Dental Public Health Activity Descriptive Report Submission Form

The Best Practices Committee requests that you complete the Descriptive Report Submission Form as follow-up to acceptance of your State Activity Submission as an example of a best practice.

Please provide a more detailed description of your **successful dental public health activity** by fully completing this form. Expand the submission form as needed but within any limitations noted.

ASTDD Best Practices: Strength of Evidence Supporting Best Practice Approaches
Systematic vs. Narrative Reviews: http://libguides.mssm.edu/c.php?g=168543&p=1107631

NOTE: Please use Verdana 9 font.

CONTACT PERSON PREPARING THE SUBMISSION AND TO ANSWER QUESTIONS

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PROVIDE CONTACT INFORMATION FOR ONE ADDITIONAL PERSON WHO COULD ANSWER QUESTIONS REGARDING THIS PROGRAM

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SECTION I: ACTIVITY OVERVIEW

Title of the dental public health activity:

Rhode Island School Oral Health Legislation, Rules and Regulations

Public Health Functions*: Check one or more categories related to the activity.

"X"	**Assessment**
	1. Assess oral health status and implement an oral health surveillance system.
	2. Analyze determinants of oral health and respond to health hazards in the community
	3. Assess public perceptions about oral health issues and educate/empower them to achieve and maintain optimal oral health
	Policy Development
x	4. Mobilize community partners to leverage resources and advocate for/act on oral health issues
x	5. Develop and implement policies and systematic plans that support state and community oral health efforts
	Assurance
	6. Review, educate about and enforce laws and regulations that promote oral health and ensure safe oral health practices
x	7. Reduce barriers to care and assure utilization of personal and population-based oral health services
	8. Assure an adequate and competent public and private oral health workforce
x	9. Evaluate effectiveness, accessibility and quality of personal and population-based oral health promotion activities and oral health services
	10. Conduct and review research for new insights and innovative solutions to oral health problems

***ASTDD Guidelines for State and Territorial Oral Health Programs that includes 10 Essential Public Health Services to Promote Oral Health**

Healthy People 2020 Objectives: Check one or more key objectives related to the activity. If appropriate, add other national or state HP 2020 Objectives, such as tobacco use or injury.

"X"	Healthy People 2020 Oral Health Objectives	
x	OH-1	Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth
x	OH-2	Reduce the proportion of children and adolescents with untreated dental decay
	OH-3	Reduce the proportion of adults with untreated dental decay
	OH-4	Reduce the proportion of adults who have ever had a permanent tooth extracted because of dental caries or periodontal disease
	OH-5	Reduce the proportion of adults aged 45 to 74 years with moderate or severe periodontitis
	OH-6	Increase the proportion of oral and pharyngeal cancers detected at the earliest stage
x	OH-7	Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year
x	OH-8	Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year
x	OH-9	Increase the proportion of school-based health centers with an oral health component
	OH-10	Increase the proportion of local health departments and Federally Qualified Health Centers (FQHCs) that have an oral health component
	OH-11	Increase the proportion of patients who receive oral health services at Federally Qualified Health Centers each year

	OH-12	Increase the proportion of children and adolescents who have received dental sealants on their molar teeth
	OH-13	Increase the proportion of the U.S. population served by community water systems with optimally fluoridated water
	OH-14	Increase the proportion of adults who receive preventive interventions in dental offices
	OH-15	Increase the number of States and the District of Columbia that have a system for recording and referring infants and children with cleft lips and cleft palates to craniofacial anomaly rehabilitative teams
	OH-16	Increase the number of States and the District of Columbia that have an oral and craniofacial health surveillance system
	OH-17	Increase health agencies that have a dental public health program directed by a dental professional with public health training

"X"	Other national or state Healthy People 2020 Objectives: (list objective number and topic)	

Provide 3-5 Key Words (e.g. fluoride, sealants, access to care, coalitions, policy, Medicaid, etc.) These will assist those looking for information on this topic:

School policy, legislation, regulation, rules, coordinated school health

Executive Summary: Complete after Section II: Detailed Activity Description. Please limit to 300 words in one or two paragraphs.

Provide a brief description of the dental public health activity. Include information on: (1) what is being done; (2) who is doing it and why; (3) associated costs; (4) outcomes achieved (5) lessons learned, both positive and negative.

