



Health and Health Care in Schools

A report from the Center for Health and Health Care in Schools on the policies, politics and financing of health programming in schools

Volume 8, Number 3

May 2007

In this issue:

Report on School Nutrition Targets 'Competitive' Foods

A long-awaited report stops short of recommending changes in federally supported school meals but urges reforms of competitive foods.

Your State and Vision Screening: What's the Score?

A state-by-state survey finds many children are never screened and others get no professional care after failing screening.

Weighing Benefits, Profits of Pediatric Drug Testing

More drugs have now been tested in children but critics say pharmaceutical manufacturers are profiting unduly.

Probing the Mysteries of Autism

Federal officials say, "We don't know" what causes or cures autism spectrum disorders.

WORTH NOTING

- GAO Warns of 'High Risk' Gaps in Food Safety
- HPV Vaccine Is Controversial in States
- Setting a Higher Bar for Health Care
- April News Alerts

Report on School Nutrition Targets 'Competitive' Foods

The Institute of Medicine (IOM) in a report released April 25 makes no recommendations for changing nutrition requirements in the National School Lunch Program or other federally supported school food programs and concentrates instead on suggestions for improving "competitive foods" available in schools.

The report, titled "Nutrition Standards for Foods in School: Leading the Way Toward Healthier Youth," says federally reimbursable nutrition programs should be the primary source of foods and beverages offered at school and defines "competitive foods" as "foods and beverages offered outside the federally reimbursable school nutrition programs."

The report recommends standards for competitive foods based on the Dietary Guidelines for Americans and organizes competitive foods and beverages into two tiers—one for all students and the other for high school students after school.

- Tier 1 foods acceptable for sale in schools under the IOM standards would include fruits, vegetables, and whole grains, plus nonfat and low-fat dairy, and would be limited to 200 calories or less per portion as packaged. These portions would be allowed to get no more than 35 percent of their total calories from fat and less than 10 percent of total calories from saturated fats, and would have to be trans fat-free. Tier I foods would get 35 percent or less of their calories from sugars, and sodium content would be restricted to 200 mg or less per portion.
- Tier I beverages acceptable for sale in schools under the IOM standards would include water without flavor-

ing, additives, or carbonation; low-fat and nonfat milk; and lactose-free and soy beverages. Beverages would have to be caffeine-free, and flavored milk could contain no more than 22 grams of total sugars per 8-ounce serving. One-hundred-percent fruit juice would be allowed, in 4-ounce portions for elementary and middle school students and 8-ounces for high schoolers.

- Tier 2 "snack foods" for high school students after school could not exceed 200 calories per portion as packaged and would have to meet the same dietary requirements as Tier 1.

As to how its recommendations for competitive foods would be implemented, the IOM suggests there should be "regulatory guidance" to federal, state, and local authorities and performance-based guidelines and technical assistance to schools or school districts. The report also suggests that federal agencies should "engage with the food industry" to establish a user-friendly system for identifying snacks, foods, and beverages that meet the Tier 1 and Tier 2 requirements, with specific guidance for wholegrain products and combination products that contain fruits, vegetables, and whole grains.

In a conclusion to its report, the IOM notes that federally reimbursable school nutrition programs such as school lunch and breakfast "have traditionally been an important means for ensuring that students have daily access to fruits, vegetables, whole-grain-based products and nonfat or low-fat dairy products during the school day."

It was the view of the committee that wrote the report that those federally reim-

Continued on page 2

Health & Health Care in Schools is a monthly journal published in html and PDF versions by The Center for Health and Health Care in Schools. The Center is located at:



School of Public Health
and Health Services
The George Washington
University Medical Center

Support for Health & Health Care in Schools is provided by The Robert Wood Johnson Foundation

Continued from page 1

bursable programs should be the main source of nutrition provided at school, but the committee also recognized that “there are an increasing number of opportunities for students to eat and drink, including a la carte services, vending machines, school stores, snack bars, concession stands, classroom or school celebrations, achievement rewards, after-school programs, and other venues.”

