educational placement of children in the public schools with human immunodeficiency virus infection have been referenced in the text or included in the Appendices. The documents are examples of national, state, and local guidelines/recommendations and/or policy related to the topic. However, they are not necessarily representative of model policy and/or best practice; they are time-bound. The information is provided as a resource for individuals involved in decision-making related to educational placement issues for HIV-infected students. The medical and legal aspects of AIDS and the HIV infection are complex. In the rapidly expanding areas of medical research and AIDS legislation and litigation, it should be advised that, while recommendations are made and trends are suggested based on this study, the materials are current as of May 1988. Continuous up-dating of medical and legal information related to the topic is necessary for effective, and informed decisions on the development, implementation, revision, and/or evaluation of policy.

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GLOSSARY OF AIDS-RELATED TERMS

Acquired Immune Deficiency Syndrome (AIDS): A medical condition that is characterized by failure of the immune system to protect against infections and certain cancers.

Acute: A medical condition that is of severe, but short duration, not chronic.

AIDS-related complex (ARC): A variety of chronic symptoms and physical findings that occur in some individuals who are infected with human immunodeficiency virus (HIV), but do not meet the Centers for Disease Control's definition of AIDS. Symptoms may include chronic swollen glands, recurrent fevers, unintentional weight loss, chronic diarrhea, lethargy, and/or less severe manifestations of those that occur in "full-blown" AIDS (Baltimore, et al, 1986).

Antibody: A protein in the blood that is produced in response to exposure to specific foreign molecules. The protein specifically combines with the substance helping to destroy it within the body, neutralizing toxins and interacting with other components of the immune system to eliminate infectious microorganisms from the body. Antibodies are manufactured by B-lymphocytes in response to the presence of specific antigens. Once the antibody

is formed the cell has a "memory" of the event. The "memory" provides the source of immunity to the antigen in the future (Fettner, 1985; Baltimore, et al, 1986).

Antigen: A substance, recognized as foreign by the immune system, that stimulates the production of antibodies. Specific substances, called antigen receptors, are found on the surfaces of both B and T-lymphocytes. Without antigen receptors the lymphocytes cannot respond to the presence of antigens and no immune response take place (Baltimore, et al, 1986; Fettner, 1985).

Autologous transfusion: A blood transfusion in which the patient receives his or her own blood, donated several weeks before elective surgery (Baltimore, et al, 1986).

B-lymphocyte (B-cell): A type of white blood cell that produces antibody in response to stimulation by an antigen (Baltimore, et al, 1986).

Burkitt's lymphoma: A cancer of the lymphatic tissue thought to be associated with Epstein-Barr virus. The cancer has mainly affected children in equatorial Africa (Fettner, 1985).

Casual contact: Contact that refers to day-to-day interactions between HIV infected individuals and others in the home, at school, or in the workplace. Casual contact does not intimate contact, e.g., sexual or parenteral contact.

Chronic: A medical condition that is long-lasting and/or recurring is considered chronic, distinguishing the condition from acute.

CDC Criteria: The specific criteria by which CDC defines an individual case of illness as AIDS. The CDC definition of AIDS requires that a person have an illness strongly suggestive of an underlying immune deficiency, e.g., opportunistic infections or Kaposi's sarcoma, in the absence of any treatment or disease condition that suppresses the immune system (Fettner, 1985).

Communicable: A medical condition that can be transmitted, by direct or indirect contact, e.g., hepatitis, infectious disease of childhood (mumps, measles, chicken).

Contagious: Carrying or capable of transmitting the causative agent of a contagious disease by means of direct or indirect contact.

Cofactor: A factor other than the basic causative agent of a disease that increases the likelihood of developing that disease. Cofactors may include the presence of other microorganisms or psychosocial factors, e.g., stress (Baltimore, et al, 1986).

Cytomegalovirus (CMV): A virus belonging to the herpes virus group that is capable of producing serious illness in infants, weakened persons, and those whose immune systems have been suppressed by drugs or cancer. CMV rarely causes serious illness in healthy adults; in AIDS

patients, CMV may produce pneumonia, as well as inflammation of the retina, liver, kidneys, and colon (Baltimore, et al, 1986; Hanshaw, 1983).

DNA (deoxyribonucleic acid): A nucleic acid found chiefly in the nucleus of living cells that is responsible for transmitting hereditary characteristics (Baltimore, et al, 1986; Fettner, 1985).

ELISA: An acronym for "enzyme-linked immunosorbent assay," a test used to detect antibodies against HIV in blood samples (Baltimore, et al, 1986).

Endemic: A condition or disease that is widespread in a population.

Epidemic: When said of a contagious disease a prevalent and spreading condition among many people in a community at the same time.

Epstein-Barr virus: A member of the herpes group of viruses and the principal cause of infectious mononucleosis in young adults. It also has been implicated as a causal factor in the development of Burkitt's lymphoma in Africa (Baltimore, et al, 1986).

Hemophilia: A rare, hereditary bleeding disorder of males, inherited through the mother, caused by a deficiency in the ability to make one or more blood-clotting products (Baltimore, et al, 1986).

Hepatitis: An inflammation of the liver that is caused by one of several viruses. Hepatitis A causes acute ill-

ness, often subclinical in the young and in the elderly. Hepatitis B can cause either acute or chronic illness and is associated with liver cancer. Hepatitis B virus induces a carrier state in about 10% of those infected. Asymptomatic, these individuals can transmit the disease by blood transfusions, from mother to newborn, or through saliva, breast milk, or genital secretions (Fettner, 1985).

Herpes simplex virus (HSV): An acute disease caused by HSV types 1 and 2 that causes groups of watery painful blisters that form on the skin or mucous membranes, especially the borders of the lips (type 1) or mucous surface of the genitals (type 2) (Baltimore, et al, 1986).

Herpes virus group: A group of viruses that includes the herpes simplex viruses, the varicella-zoster virus (the cause of chicken pox), cytomegalovirus, and Epstein-Barr virus (Baltimore, et al, 1986).

HIV (human immunodeficiency virus): The name proposed for the causative agent of AIDS by the International Committee on the Taxonomy of Viruses.

HTLV-III (human T-cell lymphotropic virus type III): The name given by researchers at the National Cancer Institute to isolates of the retrovirus that causes AIDS.

Immune system: The natural system of defense mechanisms, in which specialized cells and proteins in the blood and

other body fluids work together to eliminate disease-producing microorganisms and other foreign substances (Baltimore, et al, 1986).

Immunodeficiency: A state in which the immune system does not function properly, marked by repeated severe infections and, in extreme cases, by an increased incidence of certain cancers. Immunodeficiency can be inherited, as in congenital immunodeficiency, or caused after birth, called acquired immunodeficiency. Acquired immunodeficiency can be brought on by disease, such as cancer, or by medical treatment, such as drugs used to prevent transplant rejection (Fettner, 1985).

Infectious disease: Any disease caused by the presence in the body of bacteria, protozoa, viruses, or other parasites. The diseases may or may not be contagious.

Intravenous: Injected into or delivered through a needle into a vein.

Kaposi's sarcoma (KS): A cancer or tumor of the blood and/or lymphatic vessel walls, usually appearing as blue-violet to brownish skin blotches or bumps. Prior to the appearance of AIDS, KS was rarely seen in the United States and Europe where it occurs primarily in men over 50 or 60, usually of Mediterranean origin. AIDS-associated KS is much more aggressive than the earlier form of the disease (Baltimore, et al, 1986).

LAV (lymphadenopathy-associated virus): The name given by French researchers to the first reported isolate of the retrovirus now known to cause AIDS. (see Lentiviruses)

Lentiviruses: A sub-family of retroviruses that includes the visna viruses of sheep, the equine infections anemia virus of horses, and the caprine arthritis-encephalitis virus of goats. Most researchers believe that HIV, the cause of AIDS, also belongs to this subfamily. The animal lentiviruses produce diverse chronic diseases in their natural hosts, but all cause encephalitis. The lentiviruses persist in the body by evading natural defense mechanisms. The chronic carrier or asymptomatic state in which the infected animal does not get sick, but can transmit the virus is common (Baltimore, 1986).

Lymphadenopathy: The clinical manifestation of swollen lymph nodes common to AIDS-related complex (ARC).

Lymphocyte: A small type of white blood cell responsible for immunity. Lymphocytes originate in the bone marrow, pass through the bloodstream, and enter other organs where they become modified to B and T-lymphocytes (Fettner, 1985).

Macrophage: From the Greek words for "big" and "eater," a white blood cell that destroys foreign substances and cells. The macrophage cooperates with the B and T-lymphocytes in the immune response (Fettner, 1985).

Mycobacterium avium-intracellular (MAC): A bacterium related to the organism that causes tuberculosis in humans, rarely seen by physicians prior to the appearance of AIDS. In AIDS patients it may cause a disseminated disease that responds poorly to therapy (Baltimore, et al., 1986).

National Academy of Sciences (NAS): NAS was established in 1863 by an Act of Congress as a private, nonprofit self-governing membership corporation for the furtherance of science and technology, required to advise the federal government upon request within its field of competence. The Institute of Medicine (IOM) was chartered in 1970 by NAS to enlist distinguished members of the appropriate professions in the examination of policy matters pertaining to the health of the public.

Opportunistic Infection (OI): An infection caused by a microorganism that rarely causes disease in persons with normal defense mechanisms.

Parenteral: Involving introduction into the bloodstream.

Pediatric AIDS (PAIDS): Pediatric AIDS may be defined on the basis of epidemiologic, laboratory, and virologic data, including the history of a risk factor, laboratory evidence of immunodeficiency, and of HIV infection (Ammann, 1987).

Pneumocystis carinii pneumonia (PCP): A form of pneumonia caused by protozoan parasite. PCP is the most common life-threatening opportunistic infection diagnosed in individuals with AIDS.

Provirus: A copy of the genetic information of a virus that is integrated into the DNA of an infected cell.

Retrovirus: A class of viruses that contain the genetic material RNA. The virus has the capability to copy this RNA into DNA inside an infected cell. The resulting DNA is incorporated into the genetic structure of the cell in the form of a provirus (Baltimore, et al, 1986).

Reverse transcriptase: An enzyme produced by retroviruses that allows them to produce a DNA copy of their RNA. Production of the DNA copy is the first step in the natural cycle of reproduction in the virus (Baltimore, et al, 1986).

RNA (ribonucleic acid): A nucleic acid associated with the control of chemical activities inside a cell. Some viruses carry RNA instead of the more familiar genetic material DNA (Baltimore, et al, 1986).

Seroconversion: The initial development of antibodies specific to a particular antigen (Baltimore, et al, 1986).

Serologic study: A study that compares the characteristics of the serum of individuals, especially those markers in blood that indicate exposure to a particular agent of disease (Baltimore, et al, 1986).

Seropositive: In the context of HIV, the condition in which antibodies to the virus are found in the blood.

Syndrome: A pattern of symptoms and signs, appearing one by one or simultaneously, that together characterize a particular disease or disorder.

T-helper lymphocytes: The T-lymphocytes that assist B-lymphocytes in maturing to produce antibody and that enhance cell-mediated immunity.

T-lymphocyte (T-cell): A cell that matures in the thymus gland. The T-cells are found primarily in the blood, lymph, and lymphoid glands. T-cells are responsible for protecting against a range of infectious agents, particularly those that replicate inside cells, e.g., viruses, parasites, and fungi (Baltimore, et al, 1986).

Virus: A subcellular microorganism composed of genetic material, either DNA or RNA, and protein. In the body, viruses multiply only within host cells (Fettner, 1985).

Western blot technique: A test that involves the identification of antibodies against specific protein molecules. Thought to be more specific than the ELISA in detecting antibodies to HIV in blood samples, Western blot analysis is used by some laboratories as a confirmatory test on samples found to be repeatedly reactive on ELISA tests. The difficult is more difficult to perform and considerably more expensive (Baltimore, et al, 1986).

APPENDIX A. REVISION OF THE CDC SURVEILLANCE CASE DEFINITION
FOR ACQUIRED IMMUNODEFICIENCY SYNDROME

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Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome

Reported by
**Council of State and Territorial Epidemiologists;
AIDS Program, Center for Infectious Diseases, CDC**

INTRODUCTION

The following revised case definition for surveillance of acquired immunodeficiency syndrome (AIDS) was developed by CDC in collaboration with public health and clinical specialists. The Council of State and Territorial Epidemiologists (CSTE) has officially recommended adoption of the revised definition for national reporting of AIDS. The objectives of the revision are a) to track more effectively the severe disabling morbidity associated with infection with human Immunodeficiency virus (HIV) (including HIV-1 and HIV-2); b) to simplify reporting of AIDS cases; c) to increase the sensitivity and specificity of the definition through greater diagnostic application of laboratory evidence for HIV infection; and d) to be consistent with current diagnostic practice, which in some cases includes presumptive, i.e., without confirmatory laboratory evidence, diagnosis of AIDS-indicative diseases (e.g., *Pneumocystis carinii* pneumonia, Kaposi's sarcoma).

The definition is organized into three sections that depend on the status of laboratory evidence of HIV infection (e.g., HIV antibody) (Figure 1). The major proposed changes apply to patients with laboratory evidence for HIV infection: a) inclusion of HIV encephalopathy, HIV wasting syndrome, and a broader range of specific AIDS-indicative diseases (Section II.A); b) inclusion of AIDS patients whose indicator diseases are diagnosed presumptively (Section II.B); and c) elimination of exclusions due to other causes of immunodeficiency (Section I.A).

Application of the definition for children differs from that for adults in two ways. First, multiple or recurrent serious bacterial infections and lymphoid interstitial pneumonia/pulmonary lymphoid hyperplasia are accepted as indicative of AIDS among children but not among adults. Second, for children <15 months of age whose mothers are thought to have had HIV infection during the child's perinatal period, the laboratory criteria for HIV infection are more stringent, since the presence of HIV antibody in the child is, by itself, insufficient evidence for HIV infection because of the persistence of passively acquired maternal antibodies < 15 months after birth.

The new definition is effective immediately. State and local health departments are requested to apply the new definition henceforth to patients reported to them. The initiation of the actual reporting of cases that meet the new definition is targeted for September 1, 1987, when modified computer software and report forms should be in place to accommodate the changes. CSTE has recommended retrospective application of the revised definition to patients already reported to health departments. The new definition follows:

1987 REVISION OF CASE DEFINITION FOR AIDS FOR SURVEILLANCE PURPOSES

For national reporting, a case of AIDS is defined as an illness characterized by one or more of the following "indicator" diseases, depending on the status of laboratory evidence of HIV infection, as shown below.

I. Without Laboratory Evidence Regarding HIV Infection

If laboratory tests for HIV were not performed or gave inconclusive results (See Appendix I) and the patient had no other cause of immunodeficiency listed in Section I.A below, then any disease listed in Section I.B indicates AIDS if it was diagnosed by a definitive method (See Appendix II).

- A. Causes of immunodeficiency that disqualify diseases as indicators of AIDS in the absence of laboratory evidence for HIV infection
 - 1. high-dose or long-term systemic corticosteroid therapy or other immunosuppressive/cytotoxic therapy <3 months before the onset of the indicator disease
 - 2. any of the following diseases diagnosed <3 months after diagnosis of the indicator disease: Hodgkin's disease, non-Hodgkin's lymphoma (other than primary brain lymphoma), lymphocytic leukemia, multiple myeloma, any other cancer of lymphoreticular or histiocytic tissue, or angioblastic lymphadenopathy
 - 3. a genetic (congenital) immunodeficiency syndrome or an acquired immunodeficiency syndrome atypical of HIV infection, such as one involving hypogammaglobulinemia
- B. Indicator diseases diagnosed definitively (See Appendix II)
 - 1. candidiasis of the esophagus, trachea, bronchi, or lungs
 - 2. cryptococcosis, extrapulmonary
 - 3. cryptosporidiosis with diarrhea persisting >1 month
 - 4. cytomegalovirus disease of an organ other than liver, spleen, or lymph nodes in a patient >1 month of age
 - 5. herpes simplex virus infection causing a mucocutaneous ulcer that persists longer than 1 month; or bronchitis, pneumonitis, or esophagitis for any duration affecting a patient >1 month of age
 - 6. Kaposi's sarcoma affecting a patient < 60 years of age
 - 7. lymphoma of the brain (primary) affecting a patient < 60 years of age
 - 8. lymphoid interstitial pneumonitis and/or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child <13 years of age
 - 9. *Mycobacterium avium* complex or *M. kansasii* disease, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
 - 10. *Pneumocystis carinii* pneumonia
 - 11. progressive multifocal leukoencephalopathy
 - 12. toxoplasmosis of the brain affecting a patient >1 month of age

II. With Laboratory Evidence for HIV Infection

Regardless of the presence of other causes of immunodeficiency (I.A), in the presence of laboratory evidence for HIV infection (See Appendix I), any disease listed

A. Indicator diseases diagnosed definitively (See Appendix II)

1. bacterial infections, multiple or recurrent (any combination of at least two within a 2-year period), of the following types affecting a child < 13 years of age:
 - septicemia, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses), caused by *Haemophilus*, *Streptococcus* (including pneumococcus), or other pyogenic bacteria
 - coccidioidomycosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes)
 - HIV encephalopathy (also called "HIV dementia," "AIDS dementia," or "subacute encephalitis due to HIV") (See Appendix II for description)
 - histoplasmosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes)
 - Isosporiasis with diarrhea persisting >1 month
 - Kaposi's sarcoma at any age
 - lymphoma of the brain (primary) at any age
 - other non-Hodgkin's lymphoma of B-cell or unknown immunologic phenotype and the following histologic types:
 - a. small noncleaved lymphoma (either Burkitt or non-Burkitt type) (See Appendix IV for equivalent terms and numeric codes used in the *International Classification of Diseases*, Ninth Revision, Clinical Modification)
 - b. immunoblastic sarcoma (equivalent to any of the following, although not necessarily all in combination: immunoblastic lymphoma, large-cell lymphoma, diffuse histiocytic lymphoma, diffuse undifferentiated lymphoma, or high-grade lymphoma) (See Appendix IV for equivalent terms and numeric codes used in the *International Classification of Diseases*, Ninth Revision, Clinical Modification)

Note: Lymphomas are not included here if they are of T-cell immunologic phenotype or their histologic type is not described or is described as "lymphocytic," "lymphoblastic," "small cleaved," or "plasmacytoid lymphocytic."

9. any mycobacterial disease caused by mycobacteria other than *M. tuberculosis*, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
10. disease caused by *M. tuberculosis*, extrapulmonary (involving at least one site outside the lungs, regardless of whether there is concurrent pulmonary involvement)
11. *Salmonella* (nontyphoid) septicemia, recurrent
12. HIV wasting syndrome (emaciation, "slim disease") (See Appendix II for description)

B. Indicator diseases diagnosed presumptively (by a method other than those in Appendix II)

Note: Given the seriousness of diseases indicative of AIDS, it is generally important to diagnose them definitively, especially when therapy that would

for eligibility for antiretroviral therapy. Nonetheless, in some situations, a patient's condition will not permit the performance of definitive tests. In other situations, accepted clinical practice may be to diagnose presumptively based on the presence of characteristic clinical and laboratory abnormalities. Guidelines for presumptive diagnoses are suggested in Appendix III.

1. candidiasis of the esophagus
2. cytomegalovirus retinitis with loss of vision
3. Kaposi's sarcoma
4. lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child <13 years of age
5. mycobacterial disease (acid-fast bacilli with species not identified by culture), disseminated (involving at least one site other than or in addition to lungs, skin, or cervical or hilar lymph nodes)
6. *Pneumocystis carinii* pneumonia
7. toxoplasmosis of the brain affecting a patient >1 month of age

III. With Laboratory Evidence Against HIV Infection

With laboratory test results negative for HIV infection (See Appendix II), a diagnosis of AIDS for surveillance purposes is ruled out unless:

- A. all the other causes of immunodeficiency listed above in Section I.A are excluded; AND
- B. the patient has had either:
 1. *Pneumocystis carinii* pneumonia diagnosed by a definitive method (See Appendix II); OR
 2. a. any of the other diseases indicative of AIDS listed above in Section I.B diagnosed by a definitive method (See Appendix II); AND
 - b. a T-helper/inducer (CD4) lymphocyte count <400/mm³.

