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NEW MEXICO STATUTES, ADMINISTRATIVE CODES, REGULATIONS
AND POLICIES RELATING TO SCHOOL HEALTH*
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**NOTE**: It is recommended that copies of local district and/or school policies regarding school health issues be compared for compliance with the New Mexico Administrative Codes and State Statutes as well as appropriate Federal regulations.

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LICENSURE AND COMPETENCIES FOR SCHOOL HEALTH PROFESSIONALS

NM State Statutes – School Personnel

CHAPTER 22 PUBLIC SCHOOLS
ARTICLE 10A SCHOOL PERSONNEL ACT
http://statutes.laws.com/new-mexico/chapter-22/article-10a

SECTION 3 License or certificate required; application fee; general duties. (2003)

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SECTION 7 Level one licensure. (2010)

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SECTION 32 Licensed school employees; required training program. (2003)

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CHAPTER 63 School Personnel - Licensure Requirements for Ancillary and Support Personnel
http://www.nmcpr.state.nm.us/nmac/_title06/T06C063.htm

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PART 6  Licensure for School Counselors, K-12
http://www.nmcp.state.nm.us/nmac/parts/title06/06.063.0006.htm

PART 7  Licensure for School Social Workers, K-12
http://www.nmcp.state.nm.us/nmac/parts/title06/06.063.0007.htm

PART 15  Licensure for School Health Assistants, Grades K-12
http://www.nmcp.state.nm.us/nmac/parts/title06/06.063.0015.htm

PART 16  Licensure for School Licensed Practical Nurses, Grades K-12
http://www.nmcp.state.nm.us/nmac/parts/title06/06.063.0016.htm

CHAPTER 68  SCHOOL PERSONNEL – Denial, Suspension, and Revocation of License
http://www.nmcp.state.nm.us/nmac/_title06/T06C068.htm

SCHOOL NURSE EVALUATION TOOLS (See Section I this Manual.)

NEW MEXICO SCHOOL HEALTH PROGRAM

EDUCATION STANDARDS & BENCHMARKS

TITLE 6  PRIMARY AND SECONDARY EDUCATION
CHAPTER 29  STANDARDS FOR EXCELLENCE
http://www.nmcp.state.nm.us/NMAC/_title06/T06C029.htm

The Three-Tier Model of Student Intervention
Response to intervention (RtI) is a framework being used across the country and specifically encouraged by the federal government as school systems seek ways to ensure success for all students, provide early assistance to students who are experiencing academic and/or behavioral challenges, or need opportunities for advanced learning.
http://www.ped.state.nm.us/sat3tier/sat3tierModelComplete.pdf#pagemode=bookmarks

in New Mexico, the RtI framework is set forth in state rule at Subsection D of 6.29.1.9 NMAC for all district and charter schools, and is known as the three-tier model of student intervention.
http://www.nmcp.state.nm.us/nmac/parts/title06/06.029.0001.htm
Three-Tier Model of Student Intervention

HEALTH SCREENING PROCESS

Tier 1—Universal Screening and Appropriate Core Instruction with Universal Interventions
“The focus of Tier 1 is universal screening, delivery of the core curriculum with universal interventions, and school-wide behavioral supports as the first line of intervention. In New Mexico, all students are screened for the following:
- academics
- vision
- hearing
- language proficiency (L1 and L2)
- general health
- social and behavioral health
- socioeconomic status”

New Mexico Public Education Department: SAT and the Three-Tier Model of Student Intervention (pg.7).

The Standards for Excellence of the NM Public Education Department (PED) serves as the road map for school districts to use in preparing and carrying out the district's long-range plan, i.e. the Educational Plan for Student Success (EPSS). “A specific, measurable target for students to achieve” (pg.5).

The EPSS should be based upon extensive knowledge of the needs and abilities of a district's specific student population which can be obtained, in part, from general screening. For this reason, General Screening procedures are required and should be in use in all public school districts in New Mexico.
http://ped.state.nm.us/ped/PrioritySchoolsIndexWebEPSS.html

School Health Services 6.29.1.11.E
“E. School health. School health programs provide opportunities for all students to develop healthy behaviors. Districts and charter schools shall provide or make provisions for school health programs that address the health needs of students and staff. Districts and charter schools shall provide the following programs: health education, physical education, health services and school counseling. Additional programs may include: nutrition, staff wellness, family-school-community partnerships, healthy environment and psychological services. These programs shall:

1. be in accordance with Section 22-10A-34 and Section 24-5-1 through 24-5-6 NMSA 1978;
2. provide education and skill development program offerings;
3. provide community partnerships which help to achieve the goal of healthy students and staff;
4. be assessed as part of the EPSS process; and
5. support the local curriculum and EPSS.”

http://www.nmcpr.state.nm.us/NMAC/parts/title06/06.029.0001.htm

School Health Support Services 6.29.1.11.H

“H. Support services. Districts and charter schools shall provide support service programs which strengthen the instructional program. Required support service programs are: library media, school counseling and health services. Support services shall:

1. have a written, delivered and assessed program, K-12;
2. provide licensed staff to develop and supervise the program;
3. be assessed as part of the EPSS process; and
4. support the local curriculum and EPSS.”

http://www.nmcpr.state.nm.us/NMAC/parts/title06/06.029.0001.htm

STUDENT ASSISTANCE TEAM (SAT)

Tier 2—The Student Assistance Team (SAT) process

“In New Mexico, the focus of Tier 2 is to provide targeted, supplemental, and individualized support through the SAT process for students who are at-risk academically or behaviorally, or those exceeding expectations and for whom Tier 1 instruction and universal interventions prove insufficient” New Mexico Public Education Department: SAT and the Three-Tier Model of Student Intervention (pg.9).

The SAT addresses problems identified through general screening or as concerns by parents, teachers or other school staff. It designs interventions for students who show need for individual consideration, focusing on student strengths that may alleviate or resolve the need for intervention prior to referral for a multidisciplinary evaluation. In many cases, the SAT is able to assist students who need interventions in order to succeed, but who are not necessarily disabled and, therefore, do not qualify for special education or Section 504 accommodations. However, in New Mexico, the SAT may also serve as the Section 504 Team for students who have a disability. The SAT also has responsibilities under state statutes for designing Academic Improvement Plans (AIPs) for students facing retention or who have been retained. Simply put, the SAT is a support group for the regular education teachers and students who need it.
New Mexico Public Education Department: SAT and the Three-Tier Model of Student Intervention, pg.43

SECTION 504 TEAM AND ACCOMMODATION PLAN

Section 504 is federal civil rights law under the Rehabilitation Act of 1973. The U.S. Department of Education’s Office for Civil Rights (OCR) administers Section 504—not the State. Section 504 is the other service option available to students with disabilities, but who are not eligible and/or already receiving special education services under the eligibility requirements of the IDEA (Tier 3). It is designed to provide equal access and fairness in general education to students with disabilities, thereby leveling the playing field for them. Under New Mexico’s three-tier model of student intervention, a Section 504 Plan is a Tier 2 service and/or support.

Under this federal law, the school is responsible for managing and funding this program/service. A student is eligible and entitled to a Section 504 Accommodation Plan if an evaluation shows that the individual has a mental or physical impairment that substantially limits one or more major life activities and substantially affects the student’s overall performance in school.

—Best Practice—

Even if a district/school has fewer than 15 employees, they should appoint a Section 504/ADA Coordinator.

All schools and public agencies must comply with the following seven requirements:

1. Provide written assurances of nondiscrimination when applying for federal funds.
2. Take steps to eliminate discrimination against individuals with disabilities.
3. Appoint a 504/ADA Coordinator for local educational agencies with 15 or more employees to coordinate efforts to comply with this law.
4. Develop an ongoing process to locate and identify children who are not receiving services.
5. Provide public notice regarding nondiscrimination and responsibilities.
6. Develop a grievance procedure.
7. Conduct a self-evaluation of their programs and activities to ensure facilities are accessible and discriminatory practices are eliminated.

Three Required Elements of Section 504

1. The identification process for 504 is not the first step in determining the needs of students. The first step begins with the school’s Student Assistance Team (SAT) process who determines if the student has a need that warrants evaluation.
2. The determination of impairment must limit a major life activity.
3. Limitation on the major overall life activity must be substantial, not mild or moderate.
Example of a 504 Plan for a student with Special Health Care Needs:

ASTHMA

EXAMPLE: A student has been diagnosed as having asthma. The disability limits the major life activity of breathing.

Possible Accommodations

- Develop health care and emergency plan.
- Modify activity level for recess, physical education, etc.
- Use air purifier or inhalants.
- Provide inhalant therapy assistance.
- Administer medication as prescribed.
- Provide homebound instruction.
- Remove allergens—e.g., hairspray, lotions, perfumes, pine trees, carpet.
- Make field trips non-mandatory and supplement with videos, audios, movies, etc.
- Accommodate medical absence; arrange transportation to home/clinic.
- Provide education to peers/teachers/others (bus drivers, cooks, etc.).
- Provide access to water, gum, etc.
- Provide curriculum considerations (science class, physical education, etc.)
- Provide alternatives, if individual misses an excessive amount of school.
- Have peers available to carry materials to and from classes (e.g., lunch tray, books).
- Provide rest periods.
- Make school health care needs known to appropriate staff.
- Modify field trip experiences.
- Provide indoor space for before and after school.
- Arrange for access to wheelchair for transition purposes.
- Have a locker location that is centralized and free of atmosphere changes.
- Reimburse parent for transportation costs or provide alternate transportation to and from school.
- Modify attendance policies.
- Modify certain learning activities.

New Mexico Public Education Department: Section 504 Guide pg.110
http://ped.state.nm.us/RtI/dl10/Section504.pdf

Section 504 and Individuals with Disabilities Education Improvement Act – The Role of the School Nurse

Tier 3—Special Education/Gifted

In New Mexico, the definition of Tier 3 is special education and related services for students with identified disabilities under the federal Individuals with Disabilities Education Act (IDEA) and the state criteria of gifted. Students formally referred to Tier 3 first receive (with written parental consent) a multidisciplinary evaluation to determine their need for services at this level. In making the eligibility determination for Tier 3, the educational diagnostian and the group of qualified professionals who makes the eligibility determination will take into account data from the student’s response to interventions tried and documented from Tiers 1 and 2.

Tier 3 Referral and the Multidisciplinary Evaluation Process
When an individual student is referred to the SAT because a concern is raised, the team members are responsible for collecting information about the student and forming a hypothesis about the possible factors contributing to the student’s difficulties academically and/or behaviorally.
PUBLIC EDUCATION DEPARTMENT HEALTH SERVICES CHECKLIST

This checklist provides an outline of the items that might be addressed when assess the quality of a school health program.