“Schools are encouraged to limit such additional opportunities for students to eat and drink, but when they do arise in school, they should be used to encourage greater daily consumption of fruits, vegetables, whole grains, and nonfat or low-fat dairy products,” the report concluded.

Although the U.S. Department of Agriculture (USDA), which administers the federally reimbursable school food programs, provided funds for the report, the finished report does not necessarily reflect the views of USDA, the IOM pointed out. USDA officials have announced that they may update regulations for school food programs to take into account new dietary guidelines and problems such as childhood obesity, and legislation now pending in Congress would require changes in USDA guidelines described by one senator as “archaic.”

The full text of the report, “Nutrition Standards for Foods in Schools: Leading the Way Toward Healthier Youth,” is available at www.nap.edu.

Also see:

“Study Finds Most Schools Offer ‘Competitive’ Foods,”

www.healthinschools.org/2005/sept9a_alert

“Nutrition and Obesity: What’s Ahead for School Food?”

www.healthinschools.org/focus/2004/nol.htm

Your State and Vision Screening: What’s the Score?

As of April 2007, 19 states do not require children to receive any preventive vision care before starting school or while enrolled in school; and of the 31 states that do require vision screening, only one (Arkansas) currently insists that children who fail the screening must receive an eye examination by an eye doctor.

That’s a grim statistic that leaves two in three children without any preventive vision care before they enter elementary school, according to the Centers for Disease Control and Prevention, which points out that untreated vision problems can affect a child’s cognitive, emotional, neurologic, and physical development by limiting the range of experiences and the kinds of information to which the child is exposed.

A first-ever “vision summit” convened in April by the Virginia-based Vision Council of America described in detail the require-

ments, or lack of requirements, state-by-state, for vision screening and treatment of schoolchildren. And in an article published in *The Journal of School Nursing* in June 2006, school nurse Linda Kimmel looked at contributing factors that often prevent children from receiving full eye examinations after problems are detected in screening.

Both Kimel and the Council make clear the distinction between vision screening, which may be conducted by school nurses or volunteers in schools, and diagnostic examinations that must be conducted by eye care professionals. But they also point out that screening without follow-up is of little value.

In a survey of families in which children did not receive professional eye care after the families were informed that their children had failed a screening, Kimel found that cost and money were lesser barriers than logistics (appointment problems, no car, all adults working), and doubts on the part of parents about the screening results. (Cited as reasons for those doubts were that the child did not understand the screening task, school screening instruments are inaccurate, allergies or illness altered results, and the school nurse was not trusted.)

Lack of follow-up means that “Even states that have vision screening may not be doing enough,” according to the Vision Council. “Of the 31 states that require a vision screening for children, 29 (93 percent) do not require children who fail to receive an eye exam from an eye doctor. Because multiple studies have shown that children who fail a screening often do not receive follow-up care, neglecting to include a mandatory follow-up eye exam provision greatly minimizes the impact of these well-intended laws.”

In a summary of state laws concerning vision screening and examinations of schoolchildren, the Vision Council notes a range of requirements, from no statewide mandates for screening in Idaho, Iowa, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Wisconsin, and Wyoming to Arkansas’ comprehensive law, which reads: “*Beginning with the 2006-2007 school year, all children in pre-kindergarten (pre-K), kindergarten (k), grades one (1), two (2), four (4), six (6), and eight (8) shall receive an eye and vision screening. A child who does not pass the eye and vision screening tests, except for the color perception test, shall be required to have a comprehensive eye and vision examination conducted by an optometrist or ophthalmologist within sixty (60) days of receipt of the vision screening report identifying the need for an examination.*”

Legislation introduced in the current session of Congress focuses on providing children the follow-up needed after vision problems are identified in a vision screening, according to the Council.