COMMENTARY

The surveillance of severe disease associated with HIV infection remains an essential, though not the only, indicator of the course of the HIV epidemic. The number of AIDS cases and the relative distribution of cases by demographic, geographic, and behavioral risk variables are the oldest indices of the epidemic, which began in 1981 and for which data are available retrospectively back to 1978. The original surveillance case definition, based on then-available knowledge, provided useful epidemiologic data on severe HIV disease (1). To ensure a reasonable predictive value for underlying immunodeficiency caused by what was then an unknown agent, the indicators of AIDS in the old case definition were restricted to particular opportunistic diseases diagnosed by reliable methods in patients without specific known causes of immunodeficiency. After HIV was discovered to be the cause of AIDS, however, and highly sensitive and specific HIV antibody tests became available, the spectrum of manifestations of HIV infection became better defined, and classification systems for HIV infection were developed (2-5). It became apparent that some progressive, seriously disabling, and even fatal conditions (e.g., encephalopathy, wasting syndrome) affecting a substantial number of HIV-infected patients were not subject to epidemiologic surveillance, as they were not included in the AIDS

case definition. For reporting purposes, the revision adds to the definition most of those severe non-infectious, non-cancerous HIV-associated conditions that are categorized in the CDC clinical classification systems for HIV infection among adults and children (4,5).

Another limitation of the old definition was that AIDS-indicative diseases are diagnosed presumptively (i.e., without confirmation by methods required by the old definition) in 10%-15% of patients diagnosed with such diseases; thus, an appreciable proportion of AIDS cases were missed for reporting purposes (6,7). This proportion may be increasing, which would compromise the old case definition's usefulness as a tool for monitoring trends. The revised case definition permits the reporting of these clinically diagnosed cases as long as there is laboratory evidence of HIV infection.

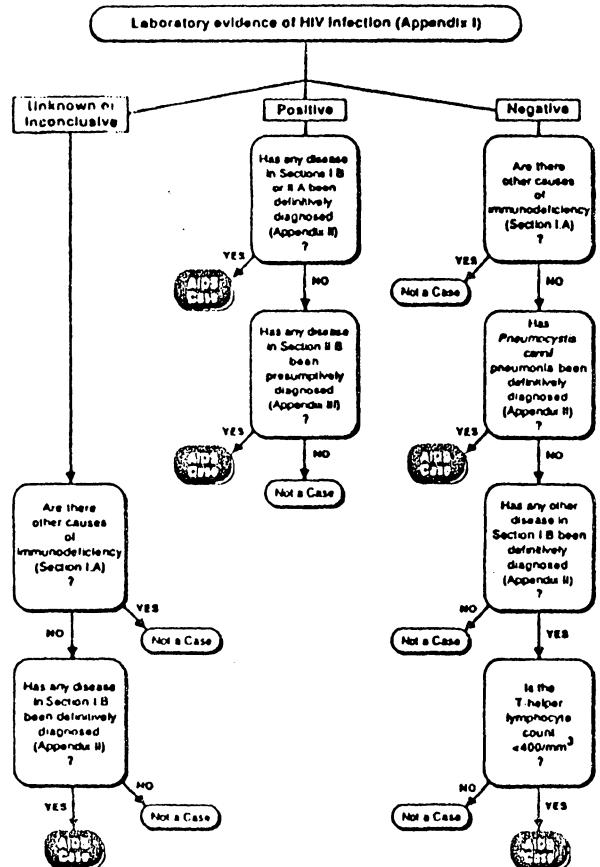
The effectiveness of the revision will depend on how extensively HIV antibody tests are used. Approximately one third of AIDS patients in the United States have been from New York City and San Francisco, where, since 1985, < 7% have been reported with HIV antibody test results, compared with > 60% in other areas. The impact of the revision on the reported numbers of AIDS cases will also depend on the proportion of AIDS patients in whom indicator diseases are diagnosed presumptively rather than definitively. The use of presumptive diagnostic criteria varies geographically, being more common in certain rural areas and in urban areas with many indigent AIDS patients.

To avoid confusion about what should be reported to health departments, the term "AIDS" should refer only to conditions meeting the surveillance definition. This definition is intended only to provide consistent statistical data for public health purposes. Clinicians will not rely on this definition alone to diagnose serious disease caused by HIV infection in individual patients because there may be additional information that would lead to a more accurate diagnosis. For example, patients who are not reportable under the definition because they have either a negative HIV antibody test or, in the presence of HIV antibody, an opportunistic disease not listed in the definition as an indicator of AIDS nonetheless may be diagnosed as having serious HIV disease on consideration of other clinical or laboratory characteristics of HIV infection or a history of exposure to HIV.

Conversely, the AIDS surveillance definition may rarely misclassify other patients as having serious HIV disease if they have no HIV antibody test but have an AIDS-indicative disease with a background incidence unrelated to HIV infection, such as cryptococcal meningitis.

The diagnostic criteria accepted by the AIDS surveillance case definition should not be interpreted as the standard of good medical practice. Presumptive diagnoses are accepted in the definition because not to count them would be to ignore substantial morbidity resulting from HIV infection. Likewise, the definition accepts a reactive screening test for HIV antibody without confirmation by a supplemental test because a repeatedly reactive screening test result, in combination with an indicator disease, is highly indicative of true HIV disease. For national surveillance purposes, the tiny proportion of possibly false-positive screening tests in persons with AIDS-indicative diseases is of little consequence. For the individual patient, however, a correct diagnosis is critically important. The use of supplemental tests is, therefore, strongly endorsed. An increase in the diagnostic use of HIV antibody tests could improve both the quality of medical care and the function of the new case definition, as well as assist in providing counseling to prevent transmission of HIV.

FIGURE I. Flow diagram for revised CDC case definition of AIDS, September 1, 1987



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1. World Health Organization. Acquired immunodeficiency syndrome (AIDS): WHO/CDC case definition for AIDS. WHO Weekly Epidemiol Rec 1986;61:69-72.
2. Havrilesky HW, Gottlieb MS, Killen JV, Edelman R. Classification of HTLV-III/LAV-related diseases [Letter]. J Infect Dis 1985;152:1095.
3. Redfield RR, Wright DC, Tramont EC. The Walter Reed staging classification of HTLV-III infection. N Engl J Med 1986;314:131-2.
4. CDC. Classification system for human T-lymphotropic virus type III/lymphadenopathy-associated virus infections. MMWR 1986;35:334-9.
5. CDC. Classification system for human immunodeficiency virus (HIV) infection in children under 13 years of age. MMWR 1987;36:225-30,235.
6. Hardy AM, Starcher ET, Morgan WM, et al. Review of death certificates to assess completeness of AIDS case reporting. Pub Hlth Rep 1987;102(4):386-81.
7. Starcher ET, Biel JK, Rivera-Castano R, Day JM, Hopkins SG, Miller JW. The impact of presumptively diagnosed opportunistic infections and cancers on national reporting of AIDS [Abstract]. Washington, DC : III International Conference on AIDS, June 1-5, 1987.

APPENDIX I**Laboratory Evidence For or Against HIV Infection****1. For Infection:**

When a patient has disease consistent with AIDS:

- a. a serum specimen from a patient ≥ 15 months of age, or from a child < 15 months of age whose mother is not thought to have had HIV infection during the child's perinatal period, that is repeatedly reactive for HIV antibody by a screening test (e.g., enzyme-linked immunosorbent assay [ELISA]), as long as subsequent HIV antibody tests (e.g., Western blot, immunofluorescence assay), if done, are positive; OR
- b. a serum specimen from a child < 15 months of age, whose mother is thought to have had HIV infection during the child's perinatal period, that is repeatedly reactive for HIV antibody by a screening test (e.g., ELISA), plus increased serum immunoglobulin levels and at least one of the following abnormal immunologic test results: reduced absolute lymphocyte count, depressed CD4 (T-helper) lymphocyte count, or decreased CD4/CD8 (helper/suppressor) ratio, as long as subsequent antibody tests (e.g., Western blot, immunofluorescence assay), if done, are positive; OR
- c. a positive test for HIV serum antigen; OR
- d. a positive HIV culture confirmed by both reverse transcriptase detection and a specific HIV antigen test or in situ hybridization using a nucleic acid probe; OR
- e. a positive result on any other highly specific test for HIV (e.g., nucleic acid probe of peripheral blood lymphocytes).

2. Against Infection:

A nonreactive screening test for serum antibody to HIV (e.g., ELISA) without a reactive or positive result on any other test for HIV infection (e.g., antibody, antigen, culture), if done.

3. Inconclusive (Neither For nor Against Infection):

- a. a repeatedly reactive screening test for serum antibody to HIV (e.g., ELISA) followed by a negative or inconclusive supplemental test (e.g., Western blot, immunofluorescence assay) without a positive HIV culture or serum antigen test, if done; OR
- b. a serum specimen from a child < 15 months of age, whose mother is thought to have had HIV infection during the child's perinatal period, that is repeatedly reactive for HIV antibody by a screening test, even if positive by a supplemental test, without additional evidence for immunodeficiency as described above (in 1.b) and without a positive HIV culture or serum antigen test, if done.

APPENDIX II**Definitive Diagnostic Methods for Diseases Indicative of AIDS****Diseases****Definitive Diagnostic Methods**

cryptosporidiosis
cytomegalovirus
isosporiasis
Kaposi's sarcoma
lymphoma
lymphoid pneumonia
or hyperplasia
Pneumocystis carinii
pneumonia
progressive multifocal
leukoencephalopathy
toxoplasmosis

microscopy (histology or cytology).

candidiasis

coccidioidomycosis
cryptococcosis
herpes simplex virus
histoplasmosis

gross inspection by endoscopy or autopsy or by microscopy (histology or cytology) on a specimen obtained directly from the tissues affected (including scrapings from the mucosal surface), not from a culture.

tuberculosis
other mycobacteriosis
salmonellosis
other bacterial
infection

microscopy (histology or cytology), culture, or detection of antigen in a specimen obtained directly from the tissues affected or a fluid from those tissues.

culture.

HIV encephalopathy*
(dementia)

clinical findings of disabling cognitive and/or motor dysfunction interfering with occupation or activities of daily living, or loss of behavioral developmental milestones affecting a child, progressing over weeks to months, in the absence of a concurrent illness or condition other than HIV infection that could explain the findings. Methods to rule out such concurrent illnesses and conditions must include cerebrospinal fluid examination and either brain imaging (computed tomography or magnetic resonance) or autopsy.

HIV wasting syndrome*

findings of profound involuntary weight loss >10% of baseline body weight plus either chronic diarrhea (at least two loose stools per day for ≥ 30 days) or chronic weakness and documented fever (for ≥ 30 days, intermittent or constant) in the absence of a concurrent illness or condition other than HIV infection that could explain the findings (e.g., cancer, tuberculosis, cryptosporidiosis, or other specific enteritis).

*For HIV encephalopathy and HIV wasting syndrome, the methods of diagnosis described here are not truly definitive, but are sufficiently rigorous for surveillance purposes.

APPENDIX III

Suggested Guidelines for Presumptive Diagnosis of Diseases Indicative of AIDS

Diseases	Presumptive Diagnostic Criteria
candidiasis of esophagus	a. recent onset of retrosternal pain on swallowing; AND b. oral candidiasis diagnosed by the gross appearance of white patches or plaques on an erythematous base or by the microscopic appearance of fungal mycelial filaments in an uncultured specimen scraped from the oral mucosa.
cytomegalovirus retinitis	a characteristic appearance on serial ophthalmoscopic examinations (e.g., discrete patches of retinal whitening with distinct borders, spreading in a centrifugal manner, following blood vessels, progressing over several months, frequently associated with retinal vasculitis, hemorrhage, and necrosis). Resolution of active disease leaves retinal scarring and atrophy with retinal pigment epithelial mottling.
mycobacteriosis	microscopy of a specimen from stool or normally sterile body fluids or tissue from a site other than lungs, skin, or cervical or hilar lymph nodes, showing acid-fast bacilli of a species not identified by culture.
Kaposi's sarcoma	a characteristic gross appearance of an erythematous or violaceous plaque-like lesion on skin or mucous membrane. (Note: Presumptive diagnosis of Kaposi's sarcoma should not be made by clinicians who have seen few cases of it.)
lymphoid interstitial pneumonia	bilateral reticulonodular interstitial pulmonary infiltrates present on chest X ray for ≥2 months with no pathogen identified and no response to antibiotic treatment.
Pneumocystis carinii pneumonia	a. a history of dyspnea on exertion or nonproductive cough of recent onset (within the past 3 months); AND b. chest X-ray evidence of diffuse bilateral interstitial infiltrates or gallium scan evidence of diffuse bilateral pulmonary disease; AND c. arterial blood gas analysis showing an arterial pO ₂ of <70 mm Hg or a low respiratory diffusing capacity (<80% of predicted values) or an increase in the alveolar-arterial oxygen tension gradient; AND d. no evidence of a bacterial pneumonia.

**Toxoplasmosis
of the brain**

- a. recent onset of a focal neurologic abnormality consistent with intracranial disease or a reduced level of consciousness; AND
- b. brain imaging evidence of a lesion having a mass effect (on computed tomography or nuclear magnetic resonance) or the radiographic appearance of which is enhanced by injection of contrast medium; AND
- c. serum antibody to toxoplasmosis or successful response to therapy for toxoplasmosis.

APPENDIX IV**Equivalent Terms and International Classification
of Disease (ICD) Codes for AIDS-Indicative Lymphomas**

The following terms and codes describe lymphomas indicative of AIDS in patients with antibody evidence for HIV infection (Section II.A.B of the AIDS case definition). Many of these terms are obsolete or equivalent to one another.

ICD-9-CM (1978)

Codes	Terms
200.0	Reticulosarcoma lymphoma (malignant): histiocytic (diffuse) reticulum cell sarcoma: pleomorphic cell type or not otherwise specified
200.2	Burkitt's tumor or lymphoma malignant lymphoma, Burkitt's type

ICD-O (Oncologic Histologic Types 1976)

Codes	Terms
9600/3	Malignant lymphoma, undifferentiated cell type non-Burkitt's or not otherwise specified
9601/3	Malignant lymphoma, stem cell type stem cell lymphoma
9612/3	Malignant lymphoma, immunoblastic type Immunoblastic sarcoma, immunoblastic lymphoma, or immunoblastic lymphosarcoma
9632/3	Malignant lymphoma, centroblastic type diffuse or not otherwise specified, or germinoblastic sarcoma: diffuse or not otherwise specified
9633/3	Malignant lymphoma, follicular center cell, non-cleaved diffuse or not otherwise specified
9640/3	Reticulosarcoma, not otherwise specified malignant lymphoma, histiocytic: diffuse or not otherwise specified reticulum cell sarcoma, not otherwise specified malignant lymphoma, reticulum cell type
9641/3	Reticulosarcoma, pleomorphic cell type malignant lymphoma, histiocytic, pleomorphic cell type reticulum cell sarcoma, pleomorphic cell type
9750/3	Burkitt's lymphoma or Burkitt's tumor malignant lymphoma, undifferentiated, Burkitt's type malignant lymphoma, lymphoblastic, Burkitt's type

APPENDIX B. MONTGOMERY COUNTY, MARYLAND, SCREENING PROCESS
FOR HEPATITIS B

SCREENING PROCESS FOR HEPATITIS B

I. Purpose

To establish procedures to provide for identification, placement, and management of Hepatitis B carriers.

II. A Hepatitis B carrier is a person with no symptoms of the disease who has the virus in his blood and other bodily fluids. Some carriers have an increased potential for transmitting Hepatitis B. It is important in the school setting that these persons be identified so that appropriate steps can be taken to minimize the risk of transmission.

A. Procedures for identification of carriers who have an increased potential for transmitting Hepatitis B:

1. Students will be considered potential carriers of Hepatitis B if they have at least one criterion in each of the two following groups simultaneously:

Group A (Potential Transmitter Group)

- a. Students who have a history of biting or scratching behavior in the three months prior to enrollment or survey.
- b. Students with weeping lesions as a result of self abuse, including open wounds which cannot be dressed completely.
- c. Students who mouth and drool consistently or spit frequently.

Group B (Potential Carrier Group)

- a. Students who were born in any country outside the United States except Canada, Great Britain, Luxembourg, Norway, Finland, Sweden, Denmark, France, Western Germany, Australia, Holland, Belgium, and Switzerland.
 - b. Students born in the United States into high risk families or to parents who come from countries not exempted.
 - c. Students receiving treatment with blood products and/or renal dialysis.
 - d. Students who ever have been or are presently in an institution for the mentally retarded.
 - e. Students who have used illicit parenteral drugs.
2. The principal will review the status of students currently enrolled based on the criteria in Groups A and B and identify those students who meet criteria from both groups. In addition, he/she will consider these criteria before admission of a new student to the school. The principal will send the name of any student who appears to have one criterion in each of the two groups simultaneously to the community health nurse (CHN) assigned to the school. An identified student will not be enrolled in school after September 1, 1981, until the community health nurse notifies the principal in writing that he/she is cleared for entrance.
 3. The CHN will review the students' health records and initiate the Hepatitis B Status Information Form, if indicated. At the conclusion of this process, the CHN will return the list he/she received from the principal with the outcome noted next to the student's name.

B. Procedures for placement and management of Hepatitis B carriers:

1. The principal, the CHN, and the school medical advisor (SMA) will meet together to:
 - a. Identify pregnant staff and staff or students under medical management for suppressed immune defenses who might be in direct physical contact with the student. Consideration may be given to reassignment within the school.

- b. Identify staff (teachers, aides, bus drivers, therapists, and volunteers) who will be/are in contact with the student and the custodian cleaning the classroom (s) the student uses.
- .. The principal, CRN, and S'A will meet with the identified staff to:
 - a. Provide general information about Hepatitis B.
 - b. Discuss hygienic measures necessary in the classroom and environmental control measures.
 - c. Advise the staff in direct physical contact with the identified student to consult their private physicians for determination of Hepatitis B status. They should be advised that testing should be repeated yearly until there is no longer direct contact with carriers.
- 3. Staff should notify the CRN and principal if accidental contact resulting in the possibility of transmission of this disease (e.g. biting or scratching) occurs so that they may be appropriately referred to their physician within 48 hours of exposure.
- 4. At the discretion of the principal in consultation with school health staff, information will be distributed to other parents in the school.
- 5. The principal and members of the School Health Team, as appropriate, will observe school and bus behavior and management of the student to:
 - a. Provide suggestions to staff for improving disease control measures.
 - b. Note behaviors which staff should work to control.
- 6. At the discretion of the principal, in consultation with school health personnel, the identified students with increased potential for spreading Hepatitis B may be rescheduled for certain activities.

The above screening process is similar to one developed in May, 1981, by the Montgomery County (Maryland) Public Schools and Montgomery County Health Department. Parts of II.A.1. have been updated for this presentation. This paper is intended as an example of a screening process developed by a school system and health department to identify those students with an increased potential for transmitting Hepatitis B who are currently enrolled in school.

This paper is part of presentation at 1985 ASHA Convention made by the Director, Special Education and Related Services, Montgomery County (Maryland) Public Schools.

APPENDIX C. SAMPLE REQUEST FOR INFORMATION

Office of Attorney General

Office of Civil Rights

Department of Education

Department of Special Education

State Chapter of American Academy of Pediatrics

General Agencies

List of Respondents

VIRGINIA TECH

Division of Administrative
and Educational Services

University City Office Building
Blacksburg, VA 24061

June 11, 1987

Nelson Kempsky
Chief Dep. Attorney General
Department of Justice
1515 K. St., Suite 511
Sacramento, CA 95814

Dear Mr. Kempsky:

I am requesting information that your office may have regarding the state antidiscrimination laws, state public health laws, and/or state special education laws and policies that may determine the legal boundaries on educational placement of children with the AIDS virus in California. The information is being compiled as part of a research study analyzing the legal issues related to the educational placement of students in the public schools with AIDS.

