NORTH COAST
SCHOOL OF EDUCATION

North Coast Teacher Induction Program

Health and Safety Resource Guide

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CHAPTER 1: INTRODUCTION

One of the most crucial responsibilities of the classroom teacher is to provide and maintain a safe and healthy environment for teaching and learning. Numerous laws, regulations and policies, guide teachers, but preparation in the beginning years as well as access to critical information, is vital in enabling the teacher to be aware of and appropriately respond to the wide array of health and safety issues present in today's schools and classrooms.

This handbook is intended as a teacher reference. It is designed to include important information about the health and safety issues which teachers are most likely to encounter in their daily work lives with their students. Not all subjects, of course, are covered, but references are provided to enable the teacher to research additional questions and issues.

In using this reference, always remember that this is a resource and that site and District policy and protocol may differ to some degree and, in fact, supersede the suggestions made here. Teachers should be aware of their local regulations and know how to respond accordingly.

We hope you find this resource helpful in the work you do with students. You make a difference in the lives of many and your focus on health and safety will ensure that all of your students have the best care and support possible throughout their educational experiences.

CHAPTER 2: STRESS

2.1 Stress Warning Signs

Stress can contribute to or mimic a variety of symptoms. Below is a chart of some common symptoms. We all experience some of them on occasion, but if these symptoms are ongoing, it's time to get some help for your stress.

Put a checkmark beside symptoms that you experience which concern you or others. These symptoms may also be exhibited as serious stress signs in your students.

PHYSICAL	MENTAL
○ Fatigue (often one of the first signs) ○ Headache ○ Insomnia ○ Muscle aches/pain (often neck, shoulders, lower back) ○ Heart palpitations ○ Chest pains ○ Abdominal cramps ○ Nausea ○ Trembling ○ Cold extremities ○ Flushing or sweating ○ Frequent colds	○ Decreased concentration/memory ○ Indecisiveness ○ Mind racing or going blank ○ Loss of sense of humor ○ Increased forgetfulness
EMOTIONAL	**BEHAVIORAL** (Poor coping techniques)
○ Anxiety ○ Nervousness ○ Depression ○ Short temper; anger ○ Frustration ○ Worry ○ Irrational fear ○ Irritability ○ Impatience with loved ones ○ Crying inappropriately	○ Pacing/fidgeting ○ Nervous habits (nail biting, etc.) ○ Increase/decrease in eating ○ Increased smoking/drinking ○ Crying ○ Yelling ○ Blaming ○ Throwing things, hitting

Source: reproduced from http://www.untrammelled.co.uk/teacherstress/stress symptoms.shtml.
Original source: Posen, David B. "Stress Management for Patient and Physician", The Canadian Journal of Continuing Medical Education, April 1995. Published on the web at http://www.mentalhealth.com

2.2 Stress Inoculators

Are you doing what you can to protect yourself from life's stresses?

Put a check mark on the blank beside everything that is almost always true of you. Next, circle the numbers of those items you KNOW you need to work on.

1. I eat at least one hot, balanced, healthy meal a day. _____
2. I get 7-8 hours each night of good sleep during the workweek. _____
3. I give and receive physical affection regularly. _____
4. I have a network of friends and acquaintances, and at least one with whom I can confide personal matters. _____
5. I exercise to the point of perspiration at least twice a week. _____
6. I do not smoke cigarettes and drink less than 5 alcoholic drinks a week. _____
7. I am the appropriate weight for my height. _____
8. I have an income adequate to meet basic expenses. _____
9. I get strength from my religious or philosophical beliefs. _____
10. I take quiet time for myself every day. _____
11. I am in good health (including eyesight, hearing, teeth). _____
12. I am able to speak openly about my feelings when upset or worried. _____
13. I have regular conversations with the people I live with about domestic issues (chores, money, daily living). _____
14. I do something I consider fun at least once a week. _____
15. I am able to organize my time effectively. _____
16. I drink fewer than three cups of a caffeinated beverage daily. _____
17. I take inventory at least once a week of my accomplishments. _____
18. I am able to receive constructive criticism from others and apply it where appropriate. _____
19. I know my strengths and weaknesses, and work hard not to overextend myself. _____
20. I do the best I know how toward accomplishing goals, but I know that the results are really not in my hands. _____

Looking over your checkmarks and circles, what are you willing to work on to improve? Put an * beside one or two of those items you circled and be ready to share it with your Mentor.

2.3 Identifying Your Stressors

2.31 Stress Record

Stress response occurs when you encounter a demand in your life that you perceive as threatening to your sense of self. Stressors can be events, circumstances, places, people, feelings or attitudes. We all respond differently.

Use the columns below to list the kinds of situations which typically cause you stress, how intensely you tend to feel this stress on a scale of 1 -10, and what negative coping strategies you often use that are not effective. The first two are given as examples.

Identified Stressor	Feeling/Intensity	Negative Coping Strategy
I have too many administrative tasks	Annoyed – 6 Confused – 7	I become impatient with my loved ones or students at school
I don't feel safe in my classroom	Anxious/Fearful – 8	I leave campus as soon as school ends and don't have time for on site planning or meeting with students.

2.32 Important and Controllable?

Some people worry so much about things they **cannot change,** they never take charge when they could make a difference.

Review each of the stressors you identified on your ***Stress Record***. Decide where you would place each stressor in the boxes below. Ask yourself: *How important is it? Can I control this event or situation?*

Use the following page to discuss or think about a ***positive coping strategy*** you could employ to take charge of the stress!

IMPORTANT / CONTROLLABLE	UNIMPORTANT / CONTROLLABLE
Example: My classroom environment is chaotic and difficult to work in.	**Example:** Sitting in the lunchroom most days listening to negative conversations about students or education in general.
IMPORTANT / UNCONTROLLABLE	**UNIMPORTANT / UNCONTROLLABLE**
Example: An immediate member of a student's family has died.	**Example:** You don't like your principal's personality.

2.4 Stress Management

A lecturer, when explaining stress management to an audience, raised a glass of water and asked, “How heavy is this glass of water?”

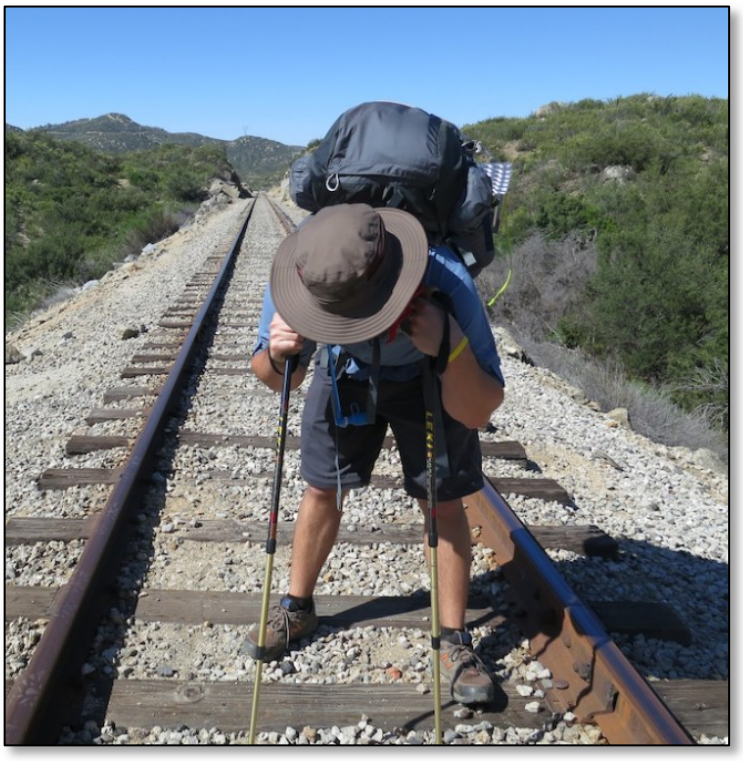
Answers called out ranged from ½ pound to 5 pounds. The lecturer replied, “The absolute weight doesn’t matter. It depends on how long you try to hold it.

If I hold it for a minute, that is not a problem. If I hold it for an hour, I will have an ache in my right arm. If I hold it for a day, you will have to call an ambulance. In each case, it is the same weight, but the longer I hold it, the heavier it becomes. Moreover, that is the way it is with stress management. If you carry your burdens all the time, eventually, as the burden becomes increasingly heavy, you will not be able to carry on.”

As with the glass of water, you have to put it down for a while and rest before holding it again.

When you are refreshed, you can carry on with the burden. So, before you return home after teaching, put the burden of work down. Do not carry it home. You can pick up tomorrow. Whatever burdens you are carrying now, let them down for a moment, if you can.

- Source unknown



2.41 Taking Charge of Stress

In any stressful situation, you have four choices: **accept, avoid, alter,** or **adapt.**

Accept	Alter
Sometimes all you can do is learn to accept things as they are. **Can you:** ✓ Learn from past experience? ✓ Talk with someone else about the situation? ✓ Use positive self-talk? ✓ Keep smiling, even in difficult times? ✓ Join a support group?	Altering a stressful situation in some way might be the best response. **Can you:** ✓ Ask someone to change their behavior? ✓ Communicate your feelings in an open way? ✓ Change the time, place, setting? ✓ Manage your time better? ✓ Be more assertive? One way to alter a stressful situation is to rehearse the situation before it occurs. Anticipate what might happen and think about what you would like to say or do.
Avoid	**Adapt**
To avoid needless stress, you must plan ahead and rearrange your surroundings. **Can you:** ✓ Avoid someone who constantly bothers you? ✓ Leave for work or home earlier to avoid traffic? ✓ Avoid taking on more work than you can handle? ✓ Leave the situation? ✓ Avoid discussing a topic or subject? Recognize your options and do what you can to avoid stressful situations. Remember that you can't avoid ALL the stresses in your life. You should try to avoid those recurring situations that are constant sources of frustration.	Adapting to stressful situations, and learning to cope with them as best you can, may be a better response than avoiding or altering. By anticipating stresses and making plans to adapt, you can go a long way towards reducing stress. **Can you:** **Change your thinking?** ✓ Think of the positive things in your life? ✓ Consider how much this will matter a year from now? ✓ Consider whether it is worth getting upset over? **Change your feelings?** ✓ Picture yourself in a pleasant environment? ✓ Use exercise to relieve stress? ✓ Learn and practice relaxation techniques? **Change your actions?** ✓ Slow down? ✓ Talk to someone about how you feel? ✓ Don't make matters worse by smoking, drinking, or overeating?

2.42 The Breathing Tool

Basic Posture: Sit with your feet flat on the floor, spine erect and your head centered on your shoulders. In fact…see if you can "drop" your shoulders. (Pause) You should not be able to drop your shoulders unless you have been hunching them higher and higher toward your ears due to stress.

Eyes: Keeping your head centered on your shoulders, drop your eyes as if you are looking down toward the floor. Close your eyes or keep them open and un-focus them.

Breath: Take a deep, slow breath in through your nose. Focus on the breath as it moves into your nostrils and moves down into the bottom part of your lungs. Feel your abdomen expand as you inhale. Hold the breath briefly and then exhale slowly through your mouth. Do the complete breath at least 3 times before slowly opening your eyes.

Hands: The hands are held gently over one of four of the seven "energy centers" in the body: the stomach, heart, base of the through or forehead. You might find gently holding your hands over your stomach feels best in one situation and holding your hands over your heart in another.

These are good tools to teach children and can be used any time, any place.

It takes only a minute to do and gives us a refreshing, comforting, pause in the middle or at the end of chaotic events.

Try using each of these strategies until you discover the one that feels right to you.

2.43 Quiet Mini's

Are you living with stress? STOP and BE KIND TO YOURSELF with one of the following quiet minis:

1. Three Quick Breaths
Take three quick inhalations followed by a deep sigh as you exhale. This automatically lowers your blood pressure.

2. Breathing Triangle
As you inhale, count to ten. Hold your breath and count to ten again. Exhale and count from ten down to one.

3. Four "S"
SMILE and make your eyes sparkle. Take a deep breath and as you exhale…Let your *jaw hang slack*…Let your *shoulders sag*…Let your *forehead smooth*…Smiling automatically breaks up the tenseness of stress!

4. Mental Vacation
With your eyes closed, breathe rhythmically and picture a favorite spot you would like to be. Use all of your senses to create the image. Include a favorite person or pet.

5. Affirmative Breath
Sit upright in a quiet place for 2-3 minutes inhaling and exhaling deeply. As you inhale, say, "I am…" As you exhale, say, "relaxed".

6. Notice the Breath
With your eyes closed, shift your attention to the "tip" of your nose. As you inhale, notice the air coming in tends to be cool. As you exhale, notice the air is warm. Fill a mental balloon with the warm air and then watch it drift away!

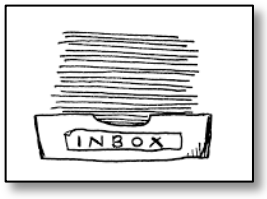
7. Five Finger Exercise
Start by doing whatever you need to feel centered, calm and focused. Gently join your index finger and your thumb. Reflect on *a time you succeeded.* Gently join your second finger and your thumb. Reflect on *something beautiful.* Gently join your ring finger and your thumb. Reflect on *a person who loves you as you are.* Gently join your little finger and your thumb. Reflect on *a place where you feel safe.*

Give yourself signals throughout the day to remind yourself to do a "*Quiet Mini*".
For example, put a piece of yarn in your teacher mailbox or put a sticky note on your car dashboard reminding you to do your favorite mini. Be thankful for time spent in lines or when stopped on the freeway

Which of these techniques will you use?

Which of these techniques will you teach your students?

2.44 When You Die, Your "In Basket" Won't be Empty



So many of us live our lives as if the secret purpose is to somehow get everything done. We stay up late, get up early, avoid having fun, and keep our loved ones waiting. Sadly, I've seen many people who put off their loved ones so long that their loved ones lost interest in maintaining the relationship. I used to do this myself. Often, we convince ourselves that our obsession with our "to do' list if only temporary—that once we get through he list, we'll be calm, relaxed, and happy. But in reality, this rarely happens. As items are checked off, new ones simply replace them.

The nature of your "in basket" is that it's *meant* to have items to be completed in it—it's not meant to be empty. There will always be phone calls that need to be made, projects to complete, and work to be done. In fact, it can be argued that a full "in-basket is essential for success. It means your time is in demand!

Regardless of who you are or what you do, however, remember that *nothing* is more important than your own sense of happiness and inner peace and that of your loved ones. If you're obsessed with getting everything done, you'll never have a sense of well-being! In reality, almost everything can wait. Very little in our work lives truly falls into the "emergency" category. If you stay focused on your work, it will all get done in due time.

I find that if I remind myself (frequently) that the purpose of life *isn't* to get it all done but to enjoy each step along the way and to live a life filled with love, it's far easier for me to control my obsession with completing my list of things to do. Remember, when you die, there *will* still be unfinished business to take care of. And you know what? Someone else will do it for you! Don't waste any more precious moments of your life regretting the inevitable.

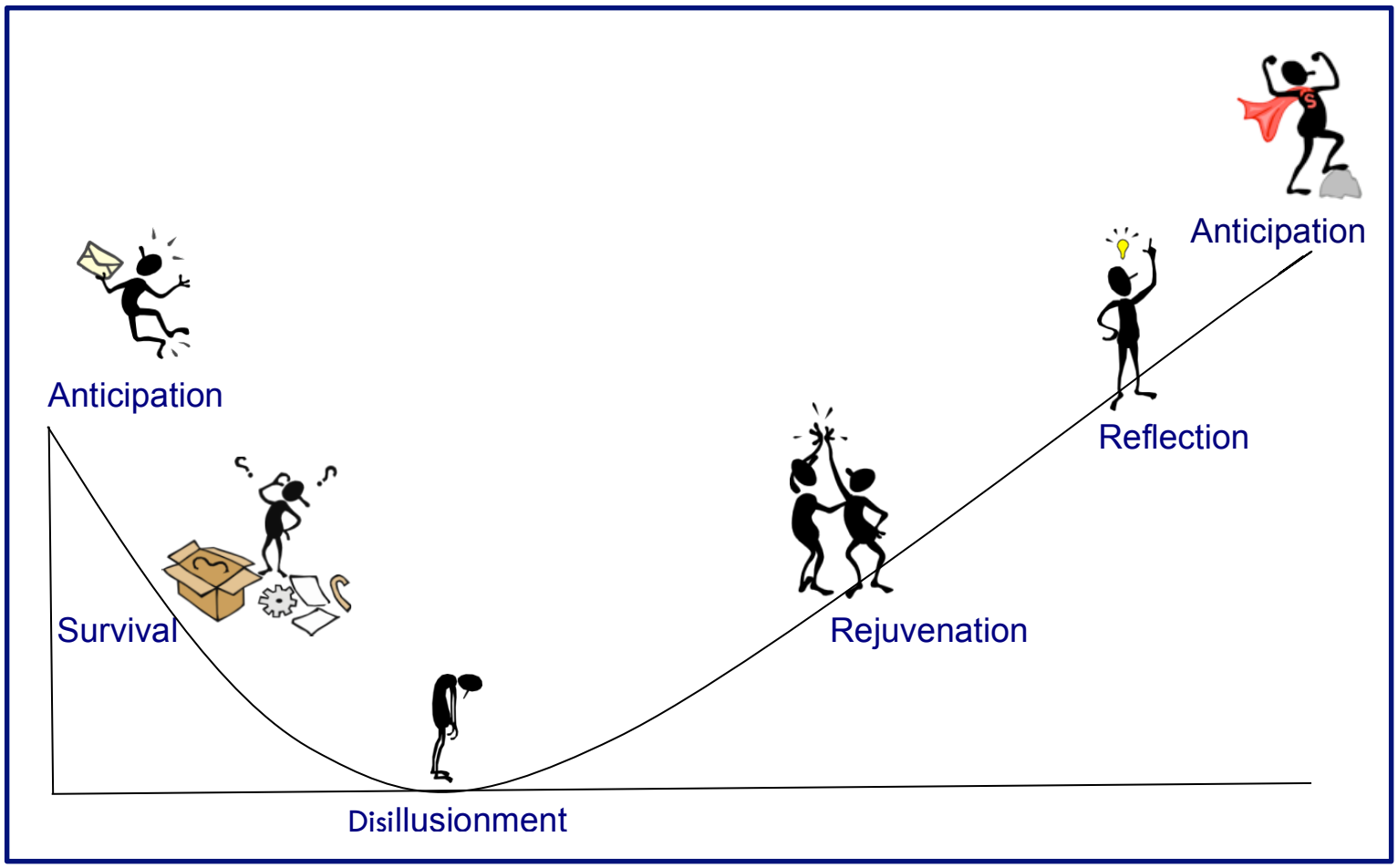
Source: copyrighted material - Carlson, Richard. Don't Sweat the Small Stuff - and It's All Small Stuff. First ed. New York: Hyperion, 1997. Print. Reprinted with permission 5/13/15.

2.5 Phases of Teaching

First-year teaching is a difficult challenge. Ellen Moir, Director at the Santa Cruz Consortium New Teacher Project and Director of Student Teaching at UC Santa Cruz, has been working with colleagues to support the efforts of new teachers. In their day-to-day interactions with new teachers, they have noted a series of phases new teachers may experience during their first year.

While not every new teacher goes through this exact sequence, Ms. Moir believes that recognizing these phases is useful in helping everyone involved in the process of supporting new teachers – administrators, other support personnel, and teacher education faculty.

Here is a look at the stages through which new teachers move during that crucial first year. New teacher quotations are from journal entries and end-of-the-year program evaluations.



ANTICIPATION PHASE: The anticipation phase begins during the student teaching portion of pre-service preparation. The closer student teachers get to completing their assignment, the more excited and anxious they become about their first teaching position. They tend to romanticize the role of the teacher and the position. New teachers enter with a tremendous commitment to making a difference and a somewhat idealistic view of how to accomplish their goals. This feeling of excitement carries new teachers through the first few weeks of school.

"I was elated to get the job but terrified about going from the simulated experience of student teaching to being the person completely in charge."

SURVIVAL PHASE: The first month of school is very overwhelming for new teachers. They are learning a lot and at a very rapid pace. Beginning teachers are bombarded instantly with a variety of problems and situations they had not anticipated. Despite preparation programs, new teachers are caught off guard by the realities of teaching.

"I thought I'd be busy, something like student teaching, but this is crazy. I'm feeling like I'm constantly running. It's hard to focus on other aspects of my life."

During the survival phase most new teachers are struggling to keep their heads above water. They become very focused and consumed with the day-to-day routine of teaching. There is little time to stop and reflect on their experiences. New teachers spend up to seventy hours a week on schoolwork. Particularly overwhelming is the constant need to develop curriculum.

Veteran teachers routinely reuse excellent lessons and units from the past. The new teacher, still uncertain of what will really work, must develop much of this for the first time. Even depending on unfamiliar prepared curriculum, such as textbooks, is enormously time consuming.

"I thought there would be more time to get everything done. It's like working three jobs: 7:30-2:30. 2:30-6:00, with more time spent in the evening and on weekends."

Although tired and surprised by the amount of work, first-year teachers usually maintain a tremendous amount of energy and commitment during the survival phase.