The Vision Care for Kids Act of 2007 can be read and tracked at

<http://thomas.loc.gov>.

Continued on page 3

Continued from page 2

Further information, including an April 2007 update of state laws on vision screening, is available at the Vision Council of America, ezb@visionsite.org.

Weighing Benefits, Profits of Pediatric Drug Testing

When Congress enacted the Best Pharmaceuticals for Children Act (BPCA) in 1997, it was accepted that nearly two-thirds of the drugs being prescribed for children had never been tested for safety or efficacy on children, and doctors were simply guessing at the proper pediatric dosages. To try to remedy the lack of pediatric testing, the law gave pharmaceutical companies six months of extended marketing rights in return for conducting tests on children.

Ten years later, Congress is due to reauthorize BPCA this year, and controversy has erupted over whether the program's benefit to children is outweighed by the windfalls many pharmaceutical companies enjoy from the extended period of copyright exclusivity. That profit can be substantial—much more than the cost of testing—if the manufacturer is protected from competition on a blockbuster drug, though smaller companies that make less popular drugs say they barely break even, according to a research report published in the *Journal of the American Medical Association*.

As of 2007, the BPCA program has generated more than 300 pediatric studies, and more than 115 products have undergone labeling changes for pediatric use. That makes the program popular with pediatricians, who told the Senate Committee on Health in March that the studies sparked by the law and the better labeling of drugs are “a tremendous improvement over the shrugging shoulders and the resigned look and the soft sigh when we had to say, ‘I’m sorry, we just don’t know enough about this drug in children.’”

Drug companies are equally pleased. In a statement to the committee, the Pharmaceutical Research and Manufacturers of America (PhRMA) said the pediatric exclusivity program “has greatly advanced the medical care of children by helping spur research.” PhRMA noted that requests by the federal Food and Drug Administration (FDA) for pediatric studies have included a wide range of therapeutic areas, including treatment of fever, skin conditions, heart disease, HIV, cancer, endocrine problems, gastrointestinal disorders, and others.

The FDA is authorized by law to request such studies, and the Government Accountability Office (GAO) reported in March that drug sponsors have initiated pediatric studies for 173 of the FDA's 214 written requests for studies of on-patent drugs. Most

drugs granted pediatric exclusivity also had labeling changes, often because the pediatric studies found that children may have been exposed to ineffective drugs, ineffective dosing, overdosing, or previously unknown side effects.

The FDA regularly makes available summaries of medical and clinical pharmacology reviews of pediatric studies that have been conducted in compliance with BPCA. For example, in January this year, the FDA notified that studies had been completed for the drugs AZOPT, BETAXON, and GLEEVA; and in April the agency announced the availability of pediatric studies of CELEBREX, COLAZAL, ELOXATIN, EMTRIVA, SUPRANE, and TOPROL-XL. Summaries of all the pediatric studies that have been conducted so far are available at www.fda.gov/cder/pediatric/index.htm.

But there is work yet to be done, according to the National Institutes of Child Health and Human Development in the National Institutes of Health, which in March published a priority list of drugs for which it believes pediatric studies are urgently needed, including drugs that are used in the treatment of pediatric cancers, pediatric hypertension, and asthma.

In addition to debating whether to reauthorize the Better Pharmaceutical for Children Act this year, Congress has to decide about another law—the Pediatric Research Equity Act (PREA)—which gives the FDA statutory authority to request companies to perform clinical trials on medications used by children. That law is also set to expire this year, and Senator Hillary Clinton (D-NY) has introduced legislation to make the FDA's authority to request studies permanent.

“The reasons for reauthorization of BPCA and PREA are clear, numerous, and resounding. Together, they provide both an incentive and a requirement crucial to the success of a robust pediatric program,” Samuel Maldonado, head of Johnson & Johnson's Pediatric Drug Development Center, told the Senate committee.