The research study is an attempt to develop an information source to the professional who most make informed conclusions on public school attendance policies. California has been chosen as one of ten states to be included in the study for profile. Results of the study will be shared with those interested individuals involved in educational policy at both state and local level.

Your assistance will be greatly appreciated.

Sincerely,

Wemme E. Walls
Doctoral Candidate
Special Education
Administration and
Supervision
Room 238
University City Office Bldg.

VIRGINIA TECH

Division of Administrative
and Educational Services

University City Office Building
Blacksburg, VA 24061

June 11, 1987

Dorothy J. Porter
Director
Civil Rights Division
Department of Regulatory Agencies
600C State Services Bldg.
1525 Sherman St.
Denver, CO 80203

Dear Ms. Porter:

I am requesting information that your office may have regarding the state antidiscrimination laws that may determine the legal boundaries on educational placement of children with the AIDS virus in Colorado. The information is being compiled as part of a research study analyzing the legal issues related to the educational placement of students in the public schools with AIDS.

The research study is an attempt to develop an information source to the professional who most make informed conclusions on public school attendance policies. Colorado has been chosen as one of ten states to be included in the study for profile. Results of the study will be shared with those interested individuals involved in educational policy at both state and local level.

Your assistance will be greatly appreciated.

Sincerely,

Wemme E. Walls
Doctoral Candidate
Special Education
Administration and
Supervision
Room 238
University City Office Bldg.

VIRGINIA TECH

Division of Administrative
and Educational Services

University City Office Building
Blacksburg, VA 24061

June 11, 1987

Kenneth W. Kizer
Director
Department of Health Services
714 P. St., Room 1253
Sacramento, CA 95814

Dear Mr. Kizer:

I am requesting information that your office may have regarding the state public health laws that may determine the legal boundaries on educational placement of children with the AIDS virus in California. The information is being compiled as part of a research study analyzing the legal issues related to the educational placement of students in the public schools with AIDS.

The research study is an attempt to develop an information source to the professional who most make informed conclusions on public school attendance policies. California has been chosen as one of ten states to be included in the study for profile. Results of the study will be shared with those interested individuals involved in educational policy at both state and local level.

Your assistance will be greatly appreciated.

Sincerely,

Wemme E. Walls
Doctoral Candidate
Special Education
Administration and
Supervision
Room 238
University City Office Bldg.

VIRGINIA TECH

Division of Administrative
and Educational Services

University City Office Building
Blacksburg, VA 24061

June 11, 1987

Bill Honig
Superintendent of Public Instruction
Department of Education
721 Capitol Mall
Sacramento, CA 95814

Dear Mr. Honig:

I am requesting information that your office may have regarding the state special laws and policies that may determine the legal boundaries on educational placement of children with the AIDS virus in California. The information is being compiled as part of a research study analyzing the legal issues related to the educational placement of students in the public schools with AIDS.

The research study is an attempt to develop an information source to the professional who must make informed conclusions on public school attendance policies. California has been chosen as one of ten states to be included in the study for profile. Results of the study will be shared with those interested individuals involved in educational policy at both state and local level.

Your assistance will be greatly appreciated.

Sincerely,

Wemme E. Walls
Doctoral Candidate
Special Education
Administration and
Supervision
Room 238
University City Office Bldg.

VIRGINIA TECH

Division of Administrative
and Educational Services

University City Office Building
Blacksburg, VA 24061

June 11, 1987

Ms. Anne Ramsey
Coordinator
Student Instructional Services
State Department of Education
1020 Monticello Court
Montgomery, AL 36117-1901

Dear Ms. Ramsey:

I am presently conducting research for a doctoral dissertation, "An Analysis of the Legal and Medical Issues Related to the Educational Placement of Students in the Public Schools with AIDS, ARC, or Asymptomatic Virus." Dr. Philip R. Jones, chairperson of my dissertation committee, has suggested that I contact you concerning information pertinent to the topic under consideration.

State statutes, federal legislation, and case law relevant to the issue will be reviewed. I am requesting information that you may have regarding the state special education laws and policies that may determine the legal boundaries for decisions on educational placement of children with the AIDS virus in Alabama.

The information will be used to develop a resource that includes selected state profiles which will attempt to provide information to the professional who must make informed conclusions on the public school attendance policies for students with a potentially lethal, complex, and controversial virus.

Your assistance will be greatly appreciated.

Sincerely,

Wemme E. Walls
Doctoral Candidate
Special Education
Administration and
Supervision
Room 238
University City Office Bldg.

VIRGINIA TECH

Division of Administrative
and Educational Services

University City Office Building
Blacksburg, VA 24061

June 11, 1987

Robert Schwartz, M.D.
Alternate Chairman
North Carolina Chapter of
American Academy of Pediatrics
Charlotte Memorial Hospital
P.O. Box 32861
Charlotte, NC 28232

Dear Dr. Schwartz:

I am presently conducting research for a doctoral dissertation concerning the medical and legal issues of educational placement for students with AIDS, ARC, or asymptomatic virus. Your name has been listed with the American Academy of Pediatrics as the state chapter chairperson available for information on AIDS.

I am requesting information regarding the North Carolina laws and policies that may determine the medical and legal boundaries for decisions on educational placement of children with the AIDS virus.

The information will be used to develop a resource that will attempt to provide information to the professional who must make informed decisions on the public school attendance policies for students with a potentially lethal, complex, and controversial virus.

Your assistance will be greatly appreciated.

Sincerely,

Wemme E. Walls
Doctoral Candidate
Special Education
Administration and
Supervision
Room 238
University City Office Bldg.

VIRGINIA TECH

Division of Administrative
and Educational Services

University City Office Building
Blacksburg, VA 24061

June 11, 1987

George Prince, M.D.
Chairman
North Carolina Chapter of
American Academy of Pediatrics
3709 St. Regis Drive
Gastonia, NC 28054

Dear Dr. Prince:

As indicated in my letter of April 30, your name has been listed with the American Academy of Pediatrics as the state chapter chairperson available for information on AIDS. I am requesting any available information that you may have regarding the North Carolina laws and policies that may determine the medical and legal boundaries for decisions on educational placement of children with the AIDS virus.

Your assistance in providing information concerning the medical and legal issues of educational placement for students with AIDS, ARC, or asymptomatic virus will be beneficial in developing a national profile on the policies being developed and utilized regarding public school attendance for this identified population of students.

Your colleague, Dr. Joseph R. Zanga, Chairman of the Virginia Chapter of AAP, was kind enough to share the Academy's recommendations established on school attendance that appeared in Pediatrics, March, 1986. Any additional information specific to North Carolina policy would be most beneficial.

Thank you for your cooperation.

Sincerely,

Wemme E. Walls
Doctoral Candidate
Special Education
Administration and
Supervision
Room 238
University City Office Bldg.

Virginia Polytechnic Institute and State University

VIRGINIA TECH

Division of Administrative
and Educational Services

University City Office Building
Blacksburg, VA 24061

June 11, 1987

Spencer E. Covert, Jr.
Parker and Covert
1901 East 4th Street
Suite 312
Santa Ana, CA 92705

Dear Mr. Covert:

As indicated in my letter of April 30, Ms. Jean B. Arnold, a member of my dissertation committee, has suggested that I contact you concerning information pertinent to research I am presently conducting for a doctoral dissertation, "An Analysis of the Legal and Medical Issues Related to the Educational Placement of Students in the Public Schools with AIDS, ARC, or Asymptomatic Virus."

State statutes, federal legislation, and case law relevant to the issue will be reviewed. I am requesting any available information or resources that you may have regarding the state antidiscrimination laws, state public health laws, and state special education laws and policies that may determine the legal boundaries for decisions on educational placement of children with the AIDS virus in California.

The information will be used to develop a resource that includes selected state profiles which will attempt to provide information to the professional who must make informed conclusions on the public school attendance policies for students with a potentially lethal, complex, and controversial virus.

I appreciate that this is a busy time of the year, but your assistance will be greatly appreciated.

Sincerely,

Wemme E. Walls
Doctoral Candidate
Special Education
Administration and
Supervision
Room 238
University City Office Bldg.

Virginia Polytechnic Institute and State University

VIRGINIA TECH

Division of Administrative
and Educational Services

University City Office Building
Blacksburg, VA 24061

June 11, 1987

AIDS Action Council/Federation
of AIDS-Related Organizations
729 8th St., SE, #200
Washington, DC 20003

As indicated by my letter of April 30, I am requesting any available information or resources that your organization may have concerning the issue of educational placement of students in the public schools with AIDS, ARC, or asymptomatic virus. The information will be used in compiling a resource which will attempt to provide sources of data for the professional who must make informed decisions on public school attendance policies.

Your assistance will be most appreciated.

Sincerely,

Wemme E. Walls
Doctoral Candidate
Special Education
Administration and
Supervision
Room 238
University City Office Bldg.

APPENDIX D. PROGRAM ADVISORY, CALIFORNIA STATE DEPARTMENT OF

EDUCATION

PILL HONG
SUPERINTENDENT OF PUBLIC INSTRUCTION

CIL: 85/6-16

PROGRAM ADVISORY

CALIFORNIA STATE DEPARTMENT OF EDUCATION
721 CAPITOL MALL, SACRAMENTO, CA 95814

DATE: May 9, 1986

PROGRAM: School Health

CONTACT: Amanda Mellinger

PHONE:

TO: County and District Superintendents of Schools

FROM: James R. Smith, Deputy Superintendent
Curriculum and Instructional Leadership Branch

SUBJECT: AIDS Guidelines

Attached are guidelines for schools and districts regarding Acquired Immune Deficiency Syndrome (AIDS). The guidelines contain:

- o Information about AIDS and its transmission
- o General precautions schools should take against the spread of infectious diseases
- o Suggestions for schooling of students infected with the AIDS virus

The Department's guidelines are in concordance with the recommendations of the national Centers for Disease Control and the American Academy of Pediatrics. They have been reviewed for medical accuracy by the California Department of Health Services.

Any questions regarding the attached guidelines should be directed to Amanda Mellinger of our Health, Nutrition and Physical Education Programs at

CALIFORNIA STATE DEPARTMENT OF EDUCATION
GUIDELINES TO SCHOOL DISTRICTS REGARDING AIDS

Acquired Immune Deficiency Syndrome (AIDS) is a medical issue of concern confronting schools. This memorandum is designed to provide:

1. Information about AIDS and its transmission
2. Precautions schools should be taking routinely to prevent the spread of infectious diseases
3. Guidelines and information for schools on how to handle students with AIDS virus infection.

AIDS and Its Transmission

According to health authorities, AIDS is a communicable disease that is transmitted via blood and semen through intimate sexual contact with an infected person, sharing of contaminated needles, transfusion of infected blood, and from an infected mother to her child before or at birth or through breast-feeding. At this time no AIDS infections are known to have been transmitted through tears or saliva or from such common exposures as sneezing, coughing, shaking hands, opening doors, sitting on toilet seats, using dishes, eating food, casual kissing, changing diapers, or daily household or hospital contact with a person who has AIDS.

As of March, 1986, over 18,000 cases of AIDS had been reported to the national Centers for Disease Control (CDC); about half the victims have died. As of March 1, 1986, in California 3,982 AIDS cases had been reported, 42 percent of the victims have died. Incidence of AIDS has been confined to a relatively well-defined population.

	<u>National</u>		<u>California</u>
Homosexual or bisexual contact	72%	Homosexual male	83%
Heterosexual contact with an AIDS case	1%	Bisexual male	10%
Intravenous drug users	17%	Intravenous drug user	2%
HTLV-III in transfusion or blood product	3%	Hemophiliac	1%
Parent HTLV-III positive (in utero)	1%	Other	4%
Others	6%		

As of August 20, 1985, only 183 cases of pediatric AIDS had been reported to the CDC in Atlanta; 20% had received blood or blood products, 70% had a parent with AIDS or at high risk for AIDS, and 10% had incomplete risk factor information. In this same group, 58% were younger than one year at diagnosis; and 69% had died. Twenty-seven cases of AIDS have been reported and diagnosed among California pre-school and school-age youngsters.

Students With AIDS

Medical experts agree that the AIDS virus will not be transmitted in the usual school setting. The only reported cases of children with AIDS are children who received blood transfusions before donor screening programs were instituted, hemophiliacs and children born with AIDS from infected mothers. Because blood is now screened for the AIDS virus, hemophiliacs are unlikely to contract AIDS through contaminated blood. Most of the other pediatric population--children born with AIDS--die within two years, long before they enter school.

There is no evidence of contracting AIDS through casual contact. For example, siblings of children with AIDS, even after sharing toothbrushes and towels and being in daily contact with victims, have not become infected with the virus.

Decisions regarding the type of education and care setting for students diagnosed as having AIDS should be made on a case-by-case basis depending on the age, behavior, neurological development, and physical condition of the child and the expected type of interaction with others in that setting. These decisions should be made by a team composed of the student's physician, public health personnel, the student's parent or guardian, and a school representative. In each case the rights and benefits of the infected student must be weighed against those of the rest of the school population.

It should be emphasized that blanket, a priori decisions regarding exclusion of infected students may be very appealing and seem to be the safe approach to the situation. However, such an expedient overall policy may prove to be counterproductive to the public health because of the reluctance of a physician (see below on confidentiality) to reveal diagnoses if it is known that the revelation will automatically exclude the student from school.

Preschool and Severely Handicapped Students

For the small number of young victims who survive to preschool or school-age, the national Centers for Disease Control (see attachment) point out that some infected students pose more of a risk than others and should be placed in a restrictive educational setting such as home instruction. This restriction would apply to preschool children, severely handicapped students, and other infected students who lack control over their body fluids, display biting behavior, have uncoverable sores or lesions, or have need for medical procedures (such as colostomy care) which might induce bleeding. In these cases, the CDC recommends that "a more restricted environment is advisable until more is known about transmission in these settings."

Confidentiality

California state law (Health and Safety 199.20-199.22) requires physicians and health officials to obtain written authorization from the patient before disclosing results of blood tests for antibody to the AIDS virus. Importantly, there is no legal requirement that school authorities must be notified. Thus, it becomes apparent why a feeling of trust and cooperation should exist between school officials and health authorities.

The Governing Board of a School District has the legal responsibility of determining whether or not a child should attend regular school classes. Thus, we believe that the Governing Board should be given any information that would impact on this responsibility. Local health department officials have a general authority over the control of communicable diseases; however, public health officials have no obligation to inform school authorities of the incidence of students infected with AIDS virus. Moreover, local health departments and the State Department of Health Services will not be aware of many children who are infected with the AIDS virus since current state law prohibits the disclosure of AIDS antibody test results without specific written authorization of the person tested.

High School Students

Secondary students need to be educated regarding AIDS and its transmission. Students sexually active or experimenting with drugs need specific information: AIDS is spread through blood and semen -- through sharing of needles and sexual intercourse. This information needs to be integrated into existing instructional courses.

Classes on sexually transmitted diseases are currently taught in schools following the Health Instruction Framework for California Public Schools. The State Department of Education's newly revised document "Teaching About Sexually Transmitted Diseases" includes an update on AIDS. Other areas of instruction need to be supplemented as follows:

- o Integrate education on AIDS in a Community Health Unit following the Framework.
- o Integrate education on AIDS in substance abuse curriculum regarding the transmission of AIDS via intravenous drug use.
- o Integrate education on AIDS in parenting and child development classes regarding the transmission of AIDS through infected mothers.

Routine Precautions

Those making recommendations for the prevention of AIDS virus transmission in school must recognize the likelihood that students and/or adults infected with AIDS virus attending school may not be known to school personnel, either because those infected are incubating the virus, are asymptomatic carriers, are undiagnosed, or are diagnosed but have physicians or parents who have chosen not to inform the school for reasons of confidentiality. Thus, it is not only the identified student or adult infected with AIDS virus for whom precautions need to be taken. Schools should not wait until they encounter an identified student or adult infected with AIDS virus before updating their infectious disease prevention techniques.

All schools should consider periodically informing parents, students, and school personnel regarding infectious disease prevention techniques in the school, regardless of whether the student or adult with an identified infectious disease is known to the school. The goal is to protect our entire school population, without segregation, discrimination, or stigma.

The following areas need reinforcement:

- o Basic hygiene, preschool through 12th grade, e.g., HANDWASHING. Refer to the State Department of Education's publication, "Techniques for Preventing the Spread of Infectious Diseases," which includes a protocol for handwashing and specifies removal of jewelry, using liquid soap, warm running water for washing and rinsing hands, and drying hands well with paper towels which are immediately discarded.
- o Nonsterile disposable gloves should be worn (particularly persons with chapped or cracked skin, eczema, sores, cuts or wounds) when handling blood (such as providing care for nosebleeds, bleeding gums, cuts or wounds); blood-soiled items (such as menstrual pads, bandages or clothing); or secretions (particularly from open sores); as well as surfaces, materials, and objects exposed to them. Gloves should be worn when changing diapers or handling vomitus, urine or feces for a student infected with AIDS. Disinfectant (a 1 in 10 solution of chlorine bleach in water) should be employed in clean-up.

Assistance for School districts

School districts that desire outside assistance in developing policy on handling of an AIDS case may contact the State Department of Education. In cooperation with other state and local medical, health, legal and educational agencies, we will form teams of experts to assist local educational agencies in dealing with this important issue.

APPENDIX E. STATE OF CONNECTICUT

- **Administrative Guidelines for Providing Education to Students with AIDS/ARC**
- **Guidelines for Handling Body Fluids in Schools**
- **Educating Students with Chronic Infectious Diseases: A Model Policy for Local Board of Education**

ADMINISTRATIVE GUIDELINES FOR PROVIDING EDUCATION TO STUDENTS WITH AIDS/ARC

The administrative guidelines for local school districts have been prepared by the Joint Task Force on Educating Children with Pediatric Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related Complex (ARC). AIDS and milder immune deficiency syndromes associated with AIDS virus infection such as ARC are transmitted through intimate sexual contact or blood to blood contact. Children with either AIDS or ARC should not pose a health risk to other children or staff in a school setting.

The following guidelines are intended to provide districts with a framework on which to develop programs to meet the needs of all children for whom the public schools are responsible.

1. All children in Connecticut have a constitutional 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) the 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 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) which could result in direct inoculation of potentially infected body fluids into the bloodstream. If any of these circumstances exist the school medical advisor, in consultation with 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 #6 until either an appropriate school program adjustment can be made, 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 which 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 accommodate the child's needs.
 - (d) In any case of temporary removal of the student from the school setting, 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 immunodeficient 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 & 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.

GUIDELINES FOR HANDLING BODY FLUIDS IN SCHOOLS

Recent concern about how children with AIDS should be educated has raised several questions regarding exposure of teachers and children to potentially infectious body fluids from children with communicable diseases in the school setting:

1. Does contact with body fluids present a risk of infection?
2. What should be done to avoid contact with potentially infected body fluids?
3. What should be done if direct contact with body fluids is made?
4. How should such fluids when spilled be removed from the environment?

The following guidelines are meant to provide simple and effective precautions against transmission of disease for all persons, including pregnant women, potentially exposed to the blood or body fluids of any student. No distinction is made between body fluids from students with a known disease or those from students without symptoms or with an undiagnosed disease.

DOES CONTACT WITH BODY FLUIDS PRESENT A RISK?

The body fluids of all persons should be considered to contain potentially infectious agents (germs). The term "body fluids" includes: blood, semen, drainage from scrapes and cuts, feces, urine, vomitus, respiratory secretions (e.g., nasal discharge) and saliva. Contact with body fluids presents a risk of infection with a variety of germs. In general, however, the risk is very low and dependent on a variety of factors including the type of fluid with which contact is made and the type of contact made with it.