Laws and policies are important tools that can be used to improve the health and safety of children and adolescents in schools. Education and public health leaders can use specific laws and policies to promote programs and strategies that foster an environment in which children and adolescents can thrive and learn. Rhode Island General Laws (RIGL), a collection of laws that govern the State of Rhode Island, have created mandates that relate to building school health programs and establishing school personnel to oversee school health. In addition, the RI Rules & Regulations for School Health Programs[i] help determine policies, practices, protocols, funding, and other systemic approaches for health improvement to Rhode Island's public and non-public schools. Notable parts of the Rules & Regulations for School Health Programs that relate to promoting oral health include: required dental screenings; required health education curriculum that include tobacco, health hygiene/habits, prevention/control of disease and injury prevention; qualifications and general duties of the school dentist/dental hygienist; healthier beverages and snacks at school; and a tobacco free school environment. Through RIGL and the Rules & Regulations for School Health Programs, Rhode Island has made significant progress in mobilizing partners and stakeholders to support children's oral health and expand school-based/school-linked dental programs for elementary schools with a high proportion of children from low-income families. Existing legislation has promoted oral health as part of the overall health of RI school children.

SECTION II: DETAILED ACTIVITY DESCRIPTION

Provide detailed narrative about the dental public health activity using the headings provided and answering the questions. Include specifics to help readers understand what you are doing and how it's being done. References and links to information may be included.

Complete using **Verdana 9 font.

Rationale and History of the Activity:

1. What were the key issues that led to the initiation of this activity?

   In Rhode Island (RI), the Rules & Regulations for School Health Programs (R16-21-SCHO)[ii] were created to address Rhode Island General Laws (RIGL 16-21, 35-4, and 21-1-18). Rules and regulations have the power of law through the statutory authority granted under specific statutes, clarify the intent of a law, and define implementation practices. The Rules & Regulations for School Health Programs guide school health programs both in the public and private setting.

   First established in 1964, the Rules & Regulations for School Health Programs have been amended over the years. The most recent update became effective as of February 19, 2009.[iii] Under these Rules & Regulations, required health services include screenings, records review, acute care, chronic disease management, and health risk prevention.

   Oral health leaders and stakeholders in RI have led efforts to expand and amend oral health requirements in school health programs through legislation. These leaders/stakeholders include school nurse teachers and the dental care providers. Often, school nurse teachers first identify a problem in the way that Rules & Regulations are worded or being implemented. Suggested changes are usually reviewed by the RI Dental Association or the RI Dental Hygienists' Association. Their efforts have resulted in legislation that has been revised over the years for clarification and to best meet the needs of RI school children.

2. What rationale/evidence (may be anecdotal) did you use to support the implementation of this activity?

   Laws and policies can contribute to improving the health of children and adolescents in the school setting. Legislation helps to refine the role of schools in protecting the health of children and adolescents in school environments, motivating them to choose healthy behaviors through policies that encourage improved health and safety, and safeguarding them from health threats. As such, laws and policies are important tools for education and public health leaders, who can use specific laws and policies to promote programs and strategies that foster an environment in which children and adolescents can thrive and learn.

   Laws, rules and regulations can be used to improve the health and safety of children and adolescents in schools. RI General Laws and the Rules & Regulations for School Health Programs address the oral health of school children with specific requirements that integrate dental screenings and other services into school health programs. Policy guidance and tools have been developed that also relate to promoting oral health as part of the overall health of RI school children.

3. What month and year did the activity begin and what milestones have occurred along the way? (May include a timeline.)

   First established in 1964, the Rules & Regulations for School Health Programs have been amended over the years. The most recent update became effective as of February 19, 2009.[iv] Under these Rules & Regulations, required health services include screenings, records review, acute care, chronic disease management, and health risk prevention.

The sections below follow a logic model format. For more information on logic models go to: W.K. Kellogg Foundation: Logic Model Development Guide

INPUTS	PROGRAM ACTIVITIES	OUTPUTS	OUTCOMES

1. What resources were needed to carry out the activity? (e.g., staffing, volunteers, funding, partnerships, collaborations with various organizations, etc.)