Saying he is concerned about the profits to pharmaceutical companies from six months of market exclusivity in return for pediatric testing, committee member Senator Sherrod Brown (D-OH) is suggesting a compromise—he would let drugmakers choose between three months of market exclusivity or six months with 10 percent of profits used to finance pediatric research centers. “I think this proposal would ensure a continued flow of pediatric testing while multiplying the benefits of the pediatric exclusivity program—for the good of our children, for the good of taxpayers, and for the good of the public health,” Brown said.

Bills introduced in Congress to reauthorize the Better Pharmaceuticals for Children Act and the Pediatric Research Equity Act can be read and tracked at website <http://thomas.loc.gov>.

Continued on page 4

Continued from page 3

A research report, “Economic Return of Clinical Trials Performed Under the Pediatric Exclusivity Program,” appeared in the February 7, 2007, issue of the *Journal of the American Medical Association*.

Probing the Mysteries of Autism

In his opening statement at a Senate hearing April 17, Senator Tom Harkin (D-IA) noted that the number of diagnosed cases of autism is on the rise, both in the U.S. and in other countries and asked, “Why is this? Are we simply doing a better job of diagnosing autism, or has there been a real increase in the incidence of this disease? What causes autism—are the causes environmental or are the causes genetic? Which therapies work best for children with autism? And what more can the federal government do to help?”

The answer to most of those questions, and particularly to the question of what causes autism, is: “We don’t know,” said the head of the federal government’s autism research at the National Institutes of Health (NIH).

Dr. Thomas Insel told the hearing that “Much remains unknown about the causes of autism, and identifying both the environmental and genetic underpinnings of autism are critical first steps in bringing the full scientific power of modern neuroscience to bear on this complex set of disorders.”

Defining autism as “a developmental brain disorder with onset by three years of age,” Insel said scientists now believe autism is part of a broader continuum of syndromes known as “autism spectrum disorders” (ASDs) that share deficits in social behavior, abnormal communication, and repetitive behaviors. ASDs range in severity, with “classic” autism being the most disabling, while others, such as Asperger’s syndrome, produce milder symptoms. Currently, Insel said, the prevalence of ASDs (meaning the number of affected individuals at a given point in time, essentially a snapshot) is estimated by the Centers for Disease Control and Prevention (CDC) to be as high as 6.7 children per 1,000.

Research into autism has stepped up in recent years, Insel pointed out, with NIH increasing its funding nearly five-fold to support research across genetic, neuroscience, environmental, and treatment studies. A recently established NIH National Database for Autism Research provides an open-access platform for sharing raw research materials and to facilitate dissemination of research into clinical practice.

On the core question “Can we cure autism?” the jury is still out, Insel said. “There is not a proven biological treatment for the core symptoms of autism,” he said, though “It is generally agreed that early identification and behavioral intervention is benefi-

cial.” And while some medications are useful for some of the symptoms of autism, such as self-injurious behaviors, “We lack medical treatments for many of the core symptoms, such as social deficits.”

Another federal agency, the Centers for Disease Control and Prevention (CDC), has also increased its presence in autism research, CDC Director Julie Gerberding told the hearing, with the CDC bringing its experience in tracking disease prevalence to bear on the question of whether apparent increases in the autism spectrum disorders are due to better identification or represent a true increase in occurrence. A summary of prevalence data released in February showed the figure of 6.7 eight-year-old children per 1,000 with ASDs, which Gerberding pointed out translates to 1 in 150 children in the communities surveyed.

“CDC recognizes that parents want answers,” Gerberding said. “We share their frustration at not having more answers about the causes and possible cure for the debilitating symptoms of autism and related conditions.”

Also testifying at the April 17 hearing, advocacy groups asked the Senate Appropriations Subcommittee on Health, which convened the hearing, to increase funding for autism research, saying, “The public health crisis posed by autism requires an extraordinary response. With every child diagnosed with autism costing an estimated \$3 million over his or her lifetime, the autism crisis demands a focused, coordinated, and acceptable response by our public health agencies, similar to the federal response to the AIDS crisis in the 1990s.”