Table 1 (page 6) provides examples of particular germs that may occur in body fluids of children and the respective transmission concerns. It must be emphasized that with the exception of blood, which is normally sterile, the body fluids with which one may come in contact usually contain many organisms, some of which may cause disease. Furthermore, many germs may be carried by individuals who have no symptoms of illness. These individuals may be at various stages of infection: incubating disease, mildly infected without symptoms, or chronic carriers of certain infectious agents including the AIDS and hepatitis viruses. In fact, transmission of

communicable diseases is more likely to occur from contact with infected body fluids of unrecognized carriers than from contact with fluids from recognized individuals because simple precautions are not always carried out.

Table 1
Transmission Concerns in the School Setting
Body Fluid Source of Infectious Agents

Body Fluid-Source	Organism Of Concern	Transmission Concern
Blood -cuts/abrasions -nosebleeds -menses -contaminated needle	Hepatitis B virus AIDS virus Cytomegalovirus	Blood stream inoculation through cuts and abrasions on hands Direct blood stream inoculation
*Feces -incontinence	Salmonella bacteria Shigella bacteria Rotavirus Hepatitis A virus Giardia	Oral inoculation from contaminated hands
*Urine -incontinence	Cytomegalovirus	Bloodstream and oral (?) inoculation from contaminated hands
Respiratory Secretions -saliva -nasal discharge	Mononucleosis virus Common cold virus Influenza virus AIDS virus Hepatitis B virus	Oral inoculation from contaminated hands Bloodstream inoculation through cuts and abrasions on hands; bites
*Vomitus	Gastrointestinal viruses, e.g., (Norwalk agent Rotavirus)	Oral inoculation from contaminated hands
Semen	Hepatitis B virus AIDS virus Gonorrhea	Sexual contact (intercourse)

*Possible transmission of AIDS and Hepatitis B is of little concern from these sources unless blood or inflammation is present.

WHAT SHOULD BE DONE TO AVOID CONTACT WITH BODY FLUIDS?

When possible, direct skin contact with body fluids should be avoided. Disposable gloves should be available in at least the office of the custodian, nurse, or principal. Gloves are recommended when direct hand contact with body fluids is anticipated (e.g., treating bloody noses, handling clothes soiled by incontinence, cleaning small spills by hand). If extensive contact is made with body fluids, hands should be washed afterwards. Gloves used for this purpose should be put in a plastic bag or lined trash can, secured, and disposed of daily.

WHAT SHOULD BE DONE IF DIRECT SKIN CONTACT OCCURS?

In many instances, unanticipated skin contact with body fluids may occur in situations where gloves may be immediately unavailable (e.g., when wiping a runny nose, applying pressure to a bleeding injury outside the classroom, helping a child in the bathroom). In these instances, hands and other affected skin areas of all exposed persons should be routinely washed with soap and water after direct contact has ceased. Clothing and other nondisposable items (e.g. towels used to wipe up body fluid) that are soaked through with body fluids should be rinsed and placed in plastic bags. If presoaking is required to remove stains, (e.g. blood, feces), use gloves to rinse or soak the item in cold water prior to bagging. Clothing should be sent home for washing with appropriate directions to parents/teachers (see page 9). Contaminated disposable items (e.g., tissues, paper towels, diapers) should be handled as with disposable gloves.

HOW SHOULD SPILLED BODY FLUIDS BE REMOVED FROM THE ENVIRONMENT?

Most schools have standard procedures already in place for removing body fluids (e.g., vomitus). These procedures should be reviewed to determine whether appropriate cleaning and disinfection steps have been included. Many schools stock sanitary absorbent agents specifically intended for cleaning body fluid spills (e.g., ZGOOP, Parson Mfg. Co., Philadelphia, PA). Disposable gloves should be worn when using these agents. The dry material is applied to the area, left for a few minutes to absorb the fluid, and then vacuumed or swept up. The vacuum bag or sweepings should be disposed of in a plastic bag. Broom and dustpan should be rinsed in a disinfectant. No special handling is required for vacuuming equipment.

HANDWASHING PROCEDURES

Proper handwashing requires the use of soap and water and vigorous washing under a stream of running water for approximately 10 seconds.

Soap suspends easily removable soil and microorganisms allowing them to be washed off. Running water is necessary to carry away dirt and debris. Rinse under running water. Use paper towels to thoroughly dry hands.

DISINFECTANTS

An intermediate level disinfectant should be used to clean surfaces contaminated with body fluids. Such disinfectants will kill vegetative bacteria, fungi, tubercle bacillus and viruses. The disinfectant should be registered by the U.S. Environmental Protection Agency (EPA) for use as a disinfectant in medical facilities and hospitals.

Various classes of disinfectants are listed below. Hypochlorite solution (bleach) is preferred for objects that may be put in the mouth.

1. Ethyl or isopropyl alcohol (70%)
2. Phenolic germicidal detergent in a 1% aqueous solution (e.g., Lysol*).
3. Sodium Hypochlorite with at least 100 ppm available chlorine (1/2 cup household bleach in 1 gallon water, needs to be freshly prepared each time it is used).
4. Quaternary ammonium germicidal detergent in 2% aqueous solution (e.g., Tri-quat*, Mytar* or Sage*).
5. Iodophor germicidal detergent with 500 ppm available iodine (e.g., Wescodyne*).

DISINFECTION OF HARD SURFACES AND CARE OF EQUIPMENT

After removing the soil, a disinfectant is applied. Mops should be soaked in the disinfectant after use and rinsed thoroughly or washed in a hot water cycle before rinse. Disposable cleaning equipment and water should be placed in a toilet or plastic bag as appropriate. Non-disposable cleaning equipment (dust pans, buckets) should be thoroughly rinsed in the disinfectant. The disinfectant solution should be promptly disposed down a drain pipe. Remove gloves and discard in appropriate receptacles.

* Brand names used only for examples of each type of germicidal solution and should not be considered an endorsement of a specific product.

APPENDIX F. HILLSBOROUGH COUNTY, FLORIDA, PUBLIC SCHOOLS,
PROTOCOL FOR INTERDISCIPLINARY TEAMS REVIEWING CASES OF
STUDENTS WITH ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

Hillsborough County Public Schools
Protocol for Interdisciplinary Team
Reviewing Cases of Students with
Acquired Immunodeficiency Syndrome (AIDS)

I. Statement of Purpose:

An interdisciplinary team should be appointed for the purpose of making recommendations on the appropriate educational environment for students with AIDS. Recommendations should be based on the medical, educational and social information for the individual and take into consideration the most recent CDC guidelines. (Recommendation adopted by the Hillsborough County School Board, October 22, 1985.)

II. Team Members:

Permanent members

- A. Director/assistant director of the Hillsborough County Health Department. Dr. Donald Kwalick; alternate, Dr. Helen Moore
- B. Supervisor of the School Health Program, Hillsborough County Health Department. Barbara Kinnee; alternate, Bobbie Thackeray
- C. Physician from the College of Medicine, University of South Florida (Allergy and Immunology). Dr. Richard Lockey; alternate Dr. Dennis Ledford
- D. Upper level administrator, Hillsborough County Public Schools, Orlan Briant.
- E. General Director/assistant director from the Department of Education for Exceptional Students, Hillsborough County Public Schools, Dr. Monte Betz; alternate, Liz Argott.
- F. Supervisor, School Health Services, Department of Student Services, Hillsborough County Public Schools, Mary Ellen Gillette.

Other participants

- A. Parents of student; student on parental request*
- B. Attending physician of student
- C. Principal of student's school

*Note: Parents will be informed prior to meeting that medical data, as well as educational information, will be discussed.

III. Team Responsibilities:

- A. To review student's medical history in tandem with current CDC guidelines.
- B. To review available educational and social data - progress reports, test results, prior school placements.
- C. To advise parents of various educational options; e.g., homebound, home education.
- D. To discuss with the parents points to consider if regular school placement is sought; e.g., issues of employee right-to-know, possible community reaction.
- E. To submit team recommendations to superintendent.
- F. To re-evaluate all cases on a regular schedule.

IV. Roles of Permanent Team Members

- A. Director/ Assistant Director, Hillsborough County Health Department and USF physician -
 - 1. To review medical information presented by student's attending physician/s
 - 2. To present to the team medical opinions based on the individual's history and current status in relationship to most recent Centers for Disease Control guidelines. (to be provided by the director at the Hillsborough County Health Department)
- B. General Director/assistant director from the Department of Education for Exceptional Students, Hillsborough County Public Schools
 - 1. To coordinate with the principal/curriculum intervention specialist from the student's school the presentation to the team of existing educational and social data - progress reports, test results, prior school placements.
 - 2. To present educational options available to student.
- C. Upper level administrator, Hillsborough County Public Schools
 - 1. To present to parents and the team points to consider if placement in a regular school setting is sought and/or recommended.
 - 2. To coordinate with the Division of Personnel recommendations of the team impacting on the assignment of staff.
- D. Supervisor of the School Health Program, Hillsborough County Health Department
 - 1. To serve as recorder for the team meetings
 - 2. To assist the supervisor of School Health Services (school district) with the preparation of the team's report (recommendations)
- E. Supervisor of School Health Services, Hillsborough County School District
 - 1. To serve as facilitator for the team (alert appropriate persons, arrange meeting time, place, etc.)
 - 2. To prepare and distribute team's report to appropriate persons

V. Procedure for Reviewing Cases

- A. Prior to team meeting
 - 1. Requests to serve students with AIDS will be forwarded to the Department of Student Services, Office of School Health Services (272-4589)
 - 2. Facilitator (Supervisor of School Health Services) will take the following action on receipt a request:
 - a. Alert team members, superintendent and assistant superintendents for instruction, operations and personnel of request.
 - b. Contact parents and discuss protocol. If parents request a home setting, the three school board members will meet with the family. Other team members will be informed of this decision and the educational plan agreed upon.

- c. Obtain written authorization from parents to contact student's attending physician/s
- d. Upon receiving authorization request attending physician/s to forward medical records to team physicians (Health Department Director and USF physician)
- e. Set date and place for team meeting and send written invitations to team members, parents, attending physician/s and principal of the school to which the student is assigned

B. Meeting Format

1. Introductions - facilitator
2. Presentation and discussion of medical data - student's attending physician and team physicians
3. Presentation of educational and social data - DEES general director/assistant director and principal
4. Presentation of school district's obligations if regular placement is sought - upper level administrator, school district
5. Discussion by parent; questioning of team by parent
- *6. Decision by parent; recommendation of team
*Note: This final activity could be delayed if parent wished time to consider options or if permanent team members felt additional information or discussion was needed.

C. Post-meeting activities

1. Supervisors of School Health Services from the Health Department and the School District will prepare the written report.
2. Facilitator (supervisor, School Health Services from the school district) will distribute drafts of the report to permanent team members.
3. Team members will contact facilitator on the receipt of report regarding any needed corrections
4. Facilitator will submit amended report to the superintendent with copies to team members.

**APPENDIX G. STATE OF ILLINOIS, ILLINOIS STATE BOARD OF
EDUCATION/ILLINOIS DEPARTMENT OF PUBLIC HEALTH**

- Management of Chronic Infectious Diseases in School Children
- Procedures for School Management of Infectious Disease

CHAPTER ONE

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 [*cf. White v. Western School Corp.*, #IP 85-1192-C, USDC, 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 EHRL 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 right 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 students 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 placements.
- 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. Recommendations 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 minimum, 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 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. The 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 diseases:
- 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 responsibility 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 hygenic 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.

CHAPTER THREE

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 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 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 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 an coat or smock (or large blouse or shirt to cover street clothes) in preparation for working with the students
 - 2 Before drinking, eating, or smoking
 - 3 Before handling clean utensils or equipment
 - 4 Before and after 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, 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 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 upon contact before applying a disinfectant
- 1 Use paper towels to absorb 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 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 seat, 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 VII)
- 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 a cloth or 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 VII)

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, nonsterile) if needed
 - e Disinfectant (see Section VII)
 - 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 utensils 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 area 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 school linens 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 nonchlorox bleach (e.g., Chlorox 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 surfaces, 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 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. (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 Quaternary ammonium germicidal detergent solution (2 percent aqueous solution)
 - c Iodophor germicidal 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 H. STATE OF MARYLAND

- Acquired Immune Deficiency Syndrome/HIV Infection: Recommendations for the Education of Children
- Recommended Public Health Educational Efforts
- Communicable Disease Policy Adopted by Consortium of Nine Eastern Shore Counties

Governor's Task Force Recommendations

**ACQUIRED IMMUNE DEFICIENCY SYNDROME/HIV INFECTION:
RECOMMENDATIONS FOR THE EDUCATION OF CHILDREN**

The Human Immuno Deficiency virus is the viral agent responsible for Acquired Immune Deficiency Syndrome (AIDS). Persons who become infected with the virus: (1) may develop AIDS, which is fatal; (2) may develop an illness which is less severe and non-fatal; or (3) may experience no symptoms of the disease.

The spread of AIDS/HIV to infants and children has resulted in questions regarding whether and how these children can be managed or placed in the school setting. Highly charged emotional issues related to HIV infection require that the placement and/or management of these children in the school setting be based on available evidence regarding the risks of transmission of the HIV agent to others in the school setting and the risks to the child with HIV infection of acquiring other infectious agents in the school setting, along with the careful consideration of the confidentiality and legal issues involved.

Based on current evidence, casual person-to-person contact as would occur among school children poses no risk of transmission of HIV, the viral agent responsible for AIDS. However, a theoretical potential for transmission between young children or neurologically handicapped children who lack control of their body secretions may exist; this theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes of a susceptible person to the blood and possibly other body fluids of an infected person.

Since HIV infections may result in immune deficiency, the infected child may have a greater risk of acquiring infectious agents. Assessment of this risk to the immuno-depressed child is best made by the child's physician who is specifically aware of the individual child's immune status.

The following recommendations apply to all children known to be infected with HIV, regardless of whether or not actual symptoms of disease are present:

1. Decisions regarding the type of educational setting for the HIV infected child should be made on a case-by-case basis taking into account the child's behavior, neurologic development, and physical condition. These decisions are best made using the team approach, including the child's physician, the child's parent or guardian, and personnel from the local education agency and local health department, and should be reviewed and approved by the local superintendent/local board of education.
 - (a) For school-aged children infected with HIV, the benefits of an unrestricted setting in most cases outweigh the risks of their acquiring potentially harmful infections in the school setting. These children should be allowed to attend school and after-school day care in an unrestricted setting. A mechanism for the sharing of information between the child's physician and the school authorities is recommended so that a significant change in the child's medical status can be addressed. In addition, if the school experiences an outbreak of a communicable disease which could be threatening to a child infected with HIV, (e.g., chickenpox, measles), the child should be temporarily excluded by the principal, pending consultation with the child's physician.

- (b) The following HIV infected children should be excluded from the classroom:
 - (1) Those who lack control of body secretions.
 - (2) Those exhibiting behavioral problems, such as biting.
 - (3) Those with uncoverable, oozing lesions.
 - (c) Evaluation to assess the continued need for exclusion should be performed regularly.
2. Persons involved in the education of HIV 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 to the minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase, e.g., bleeding injury. In individual situations, such people may include the following: principal, school nurse, and the child's teacher(s). Notification should be done by a process that would maximally assist patient confidentiality--ideally, by direct person-to-person contact. It is not necessary to notify parents of other school children regarding the HIV status of any school child.
 3. Screening for HIV infection as a condition for school entry is not warranted based on available data.

RECOMMENDED PUBLIC HEALTH EDUCATIONAL EFFORTS

1. As a coordinated activity between the local education agency and the local health department, regardless of whether HIV infected children are involved, steps should be taken to educate parents, students, and school employees regarding HIV and its transmission. Such education would serve to reduce the risk of transmission to others and to assist efforts to provide the best education for infected children.
2. All schools should adopt routine procedures to minimize the transmission of communicable diseases. Handwashing (with soap and running water for 15-30 seconds and drying with disposable paper towels) is the single most important technique for preventing the spread of disease and should be done frequently. In addition, specific precautions should be taken whenever there is potential for contact with the blood or body fluids of children:
 - (a) Exposure of open skin lesions or mucous membranes to blood or body fluids should be avoided. If open lesions are present, disposable gloves should be worn.
 - (b) Surfaces soiled with blood or body fluids should be immediately and thoroughly cleaned. It is advisable to cover the blood/body fluids with paper towels, flood with a solution of one cup of household bleach in 9 cups of water, and allow it to remain for at least 15 minutes before disposing of paper towels.
 - (c) Disposable materials, e.g., gloves, paper towels, sanitary napkins, should be promptly discarded into sealable plastic bags.

- (d) Mops and other non-disposable cleaning materials are not recommended, but if used, should be rinsed in the disinfectant.
 - (e) Hands should be washed thoroughly after contact with the blood or body fluids of any child, including after removing disposable gloves.
3. All students in a dormitory setting should be educated about appropriate hygiene measures to reduce the risk of household transmission of communicable diseases. Specifically, students should be taught to avoid the sharing of items which increase the potential for exposure to blood, e.g., toothbrushes, razors, nail files. As stated in #2 above, routine procedures for handling blood, body fluids, and soiled surfaces should be adopted, regardless of whether individuals with HIV infection are in residence. For HIV infected students in a dormitory setting, a private room may be desirable but is not mandatory.

Adapted from the Morbidity and Mortality Weekly Report (MMWR), August 30, 1985.

Policy Adopted by Consortium of Nine Eastern Shore Counties

Policy: COMMUNICABLE DISEASES (IA-34)

Communicable Diseases: An illness due to a specific infectious agent or its toxic products which arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host, either directly or indirectly, through an intermediate plant or animal host, vector, or the inanimate environment.

A. Purpose

The purpose of this policy is to insure that necessary regulations and procedures are established to:

1. Identify students and employees having a communicable disease.
2. Make decisions about the placement of students and the assignment of employees identified as having a communicable disease.
3. Provide employees, students, and parents with accurate information about communicable diseases and modes of transmission.

B. Process and Content

1. The Superintendent of Schools shall develop, with the advice of the local health department, appropriate regulations and procedures for the identification of students and employees having a communicable disease.
2. The Superintendent of Schools shall develop appropriate regulations and procedures regarding the appropriate educational setting for students with communicable diseases. Decisions should be made on a case-by-case basis based on the behavior, neurologic development, and physical condition of the child. Where appropriate, evaluations should be made using a team approach with the placement decision being made by the Superintendent of Schools. The team might typically include the student's physician, the student's parent or guardian, the local health department, and a designee of the Superintendent of Schools.
3. The Superintendent of Schools shall develop appropriate regulations and procedures regarding the appropriate placement or assignment of employees with communicable diseases. Decisions should be made on

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a case-by-case basis based on the behavior, neuro-logic development, and physical condition of the employee. Where appropriate, evaluations should be made using a team approach with the placement/assignment decision being made by the Superintendent of Schools. The team might typically include the employee's physician, the employee, the local health department, and a designee of the Superintendent of Schools.

4. The Superintendent of Schools shall direct the development and dissemination of educational materials to provide accurate information about communicable diseases to students, their parents, and school system employees.
5. The right to privacy of any student or employee with a communicable disease shall be respected and communications shall be limited to those persons who, in the Superintendent's judgment, need to be informed.

C. Authority: Annotated Code of Maryland, Education Article
Section 7-401: School Health Program

"Duty of county board. - With the assistance of the county health department, each county board shall provide:

- (1) adequate school health services;
- (2) instruction in health education; and
- (3) a healthful school environment."

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Administrative Regulation

Procedure: COMMUNICABLE DISEASES

A. Purpose

1. To identify students and employees having a communicable disease.
2. To make decisions about the placement of students and the assignment of employees identified as having a communicable disease.
3. To provide employees, students, and parents with accurate information about communicable diseases and modes of transmission.