   The RI General Laws and Rules & Regulations on School Health Programs have mobilized partners (RI Department of Education, RI Department of Health, RI Healthy School Coalition with 100 member organizations, **thrive**/coordinated school health program, communities, and school districts) to improve the oral health of school children. Legislation has expanded school-based/school-linked dental programs reaching 60% of elementary schools with more than half the

students from low-income families (eligible for the Free and Reduced Lunch Program) and has contributed to decreased tobacco use among high school students.

Legislation, rules and regulations on school health have led the RI Department of Health and the RI Department of Elementary and Secondary Education into a partnership called **thrive** to improve the health of school children. Through **thrive**, and the Coordinated School Health Model, communities and families also have become collaborative partners. The development of District Health and Wellness Subcommittees within each school committee mobilizes community members, educators, administrators, and parents to collaborate. Additionally, the RI Oral Health Program collaborates with existing school-based/school-linked dental programs to expand dental services for school children.

School Health Programs (http://www.thriveri.org/documents/Rules_Regs_School_Health.pdf). The inclusion of oral health in RI legislation establishes oral health as a major component of school health programs and services, and integrates oral health into the general health of all children in RI.

Oral Health Components of RI School Health Programs Mandated by Legislation, Rules & Regulations

1. *School Health Programs* – RIGL 16-21-7 requires that all schools have a school health program which "provide(s) for the organized direction and supervision of a healthful school environment, health education, and services."[v] The program is subject to approval by the state director of the department of health and commissioner of elementary and secondary education or commissioner of higher education.

2. *Health Education* – Rules & Regulations of School Health Programs require that a comprehensive health education program shall be provided for students in grades K through 12. The RI health education curriculum in school health programs is based on health education standards of the *Rhode Island Health Education Framework: Health Literacy for All Students.*[vi] Required oral health content areas include: alcohol, tobacco, and other substance abuse; physiology and hygiene; prevention and control of disease; and safety and injury prevention.

3. *School Health Personnel* – RIGL require that each school district must employ a school dentist to provide oral health screenings and/or supervision of dental screenings, as well as to provide oversight, guidance and consultation to school nurses, the district and the schools in establishing appropriate oral health policies and protocols.[vii] RIGL require that every public school have a certified school nurse teacher assigned to provide and coordinate services, including oral health screenings and dental services at that school.[viii] Additionally, each district must employ a school physician to provide oversight, supervision, guidance, and consultation to the school nurses and to the district and schools in establishing appropriate health policies and protocols.[ix]

   Since January 1964, the provision of a school dentist has been a part of the Rules & Regulations. However, oral health personnel requirements have been significantly expanded and refined over the years. The current Rules & Regulations include the following:[x]
   - A School Dentist establishes a contract with the school system defining mutually agreed upon expectations and objectives.
   - A School Dental Hygienist performs dental screening under the general supervision of a dentist.
   - Common duties and qualifications for the School Dentist/Dental Hygienist:
     - Participate actively to ensure implementation of all relevant state and local laws, regulations and protocols in collaboration with the school's administrative authorities and school health personnel;
     - Provide a regular report (a minimum of one (1) per year) on consultation and/or direct service activities rendered to the school system;
     - Non-invasively screen for hard tissue disease (tooth decay), soft tissue disease (gum disease) and orthodontic problems;
     - Report knowledge of any outbreak or undue prevalence of infectious or parasitic disease or infestation to the Department of Health.

   This marks a significant change from the original Rules & Regulations of 1964, which the school health personnel section simply stated that each school "shall provide the services of at least a physician and a dentist" with no clear responsibilities or qualifications stated.[xi]

4. *Dental Screenings and Follow-Up* – RIGL 16-21[xii] requires that annual health examinations and screenings must be performed including vision, dental, speech/language, hearing, and scoliosis screenings.[xiii] RIGL 16-21-9 mandates that licensed dentists and dental hygienists

with at least three years of clinical experience must perform the dental screenings. Any student who provides documentation that this screening has been performed by his/her family dentist does not need to participate in the school screening services. Rules & Regulations for School Health Programs have added that school children must be screened annually through the fifth grade and at least once between the sixth and tenth grades. Additionally, a licensed dentist must perform dental screenings for children in kindergarten, fourth and ninth grades.[xiv] As part of the dental screening requirement, the parent and/or guardian must be notified when a school dental visit has revealed that a dental problem may exist. Also, RIGL mandates that parents or custodians of children in need of follow-up treatment, receive a current list of (a) dental practices in the community that accept patients insured by Medical Assistance and/or RIte Care, and (b) dental practices that provide services on a sliding scale basis to uninsured individuals.[xv] Each school district must develop procedures or protocols for documenting and implementing a follow-up and referral plan for students identified as needing additional services.