A *National Institute of Mental Health* publication, “Autism Spectrum Disorders,” is available from the NIH website at www.nimh.nih.gov.

Also see:

“The Autistic Child,” www.healthinschools.org/focus/2005/no2.htm

WORTH NOTING

GAO Warns of ‘High Risk’ Gaps in Food Safety

The U.S. Government Accountability Office (GAO) has identified food safety as a high-risk area for the federal government. The GAO points out that responsibility for keeping the human food supply safe is fragmented among 15 federal agencies that administer at least 30 laws related to food safety; the two agencies with biggest responsibilities are the U.S. Department of Agriculture (USDA), which is responsible for the safety of meat, poultry, and processed egg products, and the Food and Drug Administration (FDA), which is responsible for virtually all other

Continued on page 5

Continued from page 4

food. The majority of federal expenditures for food safety inspections are directed to USDA programs, even though the USDA has authority over only about 20 percent of the food supply. The FDA, which is responsible for regulating the other 80 percent of the food supply, gets only about 24 percent of federal food safety expenditures. And in one of the most critical gaps, the federal agencies have no authority to require food recalls and no authority to compel companies to carry out recalls (with one exception—the FDA can require recalls of infant formula). The GAO points out that because of those limitations, federal agencies never know how promptly or completely recalls are carried out, whether the recall information reaches all segments of the distribution chain, or whether consumers are alerted to a recall. “Limitations in the federal government’s food recalls heighten the risk that unsafe food will remain in the food supply and ultimately be consumed,” the GAO warns.

HPV Vaccine Is Controversial in States

In New Hampshire, where the vaccine is being provided free, demand for the new human papillomavirus vaccine (HPV) is outstripping demand. But in California, state legislators in April decided not to mandate HPV vaccination for seventh-grade girls and are considering waiting five years before adding the vaccine to the list required for school enrollment. In New Mexico, Governor Bill Richardson vetoed legislation to require vaccination of sixth graders, saying there isn’t enough time to educate parents, schools, and health care providers about the vaccine. In Texas, an executive order by the governor requiring HPV vaccination of 11- and 12-year-old girls has been put on hold by a judge; and in South Carolina, the legislature voted down a bill requiring vaccination. Still awaiting action in at least 18 state legislatures, many of which have adjourned for the year, mandatory immunization against HPV and ovarian cancer does not seem likely for next school year in most parts of the country, according to infectious disease specialists. Among the problems cited by legislators is uncertainty about the “window of effectiveness” of the vaccine, now believed to be about five years. That would mean that girls vaccinated at age 12 would no longer be protected when they were 17 and beyond, the ages at which women seem to become most vulnerable to HPV. The vaccine, Gardasil, is manufactured by Merck, which called off lobbying state legislatures for mandatory immunizations in February.

Setting a Higher Bar for Health Care

America’s Health Insurance Plans (AHIP), an organization of private health insurers who claim to cover 200 million Americans, says the United States can do better to improve health care. For starters, the AHIP suggests we should:

- create a public/private partnership to provide up-to-date and objective information about which health care services are most effective and give the best value;

- assure that the federal Food and Drug Administration has the authority to monitor the long-term impact of new drugs, devices, and biologicals, and
- adopt a national medical research agenda that closes gaps in knowledge and provides usable information to doctors and patients.

The AHIP would like to create a system for resolving medical disputes that would replace the current tort system with review of claims by independent third parties, fair compensation for damages, and quick resolution of disputes. The AHIP also calls for finding innovative ways to manage chronic conditions, which it says account for large parts of the national medical bill.

April News Alerts

The following information appeared during the month of April 2007 in the News Alerts section of the website of the Center for Health and Health Care in Schools, at www.healthinschools.org.