B. Regulations and Procedures

1. Students: Any student suspected of having a communicable disease shall be isolated in the health room and the following steps will occur:
 - a. The principal or the principal's designee will notify parents to arrange for transfer of the student to home.
 - b. The principal will report all suspected or diagnosed cases of reportable communicable diseases to the Supervisor of Pupil Services who, in turn, will notify the local health department.
 - c. Decisions regarding the type of educational setting for students with communicable diseases will be made on a case-by-case basis by the Superintendent of Schools based on available medical knowledge and the behavior, neurologic development, and physical condition of the student. For many communicable diseases these decisions are best made using the advice of a team consisting of the student's physician, the student's parent or guardian, a designee of the local health officer, the school principal, and the Supervisor of Pupil Services or a designee. When the team approach is used, the designee of the local health officer will prepare and forward a recommendation to the Superintendent of Schools who will make the placement decision.

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I-72

d. Parents of students and students who are known carriers of a communicable disease shall be informed about the control measures for minimizing the transmission of the specific disease. All students will be informed about appropriate hygiene measures to prevent the spread of the communicable disease.

2. Employees: Where an employee is suspected of having a communicable disease, the following procedures shall apply:

- a. The principal or the principal's designee will request the employee to leave the school premises.
- b. The principal will report all suspected cases or diagnosed cases of reportable communicable diseases to the Supervisor of Pupil Services who, in turn, will notify the local health department.
- c. Decisions regarding the type of assignment, i.e., whether an infected employee should be permitted to remain employed in a capacity that involves contact with students or other school employees, will be made on a case-by-case basis by the Superintendent of Schools. For many communicable diseases these decisions are best made using the advice of a team consisting of the employee, the employee's physician, a designee of the local health officer, and the Assistant Superintendent. When the team approach is used, the designee of the local health officer will prepare and forward a recommendation to the Superintendent of Schools who will make the assignment decision. In making a decision, the following shall be considered: (1) available medical knowledge; (2) the physical condition of the employee; (3) the expected type of interaction with others in the school setting; and (4) the impact on both the infected school employee and others in that setting.

3. Education Programs About Communicable Diseases

- a. Information about communicable diseases will be included in the health education curriculum for students.

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- b. Inservice training will be provided for all central office and school-based personnel concerning communicable diseases and the modes of transmission.
- c. Principals will arrange for information sharing with parents about communicable diseases as it deemed appropriate by the Superintendent and principal.

4. Right to Privacy

Persons involved with the education of a student or the supervision of an employee with a communicable disease shall respect that person's right to privacy. The number of people aware of the person's condition should be limited to those people who need to know in order to take necessary precautions in working with the infected person.

Reportable Communicable Diseases and Conditions

AIDS	Mumps (Parotitis)
Animal Bites	Occupational Diseases
Anthrax	Pertussis
Botulism	Plague
Brucellosis	Poliomyelitis
Chancroid	Psittacosis
Cholera	Rabies
CMV	Post-Exposure Rabie Prophylaxis
Diphtheria	Relapsing Fever
Encephalitis (specify Etiology)	Reye's Snydrome
Food Poisoning Outbreak	Rocky Mountain Spotted Fever
Gonococcal Infection	Rubella (German Measles)
Granuloma Inguinale	Rubella Syndrome, Congenital
Guillain-Barre Syndrome	Rubeola (measles)
Hepatitis, Viral:	Salmonellosis
A (Infectious)	Shigellosis
B (Serum)	Small Pox
Non-A, Non-B	Staphylococcal and Other
Unspecified	Infections in Newborn
Kawasaki Disease	Syphilis
Legionellosis (Legionnaires' Disease)	Tetanus
Leprosy	Trichinosis
Leptospirosis	Tuberculosis
Lymphogranuloma Venereum	Tularemia Typhoid Fever
Malaria	Typhus
Meningitis (specify Etiology)	Yellow Fever

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APPENDIX I. COMMONWEALTH OF MASSACHUSETTS

- School Attendance Policy on AIDS/Acquired Immune Deficiency Syndrome
- Public Health Facts Sheets on AIDS
- Guidelines and Procedures Concerning AIDS--Boston Public Schools

**AIDS/Acquired Immune Deficiency Syndrome
Massachusetts School Attendance Policy***

Epidemiologic studies show that AIDS is transmitted via sexual contact or blood to blood contact. To date, there is no recorded transmission of AIDS to family members who are non-sexual contacts. This fact is also 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 by the Governor's Task Force on AIDS for implementation in school systems throughout the Commonwealth.

1. All children diagnosed as having AIDS or with clinical evidence of infection with the AIDS associated virus (HTLV-III) and receiving medical attention are able to attend regular classes.
 - A. If a child has cutaneous (skin) eruptions or weeping lesions that cannot be covered, he/she should not be in school.
 - B. If the child exhibits inappropriate behavior which increases the likelihood of transmission (i.e. biting or frequent incontinence), he/she should not be in school.
 - C. Children diagnosed with AIDS or with clinical evidence of infection with the AIDS associated virus (HTLV-III), who are too ill to attend school, should have an appropriate alternative education plan.
 - D. Siblings of children diagnosed as having AIDS or with clinical evidence of infection with the AIDS associated virus (HTLV-III) are able to attend school without any further restrictions.
2. The child's personal physician is the primary manager of the child diagnosed as having AIDS or with clinical evidence of infection with the AIDS associated virus (HTLV-III). Management includes acting as the "gate keeper" for the child's attendance at school in accordance with the policy outlined above.
 - A. The child's personal physician, after consultation with the family, is responsible for reporting cases of AIDS to the Massachusetts Department of Public Health's Division of Communicable Disease. The school superintendent will be notified and will provide assistance in identifying those educational or health care agents with an absolute need to know.
 - B. Only persons with an absolute need to know should have medical knowledge of a particular student. In individual situations, the superintendent might notify one or more of the following:
 - Principal
 - School Nurse
 - Teacher

*Not Intended for Day Care.

- C. Notification should be by a process that would maximally assist patient confidentiality. Ideally, this process should be direct person to person contact.
 - D. If school authorities believe that a child diagnosed as having AIDS or with clinical evidence of infection with the AIDS associated virus (HTLV-II) has evidence of conditions described in #1, then the school authorities can dismiss the child from the class and request authorization from the child's personal physician so that class attendance is within compliance with the school policy.
 - E. If school authorities and the child's personal physician are in conflict, then the case should be referred to the Department of Public Health for review by an appointed physician who would determine the permissibility of attendance.
3. Since the child diagnosed as having AIDS or with clinical evidence of infection with the AIDS Associated virus (HTLV-III) has a somewhat greater risk of encountering infections in the school setting, the child should be excluded from school if there is an outbreak of a threatening communicable disease such as chicken pox or measles until he/she is properly treated (possibly with hyperimmune gamma globulin) and/or the outbreak has no longer become a threat to the child.
4. HTLV-III screening is a blood test for detecting the presence of antibody to the HTLV-III virus. Antibodies are substances produced by white blood cells that help fight infection caused by viruses or bacteria. Testing for HTLV-III antibody is not recommended for any purposes other than to assist the child's personal physicians in a highly selected set of clinical decisions. Results of HTLV-III antibody tests are confidential and should not be reported to schools.
5. Blood or any other body fluids including vomitus and fecal or urinary incontinence in any child should be treated cautiously. It is recommended that gloves be worn when cleaning up any body fluids.
- A. These spills should be disinfected with bleach (one part bleach to ten parts water), or another disinfectant, by pouring the solution around the perimeter of the spill.
 - B. All disposable materials, including gloves, should be discarded in a plastic bag. The mop should also be disinfected with the bleach solution described in 5A.
 - C. Persons involved in the clean-up should wash their hands afterward.
6. In-service education of appropriate school personnel should ensure that proper medical and current information about AIDS is available.

PUBLIC HEALTH FACT SHEET

AIDS

First of Series

Massachusetts Department of Public Health, 150 Tremont Street, Boston, MA 02111, (617) 727-0049, Dr. Bailus Walker, Jr., Commissioner

What Is AIDS?

AIDS (Acquired Immune Deficiency Syndrome) is a disease that leaves an individual vulnerable to illnesses that a healthy immune system might otherwise overcome. As defined by its name, the disease is acquired, not inherited; the immune system is deficient and not able to combat disease; and it is a syndrome because there are signs and symptoms that together characterize the disease. The two diseases most commonly found in people with AIDS are Pneumocystis carinii pneumonia, a lung infection caused by a parasite, and Kaposi's sarcoma, a rare form of cancer of the skin and lymph nodes.

What Causes AIDS?

Researchers at the National Institutes of Health in Washington and the Pasteur Institute in France have discovered the cause of AIDS, a close relative of a known human retrovirus. It is called HTLV-III. The way in which the body reacts to this infection is influenced by a number of co-factors which are incompletely identified.

How Is AIDS Transmitted?

AIDS is not a disease which can be casually transmitted. AIDS appears to be transmitted primarily through intimate sexual contact with an infected partner, by shared needles that have been contaminated or by contact with blood or blood products that have been infected. The risk of developing AIDS from transfusion has been very slight and practically eliminated by high risk individuals refraining from donation, and by the screening test for the AIDS-associated antibody.

Risk groups have been established for medical and surveillance purposes to help in diagnosis and to track the occurrence of AIDS. There are six segments of the population currently identified at high risk for AIDS (in order of occurrence):

- Sexually active homosexual and bisexual men.
- Intravenous drug users.
- Patients who have been transfused with infected blood or blood products.
- Steady sexual partners of persons with AIDS or persons at high risk for AIDS.
- Hemophiliacs.

Infants and children who have developed a syndrome similar to AIDS may have been exposed to AIDS before or during birth or have a history of transfusions.

What Are the Symptoms?

Many of the signs and symptoms of AIDS vary with the type and severity of the disease process and could be common to other illnesses. Generally speaking, people with AIDS experience persistent fevers or night sweats, severe fatigue, unexplained weight loss of 10 pounds or more, swollen glands in at least two parts of the body, yeast infections, persistent coughs and/or shortness of breath, recurrent diarrhea, skin rashes and spots. Anyone with prolonged, persistent symptoms of this nature should consult a physician.

What is the Treatment?

Researchers have initiated protocols for several antiviral drugs. Some people with AIDS diagnosed as having Kaposi's sarcoma are being treated with forms of interferon, a virus fighting protein produced by the body. Other treatment includes radiation and surgery. To date no treatment has been found capable of restoring the immune system to normal function.

Can AIDS be Prevented?

The recent discovery of the AIDS-associated virus and methods for producing large quantities of this virus for experimental and production purposes has enabled scientists to work at developing a vaccine. Blood tests now available for donors who have had prior exposure to the HTLV-III virus are helping to prevent transfusion-related disease and AIDS in hemophiliacs. The following measures are recommended:

- Avoid sexual contact with persons diagnosed with AIDS.
- Avoid having sexual relations with multiple partners who may be in the high-risk groups.
- Members of the high-risk groups should refrain from donating blood.
- All donated blood be tested to ensure it is not infected by the AIDS-associated virus.
- Never use intravenous drugs unless ordered by your physician. If you must use intravenous drugs, do not share needles with others, and be sure that the needles and syringes are sterilized by boiling.
- Avoid sexual contact with people who abuse intravenous drugs.

How Has Massachusetts Responded to AIDS?

The Administration has responded to this serious social, economic and health problem by:

- Continuing the work of the Governor's Task Force on AIDS in the critical roles of policy development and education.
- Forming an interagency working group out of the Executive Office of Human Services to coordinate the full human service response to AIDS and to develop necessary guidelines.
- Creating a Health Resources Office within the Department of Public Health, the major function of which will be to oversee many of the state's efforts to address AIDS-related issues and concerns.
- Appointing a Statewide AIDS Coordinator, who will work out of the new Health Resources Office, and will be involved in the development and implementation of a wide range of AIDS-related programs and services.
- Coordinating state-funded research which has dealt with prevention, cure and treatment, basic research toward vaccine development, and protection of the Massachusetts blood supply. The broad range of research and service programs has yielded valuable scientific, epidemiological and educational data that provide significant insight into this devastating disease.
- Working with the AIDS Action Committee in education and outreach and also by establishing a toll-free hotline for AIDS-related information and referral.
- Promoting support services (including home care services) to patients with AIDS and their families.
- Implementing through the Department of Public Health, in conjunction with the American Red Cross Blood Services (Northeast Region), nine alternate testing sites throughout the Commonwealth, where individuals concerned about possible exposure to the AIDS-associated virus can receive free, confidential counseling and antibody testing.

Where Can I Call for More Information?

AIDS Action Hotline

1-800-235-2331 (statewide, toll-free hotline)

AIDS Hotline (City of Boston)
424-5916

Massachusetts Department of Public Health
(617) 727-0368 (Health Resources Office)
(617) 522-4090 (for information on alternate testing sites)

August, 1985

PUBLIC HEALTH FACT SHEET

AIDS Second of Series

Massachusetts Department of Public Health, 150 Tremont Street, Boston, MA 02111, (617) 727-0049, Dr. Ballus Walker, Jr., Commissioner

The Massachusetts Department of Public Health works to maintain, protect and improve the health and well-being of the people of the Commonwealth. AIDS has recently received national attention and raised many issues for people. Following are some of the common questions raised by citizens of the Commonwealth, with answers that are provided by research physicians and experts of the Governor's Task Force on AIDS.

In What Bodily Fluids Has the AIDS Virus, HTLV-III, Been Isolated?

The virus is found primarily in blood and semen. It has also been isolated in smaller amounts in saliva and tears. No studies have detected the virus in sweat, urine or feces but scientists are investigating these possibilities. Precaution should always be taken in handling any of these substances, but transmission by any means other than sexual contact or direct injection with infected blood has never been demonstrated.

How Contagious Is AIDS?

Research shows that large amounts of infected fluids such as blood and sexual discharges must enter the body to spread the disease. Fluids that carry the HTLV-III virus in small amounts, such as tears or saliva, are not a means of transmitting the virus casually. These infected fluids would have to enter the body through open wounds. The body's first defense is intact skin which provides a barrier to any invading organism. Therefore, the AIDS virus cannot be transmitted by a kiss, a water fountain, swimming pools, door knobs, shared pens or surfaces in restrooms. The virus is transmitted by sexual contacts, sharing of needles and blood to blood contact.

Can the Virus Live for a Long Time Outside the Body?

Unlike bacteria, the virus cannot reproduce outside a living cell. The HTLV-III virus needs a host to give it life. This host is the T-Cell, part of the body's immune response. Once the virus is outside of the body, it becomes fragile: susceptible to changes in the environment such as heat and light. Household bleach (1 part bleach to 10 parts water) kills the virus, as well as hot sudsy water used to clean utensils. In the 13,000 households where AIDS has been diagnosed, no family members have caught the disease by casual contact.

How do Children and Babies Get AIDS?

Four ways: blood transfusions; by the virus crossing into the fetus' blood through the placenta; through exposure to an infected mother's blood during childbirth; and possibly through breast milk.

Is It Safe to Allow Children With AIDS to Attend School?

Upon recommendation of the Governor's Task Force on AIDS, the Department of Public Health issued a policy on school attendance for children with AIDS. The policy, consistent with the guidelines issued by the Centers for Disease Control, and endorsed by the Department of Education, is based on sound scientific findings and allows a child with AIDS under the care of a personal physician to attend regular classes with the following exceptions: open skin sores that are not able to be covered; inappropriate behavior such as biting or frequent incontinence; or if the child is too ill. The child also may be excluded from classes if there is an outbreak of any illness in the school.

The Department of Public Health understands the existing fear and anxiety and is offering in-service education to the school districts. To date, there have been 8 children diagnosed with the disease and 4 deaths in Massachusetts. Nationally, 164 children under the age of 13 have been diagnosed with AIDS.

Should There be Any Concern About a Person With AIDS Working In the Food Industry?

There Is no scientific reason to support the notion that the virus can be transmitted by an infected person handling food. Existing standards require exclusion of food workers with open skin lesions, which is the only plausible method of contaminating food. A person with AIDS will always be under the care of a personal physician to make personal decisions about the work setting and personal activity. Researchers indicate that casual transmission of the virus has not occurred in close family environments.

Is There Any Risk of Transmission of the Virus From a Person With AIDS In Any Work Environment?

No, the virus is not casually transmitted by sharing telephones or common office equipment. Again, researchers state that casual transmission of the virus has not occurred in close family environments.

Can AIDS Be Transmitted Through Heterosexual Contact?

Epidemiological data indicates that approximately 1% of AIDS cases have resulted from heterosexual contact, usually from a partner who was an intravenous drug user. Research indicates that the virus can be passed from men to women and from women to men although transmission occurs less easily from women to men. Risk of exposure is increased through multiple anonymous sex partners.

Because of the Long Incubation Period, Isn't it Possible That AIDS Could be Transmitted In Other Ways That Will Show Up In Future Years?

The incubation period refers to the time from infection with the virus to onset of signs and symptoms associated with AIDS. Research indicates that family members of people with AIDS provide powerful evidence against modes of transmission other than those already identified. Studies show that adults diagnosed with AIDS became ill approximately two years after infection with the virus. Many family members of people with AIDS therefore have interacted closely with infected individuals before knowing about the presence of the disease and to date none has shown evidence of the AIDS virus in their blood.

How Safe are Blood Transfusions?

Blood transfusions are now safe. The number of potentially infectious donors has been greatly reduced since members of high-risk groups are urged not to donate blood. All donated blood is now screened for the AIDS virus and the established alternate test sites allow those persons who think/fear they might have been exposed to the AIDS virus to be screened.

Where Can I Call for More Information?

AIDS Hotline - (800) 235-2331 - (statewide, toll-free)
AIDS Hotline - (617) 424-5916 - (City of Boston)
AIDS Action Committee - (617) 437-6200 - (Administration)

Massachusetts Department of Public Health

(617) 727-0368 (Health Resources Office)
(617) 727-0049 (Office of Public Information and Health Education)
(617) 522-4090 (Information on blood screening at alternate test sites)

November 1985

PUBLIC HEALTH FACT SHEET

AIDS Third of Series

Massachusetts Department of Public Health, 150 Tremont Street, Boston, MA 02111, (617) 727-0049, Dr. Barliss Walker, Jr. Commissioner

Since Governor Michael S. Dukakis established the Statewide Task Force on AIDS in the summer of 1983, Massachusetts has been in the forefront of AIDS policy, research, educational, service and antibody testing efforts.

The Office of Health Resources and the Center for Laboratories and Communicable Disease Control have the primary responsibilities within the Department of Public Health of responding to growing policy and program issues related to Acquired Immune Deficiency Syndrome. A Statewide AIDS Coordinator was appointed in August 1985 as part of the recognition of these increasing responsibilities.

Ongoing Activities In Massachusetts

Policy Development

A number of AIDS-related policies have been developed and widely distributed. Based on the most up-to-date scientific and medical knowledge of the disease, these policies enable institutions, individual providers, and the public at large to respond responsibly and consistently to this public health concern.

Policies on the following subjects have been adopted by the Governor's Task Force on AIDS with approval from appropriate state and community agencies:

- Attendance of children with AIDS in school.
- Recommendations for caregivers of preschool-aged children diagnosed with AIDS or clinical infection with HTLV-III (AIDS) antibody.
- Recommendations for food industry personnel on AIDS.
- Residential treatment facility policy on AIDS.
- Clinical and hospital laboratory use of HTLV-III testing.
- Recommendations for dentists and dental professionals.
- Hospital policy for Department of Public Health hospitals.

Research Initiatives

Since July of 1984, the Commonwealth has been supporting Massachusetts scientists and clinicians researching the cause, care and treatment, and prevention of AIDS.

Research efforts have been targeted toward:

- Prevention through the development of a vaccine.
- Prevention of transmission through epidemiological studies to learn more about risk factors for transmission.
- Care and treatment of people with AIDS through effective drug therapies.
- Protection of the blood supply.
- Costs of inpatient and outpatient care.

For many researchers, state funds are their sole source of support for AIDS-related work. The Massachusetts Research Council, composed of specialists in virology, microbiology, immunology, epidemiology, infectious disease, and public health, reviews each contract annually. The determination of funding is based on the program and promise of the research.