The 1964 Rules & Regulations state: "all school children shall be given a dental examination by a dentist just before entering school (if possible) but, if not, in the first grade and annually thereafter."[xvi] The 1998 amended Rules & Regulations state: "initial dental examination preferably should be conducted by the child's family dentist." [xvii] The 1999 version added: "each community shall provide for dental screenings."[xviii] These amendments reflect a shift in having both family and community responsible for children's oral health.

5. *Beverages and Snacks* – All RI schools that sell or distribute beverages and snacks on their premises, including those sold through vending machines, are required to offer healthier beverage and snack choices for students. Schools may only permit the sale of beverages and snacks that do not comply with the above as part of school fundraising in certain circumstances.[xix]

6. *Tobacco Use* – All schools in RI are subject to the provisions of RIGL Chapter 23-20.9, "Smoking in Schools"[xx] and RIGL Chapter 23-20.10, "Public Health and Workplace Safety Act."[xxi] Each school is responsible for the development of enforcement procedures to prohibit tobacco product usage by any person utilizing any and all school facilities. According to RIGL, clearly marked "nonsmoking area" signs must be posted in all school areas where tobacco product usage is prohibited, including each building entrance, school buses and vehicles, and other areas designated by the governing body. All signs must be written with bold block lettering at least three inches high stating, "Tobacco-Free School – Tobacco Use Prohibited," which are provided, without charge, by the RI Department of Health.

Compliance of Schools to Health Regulations and Statutes

Local government determines how each school district will abide by RI General Laws (e.g., how they will perform screenings) and the Rules & Regulations. However, the RI Department of Education (DOE) tracks the compliance of schools to all health regulations and statutes. The DOE disseminates a self-reporting survey annually to all school districts, requiring proof of compliance to all health regulations and statutes. If found non-compliant or lacking, a follow-up letter is sent to applicable schools from the DOE legal office. If documentation of measured improvement is not provided to the DOE, disciplinary action may be taken. For school oral health, the DOE compliance survey asks district administrators for proof of a dentist to be utilized by the district. In the past six years that the survey has been conducted, the vast majority (more than 95%) of school districts have been compliant with the oral health personnel requirement.[xxii]

The Influence/Impact of the Legislation, Rules & Regulations on School Health Programs

RIGL and Rules & Regulations on School Health Programs have mobilized partners and stakeholders to support children's health, including oral health.

1. *RI Departments of Education and Health* – In response to the Rules & Regulations for School Health Programs, the RI Departments of Education and Health established a partnership and created **thrive**, the RI Coordinated School Health Program. The program was developed in 1994 with funding from the Centers for Disease Control and Prevention (CDC). Governed by RIGL, **thrive** was designed to prevent serious health problems and to improve educational outcomes. **thrive** provides guidance and resources for educators, administrators, policy-makers, parents, caregivers, students, and community organizations in the pursuit of healthier children and healthier school environments. Resources are offered on the **thrive** website. The website posts information on the nine components of the coordinated school health model:

counseling & psychological services, health promotion for staff, social environment in schools, physical environment in schools, family & community involvement, health education, physical education, nutrition services, and health services.[xxiii]

2. *District Health and Wellness Subcommittee* – RI '05 Public Law Chapter 05-074[xxiv]/05-076 [xxv] requires that the school committee establish a District Health and Wellness Subcommittee (DHWS) to develop policies, strategies, and plans to enhance the health and wellness of the school community. As part of this mission, the DHWSs support activities that improve oral health. The Pawtucket and Bristol Warren School Departments' DHWSs conduct nutrition workshops.[xxvi] Newport Public School's DHWS brings healthy foods to school children through a "Fresh Fruit and Vegetable Program."[xxvii] Lincoln and Portsmouth School Departments' DHWSs are reducing the availability of sugary foods at schools as a health improvement measure.[xxviii] [xxix]