DISILLUSIONMENT PHASE: After six to eight weeks of nonstop work, new teachers enter the disillusionment phase. The intensity and length of the phase varies among new teachers. The extensive time commitment, the realization that things are probably not going as smoothly as they want and low morale contribute to this period of disenchantment. New teachers begin questioning both their commitment and their competence. Many new teachers get sick during this phase. Compounding an already difficult situation is the fact that new teachers are confronted with several new events during this time frame. They are faced with back-to-school night, conferences and their first formal evaluation by the site administrator. Each of these important milestones places an already vulnerable individual in a very stressful situation.

Back-to-school night means giving a speech to parents about plans for the year that may yet be unclear in the new teacher's mind. Some parents are uneasy when they realize the teacher is just beginning and sometimes pose questions to make demands that intimidate a new teacher.

Parent conferences require that new teachers be highly organized, articulate, tactful and prepared to confer with parents about each child's course of study and progress. This type of communication with parents can be awkward and difficult for a beginning teacher. New teachers generally begin with the idea that parents are partners in the learning process and are not prepared for parents' concerns or criticisms. Unfortunately, these criticisms occur right at the time when their self-esteem is waning.

This is also the first time that new teachers are formally evaluated by their principal. They are, for the most part, uncertain about the process itself and anxious about their own competence and ability to perform. Developing and presenting a "showpiece" lesson is time-consuming and stressful.

"I thought I'd be focusing more on curriculum and less on classroom management and discipline. I'm stressed because I have some very problematic students who are low academically, and I think about them every second my eyes are open."

During the disillusionment phase, classroom management is a major source of distress.

At this point, the accumulated stress of the first-year teacher coupled with months of excessive time allotted to teaching often brings complaints from family members and friends. This is a very difficult and challenging phase for new entries in the profession. They express self-doubt, have lower self-esteem and question their professional commitment. In fact, getting through this phase may be toughest challenge they face as a new teacher.

REJUVENATION: The rejuvenation phase is characterized by a slow rise in the new teacher's attitude toward teaching. It generally begins in January. Having a winter break makes a tremendous difference for new teachers. It allows them to resume a more normal lifestyle, with plenty of rest, food, exercise, and time for family and friends. This vacation is the first opportunity that new teachers have for organizing materials and planning curriculum. It is a time for them to sort through materials that have accumulated and prepare new ones. This breath of fresh air gives novice teachers a broader perspective with renewed hope.

"I'm really excited about my story-writing center, although the organization of it has at times been haphazard. Story writing has definitely revived my journals."

They seem ready to put past problems behind them. A better understanding of the system, an acceptance of the realities of teaching, and a sense of accomplishment help to rejuvenate new teachers. Through their experiences the first half of the year, beginning teachers gain new coping strategies and skills to prevent, reduce, or manage many problems

they are likely to encounter in the second half of the year. Many feel a great sense of relief that they have made it through the first half of the year. During this phase, new teachers focus on curriculum development, long-term planning and teaching strategies.

The rejuvenation phase tends to last into spring with many ups and downs along the way. Toward the end of this phase, new teachers begin to raise concerns about whether they can get everything done prior to the end of school. They also wonder how their students will do on the tests, questioning once again their own effectiveness as teachers.

"I'm fearful of these big tests. Can you be fired if your kids do poorly? I don't know enough about them to know what I haven't taught, and I'm sure it's a lot."

REFLECTION: The reflection phase beginning in May is a particularly invigorating time for first-year teachers. Reflecting back over the year, they highlight events that were successful and those that were not. They think about the various changes that they plan to make the following year in management, curriculum, and teaching strategies. The end is in sight, and they have almost made it; but more importantly, a vision emerges as to what their second year will look like, which brings them to a new phase of anticipation.

"I think that for next year I'd like to start the letter puppets earlier in the year to introduce the kids to more letters."

It is critical that we assist new teachers and case the transition from student teacher to full-time professional. Recognizing the phases that new teachers go through gives us a framework within which we can begin to design support programs to make the first year of teaching a more positive experience for our new colleagues.

2.6 It's All About Time

When you are a new teacher, it can be difficult enough to learn how to reduce stress at school, but there is also the unspoken false belief that to be a good teacher, you also have to spend all of your personal time working on schoolwork as well. Learn to work smarter, not harder.

Here are a few tips that will help you avoid burnout:

- **Learn to say no to others and yes to yourself.** Teachers are notorious for being people pleasers and not putting their own needs first. It is not selfishness to do so – it is positive self-interest.
- **Stay late or come in early.** Coming in an hour early once or twice a week can make a big difference.
- **Keep a "to-do" list** on your desk and grade papers daily.
- **Rotate due dates and do not give tests or have projects due on Fridays.** Your students and their families will thank you, since everyone's deadlines tend to load up at the end of the week.
- **Harry Wong says, "The one who does the work gets the learning."** Not every piece of work needs to be graded. Have students trade papers with a friend and check their own work right away. This increases retention for them, and you can cross another item off of your at-home workload.
- **Share the wealth.** Make it a point to share lesson plans and swap best practices with other teachers.
- **Grade less and look for ways to give kids more hands-on experiences** instead of worksheets. You can give them quick verbal feedback or take notes as you move around the classroom. It will cut down on the amount of paperwork to grade and you still have data on what they know.
- **Prioritize and delegate tasks** by making a list of everything you want to do each day and then prioritize the important things when your energy is high and resources are available. Make a schedule which groups similar trips and tasks to take place at the same time.
- **Ask for help** when you need it at school and delegate work at home, especially during the first year of teaching.
- **Set boundaries.** Sometimes it is not always better to do today what you could save until tomorrow. Pace yourself for peace and set some boundaries so you aren't getting bogged down with swapping emails and telephone calls every day. Tell parents, for instance, that you will check messages once a day in the morning or evening. When returning calls, keep conversations brief and to the point by having a few notes that summarize what you want to say. Keep a log of your conversations so that you can save on later paperwork, should you need to write an Individualized Education Plan (IEP), a recommendation letter, or report card comments.

- **Involve your students in classroom tasks.** Not only can students help to grade their own work, they can also help to keep track of supplies in the classroom, and learn procedures that help clean up the room. This practice creates a sense of pride for students and a sense of personal ownership in their classroom.
- **Schedule your fun.** Someone once said that when you take away a task from a teacher, it is like taking a bucket of water out of a lake – something soon fills its place. The key to freeing up time for you is not to focus on eliminating tasks, but rather to schedule time for things you love. Not carving out personal time for something you enjoy can lead to burnout. Take time to think about what gives you joy and schedule a little bit of time every day.

CHAPTER 3: HEALTH EDUCATION

3.1 The California Health Framework

All credentialed teachers in California are expected to use the adopted health curriculum and know how to use instructional materials in health within the context of their specific teaching assignments. The California Health Framework includes the traditional content areas used in most other state and national comprehensive health education programs. It provides students with opportunities to work individually and cooperatively to explore concepts in depth and analyze and solve real life problems relating to health and safety.

The goal of California Health Education is the development of health literacy in all students coming from the four unifying themes emphasized throughout the curriculum:

- Acceptance of personal responsibility for personal lifelong health and the incorporation of health-related knowledge into everyday behavior.
- Respect for and promotion of the health of others and the understanding of the relationship between individual behavior, personal well-being, and the health of the environment.
- An understanding of the processes of physical, mental, emotional, and social growth and development.
- Informed use of health-related information, products, and services.

A curriculum that addresses these unifying themes should include the following major content areas:

- Personal Health
- Consumer and Community Health
- Injury Prevention and Safety
- Nutrition
- Alcohol, Tobacco, and Other Drugs
- Environmental Health
- Family Living
- Individual Growth and Development
- Communicable and Chronic Diseases

It is the responsibility of each school district and teacher to determine how these concepts will be woven into each content area. As stated in the Health Framework For California Public Schools, “Unifying ideas should run through and connect areas in a student-centered approach that makes instruction meaningful to students.”

Source: "Health Framework for California Public Schools." California Department of Education. California Department of Education, 2003. Web. 22 May 2015. <http://www.cde.ca.gov/ci/cr/cf/documents>.

3.2 Healthy and Safe Environment for Student Learning

When creating a supportive and healthy environment for student learning, teachers should consider the following:

- Implement accident prevention strategies within the classroom and the school site.
- Know your role and be able to implement the school's crisis response plan accordingly.
- Understand procedures for responding to emergency health situations and accidents.
- Communicate with students and students' families regarding student health and safety, as needed.
- Work with families, caregivers, and health professionals.
- Obtain or create an emergency first aid kit for the classroom.

Discuss with your Mentor and/or school district staff the guidelines regarding the following:

- State and local permitted health topics.
- State, federal, and local policy regarding family life education and procedures for notifying parents and/or caregivers.
- Local guidelines for accessing and using outside speakers.

3.3 Class Profile and Student Health

Some candidates may opt to complete a Class Profile (recommended, but not required). When developing and reviewing the Class Profile, the teacher should consider health and medical issues, which may affect learning. Always consider information for each student regarding the following:

1. Hearing and vision deficits
2. Substance abuse
3. Medications
4. Allergies
5. Chronic medial conditions
6. Episodic medical conditions
7. Mental health issues
8. Nutrition
9. At-risk behavior

NORTH COAST SCHOOL OF EDUCATION

North Coast Teacher Induction Program

CLASS PROFILE

Candidate Name:
Grade Level:
Subject Area(s):
1st Semester: _____ 2nd Semester: _____

Refer to the Inquiry Directions and sample packets to complete this evidentiary document.
Maintaining the document's format and completing all sections is a program requirement.

Student First Name	Last Initial	Age	Reading Level	Ethnicity	Primary Language	Language Proficiency Level Use most current data available to complete if primary language is not English.	# of Years in U.S. Schools Complete for EL students only	IEP; 504; GATE Complete for all identified students	**COMPLETE THIS COLUMN for EACH student:** Include specific comments about each student, e.g., unique qualities and/or characteristics, concerns, health issues, and/or resources needed. For identified GATE, 504, EL, and/or IEP students, **specifically describe your classroom accommodations and responsibilities as the teacher.** **This is an ongoing document** – update as you learn new information about your students throughout the Inquiry. **You will complete this again in the Spring; note changes through color-coding, strike-through font, etc.** **IMPORTANT:** Use full titles rather than acronyms in all columns.
					All three of these columns must be filled out for each of your students with a primary language other than English.				
Data Source: (spell out acronyms of the data source and year used in white boxes)			Reading Level Data Source:			Language Proficiency Level Data Source and Year Used:			

NCSOE – Class Profile – Revised 2016-17

CHAPTER 4: LEGAL CONSIDERATIONS FOR TEACHERS

1. California Education Code:
    a. 32281. (a) "Each school district and county office of education is responsible for the overall development of all comprehensive school safety plans for its schools operating kindergarten or any grades, 1-12 inclusive."

2. Health and Safety Employment Act 1992
    a. The Duty of Care Owed Minors ('In Loco Parentis'):
        i. "Teachers with minors in their care are considered to be acting in place of a parent. The doctrine of 'In loco parentis' requires these teachers to ensure that participants receive at least the degree of care to be expected from a reasonably careful and prudent parent."
        ii. "Duty of care continues for as long as the teachers have charge of the participants, whether inside or outside the school or out of normal hours. It continues even when outside helpers or instructors are involved." This duty begins when the student leaves home and continues until the student returns home.
        iii. "Where a degree of hazard or risk may be involved, and parental approval required, providers are urged to err on the side of caution."

3. U.S. Government Code, Chapter 8, Division 4 of Title 1
    a. Designation as Disaster Service Worker (Section 3100)
        i. "All public employees are hereby declared to be disaster service workers subject to such disaster service activities as may be assigned to them by their superiors or by law." In the event of emergency, teachers must remain on site and in their classrooms until relieved of duty by a superior.

4. Senate Bill 198, Title 8-General Industry Safety Order 3203
    a. Injury and Illness Prevention Program
        i. Requires all school districts to establish and maintain an effective injury and illness prevention program for all employees.
        ii. The plan must designate responsible persons.
        iii. The plan must have a process to identify, report, and correct hazards in the workplace and establish safe work practices.
        iv. The plan must provide personal protective equipment and require safety training for all employees.

5. California Code 49480
    a. Medication
        i. The parent or legal guardian of any public school pupil on a continuing medication regimen for a nonepisodic[1] condition, shall inform the school nurse or other designated certificated school employee of the medication being taken, the current dosage, and the name of the supervising physician. With the consent of the parent or legal guardian of the pupil, the school nurse may communicate with the physician and may counsel with the school personnel regarding the possible effects of the drug on the child's physical, intellectual, and social behavior, as well as possible behavioral signs and symptoms of adverse side effects, omission, or overdose. The superintendent of each school district shall be responsible for informing parents of all pupils of the requirements of this section.

[1]Episodic: A condition affecting the patient at irregular intervals and leaving him unaffected at other times. The patient expects problems, but the onset may not be predictable. Brady, **Emergency Care**, Fifth Edition, Prentice Hall, 1990.

4.1 California Minor Consent Laws

A young person is more likely to disclose sensitive information to a health care provider if the youth is provided with confidential services and has time alone with the provider to discuss their issues.

Remember that, even when the chief complaint is acne or an earache, there may be underlying issues on the part of the adolescent (such as the need for a pregnancy test or contraception), which will only surface if they are provided confidential services.

CALIFORNIA MINOR CONSENT AND CONFIDENTIALITY LAWS*

MINORS OF ANY AGE MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
PREGNANCY	"A minor may consent to medical care related to the prevention or treatment of pregnancy," except sterilization. (Cal. Family Code § 6925**).**	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
CONTRACEPTION	A minor may receive birth control without parental consent. (Cal. Family Code § 6925).	
ABORTION	A minor may consent to an abortion without parental consent. (Cal. Family Code § 6925; *American Academy of Pediatrics v. Lungren,* 16 Cal.4th 307 (1997)).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (*American Academy of Pediatrics v. Lungren,* 16 Cal.4th 307 (1997); Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
SEXUAL ASSAULT[1] SERVICES [1]For the purposes of minor consent alone, sexual assault includes acts of oral copulation, sodomy, and other crimes of a sexual nature.	"A minor who [may] have been sexually assaulted may consent to medical care related to the diagnosis,…treatment and the collection of medical evidence with regard to the …assault." (Cal. Family Code § 6928).	The health care provider must attempt to contact the minor's parent/guardian and note in the minor's record the day and time of the attempted contact and whether it was successful. This provision does not apply if the treating professional reasonably believes that the parent/guardian committed the assault. (Cal. Family Code § 6928). Both rape and sexual assault of a minor are considered child abuse under California law and must be reported as such to the appropriate authorities by mandated reporters. The child abuse authorities investigating a child abuse report legally may disclose to parents that a report was made. (See Cal. Penal § 11167 and 11167.5.)
RAPE[2] SERVICES FOR MINORS UNDER 12 YRS[3] [2]Rape is defined in Cal. Penal Code **§ 261**. [3]See also "Rape Services for Minors 12 and Over" on page 3 of this chart	A minor under 12 years of age who may have been raped "may consent to medical care related to the diagnosis,…treatment and the collection of medical evidence with regard" to the rape. (Cal. Family Code § 6928).	

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MINORS OF ANY AGE MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
EMERGENCY MEDICAL SERVICES* *An emergency is "*a situation . . . requiring immediate services for alleviation of severe pain or immediate diagnosis of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death*" (Cal. Code Bus. & Prof. § 2397(c)(2)).	A provider shall not be liable for performing a procedure on a minor if the provider "reasonably believed that [the] procedure should be undertaken immediately and that there was insufficient time to obtain [parental] informed consent." (Cal. Bus. & Prof. Code § 2397).	The parent or guardian usually has a right to inspect the minor's records. (Cal. Health & Safety Code §§ 123110(a); Cal. Civ. Code § 56.10. *But see exception at endnote ([EXC.])).*
SKELETAL X-RAY TO DIAGNOSE CHILD ABUSE OR NEGLECT* * The provider does not need the minor's or her parent's consent to perform a procedure under this section.	"A physician and surgeon or dentist or their agents . . . may take skeletal X-rays of the child without the consent of the child's parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of." (Cal. Penal Code § 11171.2).	Neither the physician-patient privilege nor the psychotherapist-patient privilege applies to information reported pursuant to this law in any court proceeding.
MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	**LAW/DETAILS**	**MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?**
INFECTIOUS, CONTAGIOUS COMMUNICABLE DISEASES (DIAGNOSIS, TREATMENT)	"A minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if the disease… is one that is required by law…to be reported…." (Cal. Family Code § 6926).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
SEXUALLY TRANSMITTED DISEASES (PREVENTIVE CARE, DIAGNOSIS, TREATMENT)	A minor 12 years of age or older who may have come into contact with a sexually transmitted disease may consent to medical care related to the diagnosis or treatment of the disease. (Cal. Family Code § 6926). Beginning in January 2012, "A minor who is 12 years of age or older may consent to medical care related to the prevention of a sexually transmitted disease." (AB 499 (2011); Cal. Family Code § 6926).	

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MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
AIDS/HIV TESTING AND TREATMENT	A minor 12 and older is competent to give written consent for an HIV test. (Cal. Health and Safety Code § 121020). A minor 12 and older may consent to diagnosis and treatment of HIV/AIDS. (Cal. Family Code § 6926).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
RAPE SERVICES FOR MINORS 12 and OVER	"A minor who is 12 years of age or older and who is alleged to have been raped may consent to medical care related to the diagnosis or treatment of the condition and the collection of medical evidence with regard to the alleged rape." (Cal. Family Code § 6927).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11). RAPE Rape of a minor is considered child abuse under California law and mandated reporters, including health care providers, must report it as such. Providers cannot disclose to parents that they have made this report without the adolescent's authorization. However, adolescent patients should be advised that the child abuse authorities investigating the report may disclose to parents that a report was made.

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MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
OUTPATIENT MENTAL HEALTH SERVICES[4]/ SHELTER SERVICES [4]This section does not authorize a minor to receive convulsive therapy, psychosurgery or psychotropic drugs without the consent of a parent or guardian.	Two statutes give minors the right to consent to mental health treatment. If a minor meets the criteria under either statute, the minor may consent to his or her own treatment. If the minor meets the criteria under both, the provider may decide which statute to apply. There are differences between them. See endnote ** for more on these differences: Family Code § 6924 "A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis or to residential shelter services, if both of the following requirements are satisfied: (1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services. AND (2) The minor (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or (B) is the alleged victim of incest or child abuse." (Cal. Family Code § 6924.) Health & Safety Code § 124260 "[A] minor who is 12 years of age or older may consent to [outpatient] mental health treatment or counseling services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services." (Cal. Health & Saf. Code § 124260.)	MENTAL HEALTH TREATMENT: The health care provider is required to involve a parent or guardian in the minor's treatment unless the health care provider decides that such involvement is inappropriate. This decision and any attempts to contact parents must be documented in the minor's record. (Cal. Fam. Code § 6924; 45 C.F.R. 164.502(g)(3)(ii).) For services provided under Health and Safety Code § 124260, providers must consult with the minor before deciding whether to involve parents. (Cal. Health & Saf. Code § 124260(a).) While this exception allows providers to inform and involve parents in treatment when appropriate, it does not give providers a right to disclose medical records to parents without the minor's authorization. The provider can only share the minor's medical records with parents with a signed authorization from the minor. (Cal. Health & Saf. Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11, 56.30; Cal. Welf. & Inst. Code § 5328. *See also endnote*(^{EXC}).) SHELTER: Although minor may consent to service, the shelter must use its best efforts based on information provided by the minor to notify parent/guardian of shelter services.

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MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
DRUG AND ALCOHOL ABUSE TREATMENT • This section does not authorize a minor to receive replacement narcotic abuse treatment without the consent of the minor's parent or guardian. • This section does not grant a minor the right to refuse medical care and counseling for a drug or alcohol related problem when the minor's parent or guardian consents for that treatment. (Cal. Family Code § 6929(f)).	"A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem." (Cal. Family Code §6929(b)).	There are different confidentiality rules under federal and state law. Providers meeting the criteria listed under 'federal' below must follow the federal rule. Providers that don't meet these criteria follow state law. **FEDERAL**: Federal confidentiality law applies to any individual, program, or facility that meets the following two criteria: 1. The individual, program, or facility is federally assisted. (Federally assisted means authorized, certified, licensed or funded in whole or in part by any department of the federal government. Examples include programs that are: tax exempt; receiving tax-deductible donations; receiving any federal operating funds; or registered with Medicare.)(42 C.F.R. §2.12); **AND** 2. The individual or program: 1) Is an individual or program that holds itself out as providing alcohol or drug abuse diagnosis, treatment, or referral; **OR** 2) Is a staff member at a general medical facility whose primary function is, and who is identified as, a provider of alcohol or drug abuse diagnosis, treatment or referral; **OR** 3) Is a unit at a general medical facility that holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral. (42 C.F.R. §2.11; 42 C.F.R. §2.12). For individuals or programs meeting these criteria, federal law prohibits disclosing any information to parents without a minor's written consent. One exception, however, is that an individual or program may share with parents if the individual or program director determines the following three conditions are met: (1) that the minor's situation poses a substantial threat to the life or physical well-being of the minor or another; (2) that this threat may be reduced by communicating relevant facts to the minor's parents; and (3) that the minor lacks the capacity because of extreme youth or a mental or physical condition to make a rational decision on whether to disclose to her parents. (42 C.F.R. §2.14). **STATE RULE**: Cal. Family Code §6929(c). Parallels confidentiality rule described under "Mental Health Treatment" at page 4 above. *See also exception at endnote ([EXC]).*

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MINOR 15 YEARS OF AGE OR OLDER	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
GENERAL MEDICAL CARE	"A minor may consent to the minor's medical re or dental care if all of the following conditions are satisfied: (1) The minor is 15 years of age or older. (2) The minor is living separate and apart om the minor's parents or guardian, whether with r without the consent of a parent or guardian and gardless of the duration of the separate residence.) The minor is managing the minor's own financial affairs, regardless of the source of the minor's income." (Cal. Family Code § 6922(a).)	"A physician and surgeon or dentist may, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the information given by the minor, the whereabouts of the parent or guardian." (Cal. Family Code § 6922(c). *See also exception at endnote (EXC)).*
MINOR MUST BE EMANCIPATED (GENERALLY 14 YEARS OF AGE OR OLDER)	**LAW/DETAILS**	**MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?**
GENERAL MEDICAL CARE for EMANCIPATED YOUTH	An emancipated minor may consent to medical, dental and psychiatric care. (Cal. Family Code § 7050(e)). *See* Cal. Family Code § 7002 for emancipation criteria.	The health care provider is not permitted to inform a parent or legal guardian without minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).