Educational Programming

With education the only way to prevent AIDS, the Department of Public Health has targeted informational campaigns to reach the general public, high-risk groups, health care workers, employers, school officials, and other concerned parties. The campaigns have been designed to increase understanding of the disease, teach the facts about transmission of the virus, implement the approved policies, and alleviate unnecessary fears.

Specific Department of Public Health efforts have included:

- Five regional Public Health Rounds held statewide to enable citizens to discuss AIDS with individuals who have expertise in the epidemiology, treatment, psychosocial, and legal aspects of AIDS.
- Production and distribution of an informational booklet for physicians and health care providers, fact sheets, and a monthly newsletter.
- Support for educational activities of the AIDS Action Committee (AAC) to reach high-risk individuals and inform them about ways to reduce the risk of exposure to the AIDS virus. The support extends to AAC's work with health care communities in sensitizing providers to the needs and concerns of patients with AIDS.
- State support for a toll-free, statewide hotline which averages 2,500 calls per month.
- In-service training and education to state agencies, local school committees, police, firefighters, emergency medical technicians, day care workers, local government officials, social service providers, and other affected groups and institutions which request or demonstrate a need for such training.

Services

Ensuring local access to health care and support services for people with AIDS in their community is a priority of the Commonwealth's AIDS program. Toward that end the Department has:

- Surveyed providers and patients and their advocates to identify issues affecting the provision of community health services for people with AIDS living at home. As a result, Community Health Resource Specialists have been hired for patient advocacy, documentation of gaps in community services, and in-service education.
- Initiated program development to train hospice volunteers in the western part of the state.
- Begun development of a Community Resource Directory for use by providers as well as by families and friends.

Alternative HTLV-III Testing Program

The Department also has established a program to provide access to the HTLV-III antibody testing by setting up alternative test sites. At these sites, individuals can anonymously have their HTLV-III antibody status determined in a supportive, informative, and confidential environment. Counselling is also provided as part of this program.

For More Information:

Massachusetts Department of Public Health

Toll-free, Statewide AIDS Hotline 1-800-235-2331

Office of Health Resources (617) 727-0368

Community Health Resource Specialists

Boston: (617) 437-6200

Western Mass.: (413) 586-7525

(413 Area Code Only) 1-800-445-1255

Office of Public Information and Health Education (617) 727-0049

Alternate Test Site Program (617) 522-4090

AIDS Action Committee

(617) 536-7733 (Hotline)

(617) 437-6200 (Administration)

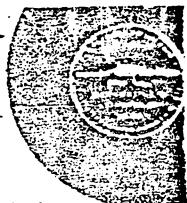
AIDS Hotline (City of Boston)

(617) 424-5916

April 1986



SUPERINTENDENT'S CIRCULAR



No. 11, 1986-1987
September 2, 1986

GUIDELINES AND PROCEDURES CONCERNING AIDS (ACQUIRED IMMUNE DEFICIENCY SYNDROME)

TO: Community Superintendents, Headmasters, Principals and Other Administrative Heads:

Community Superintendents, Headmasters, Principals and Other Administrative Heads are required to keep on file a DATED CHECK LIST signed by all personnel under their jurisdiction as evidence that each has read this circular.

INTRODUCTION

The guidelines and procedures outlined herein apply to all students and staff of the Boston Public Schools and supersede those guidelines and procedures previously distributed. These guidelines and procedures will remain in effect until such time as it is necessary to amend them to reflect new medical information as well as state or city policies as such become available.

Epidemiologic studies show that AIDS is transmitted via sexual contact or blood-to-blood contact. To date, there is no recorded transmission of AIDS to family members who are non-sexual contacts. This fact is also 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 shall be implemented in the Boston Public Schools:

I. Student Guidelines and Procedures

A. All children diagnosed as having AIDS or with clinical evidence of infection with the AIDS-associated virus (HTLV-III) and receiving medical attention are able to attend regular classes. However:

1. If a child has cutaneous (skin) eruptions or weeping lesions that cannot be covered, he/she should not be in school.
2. If the child exhibits inappropriate behavior which increases the likelihood of transmission (i.e., biting or frequent incontinence), he/she should not be in school.

No. 11, 1986-1987
September 2, 1986
Page Two

- B. Children diagnosed as having AIDS or with clinical evidence of infection with the AIDS-associated virus (HTLV-III), who are too ill to attend school, should have an appropriate alternative education plan.
- C. Siblings of children diagnosed as having AIDS or with clinical evidence of infection with the AIDS-associated virus (HTLV-III) are able to attend school without any restrictions.
- D. The personal physician of a child diagnosed as having AIDS or with clinical evidence of infection with the AIDS-associated virus (HTLV-III) is the primary manager. Management includes acting as the "gate keeper" for the child's attendance at school in accordance with the policy outlined above.
 - 1. The student's personal physician, after consultation with the family, is responsible for reporting the case to the Massachusetts Department of Public Health's Division of Communicable Diseases. The Superintendent will be notified and will provide assistance in identifying those educational or health care agents with an absolute need to be informed about the case.
 - 2. Only persons with an absolute need to know should have medical knowledge of a particular student's case. In individual situations, the Superintendent may notify one or more of the following:
 - a. Headmaster/Principal
 - b. School Nurse
 - c. Student's Teacher
 - 3. Notification should be made through a process that would maximally ensure patient confidentiality. Ideally, this process should be direct person-to-person contact.
- E. If school authorities are aware that a child diagnosed as having AIDS or with clinical evidence of infection with the AIDS-associated virus (HTLV-III) has evidence of conditions described in A. 1-2 above, the school authorities may exclude the child from school and request authorization from the child's personal physician so that class attendance is in compliance with the school policy.
- F. If school authorities and the child's personal physician are in conflict, the case should be referred to the Department of Public Health for review by an appointed physician who would determine the permissibility of attendance.

No. 11, 1986-1987
September 2, 1986
Page Three

- G. Since the child diagnosed as having AIDS or with clinical evidence of infection with the AIDS-associated virus (HTLV-III) has a somewhat greater risk of acquiring infections in the school setting, the child should be excluded from school if there is an outbreak of a threatening communicable disease such as chicken pox or measles, until he/she is properly treated (possible with hyperimmune gamma globulin) and/or the outbreak is no longer a threat to the child.
- H. HTLV-III Screening is a blood test for detecting the presence of antibodies to the HTLV-III virus. Antibodies are substances produced by the white blood cells which help fight infections caused by viruses or bacteria. Testing for HTLV-III antibodies is not recommended for any purposes other than to assist the child's personal physician make a highly selected set of clinical decisions. Results of HTLV-III Screening tests are confidential and should not be reported to schools.
- I. Blood or any other body fluids including vomitus and fecal or urinary products of any child should be treated cautiously. It is recommended that gloves be worn when cleaning up any body fluids.
 - 1. These spills should be cleaned-up with bleach (one part bleach to ten parts water) or another disinfectant, by pouring the solution around the perimeter of the spill.
 - 2. All disposable materials, including gloves, should be discarded in a plastic bag. The mop should also be disinfected with the bleach solution described above.
 - 3. Persons involved in the clean-up should wash their hands afterwards.
- J. In-service programs for school nurses and other appropriate staff will be conducted as required and as new information becomes available. Attached herewith is the most recent Public Health FACT SHEET on AIDS published by the Massachusetts Department of Public Health.

II. Employee Guidelines and Procedures

A. Statement of Purpose and Scope

This section of this memorandum establishes the policy of the Boston Public Schools for dealing with employees who have AIDS. Its purpose is the protection of the right of School Department employees who have AIDS to continued employment. The School Department also recognizes its obligation as an employer to provide not only an objectively safe environment for all employees and the public at large, but also an environment where employees and students do not have fears for their health and safety.

No. 11, 1986-1987
September 2, 1986
Page Four

This memorandum also establishes procedures to effectuate the above policy.

The policy and procedures are applicable to all bargaining unit employees of the Boston Public Schools as well as all managerial staff.

B. Employee Policy

The Boston School Department recognizes that employees with life-threatening illnesses, including, but not limited to, cancer, heart disease, and AIDS may wish to continue to work. As long as employees are able to meet acceptable performance standards, and medical evidence indicates that their condition is not a threat to themselves or others, employees shall be assured of continued employment. Federal and State laws also mandate, pursuant to the laws protecting disabled individuals, that those individuals not be discriminated against on the basis of their handicaps, and that if it becomes necessary, some reasonable accommodations be made to enable qualified individuals to continue to work.

C. Training and Education

Medical studies show that Acquired Immune Deficiency Syndrome (AIDS) is transmitted via sexual contact or blood-to-blood contact. To date, there is no record of transmission of the AIDS associated virus (HTLV-III) to co-workers, clients or consumers in offices, schools, factories, construction sites or other workplaces. There is no evidence of casual transmission by sitting near, working in the same office, sharing the same water fountain, telephones, toilets, eating facilities or office equipment with a person infected with HTLV-III.

Many of the problems which arise in the workplace when employees are confronted with a fellow employee who suffers a life-threatening illness like AIDS are caused by lack of knowledge about the disease and misunderstanding of the ways in which it is transmitted. The only means of combatting this fear is education. Supervisors should make a concerted effort to educate themselves as to the facts regarding the HTLV-III virus and how it is and is not transmitted and, further, should make the same effort to educate their employees. Any information needed will be furnished by the Office of Student Support Services. Supervisors should be sensitive and responsive to co-workers' concerns, and emphasize employee education.

No. 11, 1986-1987
September 2, 1986
Page Five

D. Confidentiality

Employers should always remember that an employee's health condition is personal and confidential. Personnel and medical files or information about employees are exempt from public disclosure by M.G.L. C. 4, §7 (26). In addition, information relating to a specifically-named individual, the disclosure of which would constitute an unwarranted invasion of personal privacy, is exempt. Thus, special precautions should be taken to protect such information regarding an employee's health condition in order to prevent instances of disclosure that may invade the personal privacy of employees. Only those managers with a clear need to know should be informed of an employee's health condition.

If any Boston Public School employee voluntarily seeks assistance regarding AIDS, he/she should contact Michael I. Grady, M.D., Program Director of Medical Services, Telephone 726-6200, Ext. 5186.

ALL INQUIRIES CONCERNING THIS CIRCULAR AND THE GUIDELINES AND PROCEDURES SHOULD BE MADE TO MICHAEL I. GRADY, M.D., PROGRAM DIRECTOR OF MEDICAL SERVICES, OFFICE OF GUIDANCE AND SUPPORT TEAM SERVICES, 26 COURT STREET, BOSTON, MA 02108, Telephone 726-6200, Ext. 5186.

Laval S. Wilson
Superintendent of Schools

Attachment

APPENDIX J. STATE OF NEW JERSEY REGULATIONS REGARDING THE
RIGHT OF SCHOOL ADMISSION OF CHILDREN WITH AIDS



STATE OF NEW JERSEY

DEPARTMENT OF EDUCATION

CN 900

TRENTON, N.J. 08625

OFFICE OF THE COMMISSIONER

November 12, 1986

TO: Chief School Administrators
SUBJECT: School Health Services Procedures Concerning Children
in Grades K-12 with HIV (AIDS) Infection

On October 1, 1986 the State Board of Education unanimously adopted regulations to establish procedures for implementing the New Jersey State Department of Health regulations which were adopted on September 10, 1986 concerning school age children with AIDS. These regulations specifically outline the necessary steps and procedures school districts must follow if confronted with a contested admission of a child afflicted with the disease.

Additionally, I would like to bring to your attention the provision in the Department of Health regulations (N.J.A.C. 8:61-1.1(j)) concerning the handling of blood and body fluids:

All schools and day care facilities, regardless of whether pupils or adults with HIV infection are present, should adopt routine procedures for handling blood and body fluids.

To guide your district with the development of this policy, I refer you to the enclosed guidelines that were included in the booklet previously sent to you entitled AIDS, A Special Report on Acquired Immunodeficiency Syndrome.

Also enclosed with this memorandum are copies of both the Department of Education and Department of Health regulations pertaining to these new procedures. They are provided as an information packet in the event your district must deal with an AIDS admission case.

Saul Cooperman
Commissioner

SC/JAV/ch:5/8567B

Enclosures

Participation in School by Individuals with HIV Infection

Attendance at School by Individuals with HIV Infection

Adopted New Rule: N.J.A.C. 8:61-1.1

Proposed August 4, 1986 at 18 N.J.R. 1512(a).

Adopted September 10, 1986 by John H. Rutledge, M.D., M.P.H., Acting Commissioner of Health.

Filed September 12, 1986 as R 1986 d 407, without change.

Authority N.J.S.A. 26:1A-15.

Effective Date October 6, 1986.

Expiration Date October 6, 1991.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the adoption follows:

**CHAPTER 61
ACQUIRED IMMUNODEFICIENCY SYNDROME**

SUBCHAPTER I. PARTICIPATION AND ATTENDANCE AT SCHOOL BY INDIVIDUALS WITH HIV INFECTION

8:61-1.1 Attendance at school by pupils or adults infected by Human Immunodeficiency Virus (HIV), also known as HTLV-III or LAV

(a) For purposes of this section, the following words shall have the following meanings:

"Adult" means a teacher, administrator, food service employee or other school staff member.

"Pupil" means an individual who is entitled to attendance at school in grades K-12, as well as a pre-kindergarten child who is entitled to attendance at school.

(b) Pupils with HIV (Human Immunodeficiency Virus) infection shall not be excluded from attending school for reason of the infection unless the following exceptional conditions are evident as determined by the pupil's physician and/or the school medical inspector:

1. The pupil is not toilet-trained or is incontinent, or is unable to control drooling.

2. The pupil is unusually physically aggressive, with a documented history of biting or harming others.

(c) In the event that disagreement exists between the pupil's physician and the school medical inspector as to the existence of the excluding conditions in (b) above, an evaluation of the pupil from the Medical Advisory Panel should be sought regarding the pupil's admissibility in accordance with N.J.A.C. 6:29-4.

(d) Adults with HIV infection in all school settings shall not be restricted from their normal employment for reason of the HIV infection unless they have another illness which would restrict that employment.

(e) The New Jersey Commissioner of Health shall establish an expert Medical Advisory Panel, of no less than four members, to be comprised of persons with expertise in childhood behavior, pediatrics and infectious disease.

(f) School districts, based upon advice of the school medical inspector, shall seek an evaluation from the Medical Advisory Panel of pupils with HIV infection whom a local school board deems have any of the conditions described in (b) above. This procedure shall be conducted in accordance with N.J.A.C. 6:29-4.

(g) The Panel shall render a report no later than four weeks from the time of referral by the Commissioner of Education.

1. The report shall be delivered by the Panel to the Commissioner of Education with a copy to the Commissioner of Health.

2. The report(s) by the Medical Advisory Panel shall be confidential except that a general summary of the conclusions shall be available.

(h) No pupil or adult shall be excluded from school solely by virtue of the fact of living with or being related to an infected individual.

(i) Any pupil or adult, with or without HIV infection, shall be removed from school if and when the individual has weeping skin lesions that cannot be covered.

(j) All schools and day care facilities, regardless of whether pupils or adults with HIV infection are present, should adopt routine procedures for handling blood and body fluids.

(k) It is not necessary that anyone in the school be notified that an HIV infected individual is present.

NEW JERSEY ADMINISTRATIVE CODE

TITLE 6

EDUCATION

SUBTITLE F. CURRICULUM AND INSTRUCTION

CHAPTER 29. HEALTH, SAFETY AND PHYSICAL EDUCATION

SUBCHAPTER 4. SCHOOL HEALTH SERVICES PROCEDURES

AUTHORITY: N.J.S.A. 18A:1-1, 18A:4-15, 18A:16-2, 18A:40-3,
18A:40-4 and 18A:40-16

6:29-4.1 through 4.3

(No change in text.)

6:29-4.4 Attendance at school by HIV (*Human Immunodeficiency Virus;* also known as HTLV-III or LAV) infected children

(a) For pupils with HIV infection who are enrolled or seeking enrollment in a school program, the regulations and procedures in this section shall apply.

(b) Pupils with HIV infection shall not be excluded from attending school unless they manifest those exceptional conditions identified by the State Department of Health and contained in N.J.A.C. 8:61-1.1.

(c) In accordance with N.J.A.C. 8:61-1.1:

1. The presence of HIV infection in a pupil does not constitute reason for exclusion of such pupil from school, nor may a pupil so infected be excluded for reason of his/her own protection against possible exposure to the infectious diseases of others.

2. The presence of HIV infection in and of itself may not serve as a basis *[of]* *for* excluding a pupil by way of classification as eligible for home instruction in accordance with N.J.A.C. 6:28-3.5(e) *[2.ii.]* *2ii.*

3. No sibling or other person in the same household as a pupil who has been diagnosed to have HIV infection shall be excluded from attendance at school.

(d) A district board of education must reach a determination on the admissibility of a pupil to school no later than 10 days after the request to admit such pupil.

(e) A district board of education may act to exclude a pupil with HIV infection only when:

1. The district medical inspector, the pupil's parent(s) or guardian(s) and physician agree that he/she manifests those exceptional conditions delineated in N.J.A.C. 8:61-1.1. In such cases, the pupil must be provided an appropriate education pursuant to N.J.A.C. 6:28-1.1 et seq.

2. Conflicting medical opinion exists between the district medical inspector and the pupil's personal physician as to whether the pupil manifests those exceptional conditions set forth in N.J.A.C. 8:61-1.1. In such instances, the procedures delineated in (f) below must be immediately followed. A district board of education may not avoid compliance with the procedures in (f) below by excluding a pupil for reasons other than those listed herein.

(f) If, based upon advice of the district medical inspector, the pupil is deemed to manifest any of the exceptional conditions

contained in N.J.A.C. 8:61-1.1 and the pupil's personal physician is in disagreement, the district board of education shall immediately submit a request for a review by the Medical Advisory Panel established by the Department of Health in accordance with the following procedures:

1. When conflicting medical opinion as to the admissibility of a pupil with HIV infection exists, the district board of education shall submit the entire medical record of the pupil and other pertinent information to the county superintendent of schools for transmission to the Department of Education which shall include but not be limited to:

i. All information and data submitted to the district board of education by the pupil's parent(s) or guardian(s) and physician.

ii. A written statement of reasons for denying admission under the exceptional conditions for exclusion contained in N.J.A.C. 8:61-1.1.

iii. An evaluation of current behaviors which specifically *[address]* *addresses* those characteristics which might be a basis for exclusion as contained in N.J.A.C. 8:61-1.1. An evaluation conducted within six months from *the* date of submission of information to the county superintendent shall be considered as being current.

iv. All medical information, both current and historical, which is available to the district board of education from its medical inspector and the pupil's physician and upon which the district board of education made its determination to exclude the pupil.

(1) A statement of the qualifications/credentials, including board certification, of all experts whose evaluations/reports were reviewed by the district board of education/medical inspector shall be provided.

v. In the case of a classified pupil, full child study team evaluation reports, recommendations, the Individualized Education Program (IEP) and any other pertinent information which is available.

vi. All references to the names of the pupil and parent(s) or guardian(s) must be obliterated when submitted to the county superintendent. The Department of Education shall assign a numerical code number and advise the district board of education of such for all reference purposes.

vii. The district board of education shall provide the parent(s), guardian(s) or other legally responsible party*(ies)* *with* a list of all documents submitted to the county superintendent of schools. Any document so listed and not already in the possession of the parent(s), guardian(s) or legally responsible party*(ies)* shall be provided by the district board *of education*.

2. Home instruction shall be provided as specified below during the pendency of a commissioner's determination.

i. Home instruction shall commence immediately upon the district board of education's determination to exclude the pupil.

ii. The teacher providing instruction shall be appropriately certified for the subject or level in which instruction is given.

iii. The pupil shall receive a program that meets the requirements of the district board of education for promotion and graduation.

iv. Instruction shall be provided for no fewer than five hours per week. The five hours of instruction per week shall be accomplished in no fewer than three visits by a teacher on three separate days. When instruction is provided by direct communication to a classroom program by telephone or television, such instruction shall be in addition to the basic five hours of instruction by a teacher.