3. *RI Healthy Schools Coalition* – The RI Healthy Schools Coalition has 100 member organizations and support activities such as developing the RI Nutrition Guidelines for School Vending & A La Carte Foods. The Guidelines are more comprehensive than the nutrition criteria in the State Law and include supporting rationale as well as product examples. The purpose of this document is to help DHWSs develop and/or adopt a comprehensive set of nutrition guidelines for competitive foods in schools that will be in compliance with the 2006 and 2007 RI State Laws.

4. *RI Oral Health Program* – The RI Oral Health Program (OHP) is currently working in partnership with community health centers to expand school-based dental programs to provide dental services for all eligible schools statewide. To deliver dental sealants to high-risk children, the school-based programs will target schools with 50% or greater of the students eligible for free or reduced school meals (FRL) programs.[xxx] Existing school-based programs will work with their school districts to provide dental sealants to children in all eligible schools, which may be provided by community-based health centers that offer school-based/school-linked dental services. School districts without school-based dental programs will be contacted to explore interest in providing dental sealants to their students; the OHP will provide technical assistance to develop sealant programs.

5. *School-based/School-linked Dental Programs* – Currently, six organizations have established school-based/school-linked dental programs reaching 60% of the low-income schools in RI. Low income schools are defined as having half or more of a school's student population eligible for free or reduced school meal programs.[xxxi] During the 2004-05 school year, the school-based/school-linked programs provided preventive care to 33 elementary schools.[xxxii] As of the 2008-09 school year, the programs provide preventive care to a total of 54 schools, a 64% increase. During the past ten years, increased capacity has expanded oral health promotion and preventive services for school children.[xxxiii] These services include oral health education, dental screenings, dental sealants, and dental care referrals.

6. *Tobacco Use* – RI legislation passed in 1992 (RIGL Chapter 23-20.9, "Smoking in Schools,") stated that the governing body of each school shall be responsible for the development of enforcement procedures to prohibit tobacco product usage by any person utilizing school facilities. This may have had an effect on declining rates of smoking among RI school children. According to the 1988 Adolescent Substance Abuse Survey (ASAS), just over half of surveyed RI public school students in grades 7-12 had ever smoked cigarettes. [xxxiv] There is some evidence of decreasing trends in smoking rates shown by the ASAS conducted since 1988. The ASAS was discontinued in 1998 and replaced by the Youth Risk Behavior Survey (YRBS). The YRBS also documented further declining rates in smoking for RI children: tobacco use in public high school students in the past 30 days decreased from 35.4% in 1997 to 15.1% in 2007; the percentage of students who smoked cigarettes on school property in the past 30 days fell from 20.4% in 1997 to 7.4 % in 2007;[xxxv] and the "ever tried cigarette smoking" rate declined from 69% in 1997 to 43% in 2007. [xxxvi] These improvements are likely due to a broad range of tobacco control and prevention efforts aimed at youth and schools and cultural trends.

INPUTS	**PROGRAM ACTIVITIES**	OUTPUTS	OUTCOMES

2. Please provide a detailed description the key aspects of the activity, including the following aspects: administration, operations, and services.

RI legislation, rules and regulations on school health programs provide efficiency by carrying out mandates for all public and non-public schools. State legislation works to improve the health of RI children while in the school setting.

The use of the 50% or greater eligibility in FRL programs for school-based/school-linked dental programs demonstrates resource efficiency. The eligibility criteria will help target services to the children who will most benefit from preventive services.

INPUTS	PROGRAM ACTIVITIES	**OUTPUTS**	OUTCOMES

3. What outputs or direct products resulted from program activities? (e.g., number of clients served, number of services units delivered, products developed, accomplishments, etc.)

INPUTS	PROGRAM ACTIVITIES	OUTPUTS	**OUTCOMES**

4. What outcomes did the program achieve? (e.g., health statuses, knowledge, behavior, care delivery system, impact on target population, etc.) Please include the following aspects:
    a. How outcomes are measured
    b. How often they are/were measured
    c. Data sources used
    d. Whether intended to be short-term (attainable within 1-3 years), intermediate (achievable within 4-6 years), or long-term (impact achieved in 7-10 years)

Budgetary Information:
NOTE: Charts and tables may be used to provide clarity.