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Endnotes:

***** There are many confidentiality and consent rules. Different rules apply in different contexts. This chart addresses the rules that apply when minors live with their parents or guardians. It does not address the rules that apply when minors are under court jurisdiction or in other special living situations. Further, the confidentiality section focuses on parent and provider access. It does not address when other people or agencies may have a right to access otherwise confidential information.

****** In addition to having slightly different eligibility criteria, there are other small differences between Health and Safety Code §124260 and Family Code § 6924. For example, the two laws both allow "professional persons" to deliver minor consent services but the two laws define "professional person" differently. Also, there is a funding restriction that applies to Health and Safety Code §124260 but not to Family Code § 6924. (See Cal. Family Code 6924, Cal. Health & Saf. Code § 124260 and Cal. Welf. & Inst. Code § 14029.8 and look for more information on www.teenhealthlaw.org.).

EXC: Providers may refuse to provide parents access to a minor's medical records, where a parent normally has a right to them, if "the health care provider determines that access to the patient records requested by the [parent or guardian] would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being." Cal. Health & Safety Code § 123115(a)(2). A provider shall not be liable for any good faith decisions concerning access to a minor's records. Id.

4.2 Professional Distance

It is generally accepted that teachers need to learn as much as they can about their students. It is also very important that teachers develop positive working relationships with each student to better understand the factors that influence their learning. The teaching profession is fortunate to attract many young, idealistic, nurturing individuals who are dedicated to the positive holistic development of each student. Because of this, teachers are particularly susceptible to getting too close to students.

When nurturing professionals' work with students, it is important that they maintain a distinct "professional distance" which allows for a degree of closeness, but does not extend into the private social world of the student. Occasionally, a teacher's overture to a student, made with the best of intentions, may be misinterpreted as a sign of inappropriateness or favoritism. This can damage the climate of justice, equity, and social appropriateness that is necessary to an effective teaching environment. Teachers must remember that their role is decidedly different from parent or friend. The role of the professional teacher is to facilitate learning. Teachers should therefore insure that their intentions and actions are to that ultimate purpose.

Additionally, students must learn socially appropriate ways of relating to teachers and others in authority that have their best interests at heart. In today's world of social networking, there are many additional avenues for communication with students. Professional teachers must apply their guidelines for professional distance to these options as well. School districts are developing and implementing policies with regard to the appropriate use of social networking for students and teachers. It is essential that teachers are aware of, and follow these policies.

A high degree of self-awareness is particularly important for teachers. They must understand why they have chosen this profession. If the answer is that they want to be liked, they are particularly vulnerable to eroding boundaries that can damage the student as well as the teacher.

4.3 Harassment Policy

Harassment of any kind is not acceptable and is against both state and federal laws. Teachers and students must adhere to strict regulations for the safety and well being of all people within the educational community.

It is policy of the State of California, pursuant to Section 200, that all persons should enjoy freedom from discrimination and/or harassment of any kind in the educational institutions of the state. This also includes sexual harassment, which is a form of sexual discrimination (EC 231.5).

Protected groups put forth under Title IX and in California are enumerated by Education Code §200 and 220, Government Code §11135, and include actual or perceived sex, sexual orientation, gender, ethnicity, race, ancestry, national origin, religion, color, mental or physical disability, and age, as well as association with a member of a protected class. However, harassment of anyone is inappropriate, whether they are part of the above-protected class or not.

Harassment, teasing, rivalry, ridicule, emotional, or physical violence is traumatic and can lead to depression and/or retaliation. Bullying is a serious form of harassment. For resources on bullying, visit the California Department of Education website at http://www.cde.ca.gov/ls/ss/se/bullyfaq.asp.

Teachers and students should report harassment of any kind immediately. The safety and well being of all members of the school community are of utmost importance.

Required by the Uniform Complaint Procedure (5 CCR 4620), each school district shall follow uniform complaint procedures when addressing grievances alleging unlawful discrimination against any protected group. The California Code of Regulations (Title 5, section 4600 et seq.) requires the districts to adopt and publish procedures referred to as the Uniform Complaint Procedures (UCP) that provide for prompt and equitable resolution of discrimination and/or harassment complaints. The district must notify students, employees, and parents, as well as others, of its local complaint procedures and identify the person or persons responsible for processing complaints.

For your safety and the safety of your students teachers are advised to read, understand, and follow the districts procedures regarding harassment, including the reporting process.

4.31 Bullying

The California Department of Education has wonderful resources on Bullying. For your convenience, we have reprinted some of the information in this section.

Bullying and Hate Motivated Behavior Prevention[2]

Bullying is a form of violence. It can be physical, verbal, psychological, or sexual. Here are some examples of bullying:

- **Physical:** hitting, kicking, spitting, pushing
- **Verbal:** taunting, malicious teasing, threatening, name-calling
- **Psychological:** excluding someone, spreading rumors, intimidating
- **Sexual:** touching, assault, exhibitionism, and many of the actions listed above

Bullying may also occur through the Internet or other forms of technology. This is known as cyberbullying. It is sending or posting hurtful material.

Bullying is common, but it should not be viewed as a normal part of growing up. It is more damaging to children than previously thought. Bullying has a negative effect on a student's ability to learn.

Schools are responsible for creating safe environments for all students. They must work to prevent bullying, and they must respond to it when it happens.

What is School Bullying?[3]

Bullying is exposing a person to abusive actions repeatedly over time. Being aware of children's teasing and acknowledging injured feelings are always important. Bullying becomes a concern when hurtful or aggressive behavior toward an individual or group appears to be unprovoked, intentional, and (usually) repeated.

Bullying is a form of violence. It involves a real or perceived imbalance of power, with the more powerful child or group attacking those who are less powerful. Bullying may be physical, verbal, or emotional. Bullying can occur face-to-face or in the online world.

Bullying is also one or more acts by a pupil or group of pupils directed against another pupil that constitutes sexual harassment, hate violence, or severe or pervasive intentional harassment, threats, or intimidation that is disruptive, causes disorder, and invades the rights of others by creating an intimidating or hostile educational environment, and includes acts that are committed personally or by means of an electronic act, as defined.

[2]"Bullying & Hate-Motivated Behavior Prevention." California Department of Education. Web. 26 May 2015. <http://www.cde.ca.gov/ls/ss/se/bullyingprev.asp>.

[3]"Bullying Frequently Asked Questions." California Department of Education. Web. 26 May 2015. <http://www.cde.ca.gov/ls/ss/se/bullyfaq.asp>.

What are the consequences of school bullying?
Bullying among children often leads to greater and prolonged violence. Not only does bullying harm the victims, it also negatively affects students' ability to learn and achieve in school.

Consequences for the target
Students who are the target of a bully experience negative emotions. Feelings of persecution prevail over feelings of safety and confidence. Fear, anger, frustration, and anxiety may lead to ongoing illness, mood swings, withdrawal from friends and family, and inability to concentrate, and loss of interest in school. If left unattended, the targeted student may develop attendance and/or discipline problems, fail at school altogether or, in the worst cases, they are suicidal or retaliatory and violent.

Consequences for the bully
Without support or intervention, students who bully will continue to bully and may engage in other types of antisocial behavior and crime. Although some students who bully are less likely to be trusted and may be seen as mean and manipulative, a bully who learns aggression toward others garners power and may find the behavior a difficult habit to break. Some acts of bullying result in suspension or expulsion of students and translate into child abuse and domestic violence in adulthood. Research shows that 60% of males who bully in grades six through nine are convicted of at least one crime as adults, compared to with 23% of males who did not bully.

Allowing bullying to continue
Bullying behavior permeates a school in the same way that it starts and continues in families. Adults who overlook bullying are, in essence, allowing bullying to continue. Just as a student may bully a student into thinking they are motivating him or her, adults who socially ostracized or humiliate a student in front of others may believe they are motivating or disciplining the student when, in fact, the student being embarrassed is actually being bullied. Adults also overlook bullying when they:

- Condone mistreatment of younger students.
- Allow derogatory names or labels for groups of students.
- Overlook casual cruelty, sexual harassment, hate or bias-based behavior, or "hazing" activities in student clubs or sports programs.

A school not only runs the risk of gaining a reputation for being dangerous or unsafe, it also risks not fulfilling its academic mission, losing enrollment, or being the subject of litigation.

Source: "Frequently Asked Questions." California Department of Education. Web. 26 May 2015. <http://www.cde.ca.gov/ls/ss/se/bullyfaq.asp>.

What Can Teachers Do About Classroom Bullying?

- Model behavior that is inclusive and promotes respect for all students.
- Provide students with opportunities to talk about bullying and enlist their support in defining bullying as an unacceptable behavior.
- Develop an action plan for what students are to do if they observe a bully or are confronted by a bully.
- Share with students the responsibility for the classroom's social and physical environment to reinforce acceptable behavior.
- Post and publicize rules against bullying, including fair and consistent consequences for bullying.
- Refer both the bully and his/her target to counseling.
- Have students and parents sign behavior contracts consistent with written and communicated behavior codes for students, teachers, and staff.
- Maintain constant monitoring of cafeterias, playgrounds, and "hot spots" where bullying is likely to occur but direct adult supervision may not be present.
- Take immediate action when bullying is observed so that both the target and the bully know that mistreating someone is not tolerated. Notify the parents of both the target and the bully and attempt resolution expeditiously at school.
- Create cooperative learning activities in which students change groups for balance and interest, and equal treatment of all the participants may be ensured.
- Incorporate classroom activities designed to build self-esteem and spotlight individual talents, interests, and abilities.
- Implement a buddy system so that students pair up with a particular friend, an older student mentor, or someone they can depend on for support, particularly if they are new to the school.
- Form friendship groups that support children who are regularly bullied by peers.
- Develop peer mediation programs to help students learn to communicate and resolve issues among them.

Source: "Frequently Asked Questions." California Department of Education. Web. 26 May 2015. <http://www.cde.ca.gov/ls/ss/se/bullyfaq.asp>.

For your safety and the safety of your students, teachers are advised to read, understand, and follow the districts procedures regarding bullying, including the reporting process.

The California Department of Education offers information and resources for parents, administrators, and students about bullying. For more information, visit www.cde.ca.gov/ls/ss/se/bullyfaq.asp.

4.32 Fights at School

Maintaining a safe classroom environment includes recognition of potentially unsafe interpersonal behavior. Teachers should be aware of any potential violence and develop strategies to prevent fighting. However, occasionally, children do get into fights. In responding to fights in the classroom, teachers must be aware of site and district protocol and their actions should always be compatible with these regulations. Teachers should know their students and factors that may influence their response.

While there is no strategy that always works for diffusing physical violence at school, the following guidelines are often effective:

1. As you approach the combatants, yell out in a loud and firm voice: "It's over!" This usually diffuses the situation.
2. If the fight continues and you decide to physically intervene, determine the aggressor and step in with your back to him/her. Continue to talk as you move the less aggressive student away. **Do not put your hands on either student.** If the involved students are over the age of 8, and you believe there is a chance of escalation, a weapon may be present, your safety is in jeopardy, or district protocol prohibits this response, don't step in.
3. Have students clear the room or immediate area and ask someone, preferably a classroom aid or trusted student, to send for an administrator.
4. Keep combatants separated.
5. Provide (or call for) first aid if necessary.
6. Have them escorted to the office by another employee.
7. Debrief with an administrator.
8. Follow site and district policy regarding parent notification.
9. Conduct follow-up meetings with combatants individually and together as soon as possible.

CHAPTER 5: HANDLING EMERGENCIES

5.1 Accessing the Emergency Medical System

Each school district and school site has specific policies indicated in their Emergency Preparation Plan, which outline the procedure of accessing the Emergency Medical System (EMS). In some plans, teachers are expected to call 911 directly from their classrooms. In others, the first emergency call is made to the site administrator who, in turn, notifies EMS. Each classroom teacher should be aware of policies and guidelines relating to EMS access and follow them.

When you call 911, the EMS dispatcher answers the call and uses information you provide to determine what help is needed. A team of emergency personnel will then be dispatched to provide care at the scene and transport the ill or injured person to the hospital where emergency department staff and other professionals take over. As a rule, the family of the patient is not charged unless medical personnel transport the patient.

When you call 911, be prepared to answer the following questions:

- What is the nature of the emergency?
- What is the exact location of the injured or ill person (of emergency)?
- What are the patient's name, age, and gender?
- What is your name and what number are you calling from?
- Will you be able to remain at that number?

5.2 The Classroom First Aid Kit

This first aid kit is designed for the classroom teacher and will differ from home first aid kits, and other emergency supply containers. It is intended for short-term response to minor medical situations. Classroom kits used for district long-term emergency preparedness will be much more extensive, but should include all of the items listed below. First aid kits should be taken on all off-site activities and should include additional supplies depending on location and type of activity.

It is important that the kit be checked at least twice every school year and updated and resupplied if necessary. If kits include batteries, they should be checked every year. Non-latex disposal gloves should be replaced every year due to potential degrading of the material. The contents include the minimal supplies that should be immediately available in each classroom. Additional supplies may be included at the discretion of the district and/or the teacher.

First Aid Kit Contents:

- A leaflet giving general information on first aid
- 2 absorbent compress dressings (5x9 inches)
- 25 adhesive bandages (assorted sizes)
- 1 adhesive cloth tape (10 yards x 1 inch) or athletic tape
- 5 antiseptic wipe packets
- 2 triangular bandages and 4 safety pins
- 1 instant cold compress
- 2 pair of non-latex gloves
- Scissors
- Tweezers
- 1 roller bandage (3 inches wide) or athletic pre-wrap
- 1 roller bandage (4 inches wide) or athletic pre-wrap
- 5 sterile gauze pads (3x3) and 5 sterile gauze pads (4x4)

5.3 Special Considerations for Students with Special Health Care Needs

As the classroom teacher, you are responsible for knowing the medical needs of your students. It is vital that you take all medications and contact information with you whenever you leave your school campus (i.e., field trips). You know your students best. Make sure that you are prepared for whatever circumstance may arise when you leave school with your students.

It is important to understand the duties you may be required to perform and those that you are not legally allowed to perform.

Being adequately prepared to handle the responsibilities of students with special healthcare needs in schools is an important aspect of being a member of the education team. It is important to understand the duties you may be required to perform and those **that you are not legally allowed to perform.** Being prepared to meet your obligation to students in terms of healthcare is critical.

Students with special healthcare needs encompass those who require specialized and, sometimes, complex health procedures. This may include special therapy, medical equipment and supplies that are necessary for successful participation throughout the school day. Some common examples include: urinary catheterization, administration of medicines, feeding through gastrostomy tubes, and suctioning mucous from airways. These procedures typically require licensed health personnel supervision or performance. In most schools, a credentialed school nurse fills this position. In many cases, non-licensed employees may be trained to perform such tasks. In addition, when a higher level of expertise is necessary, registered nurses and licensed vocational nurses can work with students under the supervision of the credentialed school nurse. However, the school nurse retains ultimate

legal responsibility for decisions regarding which tasks may be delegated and for making sure the procedures are implemented in a timely and correct manner.

While these procedures may create some questions about the obligation of schools in areas of medical concern, it is important to remember that students with special healthcare needs have a right to receive an education in the least restrictive environment that ensures the student's safety and protects their health. This is best accomplished by providing attention from professionals and well-training support personnel. These services should be listed in the Individual Education Plan (IEP) that students with special healthcare concerns should have. In addition, the procedures must be established clearly in accordance with state law. This means that the educational setting should have appropriate facilities, equipment, and services. Furthermore, the provision of this care should not disrupt the educational progress of other students. To accomplish these goals a well-developed team is necessary. Being able to identify the different team members' responsibilities is crucial to providing continuous and quality care.

Caring for students with special healthcare needs is nothing less than a team effort. It is an opportunity to forward the students' education, foster a caring environment, and develop positive rapport for all involved.

5.31 The Role of the School Nurse

The credentialed school nurse is the primary decision maker regarding issues that are related to student health and safety. This includes assessing the student's needs in relation to the school setting and coordinating these needs with the other team members. The nurse has the responsibility of training team members regarding students' needs, policies, and protocols as well as first aid and CPR. Re source materials are developed by the nurse in order to help staff follow policies, protocols, and meet students' needs. The nurse writes an Individualized Special Healthcare Procedure for each student who needs a treatment that requires training of staff.

The nurse will also develop standardized procedures for common medical emergencies such as seizures, asthma attacks, etc. A manual is often used to ensure that individual needs and emergency procedures are readily accessible in each classroom. Tracking sheets are provided to be used for documentation of administration of health related services. Nurses will also be responsible for evaluating and supervising daily care for students. Whether or not the nurse chooses to delegate certain tasks is not only the nurse's decision but is also guided by the Five Rights of Delegation set forth by the National Council of State Boards of Nursing. In brief, the nurse considers the task, the person assigned, the communication needed, the supervision required, and the circumstances.

It is also important that you understand your school's protocol for the days when the school nurse may not be on campus. Make sure you know ahead of time what to do when/if a situation arises and the school nurse is not available.

5.32 Students with Profound Disabilities

When working with students with profound (moderate to severe) disabilities, Education Specialists with specialized credentials need to consider a number of specific factors in order to effectively meet the needs of these very special students.

Body Mechanics – For orthopedically handicapped/impaired students, the teacher should first consult with the physical therapist and OH (Orthopedically Handicapped) specialist regarding both the child's and the teacher's physical considerations in lifting and transferring students as well as the proper use of standing frames and the rationale behind their use.

Toileting – Teachers must be aware of the very specific techniques for toilet training children with different disabilities. Teachers should complete an Applied Behavior Analysis (ABA) to determine:

1. Is the child physiologically and psychologically ready?
2. Is it possible to predict when the child may need to eliminate?

It is important for the teacher to be a good observer and data collector. It is also very helpful to try to get the child onto the teacher's schedule (i.e., after eating or drinking, suggest using the bathroom).

Use appropriate protocols regarding diapers, creams, or any other aids used in toileting.

Gastrointestinal tubes, tracheostomies, and catheters – When using gastrointestinal feeding tubes equipped with a "Mik-key" button, be aware of the correct procedure regarding proper use. If the child removes the tube, this can become a medical emergency. Teachers should be trained regarding the proper replacement equipment. Training by nurse or parents is also necessary for children with tracheostomies and catheters regarding proper use. It is important for the teacher to obtain documentation of training.

Seizure Protocol – A discussion of child's seizure activity with parents/guardians is important. The teacher should work closely with the RN to establish and maintain procedures and protocols for specific seizures.

Dispensing Medication – No medication should be dispensed without specific authorization from the child's physician and parents. Be aware of all medications children are taking and time of day when taken.

Universal Precautions - Teachers working with children with profound disabilities are particularly vulnerable to blood borne pathogens and should be careful to protect themselves at all times regarding potential exposure. All teachers should have Hepatitis B vaccination.

Attendance – District rules, regulations, and procedures regarding attendance may differ for students with profound disabilities. Teachers should be aware of these differences and apply the rules accordingly.

5.33 The Role of the Teacher

Every teacher is familiar with the basic role of instruction, implementing district curriculum, and incorporating academic standards in a safe and orderly classroom. Collaboration with other staff members is also an ongoing part of every teacher's job. Teacher's with students who have special healthcare needs spend substantial time coordinating schedules with the nurse and the aides. **It is not recommended that teachers provide personal care services or nursing services.** When this occurs, it often is at the expense of classroom instruction. Issues can arise in areas of legality and liability. It is important for teachers to stay informed so that educational programs are designed in consideration of health needs.

5.34 The Role of the Paraprofessional

Paraprofessionals are instrumental in the classroom for students and teachers. They provide support through small-group instruction, transitions, navigating the school setting, and monitoring activity. Paraprofessionals, particularly in special education settings, have often been faced with providing health services. These services should never be performed by the paraprofessional unless he/she has been appropriately trained by the school nurse (as described above).