3. Upon receipt of the information required above, the county superintendent shall immediately notify the assistant commissioner, Executive Services of the need for a review by the Medical Advisory Panel and shall transmit to him/her the information submitted by the district medical inspector.

4. The assistant commissioner shall immediately request the designated official within the State Department of Health to convene the Medical Advisory Panel according to N.J.A.C. *8:61-1.1* at the earliest possible time and shall transmit the information required in (f)1 above to the designated official for panel consideration.

5. The Medical Advisory Panel shall consider all written information submitted by the district board of education and such testimony as may be necessary to render its determination.

i. The district board of education shall be responsible for demonstrating that the pupil exhibits the behavior or manifests the symptoms deemed justifiable for exclusion contained in N.J.A.C. 8:61-1.1(b).

ii. The panel shall call for any oral and/or written information it deems necessary for it to reach a determination.

iii. Each party shall be permitted to submit to the panel any additional written information to provide support for its position.

6. The Medical Advisory Panel shall render a written determination to the commissioner as to whether the district board of education has demonstrated that the exclusion is warranted.

i. The Medical Advisory Panel's written determination shall include, but not be limited to, its conclusions, a statement as to how it reached those conclusions and its reasons for so concluding.

ii. The full details of the Medical Advisory Panel's determination shall be confidential, except to the parties, but a general summary of the conclusions shall be available.

7. The written determination of the Medical Advisory Panel shall be transmitted to the commissioner who shall forward the determination to the parties.

8. Within ten days of the receipt of the Medical Advisory Panel's written determination, the parties may file with the commissioner written exceptions to those findings of the panel which the parties believe to be based upon disputed issues of fact or conclusions of law.

9. The commissioner shall review the determination of the Medical Advisory Panel and the exceptions of the parties and within ten days of the receipt of the exceptions or the expiration of the time for so filing issue a written determination which shall:

i. Direct the immediate enrollment of the pupil into an appropriate educational setting; or

ii. Confirm the district board of education's determination to exclude the pupil from such setting and direct an alternative program of education; *[or]*

[iii. Direct that the matter be transmitted to the Office of Administrative Law for further determinations which are limited to those areas of material fact in dispute, if the commissioner shall determine that the exceptions raise questions as to disputed material facts. Any hearing into these matters shall be conducted on an expedited basis.]

iii. Determine that the matter is a contested case and direct that it be transmitted to the Office of Administrative Law for further determinations. If the commissioner determines the matter is a contested case, the exceptions filed by the parties to the Medical Advisory Panel's determination shall constitute the pleadings which shall establish the issues for the proceeding before the Office of Administrative Law. The hearing in the matter shall be conducted on an expedited basis.

10. Copies of the commissioner's determination shall be forwarded to the parties, the Commissioner of Health, the Medical Advisory Panel and the county superintendent of schools.

6:29-4.[4]5 Record and reports

(No change in text.)

6:29-4.5[5]6 Nursing services

(No change in text.)

APPENDIX K. NEW YORK CITY PROCEDURES FOR REVIEW OF SCHOOL
CHILDREN WITH AIDS OR OTHER RELATED CONDITIONS

THE CITY OF NEW YORK
COMMISSIONER OF HEALTH
Stephen C. Joseph, M.D., M.P.H.



125 NORTH STREET
NEW YORK, N.Y. 10013

June 20, 1986
Revised August 7, 1986

Procedures for Review of School Children with AIDS or Other Related Condition

As a result of the February 11, 1986 decision in District 27 Community School Board, et al. v. Board of Education, et al. (Index No. 14940/85), and of the February 28, 1986 policy recommendations of the Advisory Committee of Physicians, revisions have been made in the procedures for the case-by-case review of school-aged children with AIDS or other related symptomatic conditions attributed to HIV^{*} infection. The AIDS School Review Panel (hereinafter, the "Panel") shall continue to perform its screening function by reviewing the health and development of each child referred to it with AIDS or other related illness, and by recommending the appropriate educational setting for each child. The following guidelines shall govern the review process:

1. Children to be reviewed:

The Panel will review school-aged children referred to it who have AIDS or other related symptomatic conditions attributed to HIV infection.

2. Sources of referrals:

Surveillance data gathered pursuant to the requirements of the State Sanitary Code, 10 NYCRR Part 24, shall remain entirely confidential and shall not be used by the Department of Health to identify school-aged children to be reviewed by the screening panel. The panel will review only those children ready for school who are referred to it, or whose condition is confirmed, by treating physicians. Additionally, the panel will review only those children whose parents have notice of the review. When a rumored case of AIDS is brought to the attention of the Board of Education, the Board will contact the

continued....

*The designation human immunodeficiency virus (HIV) has recently been proposed by the subcommittee of the International Committee for the Taxonomy of Viruses as the appropriate name for the retrovirus that has been implicated as the causative agent of AIDS, until now known as HTLV-III or LAV.

Department of Health's Bureau of School Children and Adolescent Health (BSCAH). A BSCAH representative will then contact the child's primary treating physician to determine whether the child has AIDS or related symptomatic disease attributed to HIV infection. If the child has AIDS or other related illness, the child may then be referred to the panel.

3. Information to be considered by Panel:

a. The Panel shall:

- (1) interview the child's primary treating physician and, to the extent necessary, other professionals who have dealt with the child;
- (2) interview the child's parent/guardian when indicated;
- (3) review the child's medical records when necessary.

b. The information gathered and considered as a result of the above shall include:

- (1) the past and present social, psychological, developmental and educational status of the child;
- (2) adequate clinical and laboratory confirmation of diagnoses;
- (3) current clinical status and laboratory data, including parameters to assess the degree of immune function;
- (4) validation of an adequate medical care plan.

4. School attendance pending review:

- a. Children with AIDS or related illness, referred through appropriate channels, who have been out of school since the commencement of the 1985-86 school year shall be reviewed by the Panel as soon as possible.
- b. Henceforth, children already in school identified as having AIDS or related illness shall be permitted to remain in school pending review by the Panel. Such review shall be conducted on an expedited basis.
- c. Children identified as having AIDS or related illness who have not yet enrolled in school will be advised to delay enrollment pending review by the panel. Such review shall be conducted on an expedited basis.

5. Advisory committee of physicians:

The present advisory committee of physicians will remain available for review of Panel procedures and of specific cases as requested.

6. Educational placement:

It is anticipated that a child presented for review will fall into one of the following categories:

- a. Children who are unable physically to attend school. These children should receive home instruction.

continued....

b. Children with multiple problems (e.g., developmental delay, behavioral disorder, neurological handicaps or inadequate medical care plan). These children should receive:

- i. Specially arranged main-stream educational placement;
- ii. School-based special education; or
- iii. In severe cases, home instruction.

c. Children who have none of the problems specified above. These children should enroll or remain in school in an unrestricted setting.

7. Confidentiality:

The identities of children in category 6 shall be maintained confidential.

8. Periodic re-evaluation:

Children with AIDS or related illness who have been evaluated by the Panel shall be reevaluated as often as necessary, consistent with their medical care plan.

9. Notification of Results of Review

Results of all evaluations and reevaluations will be addressed by the Panel to the Commissioner of Health as recommendations. The Commissioner will review a background summary of the case, and, if he/she agrees with the recommendations, he/she will so notify the Panel. The Commissioner of Health may modify the recommendation or send the case back to the Panel for further review. The Panel will notify the referring physician of the results, and of the recommended time for repeat review. The Commissioner will notify the Chancellor of the Board of Education periodically of number of cases reviewed and distribution of cases referred for special education or home instruction.

10. Effective date:

The procedures described herein shall be implemented immediately.

Stephen C. Joseph, M.D., M.P.H.
Commissioner of Health

APPENDIX L. NORTH CAROLINA

- Division of Health Services--Guidelines for Managing AIDS in Schools
- Recommendations Concerning the Acquired Immunodeficiency Syndrome, Medical Center Task Force on AIDS, School of Medicine, University of North Carolina at Chapel Hill, North Carolina Memorial Hospital
- Summary of New Communicable Disease Law and Regulations for Health Care Providers

N.C. Division of Health Services
GUIDELINES FOR MANAGING AIDS IN SCHOOLS

AIDS (Acquired Immune Deficiency Syndrome) is a viral illness first recognized in 1981. It is transmitted sexually and through blood and blood products. It is not transmitted by casual contact, a fact attested to by the absence of cases in household contacts of AIDS patients who were neither sexual partners nor needlesharers. (AIDS has been transmitted by infected mothers to infants at or prior to birth or through breast feeding.) AIDS appears to be more difficult to acquire than hepatitis B, which is transmitted in the same manner. This is borne out by reports that fewer than 1% of health-care workers with needlestick exposure to blood and its derivatives from AIDS patients have developed any signs of infection with HTLV-III, while nearly 26% develop evidence of hepatitis B infection from similar exposures to hepatitis B cases or carriers.

As noted above, children may acquire HTLV-III infection perinatally from infected mothers or through transfusion of contaminated blood or blood products. While many of these children may be too ill to attend school, others will be well enough to do so.

1. Most children with AIDS or AIDS-related conditions represent no threat for AIDS transmission in the classroom and should be provided an education in the usual manner.
2. Screening for HTLV-III antibody is inappropriate as a condition for school attendance.
3. Children with HTLV-III infection who are unable to control normal bodily functions (e.g. bowel and bladder control), who have behavioral abnormalities (e.g. aggressive or destructive behaviors or biting others), or who have open oozing wounds or sores which cannot be adequately covered may pose a risk for HTLV-III transmission to others and should be removed from the classroom. A child with AIDS/ARC (AIDS Related Complex) may be temporarily removed from the classroom until either an appropriate school program adjustment can be made, an appropriate Alternative Education Program can be established (Alternative Education Program Instruction should approximate as far as possible the instruction the student will receive in the regular classroom), or the child's personal physician determines that the risk has abated and recommends that the child can return to the classroom.
4. Children whose resistance to infection is so hindered/hampered by AIDS that contact with other children and common illnesses seriously threaten their well-being should be provided alternative education program instruction. (See Alternative Education Program Instruction in 3 above.)

5. An interdisciplinary committee can best determine on an individual basis which children with HTLV-III infection may safely attend school. Each case in which a child requests to attend school should be evaluated by a committee comprised of the child's personal physician, teacher (teacher who has primary accounting responsibility for the student), school principal (or designee), school nurse, and the local health director (or designee). (Consultation with a physician with expertise in managing AIDS cases and the Communicable Disease Control Branch of the North Carolina Division of Health Services is encouraged.) Periodic reevaluation by the committee should be undertaken for each case since the child's condition may either improve or worsen over time. The deliberations of this committee should be confidential.
6. Confidentiality must be strictly protected by the school system for all children with HTLV-III infection. Only the principal, school nurse, and teacher (see teacher in 5 above) should be notified of the child's condition. In this manner confidentiality can be ensured.
7. School officials should notify parents of children with AIDS when illnesses that may represent a threat to such children are occurring in the school. These include chickenpox, measles, whooping cough, meningitis, influenza, or other serious reportable diseases.
8. North Carolina General Statute 130A-136 requires school officials to report certain diseases, including AIDS (NCAC-70:07A.0101), to their local Health Departments. Confidentiality of such reports is protected by law (G.S. 130A-143), and officials cannot be held liable for reporting (G.S. 130A-142). (See attachment.)
9. Guidelines for cleaning up blood or body fluid spills (attached) should be followed at all times. These provisions will prevent infection with HTLV-III, hepatitis B, herpes virus, and other infectious agents.
10. School personnel should receive training in how AIDS and other infectious diseases are acquired, how transmission can be prevented, and how to handle body fluids in schools.
11. Each school system should continue expanding their current health curriculum to include information about AIDS and other communicable diseases and how students can protect themselves from acquiring infections.

These guidelines were developed by a Task Force including representatives from the N.C. Division of Health Services, the N.C. Department of Public Instruction, and the N.C. School Boards Association.

**Recommendations Concerning the Acquired Immunodeficiency Syndrome
and HTLV-III/LAV (AIDS virus) infections at the
School of Medicine, University of North Carolina at Chapel Hill
and North Carolina Memorial Hospital**

- Medical Center Task Force on AIDS -

April, 1986

Since the recognition of the Acquired Immunodeficiency Syndrome (AIDS) in 1981, increasing attention has focused on the unprecedented epidemic of human T-lymphotrophic virus type 3 (HTLV-III/LAV) infection and its implications for the public health. North Carolina has not been spared from this nationwide outbreak of disease. As of March 31, 1986, 109 cases of AIDS have been reported from within the state. Many of these patients have been hospitalized at the North Carolina Memorial Hospital at some time during the course of their illness. A number of these patients have not had apparent exposure outside of the state. The local implications of the AIDS epidemic have elicited many responses, including the recent development of specific policies to guide the University in issues concerning AIDS and HTLV-III/LAV infected persons. This document outlines these policies in the context of the medical center, and provides some additional guidance in other areas that are unique to a University hospital and major medical research center.

AIDS is the most severe clinical expression of infection with HTLV-III/LAV, a recently recognized human retrovirus. Current evidence strongly supports the interpersonal transmission of this virus by means of (a) intimate, sexual contact, (b) the sharing of contaminated needles by parenteral drug abusers, (c) transfusion of blood or certain blood products (for example, plasma, cell fractions and factor concentrates)*, and (d) poorly defined mechanisms allowing transmission from infected mothers to their offspring at or before birth. A very low risk of nosocomial transmission has emerged from numerous studies, and overwhelming evidence supports the conclusion that this viral infection is not acquired through casual contact with infected persons. This singular fact underlies many of the recommendations which follow.

Any response to the AIDS epidemic should be guided by the very best contemporary knowledge of this potentially devastating infection. Unnecessary, ill conceived and possibly discriminatory actions should not be undertaken in response to a growing community fear of AIDS. However, it is essential that the potential infectivity of human body fluids or tissues processed in any medical center laboratory be recognized. Education concerning what does and what does not constitute a risk of HTLV-III/LAV transmission is the most effective means available for containing the epidemic. Therefore, every professional staff member has an ethical obligation to be aware of developments in this area, and every health professional and health educator has a major responsibility for enhancing community awareness and understanding of AIDS whenever possible.

* Hepatitis B plasma-derived vaccine (Reptavax-B) and immune globulin preparations have no apparent risk of HTLV-III/LAV transmission.

Given this introduction, the following specific recommendations should guide the medical center in its response to the HTLV-III/LAV epidemic:

1. Persons infected with HTLV-III/LAV, whether having active AIDS, AIDS-related conditions, or who are simply seropositive for viral antibodies, will not be excluded from employment or enrollment in medical center activities, nor restricted in their access to medical center services or facilities because of their HTLV-III/LAV status, unless medically-based judgments in individual cases establish that exclusion or restriction is necessary for the welfare of the individual or for the welfare of other members of the medical center community. In this connection, it is important that the facts about AIDS be publicized in order to help dispel ignorance and misinformation about risks posed by the presence of HTLV-III/LAV-infected persons.
2. Hospital employees or other persons engaged in patient care activities who know or have reason to believe that they are infected with HTLV-III/LAV are urged to share that information, on a confidential basis, with the Director of the Employee Health Service, so that the Hospital can respond appropriately to their health and educational needs. The Hospital needs such information so that every reasonable effort can be made to assure that infected persons are fully informed about the nature and consequences of their condition, for the protection of themselves and of other members of the Hospital community. This is similar to requirements for several other potentially communicable diseases.
3. Persons in the medical center who know, or have reasonable basis for believing, that they are infected with HTLV-III/LAV are expected to seek expert advice about their health circumstances and are obligated, ethically and legally, to conduct themselves responsibly in accordance with such knowledge, for the protection of other members of the community.
4. Competent and humane care shall be provided to all patients, irrespective of their known or suspected HTLV-III/LAV status. Medical personnel can protect themselves adequately by following guidelines promulgated by the US Public Health Service and interpreted and accepted for local use by the Hospital Infections Committee and the Department of Hospital Epidemiology. Any questions concerning isolation procedures or containment guidelines may be addressed to the Department of Hospital Epidemiology at 6-1636.
5. HTLV-III/LAV antibody testing should only be used in situations where it will directly benefit the patient or where it will be of public health benefit. Confidentiality of results of such tests and of AIDS-related diagnoses is essential and is the individual responsibility of each medical center employee who has access to such information. Beyond mandated reporting requirements to public health authorities or as otherwise may be required by law, results of tests for anti-HTLV-III/LAV antibody should not be communicated to any party other than the individual who has been tested. Since such results will become part of the patient's medical record, all medical center workers should accord the medical record the degree of confidentiality it deserves. Only those with a need to know should read or have knowledge of the medical record, unless specific consent to divulge such information to others is granted by the patient. In most cases, especially

when there are no clinical symptoms suggestive of AIDS or AIDS-related conditions, permission should be obtained from the patient before HTLV-III/LAV serodiagnostic tests are requested.

6. Medical center physicians are urged to incorporate into their practices standard procedures for obtaining complete sexual histories on their patients and should assume responsibility for candid communication with and education of persons known to fall into high risk groups for HTLV-III/LAV infection. All physicians should remain abreast of future advances in our understanding of AIDS and HTLV-III/LAV, and should strive to disseminate that information to individuals at risk in an effort to reduce or eliminate high risk behavior. Physicians who find this difficult to accomplish should consider referring selected patients (those thought to be in high risk groups) to other appropriate primary care providers or consultants.

7. All research and clinical laboratory directors or principal investigators should recognize their responsibility for protecting laboratory workers from hazards incumbent in handling human blood, secretions and tissues. This includes education of laboratory personnel where necessary. All medical center laboratories should strive to adhere to safety guidelines established by the US Public Health Service for the handling of blood and other body fluids and secretions. Specific queries concerning these guidelines should be addressed to the UNC Health and Safety Office (2-5507).

A medical center Task Force on AIDS has been formulated to assist in establishing and implementing policies relevant to AIDS within the medical center. These guidelines represent part of their initial effort at confronting the problems raised by HTLV-III/LAV within the medical center, and reflect policies adopted by the University system as well as those under consideration by several national organizations. Modifications of these recommendations may be warranted as additional information becomes available concerning HTLV-III/LAV infection, or with the national implementation of alternative policies for control of the epidemic. Comments concerning these guidelines or other issues relevant to AIDS may be addressed to that committee through its Chairman, Dr. Stanley M. Lemon, of the Division of Infectious Diseases, Department of Medicine.

The "Summary of New Communicable Disease Law and Regulations for Health Care Providers" which follows was submitted to us by the Division of Health Services with the request that the Medical Society help out by disseminating the information to all the physicians in the state. We are doing so as far as possible by printing this insert, which Medical Society members may remove from the Bulletin and save for future use.

Summary of New Communicable Disease Law & Regulations for Health Care Providers

A new communicable disease law and rules went into effect on February 1, 1988. This summary is provided to assist physicians in implementation of the new requirements. Physicians are required to report certain diseases and asymptomatic conditions and to instruct patients and exposed persons for whom control measures are required what they must do to limit transmission. Control measures (except for AIDS and HIV infection which are outlined below) are contained in *Control of Communicable Diseases in Man* published by the American Public Health Association. Physicians may request the local health director to provide these instructions if they prefer.

Confidentiality: Previously confidentiality has been protected by common law rather than explicit law, often leaving health care providers uncertain about what information was protected and in what cases information could be shared. The new law explicitly states that "all information and records, whether publicly or privately maintained, that identify a person who has HIV infection or who has or may have a reportable communicable disease or communicable condition are strictly confidential." Eleven exceptions are provided; the most important of these to practicing physicians are:

1. release may be made with consent of the individual named;
2. release may be made to health care providers providing direct medical care to the patient; and
3. release may be made when necessary to protect the public health but only as provided in the rules of the Commission.

Reporting:

-Reportable diseases and conditions are now to be reported to the local health director where the physician practices rather than where the patient resides.