1. What is the annual budget for this activity?

   Not applicable.

2. What are the costs associated with the activity? (Including staffing, materials, equipment, etc.)

   Not applicable.

3. How is the activity funded?

   Not applicable.

4. What is the plan for sustainability?

   Legislation, rules and regulations on school health help sustain standards and practices. Once such laws are in place, a compelling case must be made for change. Changes to existing Rules & Regulations must be vetted through a complicated process with multiple steps, levels of approval, and state department involvement.[38]

Lessons Learned and/or Plans for Addressing Challenges:

1. What important lessons were learned that would be useful for others looking to implement a similar activity? Was there anything you would do differently?

RI continues to revise the Rules & Regulations to meet the health needs of school children. Recent revisions proposed in December of 2008 have been incorporated into the February 2009 amendments to Rules & Regulations for School Health Programs.

2. What challenges did the activity encounter and how were those addressed?

Available Information Resources:

Share any models, tools, and/or guidelines developed by the program specifically for this activity that may be useful to others seeking additional information. Hyperlink resources if possible.

The **thrive** (RI Coordinated School Health Program) helps ensure that schools in RI are safe, healthy and nurturing places for students to learn: http://www.thriveri.org/.

2. To help implement state legislation and school health rules and regulations, the following model policies and/or policy guidance documents have been developed by the RI Department of Education in partnership with the RI Department of Health and other partners:
   - RI Nutrition Guidelines for School Vending & A La Carte Foods (2008)
   - RI Model Tobacco-Free Schools Policy Language (2007)
   - A Comprehensive Approach to Tobacco Prevention and Cessation: Tools for RI Schools
   - RI School District Nutrition & Physical Activity - Model Policy Language (2006)

3. A CDC Review of School Laws and Policies Concerning Child and Adolescent Health – The 2008 report provides many legal and policy themes including the importance of the integration of public health and education services. [xxxvii]

TO BE COMPLETED BY ASTDD	
Descriptive Report Number:	45002
Associated BPAR:	
Submitted by:	Division of Community Health and Equity, Rhode Island Department of Health
Submission filename:	DES45002RIschoolhealthreg-2018
Submission date:	January 2010
Last reviewed:	June 2018
Last updated:	June 2018

[i] Department of Health (RI) Rules and Regulations for School Health Programs. Effective 02/19/2009 14-000-011 (ERLID 5471). (http://www.thriveri.org/documents/Rules_Regs_School_Health.pdf).
[ii] Department of Health (RI) Rules and Regulations for School Health Programs. Effective 02/19/2009, 14-000-011 (ERLID 5471).
[iii] Department of Health (RI) Rules and Regulations for School Health Programs. Effective 02/19/2009, 14-000-011 (ERLID 5471).
[iv] Department of Health (RI) Rules and Regulations for School Health Programs. Effective 02/19/2009, 14-000-011 (ERLID 5471).
[v] RI Gen. Laws ch. § 16-21-7. (www.rilin.state.ri.us/Statutes/TITLE16/16-21/16-21-7.htm)
[vi] The Rhode Island Department of Elementary and Secondary Education, Comprehensive Literacy Plan, 2012 (http://www.ride.ri.gov/Portals/0/Uploads/Documents/Instruction-and-Assessment-World-Class-Standards/Literacy/RICLP/RICLP-Spring-2012.pdf).