April 10, 2007

AAP Fears Rising Vaccine Costs Will Lead to Under-Immunization

The American Academy of Pediatrics (AAP) in a special announcement today said it is alarmed that the soaring costs of vaccines, combined with lower reimbursements from insurance companies, will lead to under-immunization of the nation’s children and unnecessary outbreaks of preventable diseases. “The system for delivering vaccines is broken, and we’re going to be in real trouble if it isn’t fixed soon,” said AAP President Jay Berkelhammer. The AAP points out that pediatricians must often wait months for payments from insurers, including Medicaid and private health plans, and that in addition to the cost of a vaccine, additional costs of ordering, storing, inventory control, insurance, and spoilage are not taken into consideration by insurers. Approximately 85 percent of American children are vaccinated at pediatricians’ offices, but flaws in the current system “threaten to greatly reduce or even eliminate the physician provider role, causing many children not to get the comprehensive and preventive health care they need,” the AAP said. “Pediatricians are not looking to make huge profits off vaccines,” said Jon Almquist, chair of the AAP’s Task Force on Immunization. “We’re in pediatrics because we care about children—but we shouldn’t be expected to subsidize the public health system and perform our jobs at a loss. We have carried this burden for long enough.”

April 17, 2007

NIH to Study Bariatric Surgery in Adolescents

One of the techniques for controlling weight—bariatric surgery, which restricts stomach size, thereby decreasing the amounts of calories and nutrients the body absorbs—is being recommended

Continued on page 6

Continued from page 5

for extremely overweight adolescents, but the effects of such treatment on young persons has not been studied, according to the National Institute of Diabetes and Digestive and Kidney Diseases in the National Institutes of Health. To try to determine if bariatric surgery is an appropriate treatment for adolescents, the Institute over the next five years will collect data on some 200 adolescents who are scheduled for bariatric surgery and compare that information to data obtained from a similar number of adults who had the surgery after being obese in their adolescent years. The project, Teen-LABS, is being conducted by children's hospitals in Alabama, Ohio, Pennsylvania, and Texas. Study participants will be expected to pay the cost of their surgery and related medical care through medical insurance or other means. Adolescents between 14 and 19 years are eligible for the study but younger patients will also be considered under some circumstances. For more information, the central study coordinator can be contacted by e-mail at Rosemary.Miller@cchmc.org.

April 13, 2007

CDC Cites Increased Threat of Foodborne Illness

Recent outbreaks have shown that too many people in the United States are getting sick each year from foodborne illnesses, according to the federal Centers for Disease Control and Prevention (CDC). Specifically, recent cases involving tomatoes, lettuce, and spinach underscore the need to more effectively prevent contamination of produce, said CDC Director Julie Gerberding. In a report released April 12, the CDC cited data on foodborne illnesses reported to the agency in 2006 as part of a surveillance network known as FoodNet. The most recent data show little improvement in the incidence of Salmonella and E. coli 0157, possibly as the result of contamination of foods not previously associated with those illnesses, such as spinach and peanut butter, the CDC said. "Previous efforts to decrease the incidence of E. coli 0157 in ground beef and Salmonella in eggs have been successful, but contamination of other foods may be the problem now," according to Dr. Robert Tauxe, deputy director of the CDC's Division of Foodborne, Bacterial, and Mycotic Diseases. The full report, "Preliminary FoodNet Data on the Incidence of Infection with Pathogens Transmitted Commonly Through Food" appears in the April 13, 2007, issue of Morbidity and Mortality Weekly Report and is available online at www.cdc.gov/mmwr.

April 17, 2007

AAP Offers Resources to Help Cope with Tragedy

The American Academy of Pediatrics is calling attention to resources posted on its website that aim to help teachers, students, physicians, children, and teens cope with disasters such as the campus shooting at Virginia Tech University. The website includes tips on talking to children after a disaster, stress management guidelines for children and teens, and gun violence prevention. Pediatricians who are mental health and violence prevention experts are available to discuss the emotional impact of school

and community violence. The resources are posted at www.aap.org and the AAP may be contacted for more information or to set up interviews at 847-434-7131 or mweinstein@aap.org.