- Is the NM School Health Manual accessible to staff as a reference?
- Does the school nurse have access to the Web version of the NM School Health Manual? [http://nmschoolhealthmanual.org/](http://nmschoolhealthmanual.org/)
- What does your school/district offer for access to Health Services? [http://www.nmcpr.state.nm.us/NMAC/parts/title06/06.029.0001.htm](http://www.nmcpr.state.nm.us/NMAC/parts/title06/06.029.0001.htm)
- What is completed for the assessment of the physical and health status of the child during the general screen process? Which kids are screened?
- How are general Immunization Records evaluated on new students?
  - (Reference NM Statutes 24-5-1 through 24-5-15)
    - [http://www.nmcpr.state.nm.us/nmac/parts/title06/06.012.0002.htm](http://www.nmcpr.state.nm.us/nmac/parts/title06/06.012.0002.htm)
    - [http://www.nmcpr.state.nm.us/nmac/parts/title07/07.005.0002.htm](http://www.nmcpr.state.nm.us/nmac/parts/title07/07.005.0002.htm)
- Were any Immunization Exemptions granted to students for medical or religious reasons?
- Do you have a Bloodborne Pathogens Plan? Are you providing annual training? (Training log should be kept at a minimum of 3 years.)
- Do teachers have access to personal protective equipment (PPE)?
  - (Reference-OSHA Standard 29 CFR 1910.1030 and Section XVI this Manual)
- How are Health Services contributing to the District EPSS plan?
HEALTH RECORD RETENTION

All student health records should be retained, regardless of media, for the period required by the agency's records retention program for any legal, user, historical or other purpose. Electronic files are subject to the same retention rules as hard-copy files.

TITLE 1 NM GENERAL GOVERNMENT ADMINISTRATION
CHAPTER 20 EDUCATIONAL RECORDS RETENTION AND DISPOSITION SCHEDULES (EDRRDS)
PART 2 New Mexico Public Schools
http://www.nmcpr.state.nm.us/nmac/_title01/T01C020.htm

SUBPART 9 Instructions

"Data processing and other machine readable records. Many paper records are being eliminated when the information has been placed on magnetic tapes, disks, or other data processing media. In these cases, the information on the data processing medium should be retained for the length of time specified in records retention and disposition schedules for paper records and should be subject to the same confidentiality and access restrictions as paper records. When the destruction of a record is required, all versions of said record shall be electronically over-written on machine readable media on which it is stored (or media destroyed). See also 1.13.70 NMAC: Performance Guidelines for the Legal Acceptance of Public Records Produced by Information Technology Systems."

1.20.2.101.D.1 Student Cumulative Education Record File
1.20.2.101.D.2 Student Health Records

http://www.nmcpr.state.nm.us/nmac/parts/title01/01.020.0002.htm

" Student health records. Record includes but is not limited to health history, immunization record, results and recommendations from examinations, screening, treatment, parent or guardian referral record, teachers comments, etc.: 10 years after date of last entry or until individual attains age 19, whichever is longer."

1.20.2.101.D.4 Other student records
1.20.2.113 Students Accidents and Illnesses
1.20.2.115 Athletic Program Records
1.20.2.407 Vehicle Accident Report File

CONFIDENTIALITY

Introduction

"Confidentiality is an abstract concept that is inextricably intertwined with the individual's 'right to privacy' and with communication and record-keeping practices in health care settings and schools….With respect to minors in school settings, these challenges can be confounding" [Schwab & Gelman (2001), p. 261]. The issues for school nurses surrounding confidentiality include what
constitutes student health information, who has a need to know, and why they need to know unless potential disclosure is discussed. 

The Federal Educational Rights and Privacy Act (FERPA) of 1974 established confidentiality standards and access rights to student records. The "right to privacy" implies the right to be left alone. Designation of certain personal information belongs to the individual, and that individual has the right to decide whether to disclose the information to others or not. The individual, on disclosure of personal information, has the right to expect that the information volunteered will not be further disclosed.

- Over 2000 years ago the ethical basis for confidentiality was established in the Hippocratic Oath and sworn by physicians to protect the privacy of patients. Confidentiality is the premise for developing a trusting relationship in which a client will feel free to divulge complete information in order to be provided the most accurate diagnosis and treatment. Fidelity addresses the issue of keeping promises or being faithful to the professional-client relationship. Fidelity requires health professionals to protect patient information from disclosure to others, except to members of the health care team working within the same agency who have a need to know in order to care for the patient.


**Confidentiality in School Health Services**

In the health care setting, there are situations when confidentiality might not be maintained. At any time if information a student has shared indicates the student is at imminent risk of endangering him/herself or others, that information must be shared with those who need to intervene in order to protect the student or others. Therefore, a statement from the school nurse in the nurse/student discussion should disclose to the student that any information will be kept confidential unless the nurse chooses to share it to protect the student or others from what she/he perceives to be harm.

In the school setting, the issue of “need to know” arises when other school personnel need to know confidential information in order to provide appropriate educational services beneficial to the student. However, care must be given as to how the information is shared and to what extent in order to maintain the student’s privacy.

Information provided teachers of students who may require accommodations or have the potential for life-threatening emergencies should be related to signs and symptoms, not necessarily a medical diagnosis. It is recommended that school nurses utilize nursing diagnoses when teaching staff about any student’s health problem. For example, two students might be labeled with asthma. While one of them rarely uses an inhaler, the other might be at high risk for respiratory distress and require frequent (on demand) inhaler use. It is more important to meet specific needs rather than treat the diagnosed condition generically. School staff members need to know how to recognize a health problem and what to do if that problem occurs.

School administrators should be given sufficient information about the health and safety needs of students to plan appropriate programs, ensure a safe environment, and provide adequate staff training. The school administrator should also be able to access emergency care plans for students in his/her buildings of responsibility.
**Written Informed Consent**

A parent/guardian of a minor may give written informed consent for personal health information to be shared with identified school personnel. The consent should specify what information will be shared and with whom. The expected outcomes and potential ramifications associated with written informed consent should also be discussed with the individual(s) giving consent. School districts may choose to define members of the health team and obtain a blanket written informed consent from the parent/guardian to allow disclosure of information on a "need to know" basis for these members. Many times this blanket consent is on the “Emergency Health Authorization Form”

“If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED, I understand that appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need. Nothing in this section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care. I authorize the school health office staff to contact my child’s providers listed above regarding medical management of my child. I understand information on this card will be shared with appropriate personnel on an as-needed basis only. I, also, understand health screenings (including vision, hearing, height, weight, blood pressure, and BMI) may be done by school health personnel unless I provide the school health office with written notification requesting exclusion from these screenings.”


**Protecting Confidential Student Health Information**

The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students."

The following guidelines were established by the National Task Force on Confidential Student Health Information in 2000. To protect confidential health information these guidelines are recommended for use by school nurses when creating and maintaining the student health record.

- **Guideline I:** Distinguish student health information from other types of school records.
- **Guideline II:** Extend to school health records the same protections granted medical records by federal and state law.
- **Guideline III:** Establish uniform standards for collecting and recording student health information.
Guideline IV: Establish district policies and standard procedures for protecting confidentiality during the creation, storage, transfer, and destruction of student health records.

Guideline V: Require written, informed consent from the parent and, when appropriate, the student to release medical and psychiatric diagnoses to other school personnel.

Guideline VI: Limit the disclosure of confidential health information within the school to information necessary to benefit students’ health or education.

Guideline VII: Establish policies and standard procedures for requesting needed health information from outside sources and for releasing confidential health information, with parental consent, to outside agencies and individuals.

Guideline VIII: Provide regular, periodic training for all new school staff, contracted service providers, substitute teachers, and school volunteers concerning the district’s policies and procedures for protecting confidentiality. National Task Force on Confidential Student Health Information. (2000)

http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNIssueBriefsFullView/tabid/445/ArticleId/78/Privacy-Standards-for-Student-Health-Records-2004

School District Policy

Go to http://www.nmschoolhealthmanual.org/resources/forms.htm, Section II for sample school district confidentiality policy form.

CONFIDENTIAL SERVICES FOR MINORS

CHAPTER 24 HEALTH AND SAFETY


ARTICLE 1 PUBLIC HEALTH

24-1-9. Capacity to consent to examination and treatment for a sexually transmitted disease. Any person regardless of age has the capacity to consent to an examination and treatment by a licensed physician for any sexually transmitted disease.


24-1-13. Pregnancy; capacity to consent to examination and diagnosis. Any person, regardless of age, has the capacity to consent to an examination and diagnosis by a licensed physician for pregnancy.


ARTICLE 8 FAMILY PLANNING

24-8-5. Prohibition against imposition of standards and requirements as prerequisites for receipt of requested family planning services.

Neither the state, its local governmental units nor any health facility furnishing family planning services shall subject any person to any
standard or requirement as a prerequisite to the receipt of any requested family planning service except for:

A. a requirement of referral to a physician when the requested family planning service is something other than information about family planning or nonprescription items;

B. any requirement imposed by law or regulation as a prerequisite to the receipt of a family planning service; or

C. payment for the service when payment is required in the ordinary course of providing the particular service to the person involved.


ARTICLE 10
CONSENT TO MEDICAL CARE; EMERGENCY CARE; TRANSFUSIONS

24-10-2. Consent for emergency attention by person in loco parentis.

Notwithstanding any other provision of the law, in cases of emergency in which a minor is in need of immediate hospitalization, medical attention or surgery and the parents of the minor cannot be located for the purpose of consenting thereto, after reasonable efforts have been made under the circumstances, consent for the emergency attention may be given by any person standing in loco parentis to the minor.


CHAPTER 32A
CHILDREN’S CODE
ARTICLE 6
CHILDREN’S MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES


A. Except as provided in Subsection B of this section, the informed consent of a child’s legal custodian shall be required before treatment or habilitation, including psychotherapy or psychotropic medications, is administered to a child under fourteen years of age.

B. A child under fourteen years of age may initiate and consent to an initial assessment with a clinician and for medically necessary early intervention service limited to verbal therapy as set forth in this section. The purpose of the initial assessment is to allow a clinician to interview the child and determine what, if any, action needs to be taken to ensure appropriate mental health or habilitation services are provided to the child. The clinician may conduct an initial assessment and provide medically necessary early intervention service limited to verbal therapy with or without the consent of the legal custodian if such service will not extend beyond two calendar weeks. If, at any time, the clinician has a reasonable suspicion that the child is an abused or neglected child, the clinician shall immediately make a child abuse and neglect report.

Consent for services; children fourteen years of age or older.

A. A child fourteen years of age or older is presumed to have capacity to consent to treatment without consent of the child's legal custodian, including consent for individual psychotherapy, group psychotherapy, guidance counseling, case management, behavioral therapy, family therapy, counseling, substance abuse treatment or other forms of verbal treatment that do not include aversive interventions. Nothing in this section shall be interpreted to provide a child fourteen years of age or older with independent consent rights for the purposes of the provision of special education and related services as set forth in federal law.