-Reporting requirements for some diseases have been changed to require reporting within 7 days, while 24-hour reporting has been maintained for those that require an immediate public health response. When 24-hour reporting is required, it is to be made by telephone and the physician is required to notify the health department of the control measures that have been given.

-Three new diseases and conditions have been added to the list of reportable diseases and conditions: campylobacter (24 h); carriers of hepatitis B (7 d); and carriers of typhoid fever (7 d).

AIDS & HIV Infection:

-AIDS continues to be reportable; HIV-infection is not reportable.* The new case definition for AIDS now includes most symptomatic HIV-infected children and adults with HIV encephalopathy, HIV wasting syndrome, presumptively diagnosed pneumocystis, and extrapulmonary TB in HIV-infected persons.

-The control measures for HIV-infected individuals (including persons with AIDS) require that they:

1. not have sexual intercourse unless condoms are used; exercise caution when condoms are used due to possible condom failure;

*The Commission took this action to preserve the option of anonymous testing. Several studies show that many persons at high risk for HIV infection will not present for testing and counseling unless anonymous testing is offered. Since anonymous testing provides a significant opportunity to provide one-on-one risk reduction counseling to persons at high risk, it seems prudent to maintain this option at the present time. Reporting of AIDS combined with carefully designed seroprevalence studies allows clear understanding and monitoring of the HIV epidemic.

2. never share needles or syringes;
3. not donate or sell blood, blood products, semen, ova, organs, or tissues;
4. have a TB skin test; and
5. notify future sexual & needle-sharing partners and partners for the previous one year (unless the time of initial infection is known.)

-The Division of Health Services (DHS) will provide an aggressive, professional, compassionate, and skilled partner notification and counseling service. HIV-infected persons may arrange appointments with DHS AIDS counselors to enlist assistance in notifying and counseling their partners and/or for advice about how to accomplish notification. Alternatively, HIV-infected persons may send names and locating information for their partners to DHS, which will undertake notification and counseling.

-Attending physicians of HIV-infected persons (including persons without AIDS) are required to:

1. give the control measures to the patient;
2. encourage the patient to complete a DHS form** listing sexual and needle partners and to arrange an appointment with a DHS AIDS counselor or send the form to DHS;
3. advise the patient about how to clean up blood and body fluids, about the risk of perinatal transmission and transmission by breastfeeding;
4. if the physician knows the identity of the HIV-infected person's spouse, complete a DHS form listing the name of the spouse and locating information and send it to DHS; DHS will undertake notification and counseling of the spouse; the physician's responsibility to notify exposed and potentially exposed persons is satisfied by fulfilling obligations listed in #1, #2, and #4. Notification of others, except as noted below, is a violation of confidentiality provisions.

-Testing: Physicians who test persons for HIV-infection must notify tested persons of the results (whether positive or negative) and counsel them appropriately. (For local health departments appropriate counseling is defined as individual pre- and post-test counseling, with risk assessment, risk reduction guidelines, test result interpretation, and, when the person tested is determined to be infected, the control measures.)

-Beginning July 1, 1989 tests for HIV infection can be done only on specimens ordered by a physician and only by laboratories certified by the Department of Human Resources. To be certified, labs must:

1. be certified or licensed by HCFA, CLIA, JCAH, CAP, or AABB
2. participate in a periodic proficiency testing program (CAP-AABB) and perform acceptably;
3. report final results to the ordering physician only after all initially reactive screening (ELISA) tests have been repeated and a confirmatory (Western Blot) test has been done. Preliminary results may be reported to the ordering physician after all initially reactive tests have been repeated, but before confirmatory testing has been done if the results are clearly marked "preliminary." The results of all screening and confirmatory tests must be clearly reported.

-Consent for testing has not been explicitly addressed in the law. Common law applies. This generally requires informed consent when any procedure or test would or could have a significant negative impact on the patient. Legal counsel to DHS advises that routinely obtaining consent prior to testing will avoid potential legal problems.

-Special Rules for HIV-infected persons:

1. When an attending physician of an HIV-infected child believes the child may present a significant risk of transmission in school or day care, the physician is required to notify the local health director. The local health director will consult with the attending physician and, if concern about transmission remains, the local health director must consult with an interdisciplinary committee including an AIDS expert, the

*Persons with positive HIV antibody test may have been infected for 6 weeks or for years. Experience with partner notification for late latent syphilis indicates that it is seldom possible to locate partners of more than one year previous.

**Forms will be made available through local health departments in early February.

attending physician, appropriate school personnel, and the child's parent or guardian. If an alternate educational setting is needed, the local health director will notify the principal of the school the child will attend and will inform other school personnel directly involved with the student as appropriate. All informed persons are required to be notified that they are bound by the confidentiality law.

2. The attending physician of an HIV-infected person who, in good faith, has reason to suspect that the individual cannot or will not follow control measures and is thereby causing a significant risk for transmission, is required to notify the local health director. When the person cannot or will not follow control measures because of mental illness or mental retardation, the local health director is required to consult with the attending physician who made the notification and with the attending mental health physician or appropriate mental health authority to develop an appropriate plan to prevent transmission.

General AIDS Control Measures:

1. All health care workers (including emergency responders and funeral service personnel) are required to follow blood and body fluid precautions with all patients.
2. Health care workers who have HIV infection and a secondary infection or an open skin lesion which would pose a threat to patients shall not provide direct patient care. The rules require no other restrictions in the work place for HIV-infected persons.
3. When a health care worker or another person has exposure to blood or body fluid that might be infected with HIV and:

A. The source is known:

- (1) The occupational health care provider or attending physician of the exposed person who has been notified by the exposed person is required to:
 - a. Assess the exposure to determine if there is a significant risk transmission could have occurred in this manner if the source were infected with HIV.
 - b. If there is determined to be a significant risk transmission could have occurred, notify the attending physician of the source person.
- (2) The attending physician of the source person is required to:
 - a. Discuss the exposure with the source person.
 - b. Assess the risk that the source person is HIV-infected.
 - c. If the risk assessment indicates that the source is at high risk for HIV infection and has not already had a positive test for infection, request permission from the source for HIV testing.
 - d. Report the results of the risk assessment and test (if done) to the occupational health care provider or attending physician of the exposed person.
- (3) The occupational health care provider or attending physician of the exposed person is required to:
 - a. Discuss the results of the risk assessment and testing (if done) with the exposed person.
 - b. Offer periodic HIV testing for up to one year to the exposed person.
 - c. Instruct the exposed person regarding their legal obligation to protect the confidentiality of the source person.
 - d. If the occupational health care provider or attending physician believes, based on the risk assessment and testing (if done) of the source, that there is a significant risk that the source is infected, instruct the exposed person to:
 - i. avoid sexual intercourse unless condoms are used; exercise caution when using condoms because of possible condom failure;
 - ii. never share needles or syringes; and
 - iii. not donate or sell blood, blood products, semen, organs, or tissues.

B. The source is unknown:

The occupational health care provider or attending physician is required to:

- a. assess the risk that HIV infection could have been transmitted in the setting and manner in which the exposure occurred;
- b. if there is determined to be significant risk
 - (1) offer the exposed person periodic testing for HIV infection for up to one year;
 - (2) instruct the exposed person to:
 - i. avoid sexual intercourse unless condoms are used; exercise caution when using condoms because of possible condom failure;
 - ii. never share needles or syringes;
 - iii. not donate or sell blood, blood products, ova, semen, organs, or tissues.
4. All instruments used to puncture human skin (in medical and non-medical settings) must be disposed of in a puncture-resistant container and incinerated or disposed of in a sanitary landfill or be sterilized before reuse.
5. Physicians attending persons who die with known HIV infection are required to provide written notification to all persons handling the body to follow blood and body fluid precautions. (This also applies to bodies of persons who die with hepatitis B infection, rabies, and Jakob-Creutzfeldt.) The notification must be presented before the body is removed from any medical facility. If the patient dies at home or in some other non-medical setting, the attending physician is required to notify funeral service personnel by telephone (as soon as the physician becomes aware of the death) to follow blood and body fluid precautions.

REPORTABLE DISEASES AND CONDITIONS

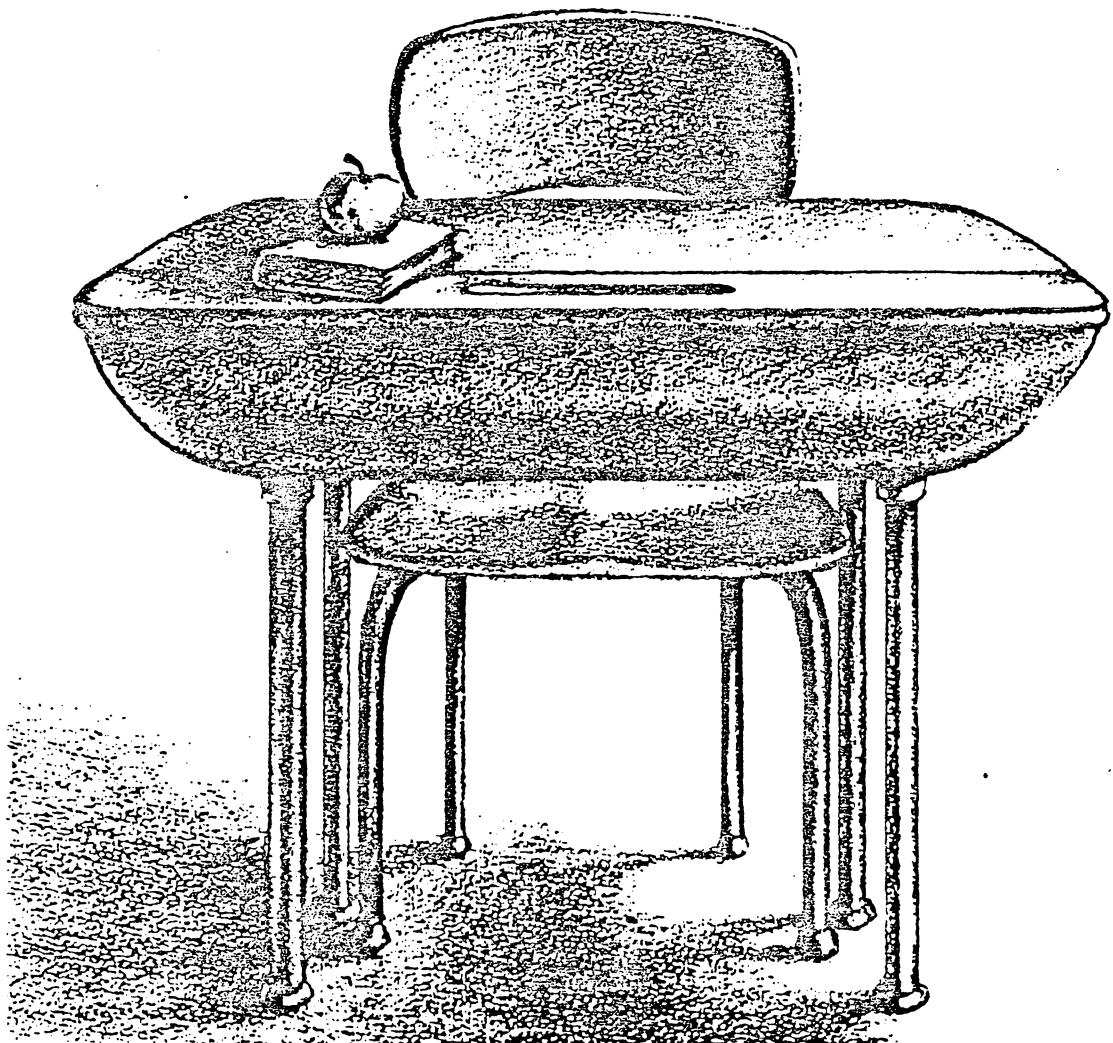
acquired immune deficiency syndrome (AIDS) - 7 days	meningitis, pneumococcal - 24 hours
amebiasis - 7 days	meningitis, viral (aseptic) - 7 days
anthrax - 24 hours	meningococcal disease - 24 hours
blastomycosis - 7 days	mucocutaneous lymph node syndrome (Kawasaki syndrome) - 7 days
botulism - 24 hours	mumps - 7 days
brucellosis - 7 days	nongonococcal urethritis - 7 days
campylobacter infection - 24 hours	plague - 24 hours
chancroid - 24 hours	paralytic poliomyelitis - 24 hours
chlamydial infection (laboratory confirmed) - 7 days	psittacosis - 7 days
cholera - 24 hours	Q fever - 7 days
dengue - 7 days	rabies, human - 24 hours
diphtheria - 24 hours	Reye's syndrome - 7 days
encephalitis - 7 days	Rocky Mountain spotted fever - 7 days
foodborne disease, including but not limited to Clostridium perfringens, staphylococcal, and Bacillus cereus - 24 hours	rubella - 24 hours
gonorhea - 24 hours	rubella congenital syndrome - 7 days
granuloma inguinale - 24 hours	salmonellosis - 24 hours
Hemophilus influenzae, invasive disease - 24 hours	shigellosis - 24 hours
hepatitis A - 24 hours	syphilis - 24 hours
hepatitis B - 24 hours	tetanus - 7 days
hepatitis B carriage - 7 days	toxic shock syndrome - 7 days
hepatitis non-A, non-B - 7 days	trichinosis - 7 days
legionellosis - 7 days	tuberculosis - 24 hours
leprosy - 7 days	tularemia - 24 hours
leptospirosis - 7 days	typhoid - 24 hours
Lyme disease - 7 days	typhoid carriage (Salmonella typhi) - 7 days
lymphogranuloma venereum - 7 days	typhus, epidemic (louse-borne) - 7 days
malaria - 7 days	whooping cough - 24 hours
measles (rubeola) - 24 hours	yellow fever - 7 days

APPENDIX M. VIRGINIA DEPARTMENT OF HEALTH, ACQUIRED
IMMUNODEFICIENCY SYNDROME (AIDS), RECOMMENDATIONS FOR SCHOOL

ATTENDANCE

Acquired Immunodeficiency Syndrome (AIDS)

Virginia Department of Health
Recommendations for
School Attendance*



These recommendations apply to all children in kindergarten through grade 12, known to be infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the causative agent of AIDS. This includes children with AIDS as defined for State Health Department reporting purposes; children who are diagnosed by their physicians as having an illness due to infection with HTLV-III/LAV but who do not meet the case definition; and children who are asymptomatic but have virologic or serologic evidence of infection with HTLV-III/LAV. These recommendations do not apply to siblings of infected children unless they are also infected.

Background

The Scope of the Problem. As of November 4, 1985, 206 of the 14,519 reported cases of AIDS in the United States were among children under 18 years of age. This number is expected to double in the next year. Children with AIDS have been reported from 23 states, the District of Columbia, and Puerto Rico, with 75% residing in New York, California, Florida, and New Jersey. Of the 156 cases of AIDS reported to date in Virginia since 1982, three have been in children.

The 206 AIDS patients reported to the Centers for Disease Control (CDC) represent only the most severe form of HTLV-III/LAV infection, i.e., those children who develop opportunistic infections or malignancies. As in adults with HTLV-III/LAV infection, many infected children may have milder illness or may be asymptomatic.

Confidentiality Issues. The diagnosis of AIDS or associated illnesses evokes much fear from others in contact with the patient and may evoke suspicion of life-styles that may not be acceptable to some persons. Parents of HTLV-III/LAV-infected children should be aware of the potential for social isolation should the child's condition become known to others in the school. School personnel and others involved in educating and caring for these children should be sensitive to the need for confidentiality and the right to privacy in these cases.

Assessment of Risks

Risk Factors for Acquiring HTLV-III/LAV Infection. In adults and adolescents, HTLV-III/LAV is transmitted primarily through sexual contact (homosexual or heterosexual) and through parenteral exposure to infected blood or blood products. HTLV-III/LAV has been isolated from

blood, semen, saliva, and tears but transmission has not been documented from saliva and tears. Adults at increased risk for acquiring HTLV-III/LAV infection include homosexual/bisexual men, intravenous drug abusers, persons transfused with contaminated blood or blood products, and sexual contacts of persons with HTLV-III/LAV infection or in groups at increased risk for infection.

The majority of infected children acquire the virus from their infected mothers in the perinatal period (1-4). In utero or intrapartum transmission is likely, and one child reported from Australia apparently acquired the virus postnatally, possibly from ingestion of breast milk (5). Children may also become infected through transfusion of blood or blood products that contain the virus. Seventy percent of the pediatric cases reported to CDC occurred among children whose mothers were infected with HTLV-III/LAV at the time of birth or were members of a group at increased risk of acquiring HTLV-III/LAV infection; 20% of the cases occurred among children who had received blood or blood products; and for 10%, investigations are incomplete.

Risk of Transmission in the School Setting. None of the identified cases of HTLV-III/LAV infection in the United States is known to have been transmitted in the school setting or through other casual person-to-person contact. Other than the sexual partners of HTLV-III/LAV-infected patients and infants born to infected mothers, none of the family members of the 14,519 AIDS patients reported to CDC has been reported to have AIDS. Six studies of family members of patients with HTLV-III/LAV infection have failed to demonstrate HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to older children who were not likely at risk from perinatal transmission (6-11).

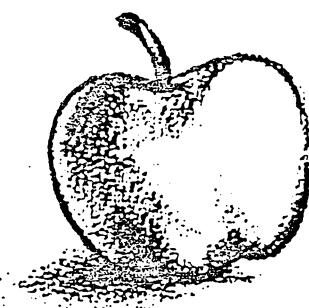
Based on current evidence, casual person-to-person contact as would occur among schoolchildren appears to pose no risk. However, studies of the risk of transmission through contact between younger children and neurologically handicapped children who lack control of their body secretions are very limited. Based on experience with other communicable diseases, a theoretical potential for transmission would be greatest among these children. It should be emphasized that any theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes to blood and possibly other body fluids of an infected person.

Risks to the Child with HTLV-III/LAV Infection. HTLV-III/LAV infection may result in immunodeficiency. Such children may have a greater risk of encountering infectious agents in a school than at home. Immunodepressed children are also at greater risk of suffering severe complications from such infections as chickenpox, cytomegalovirus, tuberculosis, herpes simplex, and measles. Assessment of the risk to the immunodepressed child is best made by the child's physician who is aware of the child's immune status.

Recommendations

1. Decisions regarding the type of educational and care setting for HTLV-III/LAV-infected children should be based on the behavior, neurologic development, and physical condition of the child and the expected type of interaction with others in that setting. These decisions should be made using the team approach; such a team should include the child's physician, public health personnel and the child's parent or guardian. 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-aged 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 to be placed in a foster home in an unrestricted setting.
3. For the infected preschool-aged 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.
4. Because other infections in addition to HTLV-III/LAV can be present in blood or body fluids, all schools 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
5. Care which involves exposure to the infected child's body fluids and excrement should be provided by persons who are aware of the child's HTLV-III/LAV infection and the modes for HTLV-III/LAV transmission. In any setting, especially involving an HTLV-III/LAV-infected person, good hand-washing after exposure to blood and body fluids and before caring for another child should be observed, and disposable gloves should be worn when handling such blood and body fluids. Any open lesions on the infected child should also be covered.
6. A plan for periodic review by the medical team described in #1 will be established at the time the initial decision is made regarding school attendance. This periodic review is important because the hygienic practices of a child with HTLV-III/LAV infection may improve sufficiently as he/she matures to allow for school attendance in the future. Alternatively, the hygienic practices may deteriorate if the child's condition worsens and the reevaluation will be necessary to determine if the deterioration of hygienic practices warrants exclusion.
7. Mandatory screening as a condition for school attendance is not warranted based on available data.
8. 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 occur (e.g., bleeding injury).

should be rinsed in disinfectant. Those who are cleaning should wear disposable gloves and avoid exposure of open skin lesions or mucous membranes to the blood or body fluids.



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*The Virginia Department of Health Recommendations for School Attendance are adopted from recommendations on the subject published by the Centers for Disease Control/U.S. Public Health Service and the American Academy of Pediatrics

November 1985



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