April 18, 2007

Supreme Court Upholds 'Partial Birth' Abortion Ban

The United States Supreme Court today said a federal law banning a method of ending fetal life in the later stages of pregnancy—often referred to as “partial birth”—is constitutional. In a 5-to-4 decision, with Justices Kennedy, Roberts, Scalia, Thomas, and Alito concurring and Justices Ginsburg, Stevens, Souter, and Breyer dissenting, the Court said its ruling leaves women free to choose an abortion “before fetal viability” but prohibits a doctor from performing an “intact D&E procedure” in the later stages of pregnancy. Planned Parenthood immediately announced that “There is no way we will let this stand,” saying the Supreme Court’s majority “turned its back on more than 30 years of decisions that protected women’s health from dangerous laws that restrict abortion.” The case before the Court was *Gonzales v. Carhart*.

April 18, 2007

Benefits of Antidepressants Found Greater than Suicide Risk

In a report published in today's issue of the *Journal of the American Medical Association* (JAMA), researchers who analyzed existing data found that depressant medications are effective in treating pediatric major depressive, obsessive-compulsive, and other anxiety disorders in children and adolescents, and that the benefits of medication outweigh the risks of suicide attempts or suicidal thinking. “Some may argue that any risk of suicidal ideation/suicide attempt cannot possibly justify use of antidepressants for children and adolescents. Instead, we believe that the strength of evidence presented here supports the cautious and well-monitored use of depressants as one of the first-line treatment options,” the researchers said. The report, “Clinical Response and Risk for Reported Suicide Ideation and Suicide Attempts in Pediatric Antidepressant Treatment,” appears in the April 18, 2007, issue of the *Journal of the American Medical Association*.

April 20, 2007

Meningococcal, HPV Vaccines Added to List of Covered Vaccines

As of today, two recently approved new vaccines have been added to the federal government's National Vaccine Injury Compensation Program, which provides a system of no-fault compensation for individuals who have been injured by covered childhood vaccines. Vaccines are added to the compensation program after they are recommended by the Centers for Disease Control

Continued on page 7

Continued from page 6

and Prevention (CDC) for routine administration to children. The CDC in May 2005 recommended routine administration of the meningococcal vaccine to young adolescents (11-12-year-olds) and vaccination before high school entry for those who did not receive the vaccine at the earlier age. For the HPV (human papillomavirus) vaccine, the CDC recommended in March this year that a series of three vaccinations be routinely administered to females aged 11-12 and to females ages 13 to 26 who have not previously received the three shots or did not complete the full series. Persons who allege injury or death as the result of childhood vaccination can file claims with the Vaccine Compensation Program within three years of the first symptoms or two years of a vaccine-related death. Further information is available in the Federal Register for April 20, 2007, at <http://origin.www.gpoaccess.gov/fr/>

April 25, 2007 Report 'Encourages' Schools to Limit Food Options

In a report released today, the Institute of Medicine (IOM) lays out 10 principles "to support the creation of healthful eating environments for U.S. schoolchildren" and cites foods and beverages that would meet "Tier 1" and "Tier 2" standards. Tier 1 options, which "are to be encouraged," would include a la carte entrées that meet fat and sugar limits, and "Tier 2" options would be snack foods that do not exceed 200 calories per portion. The full text of the IOM report is available at www.nap.edu.

Copyright©2007

All material published in Health and Health Care in Schools is protected by copyright and may not be reprinted without permission from the Center for Health and Health Care in Schools (2121 K Street, NW, Suite 250, Washington, DC 20037, 202-466-3396 fax 202-466-3467). Send permission requests to chhcs@gwu.edu