B. Psychotropic medications may be administered to a child fourteen years of age or older with the informed consent of the child. When psychotropic medications are administered to a child fourteen years of age or older, the child's legal custodian shall be notified by the clinician.

C. A clinician or other mental health and developmental disabilities professional shall promote the healthy involvement of a child's legal custodians and family members in developing and implementing the child's treatment plan, including appropriate participation in treatment for children fourteen years of age or older. However, nothing in this section shall limit the rights of a child fourteen years of age or older to consent to services and to consent to disclosure of mental health records.

History: Laws 2007, ch. 162, § 15

Consent for services; determination of capacity for children fourteen years of age or older.

A. When a child fourteen years of age or older has been determined according to the provisions of this section to lack capacity, the child's legal custodian may make a mental health or habilitation decision for the child unless the child objects to such decision or the legal custodian's assumption of authority to make mental health or developmental disability treatment decisions or determination of lack of capacity.

(1) permits a legal custodian to consent to placement of a child in a residential treatment or habilitation program without the proper consent of the child if the child is fourteen years of age or older; or

(2) in any way, limits a child's right to involuntary commitment procedures as set forth in the Children's Mental Health and Developmental Disabilities Act.

B. The determination that a child fourteen years of age or older lacks or has recovered capacity shall be made by two clinicians, one of whom shall be a person who works with children in the ordinary course of that clinician's practice.

C. A child fourteen years of age or older shall not be determined to lack capacity solely on the basis that the child chooses not to accept the
treatment recommended by the mental health or developmental disabilities professional.

D. A child fourteen years of age or older may at any time contest a determination that the child lacks capacity by a signed writing or by personally informing a clinician that the determination is contested. A clinician who is informed by a child that such determination is contested shall promptly communicate that the determination is contested to any supervising provider or institution at which the child is receiving care. Such a challenge shall prevail unless otherwise ordered by the court in a proceeding brought pursuant to the treatment guardianship provisions of the Children’s Mental Health and Developmental Disabilities Act.

E. A determination of lack of capacity under the Children's Mental Health and Developmental Disabilities Act shall not be evidence of incapacity for any other purpose.

F. The legal custodian shall communicate an assumption of authority as promptly as practicable to the child fourteen years of age or older and to the clinician and to the supervising mental health or developmental disability treatment and habilitation provider.

G. If more than one legal custodian assumes authority to act as an agent, the consent of both shall be required for nonemergency treatment. In an emergency, the consent of one legal custodian is sufficient, but the treating mental health professional shall provide the other legal custodian with oral notice followed by written documentation.

H. If more than one legal custodian assumes authority to act as an agent and the legal custodians do not agree on a nonemergency mental health treatment decision and the clinician is so informed, the clinician shall not treat the child unless a treatment guardian is appointed pursuant to the provisions of the Children's Mental Health and Developmental Disabilities Act.

I. A legal custodian shall make treatment decisions in accordance with a child's individual instructions, if any, and other wishes to the extent known to the legal custodian. Otherwise, the legal custodian shall make decisions in accordance with the legal custodian's determination of the child's best interests. In determining the child's best interests, the legal custodian shall consider the child's personal values to the extent known to the legal custodian.

J. A mental health treatment decision made by a legal custodian for a child fourteen years of age or older who has been determined to lack capacity shall not be made solely on the basis of the child's pre-existing physical or medical condition or pre-existing or projected disability.

K. A mental health treatment decision made by a legal custodian for a child fourteen years of age or older who has been determined to lack capacity is effective without judicial approval unless contested by the child.
L. If no legal custodian or agent is reasonably available to make mental health or habilitation decisions for the child, any interested party may petition for the appointment of a treatment guardian.
History: Laws 2007, ch. 162, § 16.

Summary of NM Statutes/Rules of Confidential Services for Minors

Go to http://www.nmschoolhealthmanual.org/resources/forms.htm, Section II for a summary of the NM statutes and administrative code regarding confidential services for minors.

DOCUMENTATION

Introduction

“Documentation is critical to the development and maintenance of school health service programs. It is essential to the practice of nursing and a fundamental component of the nursing process” (Schwab & Gelman (2001), p. 157).

Rationale for Documentation in School Nursing

- Through documentation a standard of care demonstrated by the school nurse’s intervention is shown to be reasonable and prudent.
- Documentation is a means of communication between the school nurse and other health care providers regarding the care delivered and/or the plan developed for student care.
- Documentation verifies use of the nursing process in delivering care.
- Documentation provides a basis for evaluating the accuracy of nursing diagnoses and the effectiveness of the school health program.
- Data collection from documentation can provide statistical information for research and funding opportunities.
- Documentation can protect the school nurse regarding risk management issues.

Student Health Record

In general, each student health record should contain the following pieces of documentation and information.
- Health history
- Health screening results—-hearing/vision/height/weight/immunizations
- Chronic conditions/diagnoses/problem list
- Emergency information/contact/health care provider list
- Progress notes
- Appropriate Individual Health Plan/Individual Emergency Management Plan (IHP/EMP)

In the school nurse’s role as guardian of the health record, listed below are some ground rules that he/she may consider when creating and while maintaining the record.
By law, the parent/guardian has the right to review his/her child’s health record with the exception of records for confidential services. (See this Section.)

No health information may be released without express consent of parent/guardian unless a student has attained the age of 18 years or is emancipated.

Daily logs that contain student identifiers and to which other individuals have access violate privacy acts.

Abbreviations approved by a recognized body of nursing may be used in charting but should be re-evaluated periodically for accuracy.

Even if a child appears not to be ill/injured, his/her actions should be documented in progress notes e.g., "he is laughing, playing with other students, talkative, etc."

Documentation should include what the nurse observed e.g., "hallucination: with ear to wall spoke with someone he called his booking agent."

Progress notes should be non-judgmental e.g., “mother reports no history of...” instead of “mother denies…”

"Will, never, always, shall, must” are inappropriate words for use in nursing documentation.

Documentation should contain exactly what is said in quotations; paraphrasing is not a quote.

Documentation forms should have a policy/procedure/directive for their use.

The health record follows a student throughout his/her public school career and should contain the documents required by the Public Education Department (PED). It is maintained by the school district until such time when it may be disposed of as directed by PED or school district policy. (See Section II)

It is the responsibility of the parent/guardian to provide updated and correct contact phone numbers to the school health office as well as the school administrative office.

A school nurse is not responsible for providing health services assigned at an Individual Education Plan unless he/she is present to give consent.

**Health Room Visit Documentation**

A description of each health room visit should be reflected in the student health record. The following inclusions in the documentation will help guide the school nurse toward completion of an adequate report of the visit.

- Document frequency and length of visits.
- Document re-assessment each time it occurs. With recurrent visits, document symptoms to demonstrate a pattern. Document gut-level feelings.
- Use the concept of "FACT" when documenting.
  - F actual
  - A accurate
  - C complete and comprehensive
  - T timely
- Complete documentation on the day of occurrence.
- Do not provide care or discontinue assessment if, in one’s professional opinion, needed medical information is lacking to arrive at a diagnosis.
- Show that a health history was taken before care was provided.
• Assure that the plan of care reflects appropriate health history and health screen(s).
• Document the method used to notify parent/guardian of the student’s health office visit e.g., by phone (emergency or need to pick up) or in writing (routine visit).
• Document what information is sent home with the student for exchange with the parent/guardian; however, the school is not responsible for assuring that information exchange occurs between the student and parent/guardian as requested.
• Failure to document delivery of nursing services violates the nurse practice act.

Consistency in Documentation
The health record is an information management document for the student throughout his/her school career. Consistency is the key to organization, continuity and accuracy. Likewise, all forms and documentation should have a signature and/or initials of the care giver and the name of the student. Any medication log sheets should contain a space for physician order, date, prescription changes as well as a comment section. The same health record forms should be used in the same manner for the same purpose in all schools within a school district.

Sign-in/Documentation Logs
Unless maintained without known patient identifiers, sign-in logs and patient activity logs may infringe upon patient confidentiality rights. Computerized logs may be acceptable if access is limited to identified individuals with a need to know.

Documentation Tools
Go to http://www.nmschoolhealthmanual.org/resources/forms.htm, Section II for sample forms and memos for school health record maintenance. These samples include the following.

• Health Records
• Sick Child Memo – English
• Sick Child Memo – Spanish
• Injured Child Memo – English
• Injured Child Memo – Spanish
• Vision Screening
• Hearing Screening
ADVERSE EVENTS REPORTING

Introduction
In New Mexico, the Department of Health (DOH) Regional Health Officers (RHO) are charged by state statute with oversight responsibilities of all school health personnel, except physical education staff.

Section 24-1-4(D) NMSA reads as follows. “All school health personnel, except physical education personnel, are under the direct supervision and control of the district health officer in their district. They shall make such reports relating to public health as the district health officer in their district requires.”

Section 24-1-3(G) NMSA states that DOH has the authority to “prescribe the duties of public health nurses and school nurses.”

In 2004 public health districts in New Mexico were reconfigured and renamed “Regions.” The district health officers became Regional Health Officers at that time; however, they maintain the power and authority of district officers for statutory purposes.

Adverse Events Reporting Process
Adverse events related to the health and safety of students occur frequently in the school setting, some posing more dangerous situations than others. In their role of supervising school nurses, the RHOs have identified certain events that they deem important for school nurses to report to the RHO in their respective public health Regions.

Reportable Adverse Events
The school nurse or the school nurse leader/supervisor of the school district is required to report the following adverse events to the public health Regional Health Officer or School Health Advocate in his/her respective Public Health Region. Reporting should occur within 24 hours in the event of (1) or (2) or within 3 working days in the event of (3), (4), (5), (6) or (7) below.

1. Any death of a student or staff member that occurs during school hours or on school grounds.

2. Any known suicide attempt (including completed or suspected) of a student, including those occurring after hours or during school vacation.

3. Any delivery of an infant on school grounds.

4. Any medication error as the result of a school nurse or other school staff action that requires an ambulance to be called or requires the student to be transported to an emergency room or urgent care facility.

5. Any error involving vaccine administration

6. Any untoward event with the potential of impacting physical or mental health of the school community.

7. Administration of emergency medication resulting in activation of EMS:
   - ☐ prescribed or ☐ stock
   - Specify medication: ____________________________________________
PROTOCOL FOR REPORTING ADVERSE EVENTS

Should a school nurse have knowledge of any of the above listed adverse events occurring in the school/school district in which he/she provides services, that nurse or the school nurse leader/supervisor of the school district is required to report the event(s) to the local RHO or SHA by phone, fax or email. A faxed or emailed report should be followed as soon as possible by a phone call to alert the RHO or SHA of the outstanding report. If there is a question regarding whether a situation should be reported the nurse should contact the Regional SHA.