[vii] RI Gen. Laws ch. § 16-21-; RI Gen. Laws ch. § 16-21-9, (http://www.rilin.state.ri.us/Statutes/TITLE16/16-21/16-21-9.HTM); RI Gen. Laws ch. § 16-21-12. (http://www.rilin.state.ri.us/Statutes/TITLE16/16-21/16-21-12.HTM)
[viii] RI Gen. Laws ch. § 16-21-8. (www.rilin.state.ri.us/Statutes/TITLE16/16-21/16-21-8.HTM)
[ix] RI Gen. Laws ch. § 16-21-7.
[x] Department of Health (RI) Rules and Regulations for School Health Programs. Effective 02/19/2009, 14-000-011 (ERLID 5471)
[xi] Department of Health (RI) Rules and Regulations for School Health Programs. Effective 01/1964. Page 3, Regulation VII.
[xii] RI Gen. Laws ch. § 16-21. (www.rilin.state.ri.us/Statutes/TITLE16/16-21/INDEX.HTM)
[xiii] Department of Health (RI) Rules and Regulations for School Health Programs. Effective 02/19/2009, 14-000-011 (ERLID 5471).
[xiv] Department of Health (RI) Rules and Regulations for School Health Programs. Effective 02/19/2009, 14-000-011 (ERLID 5471).
[xv] RI Gen. Laws ch. § 16-21-9.
[xvi] Department of Health (RI) Rules and Regulations for School Health Programs. Effective 01/1964. Page 3, Regulation VI.
[xvii] Department of Health (RI) Rules and Regulations for School Health Programs. Effective 12/1998, 13.2.
[xviii] Department of Health (RI) Rules and Regulations for School Health Programs. Effective 12/1999, 7.3.2.1.
[xix] RI Gen. Laws ch. § 16-21-7.
[xx] RI Gen. Laws ch. § 23-20.9. (www.rilin.state.ri.us/Statutes/TITLE23/23-20.9/INDEX.HTM)
[xxi] RI Gen. Laws ch. § 23-20.10. (www.rilin.state.ri.us/statutes/TITLE23/23-20.10/INDEX.HTM)
[xxii] Personal communication with Jackie Ascrizzi, School Health Specialist, Program Manager of 21st Century Community Learning Centers and Child Opportunity Zones; Rhode Island Department of Education. Oct 6, 2009.
[xxiii] *thrive* website. (www.thriveri.org/)
[xxiv] RI Public Law ch. 05-074. (www.rilin.state.ri.us/PublicLaws/law05/law05074.htm)
[xxv] RI Public Law ch. 05-076. (www.rilin.state.ri.us/PublicLaws/law05/law05076.htm)
[xxvi] Pawtucket School Department Wellness Committee. (http://www.psdri.net/School-Committee/School-Committee-Subcommittees)
[xxvii] Newport Public School Wellness Subcommittee. https://www.npsri.net/Page/4775
[xxviii] Lincoln School Department Health and Wellness Committee Minutes, 2014-18. (http://www.district.lincolnps.org/school-committee/health-wellness-committee/)
[xxix] Portsmouth Health and Wellness Committee Minutes. (https://www.portsmouthschoolsri.org/domain/91)
[xxx] School-Based Dental Sealant Programs. ASTDD Best Practice Approaches for State and Community Oral Health Programs. Association of State and Territorial Dental Directors. May 22, 2018. (https://www.astdd.org/school-based-dental-sealant-programs/)
[xxxi] Department of Health (RI) *Rhode Island Strategic Dental Sealant Plan*, October 2009.
[xxxii] Rhode Island Dental Safety Net Report, Rhode Island Department of Health, December 2017. (http://health.ri.gov/publications/databriefs/2017DentalSafetyNet.pdf)
[xxxiii] Personal communication with Jackie Ascrizzi, School Health Specialist, Program Manager of 21st Century Community Learning Centers and Child Opportunity Zones; Rhode Island Department of Education. Oct 6, 2009.
[xxxiv] Department of Health (RI) 1988 Rhode Island Adolescent Substance Abuse Survey. Page 21, question 7.
[xxxv] Department of Health (RI) Youth Risk Behavior Survey. (http://health.ri.gov/programs/detail.php?pgm_id=182)
[xxxvi] Centers for Disease Control and Prevention, Division of Adolescent and School Health, "2007 Youth Risk Behavior Survey Results: Rhode Island High School Survey Trend Analysis Report."
[38] Personal communication with Kate Telford, Administrative Records & Technical Services Specialist, Office of the Secretary of State A. Ralph Mollis; State Archives Division. November 6, 2009.
[xxxvii] The full report was published in the February 2008 issue of the American School Health Association's *Journal of School Health*. Access "A CDC Review of School Laws and Policies Concerning Child and Adolescent Health" online. (https://www.cdc.gov/healthyyouth/policy/pdf/exec_summary.pdf)