5.35 The Role of the Health Aide

The job of the health aide is distinct from that of paraprofessionals in that it explicitly implies that performing health services can be expected. However, many health aides provide duties similar to those of a paraprofessional and have legal limits regarding what services they can provide. Health aides receive direct supervision from the school nurse in terms of health care services and are not to be used in place of a school nurse.

5.36 The Role of the Transportation Personnel

Bus drivers and transportation aides have the responsibility of providing safe transport for students. In the case of students with special healthcare needs, this can be complex. There are a number of legal requirements pertaining to training, equipment, emergency responses, routing and scheduling. The Individuals with Disabilities Act (IDEA) does have specific language and guidelines surrounding transportation for students with special needs. The training of transportation personnel can be managed and directed through the bus company and the school nurse. Often, it requires a team effort to satisfactorily ensure student safety and that health needs are met.

5.37 The Role of the Nutrition Services Worker

The food services staff arranges and provides for the particular dietary requirements for students. This may include food allergies or other special diets related to physical needs. They should work closely with other team members including the nurse, teacher, paraprofessional, health aide, and parents. Not every school has a cafeteria that can accommodate these needs. In these cases, the administration will work with team members to accommodate the student's needs.

5.38 The Role of the Custodian

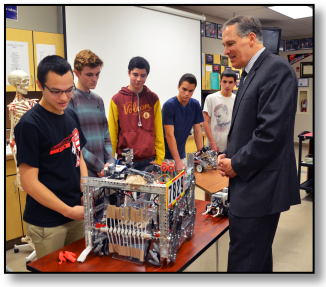
As discussed earlier, providing a safe environment is absolutely necessary for students with special healthcare needs. It is the custodian who is responsible for the provision of a clean and well-maintained learning environment. Establishing a consistently clean environment protects the health of students and staff. Whether it is bad ventilation, mold problems or dirty surfaces, they need to be corrected in order to avoid causing illness or putting a student who has a chronic health problem at further risk. Even the products used may need to be evaluated in case they contribute to a student's health issue(s). The school grounds as a whole need to be evaluated for ease of transport for crutches or wheelchairs. Doors, ramps, and elevators all need to be kept accessible and in working order. A further benefit to clean, well-maintained facilities is that it communicates the school's commitment to high quality programs.

Source: "The Medically Fragile Child in the School Setting." Second ed. Washington, D.C.: American Federation of Teachers, AFL-CIO, 1997. Print.

5.4 Special Considerations for CTE Students

Teachers who work with students in a technical setting have health and safety practices that may be different than those in a regular classroom. The current Career Technical Education Industry Sectors include:

- Agriculture and Natural Resources
- Arts, Media, and Entertainment
- Building and Construction Trades
- Business and Finance
- Education, Child Development, and Family Services
- Energy, Environment, and Utilities
- Engineering and Architecture
- Fashion and Interior Design
- Health Science and Medical Technology
- Hospitality, Tourism, and Recreation
- Information and Communication Technologies
- Manufacturing and Product Development
- Marketing, Sales, and Service
- Public Service
- Transportation



The Career Technical Education Framework for California Public Schools describes Health and Safety as "students understand health and safety policies, procedures, regulations, and practices, including the use of equipment and handling of hazardous materials" (6.0).

These policies, procedures, regulations, practices, and equipment will differ depending on the program that you teach. It will be important for teachers to "understand critical elements of health and safety practices related to storing, cleaning, and maintaining tools, equipment and supplies" (6.2).

Regardless of the curriculum you teach, there will be tools and equipment that students will be handling on a daily basis. It is important that you follow your district guidelines and procedures when it comes to Health and Safety.

Here are some ways that you can demonstrate safe practices in your classroom:

- Identify and follow OSHA (Occupational Safety and Health Administration) regulations that apply to your occupational area.
- Identify and demonstrate personal, shop, and job site safety practices and procedures.
- Establish proper dress code relevant to occupation, including proper eye gear, head protection, earplugs, etc.
- Pinpoint the safety stations in your classroom, lab, or shop. These include fire extinguishers, eyewash stations, phones, emergency exits, etc.
- Educate students in First Aid procedures for injuries that could occur in your occupational area. Students should be aware as to how to handle emergency situations and accidents. They should know the process of identifying an emergency, proper evacuation routes and follow-up procedures.
- Discuss ways to prevent violence in the occupational classroom with students. Students should be aware of district, school, and classroom consequences for non-compliance of classroom, lab, or shop guidelines.

5.5 Classroom Medical Emergencies

Control of External Bleeding:

a. Use disposable non-latex gloves and other protective equipment.
b. Obtain consent of student.
c. Cover wound with sterile dressing.
d. Apply direct pressure until bleeding stops.
e. Cover dressing with bandage.
f. If bleeding does not stop, apply additional dressings and bandages.
g. Follow district protocol regarding sending student to nurse/office and/or accessing EMS.

Control of Nosebleeds:

a. Use disposable non-latex gloves.
b. Have student sit with head slightly forward.
c. Pinch nostrils together or hold issue or gauze at nostril openings for approximately ten minutes.

d. Optional: Apply non-chemical icepack to bridge of nose or put pressure on upper lip just beneath nose. Do not apply ice directly to skin as it can damage skin tissue.
e. Follow district protocol regarding sending student to nurse/office and/or accessing EMS.

Suspected Fracture:

a. Suspect a fracture if any of the following signals are present:
    - Significant deformity
    - Bruising or swelling
    - Inability to use affected part normally
    - Bone fragments protruding from wound (use gloves)
    - Person felt or heard a snap or pop at time of injury
    - Injured area is cold or numb
    - Mechanism of injury suggests severe injury

b. Your Actions:
    - Do not move or straighten the area
    - Stabilize the injured area in the position it was found
    - Apply ice pack to area with thin barrier between ice and skin
    - Follow district protocol regarding sending student to nurse/office and accessing EMS.

Care for Insect stings and Severe Allergic Reactions:

a. If you see a stinger, remove it. Scrape away from skin with fingernail or credit card.
b. Wash site with soap and water.
c. Cover site and keep clean.
d. Apply cold pack to area over thin barrier.
e. Watch student for signs of an allergic reaction.
    - Signs of allergic reaction include: hives, itching, rash, weakness, nausea, vomiting, stomach cramps, dizziness, and trouble breathing.
    - If you know you are working with an allergic student, investigate Epinephrine Auto-Injector training.
f. Follow district protocol regarding sending student to nurse/office and/or EMS access.

Suspected head injuries:

a. Suspect a head injury if any of the following is present:
    - Student was involved in a motor vehicle crash.
    - Student was injured as a result of a fall from greater than a standing height.
    - Student complains of neck or back pain.
    - Student has tingling or weakness in extremities.
    - Student is not fully alert or unconscious.

b. Your Actions
    - Follow district protocol regarding EMS access.
    - While waiting for help, minimize movement of student's head and spine. Gently hold student's head in line with body or in position found until EMS personnel arrive.

5.6 Medical Conditions

5.61 Asthma

Asthma is a chronic disease that affects the airway. The airway is a system of tubes that carries air in and out of the lungs. The airways of patients with asthma are inflamed and very sensitive to allergens. In the presence of irritants or allergens, the sensitive airways become swollen and narrow and mucous production increases, making it difficult for the patient to breathe.

During an asthma episode or attack, muscles around the airway tighten, further constricting the passageway for air and may result in a medical emergency. The severity of asthma attacks varies widely and, under extreme circumstances, can cause death.

Teachers should be aware of students in their classrooms with asthma, especially those who have prescribed inhalers with them at school. The teacher should know where the student keeps the inhaler and if there is one in the nurse's office or other location.

Signs and Symptoms of Asthma

- Coughing: Often worse at night or early in the morning, leading to sleep deprivation
- Wheezing: A whistling or squeaky sound during breathing
- Chest tightness: Feels like a squeezing or pressure on chest
- Shortness of breath: Feeling breathless or out of breath
- More rapid and/or noisy breathing

During a suspected asthma attack, the teacher should:

- Follow District protocol regarding accessing EMS and sending student to nurse/office
- Reassure and calm student
- Assist student in locating and taking any prescribed asthma medication
- Help student into position of comfort

5.62 Childhood Obesity

The National Center for Health Statistics identifies approximately 17% of children in the United States as obese. In children or adults, chronic excess weight can lead to physical problems, but in children, of special concern are the psychological consequences. Adults have developed ways of coping with the humiliation that our society attaches to being overweight. For children, however, teasing by peers as well as peer pressure from parents and the media, are often damaging to self-esteem. This problem is particularly acute for females. With males, low self-esteem is more often associated with being too thin than with being overweight (Pierce & Wardle, 1993).

According to the Let's Move! website (http://www.letsmove.gov), "over the past three decades, childhood obesity rates in America have tripled, and today, nearly one in three children in America are overweight or obese. The numbers are even higher in African American and Hispanic communities, where nearly 40% of the children are overweight or obese. If we don't solve this problem, one third of all children born in 2000 or later will suffer from diabetes at some point in their lives. Many others will face chronic obesity-related health problems like heart disease, high blood pressure, cancer, and asthma."

Treatment for childhood obesity often includes emphasis on two strategies:

- Use of leisure time; physical exercise vs. sedentary activity
- Dietary considerations

Parents are usually involved in treatment from the beginning and their cooperation has a great influence on the child returning to and maintaining a normal weight (Foreyt & Goodrick, 1993).

Teachers should consult with families and follow site and district protocol regarding referral to site-based mental health professionals if any of the following signs and symptoms appear:

- Child is noticeable overweight; body weight more than:
- Child's use of leisure time is primarily sedentary
- Child resists physical exercise and activity
- Child's diet very high in starches and sugars
- Any observed indicators of low self-esteem

According to Let's Move!, "physical activity is an essential component of a healthy lifestyle. In combination with healthy eating, it can help prevent a range of chronic diseases, including heart disease, cancer, and stroke, which are the three leading causes of death. Physical activity helps control weight, builds lean muscle, reduces fat, promotes strong bone, muscle and joint development, and decreases the risk of obesity. Children need **60 minutes of play** with moderate to vigorous activity every day to grow up to a healthy weight.

If this sounds like a lot, consider that 8 to 18 year old adolescents spend an average of 7.5 hours a day using entertainment media including: TV, computers, video games, cell phones and movies in a typical day. Only one-third of high school students get the recommended

levels of physical activity. To increase physical activity, today's children need safe routes to walk and bike ride to school, parks, playgrounds and community centers where they can play after school, and activities like sports, dance or fitness programs that are exciting and challenging enough to keep them engaged."

5.63 Diabetes Mellitus (Type 2)

During the process of digestion, food is converted into glucose, or blood sugar. As glucose levels rise, the pancreas releases the hormone, Insulin. Insulin "unlocks" the body's cells, allowing glucose to enter and be converted to energy. Diabetes is a disease in which the pancreas does not produce Insulin, or the body does not use it properly. When glucose cannot enter cells, it builds up in the blood and the cells become starved for energy. Over time, high glucose levels may damage organs and body systems including eyes, kidneys, nerves and heart.

Patients who are diabetic must consciously balance their food intake with their Insulin intake.

Patients who are diabetic must consciously balance their food intake with their Insulin intake. Young patients often find this difficult. Occasionally students may need to take oral or injectable Insulin at school. Teachers should regularly ask these students when they last ate and when they last took their Insulin. This will establish a 'baseline' for comparison of behaviors and energy levels.

The teacher should follow District protocol regarding office/nurse contact if a student, known to be a diabetic, exhibits any of the following:

- Dry mouth and intense thirst
- Gradually increasing restlessness and confusion followed by stupor
- Dizziness and headache
- Abnormal hostile or aggressive behavior
- Fainting or convulsions
- Patient intensely hungry
- Skin pale, cold, and clammy with profuse sweating

5.64 Eating Disorders

Each year millions of people in the United States develop serious, and sometimes life-threatening, eating disorders. More than 90 percent of those afflicted with eating disorders are adolescents and young adult women. One reason that females in this age group are particularly vulnerable to eating disorders is their tendency to go on strict diets to achieve an "ideal" figure imposed on them by our current cultural values. The consequences of these disorders can be extremely severe, leading to death from starvation, cardiac arrest, or suicide in approximately 10% of cases.

Treatment for eating disorders typically involves a team of professionals: an internist, nutritionist, psychotherapists (individual and group) and a psychopharmacologist. The prognosis for successful recovery is directly related to early diagnosis and treatment.

The following information can be found in greater detail on the National Eating Disorders Association (NEDA) website (www.nationaleatingdisorders.org).

5.641 Anorexia Nervosa

According to NEDA, anorexia nervosa is a potentially life-threatening eating disorder characterized by self-starvation and excessive weight loss. The following facts are excerpts from the NED website.

Symptoms

- Inadequate food intake leading to a weight that is clearly too low.
- Intense fear of weight gain, obsession with weight and persistent behavior to prevent weight gain.
- Self-esteem overly related to body image.
- Inability to appreciate the severity of the situation.

Eating disorder experts have found that prompt intensive treatment significantly improves the chances of recovery. Therefore, it is important to be aware of some of the warning signs of anorexia nervosa.

Warning Signs

- Dramatic weight loss.
- Preoccupation with weight, food, calories, fat grams, and dieting.
- Refusal to eat certain foods, progressing to restrictions against whole categories of food.
- Frequent comments about feeling "fat" or "overweight" despite weight loss.
- Anxiety about gaining weight or being "fat".
- Denial of hunger.
- Development of food rituals (e.g. eating foods in certain orders, excessive chewing, rearranging food on a plate).
- Consistent excuses to avoid mealtimes or situations involving food.
- Excessive, rigid exercise regimen – despite weather, fatigues, illness, or injury, the need to "burn off" calories taken in.
- Withdrawal from usual friends and activities.

- In general, behaviors and attitudes indicating that weight loss, dieting, and control of food are becoming primary concerns.

Health Consequences of Anorexia Nervosa

Anorexia nervosa involves self-starvation; the body is denied the essential nutrients it needs to function normally, so it is forced to slow down all of its processes to conserve energy. This "slowing down" can have serious medical consequences:

- Abnormally slow heart rate and low blood pressure, which means that the heart muscle is changing. The risk for heart failure rises as heart rate and blood pressure levels sink lower and lower.
- Reduction of bone density (osteoporosis), which results in dry, brittle bones.
- Muscle loss and weakness.
- Severe dehydration, which can result in kidney failure.
- Fainting, fatigue, and overall weakness.
- Dry hair and skin, hair loss is common.
- Growth of a downy layer of hair called lanugo all over the body, including the face; in an effort to keep the body warm.

About Anorexia Nervosa

- Approximately 90-95% of anorexia nervosa sufferers are girls and women.
- Between 0.5-1% of American women suffer from anorexia nervosa.
- Anorexia nervosa is one of the most common psychiatric diagnoses in young women.
- Between 5-20% of individuals struggling with anorexia nervosa die. The probabilities of death increases within that range depending on the length of the condition.
- Anorexia nervosa typically appears in early to mid-adolescence.

5.642 Binge Eating Disorder

According to the NEDA, binge eating disorder (BED) is "characterized by recurrent binge eating without the regular use of compensatory measures to counter the binge eating". The following facts are excerpts from the NED website.

Symptoms

- Frequent episodes of consuming very large amount of food but without behaviors to prevent weight gain, such as self-induced vomiting.
- A feeling of being out of control during the binge eating episodes.
- Feelings of strong shame or guilt regarding the binge eating.
- Indications that the binge eating is out of control, such as eating when not hungry, eating to the point of discomfort, or eating alone because of shame about the behavior.

Health Consequences of Binge Eating Disorder

The health risks of BED are most commonly those associated with clinical obesity. Some of the potential health consequences of binge eating disorder include:

- High blood pressure
- High cholesterol levels
- Heart disease
- Diabetes mellitus
- Gallbladder disease
- Musculoskeletal problems

About Binge Eating Disorder

- The prevalence of BED is estimated to be approximately 1-5% of the general population.
- Binge eating disorder affects women slightly more often than men – estimates indicate that about 60% of people struggling with binge eating disorder are female, 40% are male.
- People who struggle with binge eating disorder can be of normal or heavier than average weight.
- BED is often associated with signs of depression.
- People struggling with binge eating disorder often express distress, shame, and guilt over their eating behaviors.
- People with binge eating disorder report a lower quality of life than non-binge eating disorder.

5.643 BULIMIA NERVOSA

According to the NED website, bulimia nervosa is a "serious, potentially life-threatening eating disorder characterized by a cycle of bingeing and compensatory behaviors such as self-induced vomiting designed to undo or compensate for the effects of binge eating". The following facts are excerpts from the NED website.

Symptoms

- Frequent episodes of consuming very large amounts of food followed by behaviors to prevent weight gain, such as self-induced vomiting.
- A feeling of being out of control during the binge-eating episodes.
- Self-esteem overly related to body image.

The chance for recovery increases the earlier bulimia nervosa is detected. Therefore, it is important to be aware of some of the warning signs of bulimia nervosa.

Warning Signs of Bulimia Nervosa

- Evidence of binge eating, including disappearance of large amounts of food in short periods of time or finding wrappers and containers indicating the consumption of large amounts of food.
- Evidence of purging behaviors, including frequent trips to the bathroom after meals, signs and/or smells of vomiting, presences of wrappers or packages of laxatives or diuretics.
- Excessive, rigid exercise regimen – despite weather, fatigue, illness, or injury, the compulsive need to "burn off" calories taken in.
- Unusual swelling of the cheeks or jaw area.
- Calluses on the back of the hands and knuckles from self-induced vomiting.
- Discoloration or staining of the teeth.
- Creation of lifestyle schedules or rituals to make time for binge-and-purge sessions.
- Withdrawal from usual friends and activities.
- In general, behaviors and attitudes indicating that weight loss, dieting, and control of food are becoming primary concerns.
- Continued exercise despite injury; overuse injuries.

Health Consequences of Bulimia Nervosa

Bulimia nervosa can be extremely harmful to the body. The recurrent binge-and-purge cycles can damage the entire digestive system and purging behaviors can lead to electrolyte and chemical imbalances in the body that affect the heart and other major organ functions. Some of the health consequences of bulimia nervosa include:

- Electrolyte imbalances that can lead to irregular heartbeats and possibly heart failure and death. Electrolyte imbalance is caused by dehydration and loss of potassium and sodium from the body as a result of purging behaviors.
- Inflammation and possible rupture of the esophagus from frequent vomiting.
- Tooth decay and staining from stomach acids released during frequent vomiting.
- Chronic irregular bowel movements and constipation as a result of laxative abuse.
- Gastric rupture is an uncommon but possible side effect of binge eating.

About Bulimia Nervosa

- Bulimia nervosa affects 1-2% of adolescent and young adult women.
- Approximately 80% of bulimia nervosa patients are female.
- People struggling with bulimia nervosa usually appear to be of average body weight.
- Many people struggling with bulimia nervosa recognize that their behaviors are unusual and perhaps dangerous to their health.
- Bulimia nervosa is frequently associated with symptoms of depression and changes in social adjustment.
- Risk of death from suicide or medical complications is markedly increased for eating disorders.

5.65 Epilepsy

Epilepsy is a chronic episodic disease most recognized by seizures. Epilepsy has a variety of causes, but the cause in a specific patient is often very difficult to determine.

Epilepsy may produce two forms of seizures: a grand mal seizure characterized by convulsions, or a petit mal seizure that does not produce convulsions. A petit mal seizure may go unnoticed by everyone except the patient and people who know him/her well.

In grand mal seizures, the patient may first be aware of bright lights or a sudden burst of colors and may also experience certain smells or tastes. This is often followed by convulsions, lasting usually between one to two minutes, in which patients may injure themselves. This convulsive phase is followed by a phase in which the convulsions stop and the patient slowly regains consciousness.

The use of special medications usually allows most epileptics to live normal lives without convulsions.

In the event of a grand mal seizure in the classroom, the teacher should:

- Follow district protocol regarding accessing EMS.
- Facilitate students leaving classroom or moving away from patient.
- Place patient on the floor or ground. If possible, position for drainage from the mouth.
- Loosen restrictive clothing.
- Protect patient from injury but do NOT attempt to restrain the patient during convulsions. Move things away from them.
- When convulsions have ended, keep the patient at rest and positioned for drainage from mouth.
- Continue to protect the patient from embarrassment by asking for privacy and reassuring and reorienting patient.
- Communicate with health care professionals.

5.66 Food Allergy

Food allergies are growing public health issues that impact almost every school across the United States. According to the Food Allergy Research & Education (FARE) website (www.foodallergy.org), nearly 6 million children in the U.S. - which equates to 1 in 13, or roughly 2 in every classroom - have a food allergy.