Adverse Events Reporting Form

The reporting form can be found in Section II of the Resource Page of the Manual: http://nmschoolhealthmanual.org/forms/sectionII/Adverse_Event_Form_9_2015%20Final.pdf

The Adverse Events Form should be used for reporting all required adverse events so that the appropriate information is collected and provided for data collection and any follow-up action.

Notification Timeframe

Reporting of adverse events should occur within:

1. 24 hours in the event of (1) or (2) above and

2. 72 hours of the occurrence in the event of (3) (4) (5) (6) or (7). If the required reporting information is inconclusive within this timeframe, the event should still be reported with additional information to follow at a later time.
SPECIFIC SCHOOL HEALTH ISSUES

ACQUIRED IMMUNE DEFICIENCY SYNDROME
TITLE 6 PRIMARY AND SECONDARY EDUCATION
CHAPTER 12 PUBLIC SCHOOL ADMINISTRATION – HEALTH AND SAFETY
PART 2 Health Services
http://www.nmcpr.state.nm.us/nmac/parts/title06/06.012.0002.htm

STUDENT SAFETY (INCLUDING EYE SAFETY)
TITLE 6 PRIMARY AND SECONDARY EDUCATION
CHAPTER 30 EDUCATION STANDARDS – GENERAL REQUIREMENTS
PART 2 Standards of Excellence
SUBPART 10E Procedural Requirements
http://www.nmcpr.state.nm.us/nmac/_title06/T06C030.htm

TOBACCO FREE SCHOOL DISTRICTS
TITLE 6 PRIMARY AND SECONDARY EDUCATION
CHAPTER 12 PUBLIC SCHOOL ADMINISTRATION – HEALTH AND SAFETY
PART 4 Tobacco Free School Districts
http://www.nmcpr.state.nm.us/nmac/parts/title06/06.012.0004.htm

PESTICIDES
TITLE 6 PRIMARY AND SECONDARY EDUCATION
CHAPTER 30 EDUCATION AND STANDARDS – GENERAL REQUIREMENTS
PART 2 Standards of Excellence
SUBPART 10E(4) Procedural Requirements
http://www.nmcpr.state.nm.us/nmac/_title06/T06C030.htm

IMMUNIZATIONS (See Section IX this Manual.)

STUDENT’S RIGHTS TO SELF ADMINISTER CERTAIN MEDICATIONS
TITLE 6 PRIMARY AND SECONDARY EDUCATION
CHAPTER 12 PUBLIC SCHOOL ADMINISTRATION – HEALTH AND SAFETY
PART 2 Health Services
SUBPART 9 Student’s Rights to Self Administer Certain Medications
http://www.nmcpr.state.nm.us/nmac/parts/title06/06.012.0002.htm
DIABETES SELF-MANAGEMENT BY STUDENTS IN THE SCHOOL SETTING

TITLE 6 PRIMARY AND SECONDARY EDUCATION
CHAPTER 12 Public School, Administration – Health and Safety
PART 8 Diabetes Management for Students in the School Setting
http://www.nmcpr.state.nm.us/nmac/parts/title06/06.012.0008.htm

Diabetes Care Management & Training Resources
Go to http://www.nmschoolhealthmanual.org/resources/forms.htm, Section IV for training curriculum modules and guidelines for care management of students with diabetes in the school setting.

VISION SCREENING STATUTES

CHAPTER 22 PUBLIC SCHOOLS
ARTICLE 13 COURSE OF INSTRUCTION AND SCHOOL PROGRAMS
A school nurse or the nurse’s designee, a primary care health provider or a lay eye screener shall administer a vision screening test for students enrolled in the school in pre-kindergarten, kindergarten, first grade and third grade and for transfer and new students in those grades, unless a parent affirmatively prohibits the visual screening.

22-12-3.1. Excused absences for pregnant and parenting students.
A. Each school district and charter school shall maintain an attendance policy that:
   (1) provides ten days of excused absences for a student who provides documentation of the birth of the student's child; provided that the student shall be allowed a time period to make up the work that the student missed that equals the number of days the student was absent for the birth of a child; and
   (2) provides four days of excused absences for a student who provides appropriate documentation of pregnancy or that the student is the parent of a child under the age of thirteen needing care; and allows the student a time period to make up the work that the student missed that equals the number of days the student was absent.
B. The pregnant or parenting student is responsible for communicating the student's pregnancy and parenting status to the appropriate school personnel if the student chooses to disclose the information.
C. The school district or charter school shall provide a copy of the pregnant and parenting student absence policies to all students in middle, junior high and high schools. History: Laws 2013, ch. 198, § 1.

CHAPTER 24 HEALTH AND SAFETY
ARTICLE 1 PUBLIC HEALTH
24-1-31 Save our children's sight fund created
Notice of the need for further vision evaluation and availability of funds.


Save our children’s sight fund option


Vision Screening Standards

Go to http://www.nmschoolhealthmanual.org/resources/forms.htm, Section II for Standards for Vision Screening in New Mexico Schools approved by the NM Department of Health Secretary.

http://www.nmcpr.state.nm.us/nmac/parts/title07/07.030.0010.htm
http://www.nmcpr.state.nm.us/nmac/parts/title07/07.030.0011.htm

NEW MEXICO PUBLIC HEALTH ACT

PUBLIC HEALTH AND SAFETY

CHAPTER 24  HEALTH AND SAFETY

ARTICLE 1  PUBLIC HEALTH
http://statutes.laws.com/new-mexico/chapter-24/article-1

SECTION 3  Powers and authority of department

SECTION 4  Creation of health districts

SECTION 9  Capacity to consent to examination and treatment for a sexually transmitted disease

SECTION 9-3  Sexually transmitted diseases; mandatory counseling

SECTION 9-4  Sexually transmitted diseases; confidentiality

SECTION 9-5  Sexually transmitted diseases; disclosure statement

SECTION 13  Pregnancy; capacity to consent to examination and diagnosis

SECTION 15  Reporting of contagious diseases
ARTICLE 8  FAMILY PLANNING

SECTION 4  Prohibition against interference with medical judgment of physicians

SECTION 5  Prohibition against imposition of standards and requirements as prerequisites for receipt of requested family planning services

SECTION 6  Health facility licensure

ARTICLE 10  CONSENT TO MEDICAL CARE; EMERGENCY CARE; TRANSFUSIONS

SECTION 1  Emancipated minors; hospital, medical and surgical care
http://statutes.laws.com/new-mexico/chapter-24/article-10/section-24-10-1

SECTION 2  Consent for emergency attention by person in loco parentis

PUBLIC HEALTH AUTHORITY FOR SCHOOL HEALTH OFFICES
See http://www.nmschoolhealthmanual.org/resources/forms.htm, Section II for letter from NM Secretary of Health granting school health offices public health authorization in the exchange of immunization information.

NEW MEXICO CHILDREN’S CODE

CHAPTER 32A  CHILDREN’S CODE

ARTICLE 4  CHILD ABUSE AND NEGLECT
32A-4-3.  Duty to report child abuse and child neglect; responsibility to investigate child abuse or neglect; penalty.

A. Every person, including a licensed physician; a resident or an intern examining, attending or treating a child; a law enforcement officer; a judge presiding during a proceeding; a registered nurse; a visiting nurse; a schoolteacher; a school official; a social worker acting in an official capacity; or a member of the clergy who has information that is not privileged as a matter of law, who knows or has a reasonable suspicion that a child is an abused or a neglected child shall report the matter immediately to:

(1) a local law enforcement agency;
(2) the department; or
(3) a tribal law enforcement or social services agency for any Indian child residing in Indian country.
B. A law enforcement agency receiving the report shall immediately report by telephone to the department and shall transmit the same information in writing within forty-eight hours. The department shall immediately transmit the facts of the report and the name, address and phone number of the reporter by telephone to a local law enforcement agency and shall transmit the same information in writing within forty-eight hours. The written report shall contain the names and addresses of the child and the child's parents, guardian or custodian, the child's age, the nature and extent of the child's injuries, including any evidence of previous injuries, and other information that the maker of the report believes might be helpful in establishing the cause of the injuries and the identity of the person responsible for the injuries. The written report shall be submitted upon a standardized form agreed to by the law enforcement agency and the department.

C. The recipient of a report under Subsection A of this section shall take immediate steps to ensure prompt investigation of the report. The investigation shall ensure that immediate steps are taken to protect the health or welfare of the alleged abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect. A local law enforcement officer trained in the investigation of child abuse and neglect is responsible for investigating reports of alleged child abuse or neglect at schools, daycare facilities or child care facilities.

D. If the child alleged to be abused or neglected is in the care or control of or in a facility administratively connected to the department, the report shall be investigated by a local law enforcement officer trained in the investigation of child abuse and neglect. The investigation shall ensure that immediate steps are taken to protect the health or welfare of the alleged abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect.

E. A law enforcement agency or the department shall have access to any of the records pertaining to a child abuse or neglect case maintained by any of the persons enumerated in Subsection A of this section, except as otherwise provided in the Abuse and Neglect Act.

F. A person who violates the provisions of Subsection A of this section is guilty of a misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978.


32A-6A-6. Rights related to treatment and habilitation; scope.

The rights set forth in the Children's Mental Health and Developmental Disabilities Act shall apply to a child who is physically present and receiving treatment or habilitation services in New Mexico. A child who receives treatment or habilitation services shall have rights with respect to such treatment or habilitation, regardless of where services are provided.
Right to individualized treatment or habilitation services and plan.

A. A child receiving mental health or habilitation services shall have the right to prompt treatment and habilitation pursuant to an individualized treatment plan and consistent with the least restrictive means principle.

B. A preliminary treatment plan shall be prepared within seven days of initial provision of mental health or habilitation services.

C. An individualized treatment or habilitation plan shall be prepared within twenty-one days of the provision of mental health or habilitation services.

D. The individualized treatment or habilitation plan shall be developed by the child’s treatment team. The child and the child’s legal custodian and parent shall, to the maximum extent possible, be involved in the preparation of the child’s individualized treatment or habilitation plan.

E. An individualized treatment or habilitation plan shall include:
   (1) a statement of the nature of the specific problem and the specific needs of the child;
   (2) a statement of the least restrictive conditions necessary to achieve the purposes of treatment or habilitation;
   (3) a description of intermediate and long-range goals, with the projected timetable for their attainment;
   (4) a statement and rationale for the plan of treatment or habilitation for achieving these intermediate and long-range goals;
   (5) specification of staff responsibility and a description of the proposed staff involvement with the child in order to attain these goals;
   (6) criteria for release to less restrictive settings for treatment or habilitation, criteria for discharge and a projected date for discharge; and
   (7) provision for access to cultural practices and traditional treatments in accordance with the child’s assessed needs, and for an Indian child, culturally competent placement, treatment and practices and, after appropriate consent, tribal consultation.

F. A treatment or habilitation plan for a child in an out-of-home treatment or habilitation program shall be based on documented assessments that may include assessments of mental status; intellectual function; psychological status, including the use of psychological testing; psychiatric evaluation and medication; education, vocation, psychosocial assessment, physical status and the child’s cultural needs.

G. The child’s progress in attaining the goals and objectives set forth in the individualized treatment or habilitation plan shall be monitored and noted in the child’s records, and revisions in the plan may be made as circumstances require. The members of the child’s treatment team shall be informed of major changes and shall have the opportunity to participate in decisions.
Personal rights of a child in an out-of-home treatment or habilitation program; scope.

A. A child in an out-of-home treatment or habilitation program shall have, in addition to other rights set forth in the Children's Mental Health and Developmental Disabilities Act, the right to:

(1) be placed in a manner consistent with the least restrictive means principle;

(2) have access to the state's designated protection and advocacy system and access to an attorney of the child's choice, provided that the child is not entitled to appointment of an attorney at public expense, except as otherwise provided in Subsection C of Section 13 [32A-6A-13 NMSA 1978] of the Children's Mental Health and Developmental Disabilities Act;

(3) receive visitors of the child's own choosing on a daily basis, subject to restrictions imposed in the best interests of the child by the child's clinician for good cause. Hours during which visitors may be received shall be limited only in the interest of effective treatment and the reasonable efficiency of the program and shall be sufficiently flexible to accommodate the individual needs of the child and the child's visitors. Notwithstanding the provisions of this subsection, each child has the right to receive visits from the child's attorney, physician, psychologist, clergy, guardian ad litem, representatives from the state's protection and advocacy system or children, youth and families department in private at any reasonable time, irrespective of visiting hours, provided the visitor shows reasonable cause for visiting at times other than normal visiting hours;

(4) have writing materials and postage stamps reasonably available for the child's use in writing letters and other communications. Reasonable assistance shall be provided for writing, addressing and posting letters and other documents upon request. The child has the right to send and receive sealed and uncensored mail. The child has the right to reasonable private access to telephones and, in cases of personal emergencies when other means of communication are not satisfactory, the child shall be afforded reasonable use of long distance calls; provided that for other than mail or telephone calls to a court, an attorney, a physician, a psychologist, a clergy, a guardian ad litem, a representative from the state's protection and advocacy system or a social worker, mailing or telephone privileges may be restricted by the child's clinician for good cause shown. A child who is indigent shall be furnished writing, postage and telephone facilities without charge;

(5) reasonable access to a legal custodian and a family member through visitation, videoconferencing, telephone access and opportunity to send and receive mail. In-person-visititation is preferred.
and reasonable efforts shall be made to facilitate such visitation unless the child and family choose otherwise. Access by legal custodians and family members to the child shall be limited only in the interest of effective treatment and the reasonable efficiency of the program and shall be sufficiently flexible to accommodate the individual needs of legal custodians and family members. Treatment needs that justify limitation on the access rights of a legal custodian or family member must be specifically documented by the clinician in the child's record and any such limitation automatically expires in seven days;

(6) follow or abstain from the practice of religion. The program shall provide appropriate assistance in this connection, including reasonable accommodations for religious worship and transportation to nearby religious services. A child who does not wish to participate in religious practice shall be free from pressure to do so or to accept religious beliefs;

(7) a humane psychological and physical environment. The child shall be provided a comfortable bed and adequate changes of linen and reasonable secure storage space for personal possessions. Except when curtailed for reasons of safety or therapy as documented in the child's record by the child's physician, the child shall be afforded reasonable privacy in sleeping and personal hygiene practices;

(8) reasonable daily opportunities for physical exercise and outdoor exercise and reasonable access to recreational areas and equipment, including equipment adapted to the child's developmental and physical needs

(9) a nourishing, well-balanced, varied and appetizing diet;

(10) prompt and adequate medical attention for a physical ailment. Each child shall receive a complete physical examination upon admission, except when documentation is provided that the child has had such examination within the six months immediately prior to the current admission. Each child shall receive a complete physical examination every twelve months thereafter;

(11) a clean, safe and comfortable environment in a structure that complies with applicable fire and safety requirements;

(12) appropriate medication and freedom from unnecessary or excessive medication. Medication shall not be used as discipline, as a substitute for programs, for the convenience of staff or in quantities that interfere with the child's treatment or habilitation program. No medication shall be administered unless by written order of a clinician licensed to prescribe medication or by an oral order noted immediately in the patient's medical record and signed by that clinician within twenty-four hours. All prescriptions for psychotropic
medications must be reviewed at least every thirty days. Notation of each child’s medication shall be kept in the child’s medical records and shall include a notation by the clinician licensed to prescribe medication of the behavioral or symptomatic baseline data upon which the medication order was made; and

(13) a free public education. The child shall be educated in regular classes with nondisabled children whenever appropriate. In no event shall a child be allowed to remain in an out-of-home treatment or habilitation program for more than ten days without receiving educational services. If the child’s placement in an out-of-home treatment or habilitation program is required by an individualized education plan that conforms to the requirements of state and federal law, the sending school is responsible for the provision of education to the child. In all other situations, the local school district in which the out-of-home treatment or habilitation program is located is responsible for the provision of educational services to the child. Nothing in this subsection shall limit a child’s right to public education under state, tribal or federal law.

B. A child receiving services in an out-of-home treatment or habilitation program, including but not limited to residential treatment or habilitation programs, shall be provided notice of rights immediately upon admission to such program.


ARTICLE 6A

CHILDREN’S MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

Consent for services; children under fourteen years of age.

A. Except as provided in Subsection B of this section, the informed consent of a child’s legal custodian shall be required before treatment or habilitation, including psychotherapy or psychotropic medications, is administered to a child under fourteen years of age.

B. A child under fourteen years of age may initiate and consent to an initial assessment with a clinician and for medically necessary early intervention service limited to verbal therapy as set forth in this section. The purpose of the initial assessment is to allow a clinician to interview the child and determine what, if any, action needs to be taken to ensure appropriate mental health or habilitation services are provided to the child. The clinician may conduct an initial assessment and provide medically necessary early intervention service limited to verbal therapy with or without the consent of the legal custodian if such service will not extend beyond two calendar weeks. If, at any time, the clinician has a reasonable suspicion that the child is an abused or neglected child, the clinician shall immediately make a child abuse and neglect report.


Consent for services; children fourteen years of age or older.

A. A child fourteen years of age or older is presumed to have capacity to consent to treatment without consent of the child's legal custodian, including consent for individual psychotherapy, group psychotherapy, guidance counseling, case management, behavioral therapy, family therapy, counseling, substance abuse treatment or other forms of verbal treatment that do not include aversive interventions. Nothing in this section shall be interpreted to provide a child fourteen years of age or older with independent consent rights for the purposes of the provision of special education and related services as set forth in federal law.

B. Psychotropic medications may be administered to a child fourteen years of age or older with the informed consent of the child. When psychotropic medications are administered to a child fourteen years of age or older, the child's legal custodian shall be notified by the clinician.

C. A clinician or other mental health and developmental disabilities professional shall promote the healthy involvement of a child's legal custodians and family members in developing and implementing the child's treatment plan, including appropriate participation in treatment for children fourteen years of age or older. However, nothing in this section shall limit the rights of a child fourteen years of age or older to consent to services and to consent to disclosure of mental health records.

History: Laws 2007, ch. 162, § 15

Consent for services; determination of capacity for children fourteen years of age or older.

A. When a child fourteen years of age or older has been determined according to the provisions of this section to lack capacity, the child's legal custodian may make a mental health or habilitation decision for the child unless the child objects to such decision or the legal custodian's assumption of authority to make mental health or developmental disability treatment decisions or determination of lack of capacity. Nothing in this subsection:

(1) permits a legal custodian to consent to placement of a child in a residential treatment or habilitation program without the proper consent of the child if the child is fourteen years of age or older; or

(2) in any way, limits a child's right to involuntary commitment procedures as set forth in the Children's Mental Health and Developmental Disabilities Act.

B. The determination that a child fourteen years of age or older lacks or has recovered capacity shall be made by two clinicians, one of whom shall be a person who works with children in the ordinary course of that clinician's practice.

C. A child fourteen years of age or older shall not be determined to lack capacity solely on the basis that the child chooses not to accept the treatment recommended by the mental health or developmental disabilities professional.
D. A child fourteen years of age or older may at any time contest a determination that the child lacks capacity by a signed writing or by personally informing a clinician that the determination is contested. A clinician who is informed by a child that such determination is contested shall promptly communicate that the determination is contested to any supervising provider or institution at which the child is receiving care. Such a challenge shall prevail unless otherwise ordered by the court in a proceeding brought pursuant to the treatment guardianship provisions of the Children’s Mental Health and Developmental Disabilities Act.

E. A determination of lack of capacity under the Children’s Mental Health and Developmental Disabilities Act shall not be evidence of incapacity for any other purpose.

F. The legal custodian shall communicate an assumption of authority as promptly as practicable to the child fourteen years of age or older and to the clinician and to the supervising mental health or developmental disability treatment and habilitation provider.

G. If more than one legal custodian assumes authority to act as an agent, the consent of both shall be required for nonemergency treatment. In an emergency, the consent of one legal custodian is sufficient, but the treating mental health professional shall provide the other legal custodian with oral notice followed by written documentation.

H. If more than one legal custodian assumes authority to act as an agent and the legal custodians do not agree on a nonemergency mental health treatment decision and the clinician is so informed, the clinician shall not treat the child unless a treatment guardian is appointed pursuant to the provisions of the Children’s Mental Health and Developmental Disabilities Act.

I. A legal custodian shall make treatment decisions in accordance with a child’s individual instructions, if any, and other wishes to the extent known to the legal custodian. Otherwise, the legal custodian shall make decisions in accordance with the legal custodian’s determination of the child’s best interests. In determining the child’s best interests, the legal custodian shall consider the child’s personal values to the extent known to the legal custodian.

J. A mental health treatment decision made by a legal custodian for a child fourteen years of age or older who has been determined to lack capacity shall not be made solely on the basis of the child’s pre-existing physical or medical condition or pre-existing or projected disability.

K. A mental health treatment decision made by a legal custodian for a child fourteen years of age or older who has been determined to lack capacity is effective without judicial approval unless contested by the child.
L. If no legal custodian or agent is reasonably available to make mental health or habilitation decisions for the child, any interested party may petition for the appointment of a treatment guardian.

History: Laws 2007, ch. 162, § 16.