According to a 2013 study released by the Centers for Disease Control and Prevention (CDC), **food allergies among children increased by 50% between 1997 and 2011.**

It is important that schools develop policies to manage food allergies appropriately, including information on handling medical emergencies and taking preventative measures to avoid a student's exposure to a known food allergen. Physicians, families, and school staff should work together to formulate reasonable and practical plans that will keep students with food allergies safe. **As a new teacher, refer to your school's guidelines for proper protocol. All allergies should also be listed on your Class Profile.**

According to the Food Allergy Research & Education website, every child at risk for anaphylaxis (see definition below) should have a written individual accommodation plan. In public schools, this plan will often be a *Section 504 plan*. In private schools, a similar written plan will serve the same purpose. Food allergies may constitute a disability under the law. This is important to understand because schools cannot exclude children with food allergies from activities (e.g. science experiments, classroom celebrations, field trips, etc.) because of their food allergies.

Anaphylaxis

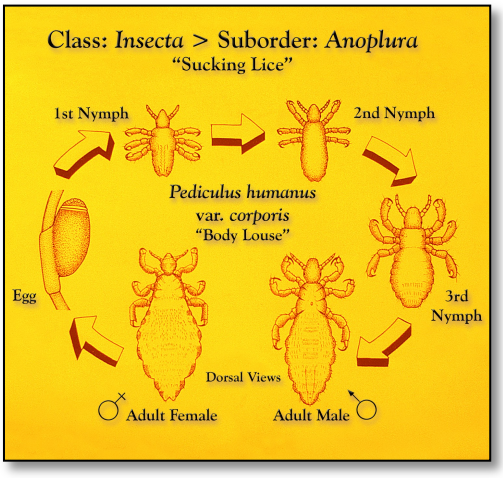
Anaphylaxis is a severe, potentially life-threatening allergic reaction. It can occur within seconds or minutes of exposure to something you're allergic to, such as a peanut or the venom from a bee sting. Common symptoms of onset can include: itchy rash, throat swelling, and low blood pressure. The primary treatment is an immediate injection of epinephrine.

5.67 Head Lice

Head lice are parasitic insects that live in the hair and scalp of humans. The scientific name for head louse is *Pediculus Humanus Capitis.* Another name for infestation with head lice is pediculosis. The following facts are excerpts from the Lice Prevention News website (www.licepreventionnews.com).

Head lice develop in three forms: *nits, nymphs, and adults*.

Nits: Nits, head lice the eggs. They are hard to see and are often mistaken for dandruff or droplets of hairspray. Nits are found firmly attached to the hair shaft. They are oval and usually yellow to white. Nits take about one week to hatch.



Nymphs: Nits hatch into nymphs. Nymphs are immature adult head lice. Nymphs mature into adults about seven days after hatching. To live, nymphs must feed on blood.

Adults: An adult louse is about the size of a sesame seed, has six legs, and is tan to greyish-white. In persons with dark hair, adult lice will look darker. Adult lice can live up to 30 days on a person's head. To live, adult lice need to feed on blood. If a louse falls off a person, it dies within two days.

Where are head lice found and who is at risk? Head lice infestations occur worldwide. Anyone can get head lice. Pre-school and elementary school aged children and their families are infested most often. Girls get head lice more often than boys, and women more often than men. Head lice is a very common condition, especially among children 3-10. As many as 6 million - 12 million people worldwide get head lice each year. Head lice is an increasing problem because lice-killing medications are becoming less effective.

How are head lice spread?

Head lice are spread easily from person to person by direct contact. People can get head lice by coming into close contact with an already infested person. In children, contact is common during play, while riding the school bus, and during classroom activities in which children sit in groups close to each other. Also, by wearing infested clothing, such as hats, scarves, coats, sports uniforms, or hair ribbons. Another way it is spread is by using infested combs, brushes, or towels or by lying on a bed, couch, pillow, carpet, or stuffed animal that has been contaminated. Lice do not jump or fly. Lice *are not spread* to humans from pets or other animals.

How is head lice infestation diagnosed?
Head lice infestation is diagnosed by looking closely through the hair and scalp for nits, nymphs, or adult lice. Nits are the easiest to see. They are found "glued" to the hair shaft. Unlike dandruff or hairspray, they will not slide along a strand of hair. If you find nits more than ¼ inch from the scalp, the infection is probably an old one. Nymphs and adults can be hard to find; there are usually few of them, and they can move quickly from searching fingers. If lice are seen, finding nits close to the scalp confirms that a person is infested. The symptoms of head lice are itching and irritability. If you are not sure if a person has head lice, the diagnosis should be made by the local health department or a health-care provider, school nurse, or agricultural extension service worker.

What is the treatment for head lice infestation?
Getting rid of head lice requires treating the individual, the family, and the household.

Treatment for the student and the family
This requires using over-the-counter or prescription lice killing medicine. Treat only infected persons. Remember that all lice-killing products are pesticides. Follow these treatment steps:

- Remove all clothing
- Apply lice-killing medicine, also called pediculicide [peh-dick-you-luh-side], according to label instructions. If the affected person has extra long hair, you may need to use a second bottle.
- WARNING: Do not use a cream rinse or combination shampoo/conditioner before using lice-killing medicine. Do not re-wash hair for 1-2 days after treatment.
- Have the affected person put on clean clothing after treatment.
- If some live lice are still found but are moving more slowly than before treatment, do not retreat. Comb dead and remaining live lice out of the hair. The medicine sometimes takes longer than the time recommended on the package to kill the lice.
- After treatment, if no dead lice are found and lice seem as active as before, the medicine may not be working. See your health-care provider for a different medicine. Follow treatment instructions.
- Remove nits and lice from the hair shaft using a nit comb; often found in lice-killing medicine packages. Flea combs used for cats and dogs can also be used.
- After treatment, check the hair, and then comb and remove nits and lice from the hair every 2-3 days.
- Re-treat in 7-10 days.
- Check all treated persons for 2-3 weeks until you are sure all ice and nits are gone.

Treat the household – To kill lice and nits, machine wash all washable clothing and bed linens that the infested person touched during the 2 days before they were diagnosed. Wash clothes and linens in the HOT water cycle (130F). Dry washed items on the hot cycle for at least 20 minutes.

- Dry clean clothing that is not washable (coats, hats, scarves, etc.)
- Seal all non-washable items (clothing, stuffed animals, comforters, etc.) in a plastic bag for 2 weeks.

- Soak combs and brushes for 1 hour in rubbing alcohol or Lysol, or wash with soap and hot water.
- Vacuum the floor and furniture. Do not use lice sprays; they can be toxic if inhaled.

Cautions

- Do not use extra amounts of lice-killing medicines.
- Do not use lice-killing medicines on the eyebrows or eyelashes.
- Scratching can lead to skin sores and skin infections.
- Consult a health-care provider before using lice-killing products on a person who has allergies, asthma, or other medical conditions.
- Women who are pregnant or breastfeeding should not use head lice medications.

How can head lice be prevented?

- Educate parents and schools about head lice. All parents should know that outbreaks of head lice have nothing to do with a family's income, social status, or level of personal hygiene.
- Avoid direct contact with a person who has lice, or with their clothing or personal belongings.
- Watch for signs of lice, such as frequent head scratching. Nits do not cause symptoms, but they can be seen on the hair shaft; they are yellow-white and oval-shaped.
- Teach children not to share combs, brushes, scarves, hair ribbons, helmets, headphones, hats, towels, bedding, clothing, or other personal items.
- Examine household members and close contacts of a person with head lice, and treat if infested.
- Make sure schools, camps, and child-care centers provide separate storage areas (cubbies or lockers) and widely spaced coat hooks for clothing and other personal articles. They should assign sleeping mats and bedding to only one child and store these separately. They should wash dress-up clothes and play costumes between uses between different children. During an outbreak, costumes should not be used in the classroom.
- Exclude children with head lice from school or day care according to the institution's policy.

For more information on Head Lice, visit www.cde.gov/parasites/lice/head.

The above information is not meant for a self-diagnosis or as a substitute for consultation with a health-care provider. If you have any questions about the disease described above or think that you may have a parasite infection, consult a health-care provider.

5.68 Stinging Insect Allergy

Most people experience a normal reaction to an insect bite: pain, redness, and swelling. A serious allergic reaction occurs when the immune system overreacts to the insect's venom. This causes the individual to experience symptoms in more than one part of the body, such as:

- Swelling of the face, throat or tongue
- Difficulty breathing
- Dizziness
- Stomach Cramps
- Nausea or diarrhea
- Itchiness and hives over large areas of the body

A toxic reaction to a sting occurs when the insect venom acts like a poison in the body. A toxic reaction can cause symptoms similar to those of an allergic reaction, including nausea, fever, swelling at the site of the sting, fainting, seizures, shock and even death. A serious allergic reaction may occur after only one sting, but it usually takes many stings from insects.

If one of your students has an anaphylactic reaction (see Anaphylaxis definition on previous page), inject epinephrine immediately and call 911. Again, make sure you refer to the procedures set forth by your district.

Source: "Stinging Insect Allergy Symptoms, Diagnosis, Treatment & Management." The American Academy of Allergy, Asthma & Immunology. Web. 28 May 2015. <http://www.aaaai.org/conditions-and-treatments/allergies/stinging-insect-allergy.aspx>.

5.69 Vision and Hearing

Vision and Hearing issues in the classroom have a significant effect on student learning. If students suffer from deficits in either of these critical avenues for sensory input, children receive inaccurate environmental cues and cannot be expected to respond appropriately.

Vision

The most common vision problem in middle childhood is myopia, or nearsightedness. By the end of the school years, nearly 25 percent of children are affected, a rate that rises to 60 percent by early adulthood (Sperduto et al., 1983, 1986).

In this condition, the elongated shape of the eye or severely convex angle of the lens causes the visual image to fall in front of the retina. Without correction, children experience a visual deficit for objects at a distance, although they see quite well in close-up situations and can excel in such activities as reading, sewing, drawing, or model building. Proper identification of children with myopia early in the school year enables the teacher to effectively place the student in the classroom for maximum engagement and to suggest an eye examination to student and/or parent.

The teacher should be aware of:

- Squinting to see distant objects
- Straining with forward leaning body
- Student asking teacher often to repeat or re-explain anything written or posted at a distance
- Lack of engagement or involvement, especially when seated at back of class
- Distracted, especially when seated at back of class

Teacher's Actions:

- Talk with student to determine cause of behavior
- Discuss with school nurse if possible
- Discuss with family regarding eye examination
- Continue to monitor student's behavior and place appropriately in classroom

Hearing

Children, who suffer from hearing deficits, are often delayed in language development as well as other indicators of academic and interpersonal skills. Among young children, the Eustachian tube becomes longer, narrower, and more slanted, preventing fluid and bacteria from traveling easily from ears to throat. This condition, known as *otitis media*, can cause chronic ear infections leading to permanent hearing deficits. This condition affects approximately 4 percent of the school-age population and 20 percent of students from families of low socioeconomic status (Mott, James, & Sperhac)

The teacher should be aware of:

- Unusual redness and warmth of ear
- Child often "tugs" at earlobe of affected ear
- Straining with forward leaning body
- Student asking teacher to repeat or re-explain verbal instructions often
- Lack of involvement or engagement, especially if seated at the back of the classroom
- Distracted, especially if seated at the back of the classroom

Teacher's actions:

- Talk with student to determine cause of behavior
- Discuss with school nurse if possible
- Discuss with family regarding hearing exam
- Continue to monitor student's behavior and place appropriately in classroom

CHAPTER 6: STUDENTS & PHYSICAL ACTIVTY

How much physical activity is needed?

Regular physical activity can produce long-term health benefits. People of all ages, shapes, sizes, and abilities can benefit from being physically active. The more physical activity you do, the greater the health benefits.

Young Children (2-5 years)
There is not a specific recommendation for the number of minutes young children should be active each day. Children ages 2-5 years should play actively several times each day. Their activity may happen in short bursts of time and not be all at once. Physical activities for young children should be developmentally appropriate, fun, and offer variety.

Children and Adolescents (6-17 years)
Children and adolescents should have 60 minutes or more of physical activity each day. Most of the 60 minutes should be either moderate-or vigorous intensity aerobic physical activity, and should include vigorous-intensity physical activity at least 3 days a week. As part of their 60 or more minutes of daily physical activity, children and adolescents should include muscle-strengthening activities, like climbing, at least 3 days a week and bone-strengthening activities, like jumping, at least 3 days a week. Children and adolescents are often active in short bursts of time rather than for sustained periods of times, and these short bursts can add up to meet physical activity needs. Physical activities for children and adolescents should be developmentally appropriate, fun, and offer variety.

Adults (18-64 years)
Adults should do at least 2 hours and 30 minutes each week of aerobic physical activity at a moderate level OR 1 hour and 15 minutes each week of aerobic physical activity at a vigorous level. Being active 5 or more hours each week provide even more health benefits. Spreading aerobic activity out over at least 3 days a week is best. Also, each activity should be done for at least 10 minutes at a time. Adults should also do strengthening activities, like push-ups, sit-ups, and lifting weights, at least 2 days a week.

Excerpted from "How Much Physical Activity Is Needed?" ChooseMyPlate.gov. USDA. Web. 28 May 2015. <http://www.choosemyplate.gov/physical-activity/amount.html>.

Why Active Schools?

Regular physical activity helps students succeed in both school – and in life!

In addition to keeping kids healthy and strong, being active for 60 minutes each day has been shown to:

- Increase concentration and focus
- Improve classroom attendance and behavior
- Boost academic performance

As the places where kids spend a majority of their time, schools are important places for kids to experience and enjoy being active. That's why, in collaboration with the groups below, the First Lady kicked off the Let's Move! Active Schools program to help schools across the country make quality physical activity a part of every kid's day.

Reprinted from: "Let's Move Active Schools." Lets Move! Web. 29 May 2015. <http://www.letsmove.gov/active-schools>.

CHAPTER 7: NUTRITIONAL NEEDS IN TEENS

Healthy eating is important for all ages, however, a balanced and nutritious diet is essential for the growth and development of adolescents. According to HelpGuide.org, a non-profit guide to mental health and well-being, the teen years is when adolescents experience rapid growth and change (kids gain 20% of adult height and 50% of adult weight) that requires an increase in nutrient intake, especially calcium and iron.

By the time a child hits the teen years, eating habits have become pretty well set. If a teen's choices are less than ideal, it can be challenging to make any changes. According to HelpGuide.org, "The best way to make teen dietary changes is to present information about short-term consequences of a poor diet: appearance, athletic ability, energy, and enjoyment of life. These are more important to most teens than long-term health. For example, *'Calcium will help you grow taller.' 'Iron will help you do better on tests and stay up later.'"*

Special nutritional needs for teens	
Calories	Due to all the growth and activity, adolescent boys need 2,500-2,800 per day, while girls need around 2,200 per day. It's best to get these calories from lean protein, low-fat dairy, whole grains, and fruits and veggies.
Protein	In order for the body to grow and maintain muscle, teens need 45-60 grams per day. Most teenagers easily meet this need from eating meat, fish, and dairy, but vegetarians may need to increase their protein intake from non-animal sources like soy foods, beans, and nuts.
Calcium	Many teens do not get sufficient amounts of calcium, leading to weak bones and osteoporosis later in life. Encourage teens to cut back on soda and other overly-sugary foods, which suck calcium from bones. The 1,200 mg of calcium needed per day should come from dairy, calcium-fortified juice and cereal, and other calcium-rich foods such as sesame seeds and leafy greens like spinach.
Iron	Iron deficiency can lead to anemia, fatigue, and weakness. Boys need 12 mg each day, and teen girls, who often lose iron during menstruation, need 15 mg. Iron-rich foods include red meat, chicken, beans, nuts, enriched whole grains, and leafy greens like spinach and kale.

Reprinted from: "Nutrition for Children and Teens." HelpGuide.org. Web. 29 May 2015. <http://www.helpguide.org/articles/healthy-eating/nutrition-for-children-and-teens.htm>.

Eating Regularly

Healthy eating means eating regularly. All too often teens skip entire meals, such as breakfast, because of distractions and busy schedules. However, skipping a meal leaves a teenager feeling hungry and vulnerable to eating too much or making unhealthy choices at the next mealtime. According to the Children's Hospital Boston, for teenagers, eating three meals with snacks in between is the best way to maintain energy and a healthy weight.

Eating Because of Hunger

Teens should learn how to eat in response to the body's hunger and full signals. When eating becomes a dominantly social or emotional practice rather than a physical one, a teen may build habits that later lead to obesity and disease. The Children's Hospital Boston states that eating when you are hungry, then stopping when you are full, helps your body balance its energy needs and stay comfortable. Teens need to ask themselves, "Am I eating because I'm hungry or because I'm stressed or bored?"

MyPyramid Food Intake Pattern Calorie Levels

MyPyramid assigns Individuals to a calorie level based on their sex, age, and activity level.

The chart below identifies the calorie levels for males and females by age and activity level. Calorie levels are provided for each year of childhood, from 2-18 years, and for adults in 5-year increments.

	MALES				FEMALES		
Activity level	Sedentary*	Mod. active*	Active*	**Activity level**	Sedentary*	Mod. active*	Active*
AGE				**AGE**			
2	1000	1000	1000	**2**	1000	1000	1000
3	1000	1400	1400	**3**	1000	1200	1400
4	1200	1400	1600	**4**	1200	1400	1400
5	1200	1400	1600	**5**	1200	1400	1600
6	1400	1600	1800	**6**	1200	1400	1600
7	1400	1600	1800	**7**	1200	1600	1800
8	1400	1600	2000	**8**	1400	1600	1800
9	1600	1800	2000	**9**	1400	1600	1800
10	1600	1800	2200	**10**	1400	1800	2000
11	1800	2000	2200	**11**	1600	1800	2000
12	1800	2200	2400	**12**	1600	2000	2200
13	2000	2200	2600	**13**	1600	2000	2200
14	2000	2400	2800	**14**	1800	2000	2400
15	2200	2600	3000	**15**	1800	2000	2400
16	2400	2800	3200	**16**	1800	2000	2400
17	2400	2800	3200	**17**	1800	2000	2400
18	2400	2800	3200	**18**	1800	2000	2400
19-20	2600	2800	3000	**19-20**	2000	2200	2400
21-25	2400	2800	3000	**21-25**	2000	2200	2400
26-30	2400	2600	3000	**26-30**	1800	2000	2400
31-35	2400	2600	3000	**31-35**	1800	2000	2200
36-40	2400	2600	2800	**36-40**	1800	2000	2200
41-45	2200	2600	2800	**41-45**	1800	2000	2200
46-50	2200	2400	2800	**46-50**	1800	2000	2200
51-55	2200	2400	2800	**51-55**	1600	1800	2200
56-60	2200	2400	2600	**56-60**	1600	1800	2200
61-65	2000	2400	2600	**61-65**	1600	1800	2000
66-70	2000	2200	2600	**66-70**	1600	1800	2000
71-75	2000	2200	2600	**71-75**	1600	1800	2000
76 and up	2000	2200	2400	**76 and up**	1600	1800	2000

*Calorie levels are based on the Estimated Energy Requirements (EER) and activity levels from the Institute of Medicine Dietary Reference Intakes Macronutrients Report, 2002.
SEDENTARY = less than 30 minutes a day of moderate physical activity in addition to daily activities.
MOD. ACTIVE = at least 30 minutes up to 60 minutes a day of moderate physical activity in addition to daily activities.
ACTIVE = 60 or more minutes a day of moderate physical activity in addition to daily activities.

United StatesDepartment of Agriculture
Center for Nutrition Policy and Promotion
April 2005
CNPP-XX

Reprinted from: "Nutrition for Children and Teens." ChooseMyPlate.gov. USDA. Web. 29 May 2015. <http://www.choosemyplate.gov/food-groups/downloads/MyPyramid_Calorie_Levels.pdf>.

CHAPTER 8: STUDENT MENTAL AND EMOTIONAL HEALTH

8.1 Depression

Depression is a serious mental illness that negatively affects feelings, thoughts, and actions. There are a variety of symptoms associated with depression, but the most common are a deep feeling of sadness and/or a marked loss of interest or pleasure in activities. Although it is quite normal to feel sad or depressed due to environmental factors, symptoms usually lesson over time. With true clinical depression, however, symptoms can continue for months or years.

At one time, it was believed, that children did not experience true depression, but research now strongly indicates that it is quite common in children. The best treatment approach seems to be a combination of medication and psychotherapy. Even when symptoms disappear, both are usually continued for several months to reduce the risk of recurrence. Older children with chronic depression may be at risk of suicidal thoughts and actions.

Teachers should consult with families and follow site and district protocol regarding referral to site-based mental health professionals if any of the following signs and symptoms appear:

Preschool

- Listless
- Decreased interest in playing
- Cries easily and more often than usual

Elementary School

- Listless and moody
- More irritable than usual
- Often looks sad
- Easily discouraged
- Complains of boredom
- More distant with friends and family
- Increased difficulty with school work
- Talks about death

Teenager

- Always tired
- Feeling worthless or guilty
- Drops out of favorite activities
- Has more arguments with parents and teachers
- Refuses to do chores or homework
- Engages in harmful behavior such as self-mutilation
- Has suicidal thoughts

8.2 Student Stress

As stated in Chapter 2, Section 2.41, some people worry so much about the things they cannot change that they never take charge of what they can do to change their situation. As adults, we have the ability to analyze our stressors and seek out coping strategies, however, this does not immediately solve our problems. Learning to control stress can be a challenging task that most adults struggle with daily.

As Hank Pellissier describes in his article "Stress and your child's brain", "We've seen the articles, watched the 11 o'clock news reports on the "silent killer," and complained to friends and family about how stressed-out we are. While we all know that adult stress can lead to serious illnesses such as ulcers and hypertension, we don't associate these maladies with children." Pellissier explains that, today, our children are experiencing record amounts of stress, resulting in the suicide rate among adolescents to have quadrupled since the 1950's. He further states that, because a child's brain is not fully developed yet, chronically stressed kids are at risk of cognitive damage. Stress can affect a person's health whether they are aware of it or not.

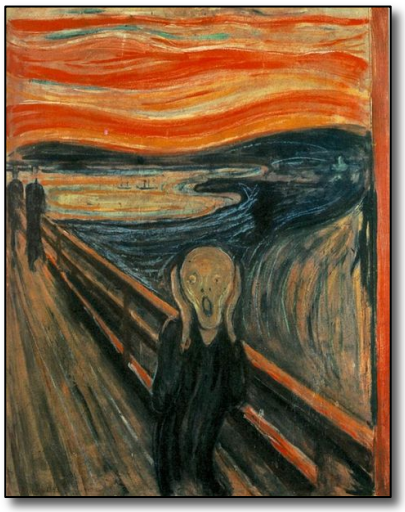
Now imagine that you are a child. It does not matter if you are 3, 7, 14, or 18 years old, children lack the cognitive ability and life experience to recognize and manage their stress the same way adults do. As a new teacher, it is very important that you remember that each student in your class has just come from his/her unique circumstance that may hold personal stressors. The behaviors that they display in the classroom are in direct correlation with what they are experiencing outside of the limits of your classroom walls. It is important that you provide a safe and stress-free environment for each of our students.

The chart below depicts common effects of stress.

Common effects of stress ...		
... On your body	**... On your mood**	**... On your behavior**
• Headache • Muscle tension or pain • Chest pain • Fatigue • Change in sex drive • Stomach upset • Sleep problems	• Anxiety • Restlessness • Lack of motivation or focus • Irritability or anger • Sadness or depression	• Overeating or undereating • Angry outbursts • Drug or alcohol abuse • Tobacco use • Social withdrawal

Reprinted from: "Stress Management." Mayo Clinic. Web. 29 May 2015.
<http://www.mayoclinic.org/healthy-living/stress-management/in-depth/stress-symptoms/art-20050987>.

8.21 Post-Traumatic Stress Disorder (PTSD)



In today's classrooms, teachers are working with students suffering from stress disorders. These disorders range from mild to severe. You must be aware of situations concerning your students and should seek assistance from the school counselor. The following, along with more in-depth information, can be found at www.aftertheinjury.org.

There are three main types of traumatic stress reactions:

- Re-experiencing: Reliving what happened
- Avoidance: Staying away from reminders
- Hyper-arousal: Feeling anxious or jumpy

These reactions are normal and are not considered PTSD unless they persist for over a month and interfere with daily life.

What is 'PTSD'?

PTSD is diagnosed when traumatic stress reactions are so severe that they get in the way of normal life and last for more than one month.

According to the U.S. National Library of Medicine website, there are four types of symptoms:

1. Reliving the event, which disturbs day-to-day activity

- Flashback episodes in which the event seems to be happening again and again
- Repeated upsetting memories of the event
- Repeated nightmares of the event
- Strong, uncomfortable reactions to situations that remind you of the event

2. Avoidance

- Emotional numbing or feeling as though you do not care about anything
- Feeling detached
- Not able to remember important parts of the event
- Not interested in normal activities
- Showing less of your moods
- Avoiding places, people, or thoughts that remind you of the event
- Feeling like you have no future

3. Hyperarousal

- Always scanning your surroundings for signs of danger (hypervigilance)
- Not able to concentrate
- Startling easily
- Feeling irritable or having outbursts of anger
- Trouble falling or staying asleep

4. Negative thoughts and mood or feelings

- Constant guilt about the event, including survivor guilt

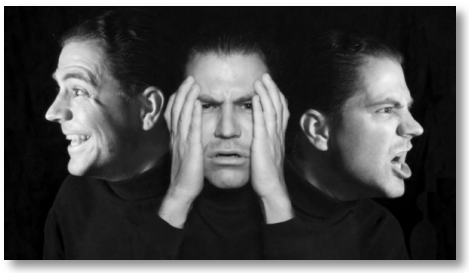
- Blaming others for the event
- Not being able to recall important parts of the event
- Loss of interest in activities or other people

Students may also have symptoms of anxiety, stress, and tension:

- Agitation or excitability
- Dizziness
- Fainting
- Feeling your heartbeat in your chest
- Headache

Reprinted from: "Learn about injury and trauma" After the Injury. Web. 29 June 2015. <http://www.aftertheinjury.org/what-are-traumaticstress-reactions>.

8.3 Bipolar Disorder



Bipolar disorder, also called manic-depressive illness, is a serious mental illness that causes extreme mood swings between a manic and a depressive phase. It affects persons of all ages and appears to have a genetic component.

Persons with bipolar disorder may feel euphoric, full of energy, unwilling to rest, and able to do anything during the manic phase. During the depressive phase, individuals may be overwhelmed with sadness and completely lacking in energy or desire to do anything. Patients can cycle between these phases over days or weeks. As with depression, the most effective treatment seems to be a combination of medication and psychotherapy.

Teachers should consult with families and follow site and district protocol referral to site-based mental health professionals if any of the following signs and symptoms appear:

Manic Phase:

- Feeling very irritable and angry
- Thinking and talking so fast that people can't follow
- Insomnia
- Feeling very powerful and important
- Trouble with concentration
- Substance abuse
- Having unprotected sex

Depressive Phase:

- No interest or pleasure in past enjoyable activities
- Feeling sad or numb
- Crying easily or for no reason
- Feeling slowed down, restless, or irritable
- Feeling worthless or guilty
- Change in appetite and/or unintended change in weight
- Trouble recalling things, concentrating, or decision making
- Headaches, backaches, or digestive problems
- Sleep problems; wanting to sleep all the time

8.4 Gay, Lesbian, Bisexual, and Transgender (GLBT) Students

Educators know that in order for meaningful learning to take place, students must feel safe and supported at school. How you relate to the students in your classroom is extremely important. Your relationship with your students affects how they respond to you and what you are asking them to do in the classroom. The challenge is creating an emotionally safe environment without relinquishing your role as the teacher. You are not their friend. To achieve this, you have to find the right balance of being emotionally open and authentic without sacrificing the boundaries and hierarchy that keep you in charge. Students need to know that you are in charge of the classroom and of their relationship with you. At the same time, you should be a truly caring person who is in their corner to help combat the loneliness felt by so many adolescents.

Students may reach out and confide in you. They may become comfortable with you and tell you things that they don't feel comfortable telling their parents, and maybe even their friends. Teachers are not supposed to and are not trained to be therapists. When a student has emotional problems, teachers should make sure they don't try to play that role and should instead refer the student to a school counselor. What teachers *can* do is create a classroom environment that helps alleviate the normal problems many students wrestle with and, at the very least, not add to them.

This is especially true for students who identify themselves as lesbian, gay, bisexual, or transgender (GLBT). A teacher who acts as an advocate, or simply avails himself/herself as a safe person to talk to, can make a tremendous difference for a student who is struggling.

What can educators do to be more supportive of GLBT students?

Being supportive means more than just preventing bullying in your classroom. It means never tolerating derogatory or belittling language, for any child. It means recognizing the struggles of all students, listening and displaying empathy, and providing them with a safe space for self-expression. And lastly, it means constantly examining your school's climate to determine how the faculty and staff can improve inclusiveness for ALL students.

Finally, you are the classroom teacher. You must do what is best for each child in your classroom, regardless of gender, ethnicity, sexual orientation, economic status, etc. If you need guidance on how to work with students in your classroom, ask your school site for assistance. Remember, the school is the larger community and should be the model that each classroom follows.

For more information and resource, please contact the GLBT National Help Center at 1-888-843-4565 and help@GLBThotline.org or visit their website at www.glbthotline.org.

8.5 Schizophrenia

Schizophrenia is a psychiatric diagnosis that describes a mental disorder characterized by impairments in the perception or expression of reality and by significant social or occupational dysfunction. A person experiencing schizophrenia is typically characterized as demonstrating disorganized thinking, and as experiencing delusions or hallucinations, in particular auditory hallucinations.

Schizophrenia is a serious illness for which early diagnosis and medical treatment are crucial. Although causes are not specifically known, research suggests that brain chemistry, environment, and genetics play an important role. The disease usually manifests during the early teenage years and peaks during the ages of 15 to 30. Males usually show signs and symptoms earlier than females. Medications, as well as coordinated mental health services, help families manage and cope with the effects of the disease to facilitate recovery.

Although childhood schizophrenia is essentially the same brain disorder as in adults, the early age of onset presents special considerations for diagnosis, treatment, educational needs, emotional and social development, family relationships, and other factors.

Teachers should consult with families and follow site and district protocol regarding referral to site-based mental health professionals if two or more of the following signs and symptoms appear during a one-month period:

- Difficulty discerning dreams (or television) from reality
- Seeing and hearing things that are not real (visual and auditory hallucinations)
- Confused and/or disorganized thinking
- Vivid and bizarre thoughts and ideas
- Extreme moodiness
- Odd behavior
- Ideas that people are “out to get them” (delusions)
- Behaving like a younger child (regression)
- Severe anxiety and fearfulness
- Severe problems in making or keeping friends (may become more shy or withdrawn over time)

8.6 Oppositional Defiant Disorder (ODD)

The American Academy of Child & Adolescent Psychiatry (www.aacap.org) published a guide on Oppositional Defiant Disorder (ODD). The following are excerpts from their guide book[1].

Physicians define ODD as a pattern of disobedient, hostile, and defiant behavior directed toward authority figures. Children and adolescents with ODD often rebel, are stubborn, argue with adults, and refuse to obey. They have angry outbursts and have a hard time controlling their temper. These behaviors cause significant impairment with family, social activities, school, and work.

The most common behaviors that children and adolescents with ODD show are:

- Defiance
- Spitefulness
- Negativity
- Hostility and verbal aggression

How Common is ODD?

There is a range of estimates for how many children and adolescents have ODD. Evidence suggests that between 1 and 16 percent of children and adolescents have ODD. However, there is not much information on the prevalence of ODD in preschool children and estimates cannot be made.

ODD usually appears in late preschool or early school-aged children. In younger children, ODD is more common in boys than girls. However, in school-age children and adolescents the condition occurs about equally in boys and girls.

Although the disorder seems to occur more often in lower socioeconomic groups, ODD affects families of all backgrounds.

Biological Factors

Children and adolescents are more susceptible to developing ODD if they have:

- A parent with a history of attention-deficit/hyperactivity disorder (ADHD), ODD, or Conduct Disorder (CD).
- A parent with a mood disorder (such as depression or bipolar disorder)
- A parent who has a problem with drinking or substance abuse
- Impairment in the part of the brain responsible for reasoning, judgment, and impulse control
- A brain-chemical imbalance
- A mother who smoked during pregnancy
- Exposure to toxins
- Poor nutrition

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Psychological Factors

- A poor relationship with one or more parent
- A neglectful or absent parent
- A difficulty or inability to form social relationships or process social cues

Social Factors

- Poverty
- Chaotic environment
- Abuse
- Neglect
- Lack of supervision
- Uninvolved parents
- Inconsistent discipline
- Family instability (such as divorce or frequent moves)

There is no clear-cut cause of ODD. However, most experts believe that a combination of biological, psychological, and social risk factors play a role in the development of the disorder. Children with ODD who are not treated are at an increased risk for substance abuse and delinquency.

ODD Patterns of Behavior

According to the Mayo Clinic, "for some children, symptoms may first be seen only at home, but with time extend to other settings, such as school and with friends." They may have trouble with their parents and siblings, in school with teachers, at work with supervisors and other authority figures, and may struggle to make and keep friends and relationships.

The American Psychiatric Association's criteria for diagnosis of ODD show a pattern of behavior that:

- Includes at least four symptoms from any of these categories – angry and irritable mood; argumentative and defiant behavior; or vindictiveness
- Occurs with at least one individual who is not a sibling
- Causes significant problems at work, school, or home
- Occurs on its own, rather than as part of the course of another mental health problem, such as a substance abuse disorder, depression or bipolar disorder
- Lasts at least six months

This criteria for diagnosis includes both emotional and behavioral symptoms such as:

Angry and irritable mood

- Often loses temper
- Is often touchy or easily annoyed by others
- Is often angry and resentful

Argumentative and defiant behavior

- Often argues with adults or people in authority
- Often actively defies or refuses to comply with adults' requests or rules
- Often deliberately annoys people
- Often blames others for his or her mistakes or misbehavior

Vindictiveness

- Is often spiteful or vindictive
- Has shown spiteful or vindictive behavior at least twice in the past six months

ODD can vary in severity, from mild to severe:

- **Mild.** Symptoms occur only in one setting, such as only at home, school, work, or with peers.
- **Moderate**. Some symptoms occur in at least two settings.
- **Severe**. Some symptoms occur in three or more settings.

Many children with ODD also have other mental health conditions, such as:

- Attention-deficit/hyperactivity disorder (ADHD)
- Depression
- Anxiety
- Conduct Disorder
- Learning and communication disorders

CHAPTER 9: CHILD ABUSE

The abuse and maltreatment of children is an extremely serious problem in today's society. Research suggests that it is related to factors within the family, community, and larger culture. Child and parent characteristics often interact to produce abusive behavior, and the results of this abuse can be evident in school.

Because **all teachers are designated as mandated reporters of child abuse**, it is extremely important that you become adept at recognizing the signs of child abuse, be able to discuss this issue with your students, and be thoroughly informed as to the proper reporting procedures and agencies to contact.

For the rules of conduct, visit www.ctc.ca.gov/credentials/rules-of-conduct.html.

The Chadwick Center for Children and Families offers an online Child Abuse Mandated Reporter Training that is funded by the California Department of Social Services, Office of Child Abuse Prevention. Their website (http://mandatedreporterca.com) also provides helpful resources. For your convenience, we have reprinted some of their FAQs below:

1. **What is a mandated reporter?**
   Mandated reporters are individuals who are mandated by law to report known or suspected child maltreatment. They are primarily people who have contact with children through their employment. Mandated reporters are required by the state of California to report any known or suspected instances of child abuse or neglect to the county child welfare department or to a local law enforcement agency (local police/sheriff's department).

2. **Why must you report?**
   The primary intent of the reporting law is **to protect the child from abuse and neglect**. However, a report of suspected child abuse or neglect might also present an opportunity to provide help for the family. Parents who are under stress may be unable to ask for help directly, and may not know where or how to access support/help. A report of suspected abuse or neglect might be the catalyst for bringing about change in the home environment, which in turn may help to lower the risk of abuse or neglect in the home.

3. **How much proof do I need to provide that abuse of neglect has occurred?**
   No proof of abuse or neglect is needed, only "reasonable suspicion" that child abuse or neglect may have occurred. If you are at all concerned about the possibility of abuse or neglect, you should report. Investigations will be conducted by law enforcement and/or the county child welfare department to determine if abuse or neglect has occurred. Delayed reporting while awaiting further information may hinder investigation by the appropriate agencies.

4. **How do I report?**
   Mandated reporters must report to a county child welfare department or to local law enforcement (police or sheriff's department) immediately by phone. A written report must then be sent within 36 hours by fax, or it may be sent by electronic submission, if a secure system has been made available for that purpose in your county. Written reports must be submitted on the California Suspected Child Abuse Report Form 8572. This form can be downloaded at http://ag.ca.gov/childabuse/pdf/ss_8572.pdf.

5. **Can I report the abuse of neglect anonymously?**
   No. Mandated reporters must identify themselves to the county child welfare department when making child abuse or neglect reports. However, persons who are not legally mandated may make anonymous reports.

6. **Who will know that I made the child abuse or neglect report?**
   The law enforcement officer and/or county child welfare worker investigating the case will have your name in order to contact you about the report. Other professionals involved in the case, such as detectives, and attorneys will have access to your name as well. However, your identity cannot be disclosed to the family or anyone else not directly involved in the investigation of the case. If your case results in a trial and you are required to testify, your identity may be revealed in court.

7. **If I tell my supervisor about my concerns of abuse or neglect, have I met the obligation for mandated reporting?**
   No. Telling a supervisor does not meet the mandated reporting requirement. If a decision is made that the supervisor will complete and submit the report to the county child welfare department or law enforcement agency, then one report is sufficient.

8. **What happens if I am concerned about abuse or neglect and I do not make a report?**
   Legally mandated reporters can be criminally liable for failing to report suspected abuse or neglect. The penalty for this misdemeanor is up to six months in jail and/or up to a $1,000 fine. Mandated reporters can also be subject to a civil lawsuit, and found liable for damages, especially if the child-victim or another child is further victimized because of the failure to report.

9. **What if my supervisor tells me not to report my concerns because they are not sufficient?**
   You must still make a report to the county child welfare department or local law enforcement. If the supervisor disagrees, the individual with the original suspicion must report.

CHAPTER 10: SUBSTANCE ABUSE

10.1 Substance Use

Substance use is the ingestion of psychoactive substances in moderate amounts that do not significantly interfere with social, educational, or occupational functioning.

Substance Abuse
Substance abuse is a maladaptive pattern of substance use, although not outright dependence, leading to clinically significant impairment or distress, as evidenced by one or more of the following during a 1-year period:

- Recurrent substance use causing a failure to fulfill work, school, or family obligations.
- Recurrent substance use in situations that are physically hazardous (e.g., driving).
- Recurrent legal problems related to substance abuse.
- Continued substance use despite having persistent or recurring social or interpersonal problems caused or made worse by the use of the substance.

Substance Dependence (Addiction)
Substance dependence is a maladaptive pattern of substance use characterized by the following elements:

- Tolerance: The need for increased amounts of a substance to achieve the desired effect, and a diminished effect with continued use of the same amount.
- Withdrawal: Severely negative physiological responses to discontinued use of a psychoactive substance. These reactions can be alleviated by the same or by similar substances.
- A history of unsuccessful efforts to control substance use.
- A preoccupation with efforts to seek and obtain the substance.

Substance Abuse Related Disorders
Substance abuse related disorders result in behavior that is deviant, maladaptive, and personally distressful. Any or all of the following may be present:

- Patient cannot meet his/her needs.
- Patient is generally distressed.
- Patient is not reality-based.

Signs and Symptoms include:

- Any observed evidence of injury, illness, medical conditions, behaviors, or mental state.
- Evidence of injury, illness, medical conditions, or mental state reported to you by the patient.

If you know someone who is seeking treatment, the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services, offers a Behavior Health Treatment Services Locator at 1-800-662-HELP or online at http://www.findtreatment.samhsa.gov.

10.2 Types of Substances

The National Institute on Drug Abuse (NIDA) has a website called **NIDA for Teens** (http://teens.drugabuse.gov) that was created for middle and high school students and their teachers in order to provide up-to-date information on drug abuse. The content in this section are excerpts from their website.

10.21 Cocaine

Also known as: Coke, Coca, C, Snow, Flake, Blow, Bump, Candy, Charlie, Rock, and Toot.

Cocaine is a powerfully addictive stimulant drug made from the leaves of the coca plant native to South America. Cocaine comes in two forms: **powder** and **crack.**

How Does Cocaine Affect the Brain?

Stimulants like cocaine change the way the brain works by changing the way nerve cells communicate. Nerve cells, called neurons, send messages to each other by releasing chemicals called neurotransmitters. These neurotransmitters attach to molecules on neurons called receptors.

There are many neurotransmitters, but dopamine is the main one that makes people feel good when they do something they enjoy, like eating a piece of chocolate cake or playing a video game. It is then recycled back into the cell that released it, thus shutting off the signal. Cocaine prevents the dopamine from being recycled, causing a buildup of the neurotransmitter in the brain. It is this flood of dopamine that causes the cocaine's high. The drug can cause a feeling of intense pleasure and increased energy.

With repeated use, stimulants can disrupt how the brain's dopamine system works, reducing a person's ability to feel any pleasure at all. People may try to make up for it by taking more and more of the drug to feel the same pleasure.

After the "high" of the cocaine wears off, many people experience a "crash" and feel tired or sad for days. They also experience a strong craving to take cocaine again to try to feel better.

What Are the Other Effects of Cocaine?

- Constricted blood vessels and dilated pupils
- Higher body temperature
- Higher blood pressure and faster heartbeat
- Feeling sick to the stomach
- Restlessness
- Decreased appetite and, over time, a loss of weight
- Inability to sleep
- Increased risk of heart attack or stroke due to high blood pressure
- Increased risk of HIV because of impaired judgment leading to risky sexual behavior

- Strange, unpredictable behavior, panic attacks, or paranoid psychosis (losing touch with reality)

10.22 Depressants

Depressants, sometimes referred to as central nervous system (CNS) depressants or tranquilizers, slow down (or "depress") the normal activity that goes on in the brain and spinal cord. Doctors often prescribe them for people who are anxious or can't sleep. Taken as prescribed by a doctor, they can be relatively safe and helpful. However, dependence and addiction are still potential risks when taking prescription depressants. The risks increase when these drugs are abused. Taking someone else's prescription drugs or taking the drugs to get "high" can cause serious, and even dangerous, problems.

Depressants can be divided into three primary groups: barbiturates, benzodiazepines, and sleep medications. Also known as: barbs, reds, red birds, phennies, tooies, yellows, or yellow jackets, candy, downers, sleeping pills, or tranks, A-minus, or zombie pills.

Depressants	
Type	**Conditions They Treat**
Barbiturates • Mephobarbital (Mebaral) • Sodium pentobarbital (Nembutal)	• Seizure disorders • Anxiety and tension
Benzodiazepines • Diazepam (Valium) • Alprazolam (Xanax) • Estazolam (ProSom) • Clonazepam (Klonopin) • Lorazepam (Ativan)	• Acute stress reaction • Panic Attacks • Convulsions • Sleep Disorders
Sleep Medications • Zolpidem (Ambien) • Zaleplon (Sonata) • Eszopiclone	• Sleep Disorders

How do Depressants Affect the Brain?

Most depressants affect the brain by increasing the activity of gamma-aminobutyric acid (GABA), a chemical in the brain that sends messages between cells. The increased GABA activity in turn slows down brain activity. This causes a relaxing effect that is helpful to people with anxiety or sleep problems. Too much GABA activity, though, can be harmful.

What Are Other Effects of Depressants?

- Slurred Speech
- Shallow breathing, which can lead to overdose and even death
- Sleepiness
- Disorientation
- Lack of Coordination

10.23 Heroin

Also known as: Smack, Junk, H, Black Tar, Ska, and Horse.

Heroin is a type of opioid drug that is partly manmade and partly natural. It is made from morphine, a psychoactive (mind-altering) substance that occurs naturally in the resin of the opium poppy plant. Heroin's color and look depend on how it is made and what else it may be mixed with. It can be white or brown powder or a black, sticky substance called "black tar heroin".

Heroin is becoming an increasing concern in areas where lots of people abuse prescription opioid painkillers, like OxyContin and Vicodin. They may turn to heroin since it produces a similar high but is cheaper and easier to obtain.

How Does Heroin Affect the Brain?

When heroin enters the brain, it is converted back into morphine. It then binds to molecules on cells known as opioid receptors. These receptors are located in many areas of the brain and body, especially areas involved in the perception of pain and pleasure.

Short-term effects of heroin include a rush of good feelings and clouded thinking. For the first several hours after taking heroin, people want to sleep, and their heart rate and breathing slow down. When the drug wears off, people may feel a strong urge to take more.

Regular heroin use changes the functioning of the brain. Using heroin repeatedly can result in:

- Tolerance – more of the drug is needed to achieve the same "high"
- Dependence – the need to continue use of the drug to avoid withdrawal symptoms
- Addiction – a devastating brain disease where, without proper treatment, people can't stop using drugs even when they really want to and even after it causes terrible consequences to their health and other parts of their lives.

What Are the Other Effects of Heroin?

The changes that take place in the brain from heroin use have effects on the rest of the body. Heroin use can cause:

- Feeling sick to the stomach and throwing up
- Severe itching
- Slowed (or even stopped) breathing
- Increased risk of HIV and hepatitis (a liver disease) through shared needles
- Coma – a deep state of unconsciousness

  In addition to the effects of the drug itself, heroin bought on the street often contains a mix of substances; some of which can be toxic and can clog the blood vessels leading to the lungs, liver, kidney, or brain. This can cause permanent damage to those organs.

10.24 Methamphetamine (Meth)

Also known as: Meth, Speed, Chalk, and Tina, or for crystal meth, ice, crank, glass, fire, and go fast.

Methamphetamine is a very addictive stimulant drug. Stimulants are a class of drugs that can boost mood, increase feelings of well-being, increase energy, and make you more alert – but they also have dangerous effects like raising heart rate and blood pressure.

How Does Methamphetamine Affect the Brain?

Methamphetamine causes a release of the neurotransmitter dopamine in the brain. The release of small amounts of dopamine makes a person feel pleasure when they do things like listen to music, play video games, or eat tasty food. Methamphetamine's ability to release dopamine very quickly in the brain produces the feelings of extreme pleasure, sometimes referred to as a "rush" or "flash," that many users experience. After the effects have worn off, the brain has less dopamine, which can lead to depression.

Regular use of methamphetamine causes chemical and molecular changes in the brain. The activity of the dopamine system changes, causing problems with movement and thinking. Some of these changes remain long after methamphetamine use has stopped. Although, some may reverse after a person is off the drug for a long period of time, perhaps more than a year, methamphetamine may destroy nerve cells that produce dopamine and another neurotransmitter called serotonin.

What Are the Other Effects of Methamphetamine?

- Feeling very awake and active
- Fast heart rate and irregular heartbeat
- Higher blood pressure
- Higher body temperature
- Increased risk for HIV/AIDS or hepatitis (a liver disease) from unsafe sex and shared needles

Effects of Long-Term Use

- Anxiety and confusion
- Problems sleeping
- Mood swings
- Violent Behavior
- Psychosis (hearing, seeing, or feeling things that are not there)
- Skin sores caused by scratching
- Severe weight loss
- Severe dental problems, known as "meth mouth"
- Problems with thinking, emotion, and memory

10.25 Prescription pain Medications (OPIOIDS)

Opioids, which usually come in pill form, are prescription medications used to reduce pain. Doctors prescribe them after surgery or to help patients with severe pain or pain that lasts a long time. When opioids are taken as prescribed by a medical professional, they are relatively safe and can reduce pain effectively. However, dependence and addiction are still potential risks when taking prescription opioids. These risks increase when these drugs are abused. Painkillers are one of the most commonly abused drugs by teens, after tobacco, alcohol, and marijuana.

How Do Opioids Affect the Brain?

Opioids attach to specific proteins, called opioid receptors, in the brain, spinal cord, gut, and other organs. When these drugs attach to their receptors, they block pain messages sent from the body through the spinal cord to the brain.

Opioids also can change the part of the brain that controls emotions and cause a person to feel relaxed and extremely happy (euphoric). Repeated abuse of opioids can lead to addiction.

What Are the Other Effects of Opioids?

Opioids can have effects on many parts of the brain and body beyond those that are involved in pain. Other effects of opioids include:

- Sleepiness
- Confusion
- Nausea (feeling sick to the stomach)
- Constipation
- Breathing problems. Taking just 1 large dose could cause serious breathing problems that lead to death.

These medications are not safe to use with alcohol or other medications that may slow breathing, such as depressants, because their combined effects also cause serious breathing problems that could lead to death.

10.26 Stimulants

Also known as: Skippy, the Smart Dog, Vitamin R, Bennies, Black Beauties, Roses, Hearts, Speed, or Uppers

Prescription stimulants increase – or "stimulate" – activities and processes in the body. This increased activity can boost alertness, attention, and energy. It also can raise a person's blood pressure and make their heart beat faster. When described by a doctor for a specific health condition, they can be relatively safe and effective.

There are two commonly abused types of stimulants: amphetamines and methylphenidate. In the past, stimulants were used to treat a variety of conditions, including asthma and other breathing problems, obesity, and health problems that affect your nervous system.

How Do Prescription Stimulants Affect the Brain?

The brain is made up of nerve cells that send messages to each other by releasing chemicals called neurotransmitters. Common stimulants, such as amphetamines (e.g., Adderall) and methylphenidate (e.g., Ritalin), have chemical structures that are similar to certain key brain neurotransmitters including dopamine and norepinephrine. Stimulants boost the effects of these chemicals in the brain and body.

When doctors prescribe stimulants, they start with low doses and increase them slowly until they find the appropriate dose for the patient to treat the condition for which they are prescribed. However, when taken in doses and in ways other than those prescribed, like snorting or injecting, stimulants can increase the dopamine in the brain very quickly. This changes the normal communication between brain cells, producing a "high" while also increasing the risk for dangerous side effects and, over time, for addiction.

What Are the Other Effects of Stimulant Abuse?

- Increased blood pressure
- Irregular heartbeat
- Dangerously high body temperatures
- Decreased sleep
- Lack of interest in eating, which can lead to poor nutrition
- Intense anger or paranoia (feeling like someone is going to harm you even though they aren't)
- Risk for seizures and stroke at high doses.

Stimulants	
Type	**Conditions They Treat**
• Amphetamines (Adderall & Dexedrine) • Methylphenidate (Ritalin & Concerta)	• ADHD • Narcolepsy (sleep disorder) • Depression

10.27 Tobacco, Nicotine, and E-Cigarettes

Cigarettes: *also known as smokes, cigs, or butts*
Smokeless tobacco: *also known as chew, dip, spit tobacco, snus, or snuff*
Hookah: *also knows as narghile, argileh, shisha, hubble-bubble, or goza*

Tobacco is a leafy plant grown around the world. There are many chemicals found in tobacco or created by burning it (as in cigarettes), but nicotine is the ingredient that can lead to addiction. Other chemicals produced by smoking, such as tar, carbon monoxide, acetaldehyde, and nitrosamines, also can cause harm to the body.

Tobacco use is the leading preventable cause of disease, disability, and death in the United States. According to the Centers for Disease Control and Prevention (CDC), cigarettes cause more than 480,000 premature deaths in the United States eac h year – from smoking or exposure to secondhand smoke – about 1 in every 5 U.S. deaths, or 1,300 deaths every day.

Tobacco and nicotine products come in many forms. People either smoke, chew, or sniff them, or inhale their vapors.

Smoked tobacco products:

- Cigarettes (regular, light, and menthol) - No evidence exists that “lite” or menthol cigarettes are safer than regular cigarettes.
- Cigars and pipes
- Bidis and kreteks (clove cigarettes) - Bidis are small, thin, hand-rolled cigarettes primarily imported to the U.S. from India and other Southeast Asian countries. These clove cigarettes contain about 60-80% tobacco and 20-40% ground cloves.
- Hookahs or water pipes - Practiced for centuries in other countries, smoking hookahs has become popular among teens in the United States. Hookah tobacco comes in many flavors, and the pipe is typically passed around in groups. As with smoking cigarettes, water pipe smoking still delivers the addictive drug nicotine and is at least as toxic as cigarette smoking.

Smokeless tobacco products where the tobacco is not burned:

- Chewing tobacco, which is placed between the cheek and gums.
- Snuff, ground tobacco, which can be sniffed if dried or placed between the cheek and gum.
- Dip, moist snuff that is used like chewing tobacco.
- Snus, a small pouch of moist snuff.
- Dissolvable products, including lozenges, orbs, sticks, and strips.

Electronic cigarettes. Also called e-cigarettes, electronic nicotine delivery systems, or e-cigs, electronic cigarettes are smokeless, battery-operated devices that deliver flavored nicotine to the lungs without burning tobacco (the usual source of nicotine). In most e-cigarettes, puffing activates the battery-powered heating device, which vaporizes the liquid in the cartridge. The resulting vapor is then inhaled (called “vaping”).

How Do Tobacco and Nicotine Affect the Brain?

Like cocaine, heroin, and marijuana, nicotine increases levels of a neurotransmitter called dopamine. Dopamine is released normally when you experience something pleasurable like good food, your favorite activity, or spending time with people you care about. When a person uses tobacco products, the release of dopamine causes similar effects. This effect wears off quickly, causing people who smoke to get the urge to light up again for more of that good feeling, which can lead to addiction.

Studies suggest that other chemicals in tobacco smoke, such as acetaldehyde, may enhance the effects of nicotine on the brain.

When smokeless tobacco is used, nicotine is absorbed through the mouth tissues directly into the blood, where it goes to the brain. Even after the tobacco is removed from the mouth, nicotine continues to be absorbed into the bloodstream. Also, the nicotine stays in the blood longer for users of smokeless tobacco than for smokers.

What About E-Cigarettes?

E-Cigarettes have emerged over the past decade and researchers are in the early stage of investigating what the health effects are for people who use these products or who are exposed to the aerosol (vapor) secondhand.

E-Cigarettes are designed to deliver nicotine without the other chemicals produced by burning tobacco leaves. Puffing on the mouthpiece of the cartridge activates a battery-powered inhalation device (called a vaporizer). The vaporizer heats the liquid inside the cartridge, which contains nicotine, flavors, and other chemicals. The heated liquid turns into an aerosol (vapor), which the user inhales – referred to as “vaping”.

Health experts have raised many questions about the safety of these products, particularly for teens:

- Testing of some e-cigarette products found the aerosol (vapor) to contain known cancer-causing and toxic chemicals, and particles from the vaporizing mechanism that may be harmful. The health effects of repeated exposure to these chemicals are not yet clear.
- There is animal research which shows that nicotine exposure may cause changes in the brain that make other drugs more rewarding.
- There is an established link between e-cigarette use and tobacco cigarette use in teens. Researchers are investigating this relationship. The concern is that e-cigarette use may serve as a “gateway” or introductory product for youth to try other tobacco products, including regular cigarettes, which are known to cause disease and lead to early death.
- The liquid in e-cigarettes can cause nicotine poisoning if someone drinks, sniffs, or touches it. Recently there has been a surge of poisoning cases in children under age 5. There is also concern for users changing cartridges and for pets.

How Many Teens Use Tobacco and Nicotine?

Smoking and smokeless tobacco use generally start during adolescence. Among people who use tobacco:

- More than 3,000 people younger than 18 years of age smoke their first cigarette.
- An estimated 2,100 youth and young adults who have been occasional smokers becom e daily cigarette smokers.
- If smoking continues at the current rate among youth in this country. 5.6 million of today's Americans younger than 18 years of age could die prematurely from a smoking-related illness. This is about 1 in every 13 Americans age 17 years or younger who are alive today.
- Most smokeless tobacco users will also smoke cigarettes at some time in their lives.
- Using smokeless tobacco remains a mostly male behavior. About 15% of high school boys use smokeless tobacco.

10.28 Other Drugs

Anabolic Steroids

Also known as: Anabolic-androgenic steroids, roids, or juice.

Common Brand Names: Androsterone, Oxandrin, Dianabol, Winstrol, Deca-durabolin, and Equipoise.

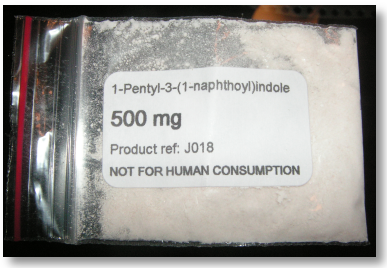
Anabolic steroids are manmade substances related to testosterone (male sex hormone). Doctors use anabolic steroids to treat hormone problems in men, delayed puberty and muscle loss from some diseases.

Bodybuilders and athletes may use anabolic steroids to build muscles and improve athletic performance, often taking doses much higher than would be prescribed for a medical condition. Using them this way is not legal – or safe.

How Do Anabolic Steroids Affect the Brain?

Anabolic steroids affect a part of the brain called the limbic system, which controls mood. Long-term steroid abuse can lead to aggressive behavior and extreme mood swings. This is sometimes referred to as "roid rage." Steroids can also lead to feeling paranoid (like someone or something is out to get you), jealousy, delusions, and feeling invincible.

Bath Salts



Also known as: Bloom, Cloud Nine, Vanilla Sky, White Lightning, and Scarface.

"Bath Salts" is the name given to a family of drugs that have one or more manmade chemicals related to cathinone. Cathinone is an amphetamine-like stimulant found naturally in the khat plant. Chemically, they are similar to Ecstasy or Molly.

Bath salts are usually white or brown crystal-like powder and are sold in small plastic or foil packages labeled "Not for Human Consumption." Sometimes labeled as "plant food" – or, more recently, as "jewelry cleaner" or "phone screen cleaner" – they are sold online and in drug product stores. These names or descriptions have nothing to do with the product. It's a way for the drug makers to avoid detection by the Drug Enforcement Administration or local police.

The manmade cathinone products sold as "bath salts" should not be confused with Epsom salts (the original bath salts), which are made of a mineral mixture of magnesium and sulfate and are added to bathwater to help ease stress and relax muscles.

Use of bath salts sometimes causes severe intoxication (a person seems very drunk or "out of it") and dangerous health effects. There are also reports of people becoming psychotic and violent. Although it is rare, there have been several cases where bath salts have been the direct cause of death.

How Do Bath Salts Affect the Brain?

The manmade cathinones in bath salts can produce feelings of joy and increased social interaction and sex drive. These chemicals can also cause people to feel paranoid and nervous and to have hallucinations. There is a lot we still don't know about how the different chemicals in bath salts affect the brain.

The energizing and often agitating effects reported in people who have taken bath salts are similar to the effects of other drugs like amphetamines and cocaine. These drugs raise the level of dopamine in brain paths that control reward and movement. Dopamine is the main neurotransmitter that makes people feel good when they do something they enjoy. A rush of dopamine causes feelings of joy and increased activity and can also raise heart rate and blood pressure.

A study in animals found that cathinones raises brain dopamine in the same way as cocaine but is at least 10 times stronger. If this is also true in people, it may account for the reason that MDPV (a common manmade cathinone) is the most common manmade cathinone found in the blood and urine or patients admitted to emergency rooms after taking bath salts.

Additionally, the hallucinations often reported by users of bath salts are similar to the effects caused by other drugs such as MDMA or LSD. These drugs raise levels of the neurotransmitter serotonin.

Cough and Cold Medicine (DXM and Codeine Syrup)

Also known as: robotripping, robo, tussin, triple c, dex, skittles, candy, velvet, and drank.

Millions of Americans take cough and cold medicines each year to help with symptoms of colds, and when taken as instructed, these medicines can be safe and effective. However, several cough and cold medicines contain ingredients that are psychoactive (mind-altering) when taken in higher-than-recommended dosages, and some people may abuse them.

Two commonly abused cough and cold medicines are:

- **Cough syrups and capsules containing dextromethorphan (DXM)**. These over the counter cough medicines are safe for stopping coughs during a cold if you take them as directed. Taking more than the recommended amount can produce euphoria and dissociative effects.
- **Promethazine-codeine cough syrup**. These prescription medications contain an opioid drug called codeine, which stops coughs, but when taken in higher doses produces euphoria.

How Do Cough and Cold Medicines Affect the Brain?

When cough and cold medicines are taken as directed, they safely treat symptoms caused by colds and flu. But when taken in higher quantities or when such symptoms aren't present, they may affect the brain in ways very similar to illegal drugs.

DXM acts on the same brain cell receptors as drugs like ketamine or PCP. A single dose of DXM can cause hallucinations (imagined experiences that seem real). Ketamine and PCP are called "dissociative" drugs, which means they make you feel separated from your body or your environment, and they twist the way you think or feel about something or someone.

Codeine attaches to the same cell receptors as opioids like heroin. High doses of promethazine-codeine cough syrup can produce euphoria similar to that produced by other opioid drugs. Also, both codeine and promethazine depress activities in the central nervous system (brain and spinal cord), which produces calming effects.

Both codeine and DXM cause and increase in the amount of dopamine in the brain's reward pathway. Extra amounts of dopamine increase the feeling of pleasure and at the same time cause important messages to get lost, causing a range of effects from lack of motivation to serious health problems.

Inhalants

Also known as: laughing gas (nitrous oxide), snappers, poppers, whippets, bold, and rush.

Inhalants are chemicals fou nd in ordinary household or workplace products that people inhale on purpose to get "high". Because many inhalants can be found around the house, people often don't realize that inhaling their fumes, even just once, can be very harmful to the brain and body and can lead to death. In fact, the chemicals found in these products can change the way the brain works and cause other problems in the body.

Volatile solvents are liquids that become a gas at room temperature. They are found in:

- Paint thinner, nail polish remover, degreaser, dry-cleaning fluid, gasoline, and contact cement
- Some art or office supplies, such as correction fluid, felt-tip marker fluid, and electronic contact cleaner

Aerosols are sprays that contain propellants and solvent. They include:

- Spray paint, hair spray, deodorant spray, vegetable oil sprays, and fabric protector spray

Gases may be in household or commercial products, or used in the medical field to provide pain relief. They are found in:

- Butane lighters, propane tanks, whipped cream dispensers, and refrigerant gases
- Anesthesia, including ether, chloroform, halothane, and nitrous oxide (commonly called "laughing gas")

Nitrites are a class of inhalants used mainly to enhance sexual experiences. Organic nitrites include amyl, butyl, and cyclohexyl nitrites and other related compounds. Amyl nitrite was used in the past by doctors to help with chest pain and is sometimes used today to diagnose heart problems.

How Are Inhalants Used?

People who use inhalants breathe in the fumes through their nose or mouth, usually by:

- Sniffing or snorting fumes from containers
- Spraying aerosols directly into the nose or mouth
- Sniffing or inhaling fumes from substances sprayed or placed into a plastic or paper bag (bagging)
- Huffing from an inhalant-soaked rag stuffed in the mouth
- Inhaling from balloons filled with nitrous oxide

Because the "high" lasts only a few minutes, people who use inhalants often try to make the feeling last longer by inhaling repeatedly over several hours.

How Do Inhalants Affect the Brain?

The lungs absorb inhaled chemicals into the bloodstream very quickly, sending them throughout the brain and body. Nearly all inhalants (except nitrites) produce a pleasurable effect by slowing down brain activity. Nitrites, in contrast, expand and relax blood vessels.

Short-Term Effects

Within seconds, users feel intoxicated and experience effects similar to those of alcohol, such as slurred speech, lack of coordination, euphoria, and dizziness. Some users also experience lightheadedness, hallucinations, and delusions. If enough of the chemical is inhaled, nearly all solvents and gases produce anesthesia – a loss of sensation – and can lead to unconsciousness.

The high usually lasts only a few minutes, causing people to continue the high by inhaling repeatedly, which is very dangerous. Repeated use in one session can cause a person to lose consciousness and possibly even die.

With repeated inhaling, many users feel less inhibited and less in control. Some may feel drowsy for several hours and have a headache that lasts a while.

Long-Term Effects

Inhalants often contain more than one chemical. Some chemicals leave the body quickly, but others stay for a long time and get absorbed by fatty tissues in the brain and central nervous system. Over the long term, the chemicals can cause serious problems:

- **Damage to nerve fibers.** Long-term inhalant use can break down the protective sheath around certain nerve fibers in the brain and elsewhere in the body. When this happens, nerve cells are not able to send messages as well, which can cause muscle spasms and tremors or even permanent trouble with basic actions like walking, bending, and talking. These effects are similar to what happens to people with multiple sclerosis.
- **Damage to brain cells.** Inhalants also damage brain cells by preventing them from getting enough oxygen. The effects of this condition, also known as brain hypoxia, depend on the area of the brain affected. The hippocampus, for example, is responsible for memory, so someone who repeatedly uses inhalants may be unable to learn new things or may have a hard time carrying on simple conversations. If the cerebral cortex is affected, it can cause a person to move slowly or be clumsy.

Marijuana

Also known as: weed, pot, bud, grass, herb, Mary Jane, MJ, reefer, skunk, boom, gangster, kif, chronic, and g anja

Marijuana is a mixture of the dried and shredded leaves, stems, seeds, and flowers of the hemp plant. The mixture can be green, brown, or gray. Of the approximately 400 chemicals in marijuana, delta-9-tetrahydrocannabinol, known as THC, is responsible for many of the drug's psychotropic effects. It's this chemical that changes how the brain works, distorting how the mind perceives the world.

How is Marijuana Used?

Marijuana is commonly smoked using pipes, water pipes called "bongs", or hand-rolled cigarettes called "joints" or "nails". It is sometimes also combined with tobacco in partially hollowed-out cigars, known as "blunts". Recently vaporizers, that use heat without burning to produce vapor, have increased in popularity, Marijuana can also be brewed as a tea or mixed with food, sometimes called edibles.

In addition, concentrated resins containing high doses of marijuana's active ingredients, including honey-like "hash oil", waxy "budder," and hard amber-like "shatter," are increasingly popular among both recreational and medical users.

How Does Marijuana Affect the Brain?

The main chemical in marijuana that affects the brain is delta-9-tetrahydrocannabinol (THC). When marijuana is smoked, THC quickly passes from the lungs into the bloodstream, which carries it to organs throughout the body, including the brain. As it enters the brain, THC attaches to cells, or neurons, with specific kinds of receptors called cannabinoid receptors. Normally these receptors are activated by chemicals that occur naturally in the body. They are part of a communication network in the brain called the endocannabinoid system. This system is important in normal brain development and function.

Most of the cannabinoid receptors are found in parts of the brain that influence pleasure, memory, thinking, concentration, sensory and time perception, and coordinated movement. Marijuana triggers an increase in the activity of the endocannabinoid system, which causes the release of dopamine in the brain's reward centers, creating the pleasurable feelings or "high". Other effects include changes in perceptions and mood, lack of coordination, difficulty with thinking and problem solving, and disrupted learning and memory.

Effects on School and Social Life

The effects of marijuana on the brain and body can have a serious impact on a person's life.

Reduced school performance. Students who smoke marijuana tend to get lower grades and are more likely to drop out of high school than their peers who do not use. The effects of marijuana on attention, memory, and learning can last for days or weeks. These effects have a negative impact on learning and motivation. In fact, people who use marijuana regularly for

a long time are less satisfied with their lives and have more problems with friends and family compared to people who do not use marijuana.

Impaired driving. It is unsafe to drive while under the influence of marijuana. Marijuana affects a number of skills required for safe driving – alertness, concentration, coordination, and reaction time – so it's not safe to drive high or ride with someone who's been smoking. Marijuana makes it hard to judge distances and react to signals and sounds on the road. Marijuana is the most common illegal drug involved in auto fatalities.

Potential gateway to other drugs: Most young people who use marijuana do not go on to use other drugs. However, those who use marijuana, alcohol or tobacco during their teen years are more likely to use other illegal drugs. It isn't clear why some people do go on to try other drugs, but researchers have a few theories. The human brain continues to develop into the early 20s. Exposure to addictive substances, including marijuana, may cause changes to the developing brain that make other drugs more appealing.

MDMA (Ecstasy or Molly)

Also known as: Ecstasy, Molly, E, XTC, Adam, hug, beans, clarity, lover's speed, and love drug.

MDMA, short for 3,4-methylenedioxymethamphetamine, is most commonly known as Ecstasy or Molly. It is a manmade drug that produces energizing effects similar to the stimulant class amphetamines as well as psychedelic effects, similar to the hallucinogen mescaline. MDMA is knows as a "club drug" because of its popularity in the nightclub scene, at "raves" and music festivals or concerts.

How Does MDMA Affect the Brain?

Once the pill or capsule is swallowed, it takes about 15 minutes for MDMA to enter the bloodstream and reach the brain. MDMA produces its effects by increasing the activity of three neurotransmitters: serotonin, dopamine, and norepinephrine.

The serotonin system plays a role in controlling our mood, aggression, sexual activity, sleep, and feeling of pain. The extra serotonin that is released by MDMA likely causes mood-lifting effects in users. People who use MDMA might feel very alert, or "hyper" at first. Some lose a sense of time and have other changes in perception, such as a more intense sense of touch. Serotonin also triggers the release of the hormones oxytocin and vasopressin, which play a role in feelings of love, sexual arousal, and trust. This may be why users report feeling a heightened sense of emotional closeness and empathy.

Some users experience negative effects. They may become anxious and agitated, become sweaty, have chills, or feel faint or dizzy.

Even those who don't feel negative effects during use can experience negative aftereffects. These aftereffects are caused by the brain no longer having enough serotonin after the surge

that was triggered by using MDMA. Days or even weeks after use, people can experience confusion, depression, sleep problems, drug craving, and anxiety.

Spice

Also known as: K2, fake weed, Bliss, Black Mamba, Bombay Blue, Genie, Zohai, Yucatan Fire, Skunk, and Moon Rocks.

Spice is a mix of herbs and manmade chemicals with mind-altering effects. It is often called "synthetic marijuana" because some of the chemicals in it are similar to ones in marijuana; but its effects are sometimes very different from marijuana, and frequently much stronger. It is most often labeled "Not for Human Consumption and disguised as incense.

Sellers of Spice products try to lead people to believe they are "natural" and therefore harmless, but they are neither.

How Does Spice Affect the Brain?

Some Spice users report feeling relaxed and having mild changes in perception. Users also report extreme anxiety, feeling like someone is out to get them (paranoia), and seeing or hearing things that aren't there (hallucinations).

Spice is a new drug and research is only just beginning to measure how it affects the brain. What is known is that the chemicals found in Spice attach to the same nerve cell receptors as THC, the main mind-altering ingredient in marijuana. Some of the chemicals in Spice, however, attach to those receptors more strongly than THC, which could lead to a much stronger and more unpredictable effect. Additionally, there are many chemicals that remain unidentified in products sold as Spice and it is therefore not clear how they may affect the user. Moreover, these chemicals are often being changed as the makers of Spice alter them to avoid the products being illegal.

CHAPTER 11: PRECAUTIONS TO PREVENT THE SPREAD OF INFECTIOUS DISEASES IN THE SCHOOL SETTING

The California State Department of Education and the National Center for Disease Control (CDC) recommends that schools implement procedures regarding the handing of body fluids.

"THE BODY FLUIDS OF ALL PERSONS SHOULD BE REGARDED AS POTENTIALLY INFECTIOUS."

The term "body fluids" includes blood, semen, drainage from scrapes and cuts, feces, urine, vomit, respiratory secretions (such as nasal drainage) and saliva.

11.1 Universal Precautions

Universal Precautions are precautions used in all situations and not limited to use with individuals known to be carrying a specific virus such as HIV or the virus causing Hepatitis B or Hepatitis C. In the school setting, those precautions should include: hand washing, using gloves, careful trash disposal, using disinfectants, and modification of cardiopulmonary resuscitation (CPR).

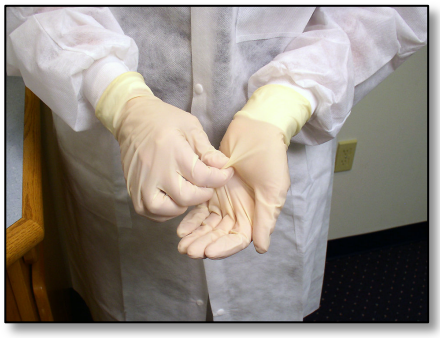
11.2 Hand Washing

Thorough hand washing is the single most important factor in preventing the spread of infectious diseases and should be practiced routinely by all school personnel and taught to students as routine hygiene practice.

1. All staff should wash their hands in the following circumstances:
    - Before handling food, drinking, eating, or smoking
    - After toileting
    - After contact with body fluids or items soiled with body fluids
    - After touching or caring for students, especially those with nose, mouth, or other discharge
2. Scheduling time for students to wash hands before eating is suggested to encourage the practice.
3. How to wash hands: Wet hands with running water and apply soap from dispenser. Lather well and wash vigorously for fifteen to twenty seconds. Soap suspends easily – removing soil and microorganisms, allowing them to be washed off. Running water is necessary to carry away dirt and debris. Rinse well under running water with water draining from wrist to fingertips. Leave water running. Dry hands well with a paper towel and then turn off the faucet with the paper towel. Discard towel. Antibacterial gel can be used as a temporary method to sanitize hands until thorough hand washing can be done.

4. Classroom instruction about proper hand washing should be integrated into health instruction at all grade levels.

11.3 First Aid Involving Body Fluids



- Avoid direct skin contact with body fluids. If direct skin contact occurs, hands and other affected skin areas should be washed with soap and water immediately after contact has ended, to the extent practicable, using running water, liquid soap and disposable gauze, towels, or tissues.
- Disposable single use gloves should be used when contact with body fluids is anticipated (such as bloody nose, diapering, etc.). Gloves should be standard components of first-aid supplies in the schools so that they are readily accessible for emergencies and regular care given in school health offices, cafeterias, and other athletic training rooms.
- Any soiled clothing should be placed in a separate plastic bag, sealed and placed in a plastic bag labeled with the student's name. Send home with the student.

11.4 Using Disinfectants

1. Environmental surfaces contaminated with body fluids should be cleaned promptly with disposable towels and approved disinfectants.
2. Disposable gloves should be worn.
3. Disposable items should be discarded in a plastic-lined wastebasket.
4. Mop solution used to clean bodily fluid spills should consist of the approved disinfectant. Used mops should be soaked in this solution 30 minutes and rinsed thoroughly before re-using.
5. After clean up, remove and disgard gloves and wash hands.
6. If carpet is soiled, clean up immediately and disinfect with District approved disinfectant.

11.5 Trash Disposal

Place soiled tissues, pads, gauze bandages, towels, etc. into a plastic bag and tie or seal the bag. Place it in a second plastic bag and leave sealed.

If needles, syringes, or lancets are used in the school setting, you will need a puncture-proof container for storage. Place intact needles and syringes in the designated container. Do not bend or break needles. Do not recap needles. Contact your local Health Department for directions about disposal of contaminated materials.

11.6 Risk of Exposure to HIV, Hepatitis B, & Hepatitis C Viruses

11.61 HIV

AIDS (Acquired Immune Deficiency Syndrome) is the advanced stage of HIV (Human Immunodeficiency Virus) infection. The HIV virus attacks the body's immune system, leaving it vulnerable to life-threatening opportunistic infections and malignancies. The virus also may directly attack the central nervous system. Persons infected with HIV frequently have no apparent symptoms and usually appear to be in good health. When HIV is diagnosed before it advances into AIDS, medications have proven to help slow or even stop the damage to the immune system, enabling many people with HIV to live long and active lives.

How is HIV Infection transmitted?

The possibility that AIDS/HIV will be transmitted in schools, the workplace and other public gatherings is remote. Because the HIV virus does not survive well outside the body, it cannot be spread through casual contact like kissing or sharing an infected person's drinking glass. As a result, you will not get AIDS by being around or working with a person who is infected or by having ordinary daily contact with an HIV infected person.

The HIV virus can only be transmitted through:

1. Any sexual activity involving direct contact with semen, blood or vaginal secretion of someone who is infected.
2. Sharing intravenous (IV) needles and/or syringes with someone who is infected.
3. Penetrating the skin with needles that have been used to inject an infected person.
4. Direct contact on broken skin with infected blood.
5. Receiving blood transfusion or blood products from someone who is infected (a screening test has been used since 1985 has reduced the risk significantly).
6. An infected mother to her baby before or during birth or through breast milk.

The HIV virus cannot be transmitted through saliva, tears, sweat, feces and urine.

11.62 Hepatitis B (HBV)

Hepatitis B (HBV) is an infection of the liver caused by a virus present in the blood and other bodily fluids. One major sign of liver damage is jaundice, which causes the skin and whites of the eyes to look yellow. However, less than 50% of infected people actually show symptoms (such as fatigue, mild fever, headache, loss of appetite, nausea, vomiting, diarrhea or constipation, muscle or joint pain, or skin rash). The onset of symptoms may appear 6 weeks - 6 months after becoming infected with the virus. Death is uncommon, but 5-10% of those infected become long-term virus carriers. Up to 25% of carriers may develop serious chronic liver disease.

How is HBV transmitted?

HBV can only be transmitted through blood and bodily fluids. Transmission may occur as early as four weeks before any symptoms occur. A small number of people are chronic carries that carry the virus in their blood for years without experiencing symptoms.

HBV is transmitted by:

- Sexual activity involving semen, blood, or vaginal secretions
- Sharing unsterile instruments used to penetrate the skin, such as those used for tattooing, ear piercing, and razors
- Sharing intravenous (IV) needles and/or syringes with someone who is infected
- Direct contact of infected blood with mucous membranes of the eye or mouth
- Direct contact with infected blood with broken skin (e.g., cuts)
- Accidental needle sticks with needles containing blood from a virus carrier
- Being born to an infected mother

11.63 Risk of Exposure to HIV and HBV Viruses

Type of Exposure	Volume of Blood	HIV % of Risk	HBV % of Risk
Receipt of infected blood transfusion	500 cc (1 unit or 1 pint)	95.0%	100%
Accidental needle stick contaminated with infected blood in clinical setting	Minute (less than 1 cc)	0 - .03%	12-35.0 %
Infected blood on broken skin in clinical setting	Minute to small volume	Some risk	Some risk
Infected blood on healthy unbroken skin in clinical setting	Minute to small volume	No reported cases	No reported cases
Care for infected persons within household	Minute to small volume	No reported cases among family members of thousands of persons with AIDS	Some risk

Notes:

- Some health care workers have been infected with HBV in absence of needle stick. Presumable, those infections were acquired by blood transfers to oral or nasal mucous membranes via the hands.
- No family members have contracted HIV infection unless they were themselves at risk because of sexual activity, inoculation with blood products and perinatal events.
- HBV transmission has occurred between babies and their family contacts, infected developmentally delayed children and their classmates and caregivers, and in other situations when chronic carriers are present for prolonged periods.

11.64 Hepatitis C (HCV)

Hepatitis C (HCV) causes an inflammation of the liver. It is the most common chronic blood borne infection in the United States. According to the U.S. Centers for Disease Control and Prevention, approximately 1.8% of the U.S. population or 3.2 million Americans have been infected with the virus. About 17,000 new cases of HCV are estimated to occur in the United States each year. Currently, no vaccine is available to prevent people from contracting HCV, but some treatments are available that may help clear the virus from the blood.

How is HCV transmitted?

HCV is blood borne, which means that it is spread through blood or blood products. Common routes of infection include needle stick accidents; blood transfusions before mid-1992 (after 1992, blood banks began rigorous screening for HCV with effective new testing methods); and the use of recreational drugs (i.e., sharing needles). There are also other modes of transmission and factors that may also put people at risk for contracting Hepatitis C.

How Does HCV Develop?

HCV progresses slowly over many years. Some people who have become infected may not be aware of the virus for as long as one to two decades. By the time symptoms appear, the virus has most likely already begun to damage the liver. Liver failure due to HCV is one of the most common causes of liver transplants in the United States. Once the virus infects a person's blood, it enters the cells in the liver and begins to reproduce itself rapidly.

What are the Symptoms of HCV?

The initial stages of HCV is called acute Hepatitis C. During this stage, which can last for up to 6 months, 60%-70% of patients have no symptoms. However, some people in the acute stage may experience extreme tiredness, weakness, loss of appetite, and jaundice. They may also complain of abdominal discomfort, which may be a sign that the liver is inflamed and tender. With or without symptoms, initial damage to the liver cells can take place soon after infection, within an average 2-8 weeks.

Most people are able to rid their bodies of the virus on their own. In more than 80% of individuals with acute infection, the disease progresses to a chronic condition. HCV is considered a chronic condition when the virus remains in the blood for longer than 6 months, although tests may not detect it at all times. Chronic HCV usually progresses at a very slow rate, often over a period of 10 to 30 years. However, the longer the virus is in the body, the more damage is done to the liver. Individual factors, such as increased alcohol intake, age, and gender can also influence the progression of Hepatitis C. If the disease remains untreated, serious consequences, such as cirrhosis, liver failure, liver cancer, or even death, may occur.

CHAPTER 12: RESOURCES

- Adolescent Health Issues
  - Adolescent Health Working Group - www.ahwg.net/
  - CDC, Adolescent and School Health - www.cdc.gov/healthyyouth/adolescenthealth/

- Child Abuse
  - Child Help - www.childhelp.org
  - National Sexual Violence Resource Center - www.nsvrc.org/
  - The Child Abuse Prevention Center - www.thecapcenter.org

- Exercise
  - Project Healthy Schools - www.projecthealthyschools.org/resources/activity.html
  - US Government, Kids.gov - www.kids.usa.gov

- Health Education
  - California Department of Education's Resource Catalog - www.cde.ca.gov/re/pn/rc/
  - California Healthy Kids - www.californiahealthykids.org/index

- Legislation
  - California Department of Education - www.cde.ca.gov
  - California Legislative Information - http://leginfo.legislature.ca.gov/

- Medical Conditions and Injuries
  - American Diabetes Association - www.diabetes.org/
  - Directors of Health Promotion in Education - www.dhpe.org
  - National Heart, Lung, and Blood Institute - www.nhlbi.nih.gov/
  - Red Cross - www.redcross.org/

- Mental Health
  - Dept. of Health and Human Services, Mental Health.gov - www.mentalhealth.gov
  - National Alliance on Mental Illness - www.nami.org

- Nutrition
  - Dairy Council of California - www.dairycouncilofca.org/
  - USDA Choose My Plate - www.choosemyplate.gov

- Suicide Prevention
  - National Institute of Mental Health - nimh.nih.gov/index.shtml
  - National Suicide Prevention Lifeline - www.suicidepreventionlifeline.org

ARTS AND CRAFTS SAFETY

Arts, Crafts & Theater Safety
181 Thompson Street, #23
New York, New York 10012
(212) 777-0062
www.artscraftstheatersafety.org/

CA. Department of Health Care Services
1501 Capital Ave., Suite 2101
Sacramento, CA 95814
(916) 445 -4171
www.dhcs.ca.gov/Pages/default.aspx

BLOOD BORNE PATHOGENS AND UNIVERSAL PRECAUTIONS

Sonoma County Public Health Dept.
3313 Chanate Road
Santa Rosa, CA 95404
(707) 565-4400
www.sonoma-county.org/health

Sonoma County Office of Education
5340 Skylane BLVD
Santa Rosa, CA 95403
(707) 524 -2700
www.scoe.org

EARTHQUAKE SAFETY

Cal. Office of Emergency Services
Costal Region
1300 Clay Street, Suite 400
Oakland, CA 94612
www.caloes.ca.gov/cal-oes-divisions/regional-operations/coastal-region

California Seismic Safety Commission
1755 Creekside Oaks Drive
Suite 100
Sacramento, CA 95833-3637
(916) 263 – 5506
www.seismic.ca.gov/

GENERAL SAFETY INFORMATION

Cal OSHA Consultation Services
2424 Arden Way, Suite 485
Sacramento, CA 95825
(916) 263-5765
www.dir.ca.gov/dosh/consultation.html

National Safety Council
San Francisco Chapter
303 Twin Dolphins Drive, Suite 520
Redwood City, CA 94065-1409
(800) 544-1030
sanfrancisco@nsc.org
www.nsc.org/Pages/Home.aspx

US Department of Labor
OSHA Publications
PO Box 37535
395 Oyster Point BLVD
Washington, D.C. 20013-753
(202) 693 -1888
www.osha.gov/pls/publications/publication.html