32A-6A-17. Treatment guardianship proceedings.

A. If no legal custodian is reasonably available to make mental health decisions for a child fourteen years of age or older who has been determined to lack capacity or if a clinician who proposes a course of treatment objects to a challenge made by the child to a determination of incapacity, the clinician shall request that the children's court attorney petition the court for appointment of a treatment guardian to make a substitute decision for the child.

B. In a treatment guardian proceeding, the court shall appoint an attorney for the child unless the child already has an attorney available.

C. A petition shall be served on the child and the child's attorney. A hearing on the petition shall be held within three business days. At the hearing, the child shall be represented by counsel and shall have the right to be present, to present witnesses and to cross-examine opposing witnesses.

D. If, after the hearing, the court finds that the child is not capable of making treatment decisions and treatment is needed, the court shall order the appointment of a treatment guardian. When appointing a treatment guardian, the court shall appoint the child's legal custodian unless the legal custodian is not readily available or the court finds that such an appointment is not in the child's best interests.

E. The treatment guardian shall make a decision on behalf of the child based on the treatment guardian's best judgment of whether the treatment appears to be in the child's best interests and is consistent with the least restrictive means principle for accomplishing the treatment objective. In making this decision, the treatment guardian shall consult with the child and consider the child's expressed opinions. The treatment guardian shall give consideration to previous decisions made by the child in similar circumstances when the child was able to make treatment decisions and shall make the decision in accordance with the values of the child if known, or in the best interests of the child if the values are not known; provided that, if the child has given an individual instruction that is available to the treatment guardian, the instruction shall be followed.

F. If a child who is not a resident of a residential treatment and habilitation program has a treatment guardian and refuses to comply with the decision of the treatment guardian, the treatment guardian may obtain an enforcement order. The enforcement order may authorize a peace officer to take the child into custody or to transport the child to an evaluation facility and may authorize the facility to forcibly administer treatment. The treatment guardian shall consult with the clinician who is proposing treatment, the child's attorney or guardian ad litem and, as deemed appropriate, interested friends or
relatives of the child. The evaluation facility shall comply with the treatment guardi

G. A child, physician or other professional wishing to contest the decision of the treatment guardian may do so by filing a petition with the court within three calendar days or the next business day, whichever is later, of receiving notice of the treatment guardian's decision. The child shall be represented by counsel in all proceedings before the court. The court may overrule the treatment guardian's decision if it finds that decision to be against the best interests of the child. The court shall rule within seven days of the filing of the petition.

H. If both a petition for an enforcement order and a petition to contest the treatment guardian's decision are filed, they shall be heard in the same proceeding at the same time.

I. When the court appoints a treatment guardian, it shall specify the length of time during which the treatment guardian may exercise treatment guardian powers, up to a maximum period of one year. If, at the end of the guardianship period, the treatment guardian believes that the child still lacks capacity, the treatment guardian shall petition the court for reappointment or for appointment of a new treatment guardian. The guardianship shall be extended or a new guardian shall be appointed only if the court finds the child does not have capacity to make treatment or habilitation decisions at the time of the hearing. The court shall appoint an attorney for the child, and the child shall have the right to be present and to present evidence at all such hearings.

J. If, during the period of a treatment guardian's power, the treatment guardian, the child, the treatment provider or a member of the child's family believes that the child has regained capacity, that person may petition the court for a termination of the treatment guardianship. If the court finds the child has regained capacity, it shall terminate the power of the treatment guardian and restore to the child the power to make treatment decisions.

K. A treatment guardian shall have only those powers enumerated in the Children's Mental Health and Developmental Disabilities Act.

L. If a clinician licensed to prescribe medication believes that the administration of psychotropic medication is necessary to protect the child from serious harm that could occur while the provisions of this section are being satisfied, the licensed clinician may order or administer the medication on an emergency basis. When medication is administered to a child on an emergency basis, the clinician shall prepare and place in the child's medical records a report explaining the nature of the emergency and the reason that no treatment less restrictive than administration of psychotropic medication without proper consent would have protected the child from serious harm. When medication is administered to a child on an emergency basis, the child's legal custodian and the child's attorney or guardian ad litem shall be notified by the residential treatment or habilitation program. If the child is
not in a residential setting, the clinician shall petition for a pickup order pursuant to Section 19 [32A-6A-19 NMSA 1978] of the Children's Mental Health and Developmental Disabilities Act and have the child transported to a residential facility where the medication will be administered.
History: Laws 2007, ch. 162, § 17.

**32A-6A-19.** Emergency mental health evaluation and care.

A. A peace officer may detain and transport a child for emergency mental health evaluation and care in the absence of a legally valid order from the court only if the peace officer:
   (1) has reasonable grounds to believe the child has just attempted suicide;
   (2) based upon personal observation and investigation, has reasonable grounds to believe that the child, as a result of a mental disorder, presents a likelihood of serious harm to self or others and that immediate detention is necessary to prevent such harm. The peace officer shall convey the peace officer's beliefs to the admitting physician or licensed psychologist immediately upon the officer's arrival at the evaluation facility;
   (3) has certification from a clinician that the child, as a result of a mental disorder, presents a likelihood of serious harm to self or others and that immediate intervention is necessary to prevent the harm; or
   (4) has an involuntary placement order issued by a tribal court that orders the child to be admitted to an evaluation facility.

B. A peace officer shall immediately transport a child detained under this section to an evaluation facility. In the case of an extreme emergency, the child may be held for a period of up to twenty-four hours in temporary emergency placement in:
   (1) a foster home licensed to provide specialized or therapeutic care;
   (2) a facility operated by a licensed child services agency that meets standards promulgated by the department for the care of children who present the likelihood of serious harm to themselves or others; and
   (3) residential care on an emergency basis.

C. A child shall not be held for the purposes of emergency mental health evaluation or care in a jail or other facility intended or used for the incarceration of adults charged with criminal offenses or for the detention of children alleged or adjudicated to be delinquent children.

D. The director of an evaluation facility shall accomplish an emergency evaluation upon the request of a child's legal custodian, a peace officer, a detention facility administrator or the administrator's designee or upon the certification of a clinician. A court order is not required under this section. If an application is made to a court, the court's power to act in furtherance of an emergency admission shall be limited to ordering that:
(1) the child be seen by a clinician prior to transport to an evaluation facility; and
(2) a peace officer transport the child to an evaluation facility.

E. The admitting physician or licensed psychologist shall evaluate whether reasonable grounds exist to detain the child for evaluation and treatment, and, if reasonable grounds are found, the child shall be detained. If the admitting physician or licensed psychologist determines that reasonable grounds do not exist to detain the child for evaluation and treatment, the child shall not be detained but shall be released to the custody of the child's legal custodian.

F. Upon arrival at an evaluation facility, the child shall be informed orally and in writing by the evaluation facility of the purpose and possible consequences of the proceedings, the allegations in the petition, the child's right to a hearing within seven days, the child's right to counsel and the child's right to communicate with an attorney or a guardian ad litem and an independent mental health professional of the child's own choosing. A child shall have the right to receive necessary and appropriate treatment.

G. A peace officer who transports a child to an evaluation facility pursuant to the provisions of this section shall not require a court order to be reimbursed by the referring county.

H. If a child is transported to or detained at an evaluation facility and is not released to the child's legal custodian, the peace officer transporting the child shall give written notice thereof as soon as possible within twenty-four hours to the child's legal custodian, together with a statement of the reason for taking the child into custody.


32A-6A-20. Consent to placement in a residential treatment or habilitation program; children younger than fourteen years of age.

A. A child younger than fourteen years of age shall not receive residential treatment for a mental disorder or habilitation for a developmental disability, except as provided in this section.

B. A child younger than fourteen years of age may be admitted to a residential treatment or habilitation program for a period not to exceed sixty days with the informed consent of the child's legal custodian, subject to the requirements of this section.

C. In order to admit a child younger than fourteen years of age to a residential treatment or habilitation program, the child's legal custodian shall knowingly and voluntarily execute a consent to admission document prior to the child's admission. The consent to admission document shall be in a form designated by the supreme court. The consent to admission document shall include a clear statement of the legal custodian's right to consent voluntarily to or refuse the child's admission, the legal custodian's right to request the child's immediate discharge from the residential treatment program at any
time and the legal custodian’s rights when the legal custodian requests the child’s discharge and the child’s physician, licensed psychologist or the director of the residential treatment or habilitation program determines that the child needs continued treatment. The residential treatment or habilitation program shall ensure that each statement is clearly explained in the child’s and legal custodian’s primary language, if that is their language of preference, and in a manner appropriate to the child’s and legal custodian’s developmental abilities. Each statement shall be initialed by the child’s legal custodian.

D. The legal custodian’s executed consent to admission document shall be filed with the child’s treatment records within twenty-four hours of the time of admission.

E. Upon the filing of the legal custodian’s consent to admission document in the child’s hospital records, the director of the residential treatment or habilitation program or the director’s designee shall, on the next business day following the child’s admission, notify the district court or the special commissioner appointed pursuant to Section 32A-6A-25 NMSA 1978 regarding the admission and provide the child’s name, date of birth and the date and place of admission. The court or special commissioner shall, upon receipt of notice regarding a child’s admission to a residential treatment or habilitation program, establish a sequestered court file.

F. The director of a residential treatment or habilitation program or the director’s designee shall, on the next business day following the child’s admission, petition the court to appoint a guardian ad litem for the child. When the court receives the petition, the court shall appoint a guardian ad litem.

G. Within seven days of a child’s admission to a residential treatment or habilitation program, a guardian ad litem, representing the child’s best interests and in accordance with the provisions of the Children’s Mental Health and Developmental Disabilities Act [32A-6A-1 NMSA 1978], shall meet with the child, the child’s legal custodian and the child’s clinician. The guardian ad litem shall determine the following:

1. whether the child’s legal custodian understands and consents to the child’s admission to a residential treatment or habilitation program;
2. whether the admission is in the child’s best interests; and
3. whether the admission is appropriate for the child and is consistent with the least restrictive means principle.

H. If a guardian ad litem determines that the child’s legal custodian understands and consents to the child’s admission and that the admission is in the child’s best interests, is appropriate for the child and is consistent with the least restrictive means principle, the guardian ad litem shall so certify on a form designated by the supreme court. The form, when completed by the guardian ad litem, shall be filed in the child’s patient record kept by the residential treatment or habilitation program, and a copy shall be forwarded...
to the court or special commissioner within seven days of the child's admission. The guardian ad litem's statement shall not identify the child by name.

I. On reaching the age of fourteen, a child who was admitted to a residential treatment or habilitation program pursuant to this section may petition the district court for the records of the district court regarding all matters pertinent to the child's admission to a residential treatment or habilitation program. The district court, upon receipt of the petition and upon a determination that the petitioner is in fact a child who was admitted to a residential treatment or habilitation program, shall provide all court records regarding the admission to the petitioner, including all copies in the court's possession, unless there is a showing that release of records would cause substantial harm to the child. Upon reaching the age of eighteen, a person who was admitted to a residential or treatment or habilitation program as a child may petition the district court for such records, and the district court shall provide all court records regarding the admission to the petitioner, including all copies in the court's possession.

J. A legal custodian who consents to admission of a child to a residential treatment or habilitation program has the right to request the child's immediate discharge from the residential treatment or habilitation program, subject to the provisions of this section. If a child's legal custodian informs the director, a physician or other member of the residential treatment or habilitation program staff that the legal custodian desires the child to be discharged from the program, the director, physician or other staff shall provide for the child's immediate discharge and remit the child to the legal custodian's care. The residential treatment or habilitation program shall also notify the child's guardian ad litem. A child whose legal custodian requests the child's immediate discharge shall be discharged, except when the director of the residential treatment or habilitation program, a physician or a licensed psychologist determines that the child requires continued treatment and that the child meets the criteria for involuntary residential treatment. In that event, the director, physician or licensed psychologist shall, on the first business day following the child's legal custodian's request for release of the child from the program, request that the children's court attorney initiate involuntary residential treatment proceedings. The children's court attorney may petition the court for such proceedings. The child has a right to a hearing regarding the child's continued treatment within seven days of the request for release.

K. A residential treatment or habilitation program shall review the admission of a child at the end of a sixty-day period after the date of initial admission, and the child's physician or licensed psychologist shall review the admission to determine whether it is in the best interests of the child to continue the admission. If the child's physician or licensed psychologist concludes that continuation of the residential treatment or habilitation program is in the child's best interests, the child's clinician shall so state in a form to be filed in the child's patient records. The residential treatment or habilitation program shall notify the guardian ad litem for the child at least seven days prior to the date that the sixty-day period is to end or, if necessary, request a guardian
ad litem pursuant to the provisions of the Children's Mental Health and Developmental Disabilities Act. The guardian ad litem shall then personally meet with the child, the child's legal custodian and the child's clinician and ensure that the child's legal custodian understands and consents to the child's continued admission to the residential treatment or habilitation program. If the guardian ad litem determines that the child's legal custodian understands and consents to the child's continued admission to the residential treatment or habilitation program, that the continued admission is in the child's best interest, that the placement continues to be appropriate for the child and consistent with the least restrictive means principle and that the clinician has recommended the child's continued stay in the program, the guardian ad litem shall so certify on a form designated by the supreme court. The disposition of these forms shall be as set forth in this section, with one copy going in the child's patient record and the other being sent to the district court in a manner that preserves the child's anonymity. This procedure shall take place every sixty days following the child's last admission or a guardian ad litem's certification, whichever occurs first.

L. When a guardian ad litem determines that the child's legal custodian does not understand or consent to the child's admission to a residential treatment or habilitation program, that the admission is not in the child's best interests, that the placement is inappropriate for the child or is inconsistent with the least restrictive means principle or that the child's clinician has not recommended a continued stay by the child in the residential treatment or habilitation program, the child shall be released or involuntary placement procedures shall be initiated.

M. If the child's legal custodian is unavailable to take custody of the child and immediate discharge of the child would endanger the child, the residential treatment or habilitation program may detain the child until a safe and orderly discharge is possible. If the child's legal custodian refuses to take physical custody of the child, the residential treatment or habilitation program shall refer the case to the department for an abuse and neglect or family in need of court-ordered services investigation. The department may take the child into protective custody pursuant to the provisions of the Abuse and Neglect Act [32A-4-1 NMSA 1978] or the Family in Need of Court-Ordered Services Act [32A-3B-1 NMSA 1978].


32A-6A-21. Voluntary residential treatment or habilitation for children fourteen years of age or older.

A. A child fourteen years of age or older shall not receive treatment for mental disorders or habilitation for developmental disabilities on a voluntary residential basis, except as provided in this section.

B. An admission of a child fourteen years of age or older to a residential treatment or habilitation program is voluntary when it is medically necessary and consented to by the child and the child's legal custodian as set forth in this section, provided that the admission does not exceed sixty days, subject to the requirements of this section.
C. To have a child voluntarily admitted to a residential treatment or habilitation program, the child and the child's legal custodian shall knowingly and voluntarily execute, prior to admission, a child's voluntary consent to admission document. The document shall include a clear statement of the child's right to voluntarily consent or to request an immediate discharge from the residential treatment or habilitation program at any time; and the child's rights when the child requests a discharge and the child's physician, licensed psychologist or the director of the residential treatment or habilitation program determines the child needs continued treatment. The residential treatment or habilitation program shall ensure that each statement is clearly explained in the child's and legal custodian's primary language, if that is their language of preference, and in a manner appropriate to the child's and legal custodian's developmental abilities, and each statement shall be initialed by the child and the child's legal custodian.

D. A child who is admitted on a voluntary basis has a right to an attorney. Prior to admission, the residential treatment or habilitation program shall inform the child's legal custodian of the child's right to an independent attorney within seventy-two hours. If the child's legal custodian is unable to obtain an independent attorney, the legal custodian may petition the court to appoint an attorney for the child. If the child's legal custodian obtains an independent attorney for the child, the legal custodian shall notify the residential treatment or habilitation program of that attorney's name within seventy-two hours of the child's voluntary admission.

E. The child's executed voluntary consent to admission document shall be filed in the child's treatment record within twenty-four hours of the time of admission.

F. Upon the filing of the child's voluntary consent to admission document in the child's treatment record, the director of the residential treatment or habilitation program or the director's designee shall, on the next business day following the child's admission, notify the district court or the special commissioner of the admission, giving the child's name, date of birth and the date and place of admission. Upon receipt of notice of a child's voluntary admission to a residential treatment or habilitation program, the court or special commissioner shall establish a sequestered court file.

G. If within seventy-two hours of the child's voluntary admission the child has not met with an independent attorney and the child’s legal custodian has not notified the residential treatment or habilitation program of the name of the child's independent attorney, the residential treatment or habilitation program shall during the next business day petition the court to appoint an attorney. When the court receives the petition, the court shall appoint an attorney.

H. If within seventy-two hours of the child's voluntary admission the child has met with an independent attorney or the child's legal custodian has notified the residential treatment or habilitation program of the name of the child's independent attorney, the residential treatment or habilitation program
shall during the next business day notify the court or the special commissioner of the name of the child's independent attorney.

I. Within seven days of the admission, an attorney representing the child pursuant to the provisions of the Children's Mental Health and Developmental Disabilities Act shall meet with the child. At the meeting with the child, the attorney shall explain to the child the following:

1. the child's right to an attorney;
2. the child's right to terminate the child's voluntary admission and the procedures to effect termination;
3. the effect of terminating the child's voluntary admission and options of the clinician and other interested parties to petition for an involuntary admission; and
4. the child's rights under the provisions of the Children's Mental Health and Developmental Disabilities Act, including the right to:
   a. legal representation;
   b. a presumption of competence;
   c. receive daily visitors of the child's choice;
   d. receive and send uncensored mail;
   e. have access to telephones;
   f. follow or abstain from the practice of religion;
   g. a humane and safe environment;
   h. physical exercise and outdoor exercise;
   i. a nourishing, well-balanced, varied and appetizing diet;
   j. medical treatment;
   k. educational services;
   l. freedom from unnecessary or excessive medication;
   m. individualized treatment and habilitation; and
   n. participation in the development of the individualized treatment plan and access to that plan on request.

J. If the attorney determines that the child understands the child's rights and that the child voluntarily and knowingly desires to remain as a patient in a residential treatment or habilitation program, the attorney shall so certify on a form designated by the supreme court. The form, when completed by the attorney, shall be filed in the child's patient record at the residential treatment or habilitation program, and a copy shall be forwarded to the court or special commissioner within seven days of the child's admission. The attorney's statement shall not identify the child by name.

K. Upon reaching the age of fourteen, a child who was a voluntary admittee to a residential treatment or habilitation program may petition the district court for the records of the court regarding all matters pertinent to the child's voluntary admission to a residential treatment or habilitation program. The court, upon receipt of the petition and upon a determination that the petitioner was in fact the child who was a voluntary admittee to a residential treatment or habilitation program, shall give all court records regarding the admission to the petitioner, including all copies in the court's possession unless there is a showing that provision of records would cause substantial harm to the child. A person who was admitted
to a residential or treatment or habilitation program as a child, upon reaching the age of eighteen, may petition the district court for such records and the district court shall provide all court records regarding the admission to the petitioner, including all copies in the court's possession.

L. Any child voluntarily admitted to a residential treatment or habilitation program has the right to an immediate discharge from the residential treatment or habilitation program upon the child's request, except as provided in this section. If a child informs the director, clinician or other member of the residential treatment or habilitation program staff that the child desires to be discharged from the voluntary program, the director, clinician or other staff member shall provide for the child's immediate discharge. The residential treatment or habilitation program shall not require that the child's request be in writing. Upon the request, the residential treatment or habilitation program shall notify the child's legal custodian to take custody of the child and remit the child to the legal custodian's care. The residential treatment or habilitation program shall also notify the child's attorney. If the child's legal custodian is unavailable to take custody of the child and immediate discharge of the child would endanger the child, the residential treatment or habilitation program may detain the child until a safe and orderly discharge is possible. If the child's legal custodian refuses to take physical custody of the child, the residential treatment or habilitation program shall refer the case to the department for an abuse and neglect or family in need of court-ordered services investigation. The department may take the child into protective custody pursuant to the provisions of the Abuse and Neglect Act [32A-4-1 NMSA 1978] or the Family in Need of Court-Ordered Services Act [32A-3B-1 NMSA 1978]. A child requesting immediate discharge shall be discharged, except in those situations when the director of the residential treatment or habilitation program, a physician or a licensed psychologist determines that the child requires continued treatment and that the child meets the criteria for involuntary residential treatment or habilitation services as otherwise provided under the Children's Mental Health and Developmental Disabilities Act. In that event, the director, physician or licensed psychologist, after making the determination, shall, on the first business day following the child's request for release from the voluntary program, request that the child's court attorney initiate involuntary placement proceedings. The child's court attorney may petition for such a placement. The child has a right to a hearing on the child's continued treatment within five days of the child's request for release.

M. A child who is voluntarily admitted to a residential treatment or habilitation program shall have the child's voluntary admission reviewed at the end of a sixty-day period from the date of the child's initial admission to the program. The review shall be accomplished by having the child's physician or licensed psychologist review the child's treatment and determine whether it would be in the best interests of the child to continue the voluntary admission. If the child's physician or licensed psychologist concludes that continuation of treatment is in the child's best interests, the child's clinician shall so state in a form to be filed in the child's patient record. The residential treatment or habilitation program shall notify the
child's attorney at least seven days prior to the date that the sixty-day period is to end or, if necessary, request an attorney pursuant to the provisions of the Children's Mental Health and Developmental Disabilities Act. The attorney shall then personally meet with the child and ensure that the child understands the child's rights as set forth in this section, that the child understands the method for voluntary termination of the child's admission and that the child knowingly and voluntarily consents to the child's continued treatment. If the attorney determines that the child understands these rights and that the child voluntarily and knowingly desires to remain in the residential treatment or habilitation program and that the clinician has recommended the continued stay in the program, the attorney shall so certify on a form designated by the supreme court. The disposition of these forms shall be as set forth in this section, with one copy going in the child's patient record and the other being sent to the district court in a manner that preserves the child's anonymity. This procedure shall take place every sixty days from the last admission or attorney's certification, whichever comes first.

N. If the attorney determines that the child does not voluntarily desire to remain in the program or if the child's clinician has not recommended continued stay by the child in the residential treatment or habilitation program, the child shall be released pursuant to the involuntary placement procedures set forth in this section and the Children's Mental Health and Developmental Disabilities Act shall be followed.


A. Except as otherwise provided in the Children's Mental Health and Developmental Disabilities Act, a person shall not, without the authorization of the child, disclose or transmit any confidential information from which a person well-acquainted with the child might recognize the child as the described person or any code, number or other means that could be used to match the child with confidential information regarding the child.

B. When the child is under fourteen years of age, the child's legal custodian is authorized to consent to disclosure on behalf of the child. Information shall also be disclosed to a court-appointed guardian ad litem without consent of the child or the child's legal custodian.

C. A child fourteen years of age or older with capacity to consent to disclosure of confidential information shall have the right to consent to disclosure of mental health and habilitation records. A legal custodian who is authorized to make health care decisions for a child has the same rights as the child to request, receive, examine, copy and consent to the disclosure of medical or other health care information when evidence exists that such a child whose consent to disclosure of confidential information is sought does not have capacity to give or withhold valid consent and does not have a treatment guardian appointed by a court. If the legal custodian is not authorized to make decisions for a child under the Children's Mental Health and Developmental Disabilities Act, the person seeking authorization shall
petition the court for the appointment of a treatment guardian to make a decision for such a child.

D. Authorization from the child or legal custodian for a child less than fourteen years of age shall not be required for the disclosure or transmission of confidential information when the disclosure or transmission:

(1) is necessary for treatment of the child and is made in response to a request from a clinician;
(2) is necessary to protect against a clear and substantial risk of imminent serious physical injury or death inflicted by the child on self or another;
(3) is determined by a clinician not to cause substantial harm to the child and a summary of the child's assessment, treatment plan, progress, discharge plan and other information essential to the child's treatment is made to a child's legal custodian or guardian ad litem;
(4) is to the primary caregiver of the child and the information disclosed was necessary for the continuity of the child's treatment in the judgment of the treating clinician who discloses the information;
(5) is to an insurer contractually obligated to pay part or all of the expenses relating to the treatment of the child at the residential facility. The information disclosed shall be limited to data identifying the child, facility and treating or supervising physician and the dates and duration of the residential treatment. It shall not be a defense to an insurer's obligation to pay that the information relating to the residential treatment of the child, apart from information disclosed pursuant to this section, has not been disclosed to the insurer;
(6) is to a protection and advocacy representative pursuant to the federal Developmental Disabilities Assistance and Bill of Rights Act and the federal Protection and Advocacy for Individuals with Mental Illness Act; or
(7) is pursuant to a court order issued for good cause shown after notice to the child and the child's legal custodian and opportunity to be heard is given. Before issuing an order requiring disclosure, the court shall find that:

(a) other ways of obtaining the information are not available or would not be effective; and
(b) the need for the disclosure outweighs the potential injury to the child, the clinician-child relationship and treatment services.

E. A disclosure ordered by the court shall be limited to the information that is essential to carry out the purpose of the disclosure. Disclosure shall be limited to those persons whose need for the information forms the basis for the order. An order by the court shall include such other measures as are necessary to limit disclosure for the protection of the child, including sealing from public scrutiny the record of a proceeding for which disclosure of a child's record has been ordered.
F. An authorization given for the transmission or disclosure of confidential information shall not be effective unless it:

(1) is in writing and signed; and
(2) contains a statement of the child's right to examine and copy the information to be disclosed, the name or title of the proposed recipient of the information and a description of the use that may be made of the information.

G. The child has a right of access to confidential information about the child and has the right to make copies of information about the child and submit clarifying or correcting statements and other documentation of reasonable length for inclusion with the confidential information. The statements and other documentation shall be kept with the relevant confidential information, shall accompany it in the event of disclosure and shall be governed by the provisions of this section to the extent the statements or other documentation contain confidential information. Nothing in this subsection shall prohibit the denial of access to the records when a physician or other mental health or developmental disabilities professional believes and notes in the child's medical records that the disclosure would not be in the best interests of the child. In all cases, the child has the right to petition the court for an order granting access.

H. Information concerning a child disclosed under this section shall not be released to any other person, agency or governmental entity or placed in files or computerized data banks accessible to any persons not otherwise authorized to obtain information under this section. Notwithstanding the confidentiality provisions of the Delinquency Act [32A-2-1 NMSA 1978] and the Abuse and Neglect Act [32A-4-1 NMSA 1978], information disclosed under this section shall not be re-released without the express consent of the child or legal custodian authorized under the Children's Mental Health and Developmental Disabilities Act to give consent and any other consent necessary for redisclosure in conformance with state and federal law, including consent that may be required from the professional or the facility that created the document.

I. Nothing in the Children's Mental Health and Developmental Disabilities Act shall limit the confidentiality rights afforded by federal statute or regulation.

J. The department shall promulgate rules for implementing disclosure of records pursuant to this section and in compliance with state and federal law and the Children's Court Rules [10-101 NMRA].

court shall grant relief as is appropriate, subject to the provisions of the Tort Claims Act [41-4-1 NMSA 1978].
History: Laws 2007, ch. 162, § 27.
NEW MEXICO NURSE PRACTICE ACT

NURSING PRACTICE

CHAPTER 61  PROFESSIONAL AND OCCUPATIONAL LICENSURE

ARTICLE 3  NURSING

LICENSING RULES
TITLE 16  OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 12  NURSING AND HEALTH CARE RELATED PROVIDERS
http://www.nmcpr.state.nm.us/nmac/_title16/T16C012.htm

PART 1  General Provisions
http://www.nmcpr.state.nm.us/nmac/parts/title16/16.012.0001.htm

PART 2  Nurse Licensure
http://www.nmcpr.state.nm.us/nmac/parts/title16/16.012.0002.htm

SUBPART 12  Standards of Nursing Practice
16.12.2.12
SUBPART 12.3  Standards for Professional Registered Nursing Practice
16.12.2.13
SUBPART 12.4  Standards for Licensed Practical Nursing Practice
16.12.2.10
HIPAA AND FERPA GUIDELINES

INTRODUCTION

There are two federal laws that impact the sharing of confidential health and education records. The first, Family Educational Rights and Privacy Act (FERPA) was passed in 1974. FERPA requires that schools receiving federal funding must hold as confidential the information in a student’s education records, making it available only to parents and to those within the school who have a “need to know” in order to provide adequate education for a student. This parental right is transferred to the student at the age of 18 or when he/she enters a postsecondary institution at any age. Exceptions to the privacy rule includes information that the school may designate as “directory information.”

FERPA is administered and enforced by the US Department of Education’s Office for Civil Rights. School districts have been operating under FERPA for many years and all school districts should have standards in place to comply with the requirements of this law. http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html.

Congress enacted the second law, the Health Insurance Portability and Accountability Act (HIPAA) in 1996 to address the problem of health insurance confidentiality in the era of electronic information. Schools are specifically exempted from HIPAA which has created ambiguities that are not yet resolved as of February, 2008. Under HIPAA any identifiable personal health information is protected, and specific authorization is required for transfer of that information. However, in New Mexico school nurses have been granted public health authority in the exchange of immunization information and, therefore, can obtain this information without parental authorization (See Section IX).

A HIPAA compliant release of information form is required when obtaining authorization from parents to access other student health records. In addition there is a “minimum necessary disclosure” limitation, requiring covered entities to limit the amount of information released to only that information absolutely necessary for the job at hand—i.e. billing or patient care. HIPAA regulations are detailed and carry both financial as well as criminal penalties for lack of compliance. http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNIssueBriefsFullView/tabid/445/ArticleId/78/Privacy-Standards-for-Student-Health-Records-2004

GUIDELINES

School nurses are encouraged to be knowledgeable of both HIPAA and FERPA regulations and be proactive in assisting school districts with establishing policy for sharing student medical information that is compliant with both.

Implications for the School Nurse

How HIPAA and FERPA interface at the school level is not entirely clear as of this writing. School medical records are considered part of the educational record of the student; and thus, are protected under FERPA. However, there are clearly situations in a school where HIPAA must come into play—for example, Medicaid in the Schools billing procedures must be HIPAA compliant. In
addition, under HIPAA the ability to transfer personally identifiable health information between the school nurse and outside medical providers is still a fuzzy area.

The 2000 regulations state that “the educational institution or agency that employs a school nurse is subject to our regulation as a health care provider if the school nurse or the school engages in a HIPAA transaction.” An example of a HIPAA transaction would be electronically transmission of individually identifiable health care information to medical health plans or health clearing houses for the purpose of billing Medicaid.

The New Mexico Departments of Health and Human Services, at the time of this writing, continue to work on some broad-based solutions to ambiguities in HIPAA regulations. In May, 2004, New Mexico school nurses were granted Public Health authority regarding the exchange of immunization information to facilitate HIPAA compliance. (See Attachment this Section.) It is advisable that the school nurse obtain appropriate consent from parents before sharing protected health information outside of the school if there is any question regarding the need for consent.

**Implications for the School-Based Health Center**

School-based health centers are subject to HIPAA regulations and should follow procedures established by the sponsoring agency.

**REFERENCES**

- New Mexico Administrative Code, [http://www.nmcpr.state.nm.us/nmac/ titles.htm](http://www.nmcpr.state.nm.us/nmac/ titles.htm)
- New Mexico School Health Manual [http://www.nmschoolhealthmanual.org/resources/forms.htm](http://www.nmschoolhealthmanual.org/resources/forms.htm)
- Public Access [http://public.nmcompcomm.us/nmpublic/gateway.dll/?f=templates&fn=default.htm](http://public.nmcompcomm.us/nmpublic/gateway.dll/?f=templates&fn=default.htm)
- US Office for Civil Rights, [www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa)