(July 1, 1944, ch. 373, title III, § 399G, formerly § 399F, as added Pub. L. 102–531, title II, § 201, Oct. 27, 1992, 106 Stat. 3474; renumbered § 399G, Pub. L. 106–310, div. A, title V, § 502(3), Oct. 17, 2000, 114 Stat. 1115; amended Pub. L. 109–245, § 1, July 26, 2006, 120 Stat. 575.)

REFERENCES IN TEXT

The Ethics in Government Act, referred to in subsec. (h)(4)(A), probably means the Ethics in Government Act of 1978, Pub. L. 95–521, Oct. 26, 1978, 92 Stat. 1824, as amended. For complete classification of this Act to the Code, see Short Title note set out under section 101 of Pub. L. 95–521 in the Appendix to Title 5, Government Organization and Employees, and Tables.

The Technology Transfer Act, referred to in subsec. (h)(4)(A), may mean the Federal Technology Transfer Act of 1986, Pub. L. 99–502, Oct. 20, 1986, 100 Stat. 1785, as amended, or the National Competitiveness Technology Transfer Act of 1989, part C (§§ 3131–3133) of title XXXI of div. C of Pub. L. 101–189, Nov. 29, 1989, 103 Stat. 1674. For complete classification of these Acts to the Code, see Short Title of 1986 Amendment note and Short Title of 1989 Amendment note both set out under section 3701 of Title 15, Commerce and Trade, and Tables.

CODIFICATION

Section was formerly classified to section 280d–11 of this title prior to renumbering by Pub. L. 106–310.

PRIOR PROVISIONS

A prior section 399G of act July 1, 1944, was renumbered section 399H and was classified to section 280f of this title, prior to being omitted from the Code.

AMENDMENTS

2006—Subsec. (h)(2)(A). Pub. L. 109–245, § 1(a), substituted ''In the case of an individual, such Director may accept the services provided under the preceding sentence by the individual until such time as the private funding for such individual ends.'' for ''In the case of an individual, such Director may accept the services provided under the preceding sentence by the individual for not more than 2 years.''

Subsec. (h)(7)(A). Pub. L. 109–245, § 1(b)(1), inserted '', including an accounting of the use of amounts provided for under subsection (i)'' before period at end of second sentence.

Subsec. (h)(7)(C). Pub. L. 109–245, § 1(b)(2), added subpar. (C) and struck out former subpar. (C) which read as follows: ''The Foundation shall make copies of each report submitted under subparagraph (A) available for public inspection, and shall upon request provide a copy of the report to any individual for a charge not exceeding the cost of providing the copy.''

Subsec. (i)(2)(A). Pub. L. 109–245, § 1(c)(1)(A), substituted ''$1,250,000'' for ''$500,000''.

Subsec. (i)(2)(B). Pub. L. 109–245, § 1(c)(1)(B), substituted ''not less than $500,000, and not more than $1,250,000'' for ''not more than $500,000''.

Subsec. (i)(4). Pub. L. 109–245, § 1(c)(2), added par. (4).

PART O—FETAL ALCOHOL SYNDROME PREVENTION AND SERVICES PROGRAM

§§ 280f to 280f–3. Omitted

CODIFICATION

Sections 280f to 280f–3, which provided for the establishment of a Fetal Alcohol Syndrome prevention and services program, were omitted pursuant to section 280f–3 which provided that this part would no longer apply on the date that was 7 years after the date on which all members of the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect established under section 280f(d)(1) were appointed, which occurred May 17, 2000.

Section 280f, act July 1, 1944, ch. 373, title III, § 399H, formerly § 399G, as added Pub. L. 105–392, title IV, § 419(d), Nov. 13, 1998, 112 Stat. 3593; renumbered § 399H and amended Pub. L. 106–310, div. A, title V, § 502(4)(A), (B), Oct. 17, 2000, 114 Stat. 1115, required the Secretary of Health and Human Services to establish a comprehensive Fetal Alcohol Syndrome and Fetal Alcohol Effect prevention, intervention and services delivery program and to establish the National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect.

Section 280f–1, act July 1, 1944, ch. 373, title III, § 399I, formerly § 399H, as added Pub. L. 105–392, title IV, § 419(d), Nov. 13, 1998, 112 Stat. 3594; renumbered § 399I, Pub. L. 106–310, div. A, title V, § 502(4)(A), Oct. 17, 2000, 114 Stat. 1115, provided eligibility criteria for receiving a grant or entering into a cooperative agreement or contract under this part.

Section 280f–2, act July 1, 1944, ch. 373, title III, § 399J, formerly § 399I, as added Pub. L. 105–392, title IV, § 419(d), Nov. 13, 1998, 112 Stat. 3595; renumbered § 399J and amended Pub. L. 106–310, div. A, title V, § 502(4)(A), (C), Oct. 17, 2000, 114 Stat. 1115, authorized appropriations to carry out this part.

Section 280f–3, act July 1, 1944, ch. 373, title III, § 399K, formerly § 399J, as added Pub. L. 105–392, title IV, § 419(d), Nov. 13, 1998, 112 Stat. 3595; renumbered § 399K and amended Pub. L. 106–310, div. A, title V, § 502(4)(A), (D), Oct. 17, 2000, 114 Stat. 1115, provided for the expiration of this part 7 years after the date on which all members of the National Task Force had been appointed.

CONGRESSIONAL FINDINGS AND PURPOSE

Pub. L. 105–392, title IV, § 419(b), (c), Nov. 13, 1998, 112 Stat. 3591, 3592, as amended by Pub. L. 111–256, § 2(g), Oct. 5, 2010, 124 Stat. 2644, provided findings and purpose related to prevention of Fetal Alcohol Syndrome and Fetal Alcohol Effect.

PART P—ADDITIONAL PROGRAMS

§ 280g. Children's asthma treatment grants program

(a) Authority to make grants

(1) In general

In addition to any other payments made under this chapter or title V of the Social Security Act [42 U.S.C. 701 et seq.], the Secretary shall award grants to eligible entities to carry out the following purposes:

(A) To provide access to quality medical care for children who live in areas that have a high prevalence of asthma and who lack access to medical care.

(B) To provide on-site education to parents, children, health care providers, and medical teams to recognize the signs and symptoms of asthma, and to train them in the use of medications to treat asthma and prevent its exacerbations.

(C) To decrease preventable trips to the emergency room by making medication available to individuals who have not previously had access to treatment or education in the management of asthma.

(D) To provide other services, such as smoking cessation programs, home modification, and other direct and support services that ameliorate conditions that exacerbate or induce asthma.

(2)[1] Certain projects

In making grants under paragraph (1), the Secretary may make grants designed to develop and expand the following projects:

[1] So in original. Two pars. (2) have been enacted.

(A) Projects to provide comprehensive asthma services to children in accordance with the guidelines of the National Asthma Education and Prevention Program (through the National Heart, Lung and Blood Institute), including access to care and treatment for asthma in a community-based setting.

(B) Projects to fully equip mobile health care clinics that provide preventive asthma care including diagnosis, physical examinations, pharmacological therapy, skin testing, peak flow meter testing, and other asthma-related health care services.

(C) Projects to conduct validated asthma management education programs for patients with asthma and their families, including patient education regarding asthma management, family education on asthma management, and the distribution of materials, including displays and videos, to reinforce concepts presented by medical teams.

(2)[1] Award of grants

(A) Application

(i) In general

An eligible entity shall submit an application to the Secretary for a grant under this section in such form and manner as the Secretary may require.

(ii) Required information

An application submitted under this subparagraph shall include a plan for the use of funds awarded under the grant and such other information as the Secretary may require.

(B) Requirement

In awarding grants under this section, the Secretary shall give preference to eligible entities that demonstrate that the activities to be carried out under this section shall be in localities within areas of known or suspected high prevalence of childhood asthma or high asthma-related mortality or high rate of hospitalization or emergency room visits for asthma (relative to the average asthma prevalence rates and associated mortality rates in the United States). Acceptable data sets to demonstrate a high prevalence of childhood asthma or high asthma-related mortality may include data from Federal, State, or local vital statistics, claims data under title XIX or XXI of the Social Security Act [42 U.S.C. 1396 et seq., 1397aa et seq.], other public health statistics or surveys, or other data that the Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, deems appropriate.

(3) Definition of eligible entity

For purposes of this section, the term ''eligible entity'' means a public or nonprofit private entity (including a State or political subdivision of a State), or a consortium of any of such entities.

(b) Coordination with other children's programs

An eligible entity shall identify in the plan submitted as part of an application for a grant under this section how the entity will coordinate operations and activities under the grant with—

(1) other programs operated in the State that serve children with asthma, including any such programs operated under title V, XIX, or XXI of the Social Security Act [42 U.S.C. 701 et seq., 1396 et seq., 1397aa et seq.]; and

(2) one or more of the following—

(A) the child welfare and foster care and adoption assistance programs under parts B and E of title IV of such Act [42 U.S.C. 620 et seq., 670 et seq.];

(B) the head start program established under the Head Start Act (42 U.S.C. 9831 et seq.);

(C) the program of assistance under the special supplemental nutrition program for women, infants and children (WIC) under section 1786 of this title;

(D) local public and private elementary or secondary schools; or

(E) public housing agencies, as defined in section 1437a of this title.

(c) Evaluation

An eligible entity that receives a grant under this section shall submit to the Secretary an evaluation of the operations and activities carried out under the grant that includes—

(1) a description of the health status outcomes of children assisted under the grant;

(2) an assessment of the utilization of asthma-related health care services as a result of activities carried out under the grant;

(3) the collection, analysis, and reporting of asthma data according to guidelines prescribed by the Director of the Centers for Disease Control and Prevention; and

(4) such other information as the Secretary may require.

(d) Preference for States that allow students to self-administer medication to treat asthma and anaphylaxis

(1) Preference

The Secretary, in making any grant under this section or any other grant that is asthma-related (as determined by the Secretary) to a State, shall give preference to any State that satisfies the following:

(A) In general

The State must require that each public elementary school and secondary school in that State will grant to any student in the school an authorization for the self-administration of medication to treat that student's asthma or anaphylaxis, if—

(i) a health care practitioner prescribed the medication for use by the student during school hours and instructed the student in the correct and responsible use of the medication;

(ii) the student has demonstrated to the health care practitioner (or such practitioner's designee) and the school nurse (if available) the skill level necessary to use the medication and any device that is necessary to administer such medication as prescribed;

(iii) the health care practitioner formulates a written treatment plan for managing asthma or anaphylaxis episodes of the student and for medication use by the student during school hours; and

(iv) the student's parent or guardian has completed and submitted to the school any written documentation required by the school, including the treatment plan formulated under clause (iii) and other documents related to liability.

(B) Scope

An authorization granted under subparagraph (A) must allow the student involved to possess and use his or her medication—

(i) while in school;

(ii) while at a school-sponsored activity, such as a sporting event; and

(iii) in transit to or from school or school-sponsored activities.

(C) Duration of authorization

An authorization granted under subparagraph (A)—

(i) must be effective only for the same school and school year for which it is granted; and

(ii) must be renewed by the parent or guardian each subsequent school year in accordance with this subsection.

(D) Backup medication

The State must require that backup medication, if provided by a student's parent or guardian, be kept at a student's school in a location to which the student has immediate access in the event of an asthma or anaphylaxis emergency.

(E) Maintenance of information

The State must require that information described in subparagraphs (A)(iii) and (A)(iv) be kept on file at the student's school in a location easily accessible in the event of an asthma or anaphylaxis emergency.

(2) Rule of construction

Nothing in this subsection creates a cause of action or in any other way increases or diminishes the liability of any person under any other law.

(3) Definitions

For purposes of this subsection:

(A) The terms ''elementary school'' and ''secondary school'' have the meaning given to those terms in section 7801 of title 20.

(B) The term ''health care practitioner'' means a person authorized under law to prescribe drugs subject to section 353(b) of title 21.

(C) The term ''medication'' means a drug as that term is defined in section 321 of title 21 and includes inhaled bronchodilators and auto-injectable epinephrine.

(D) The term ''self-administration'' means a student's discretionary use of his or her prescribed asthma or anaphylaxis medication, pursuant to a prescription or written direction from a health care practitioner.

(e) Authorization of appropriations

For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

(July 1, 1944, ch. 373, title III, § 399L, as added Pub. L. 106–310, div. A, title V, § 501, Oct. 17, 2000, 114 Stat. 1113; amended Pub. L. 108–377, § 3(a), Oct. 30, 2004, 118 Stat. 2203.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (a)(1), (2)(B) and (b)(1), (2)(A), is act Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended. Parts B and E of title IV of the Act are classified generally to parts B (§ 620 et seq.) and E (§ 670 et seq.), respectively, of subchapter IV of chapter 7 of this title. Titles V, XIX, and XXI of the Act are classified generally to subchapters V (§ 701 et seq.), XIX (§ 1396 et seq.), and XXI (§ 1397aa et seq.), respectively, of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

The Head Start Act, referred to in subsec. (b)(2)(B), is subchapter B (§§ 635–657) of chapter 8 of subtitle A of title VI of Pub. L. 97–35, Aug. 13, 1981, 95 Stat. 499, as amended, which is classified generally to subchapter II (§ 9831 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 9801 of this title and Tables.

PRIOR PROVISIONS

A prior section 399L of act July 1, 1944, was renumbered section 399F and is classified to section 280e–4 of this title.

AMENDMENTS

2004—Subsecs. (d), (e). Pub. L. 108–377 added subsec. (d) and redesignated former subsec. (d) as (e).

EFFECTIVE DATE OF 2004 AMENDMENT

Pub. L. 108–377, § 3(b), Oct. 30, 2004, 118 Stat. 2204, provided that: ''The amendments made by this section [amending this section] shall apply only with respect to grants made on or after the date that is 9 months after the date of the enactment of this Act [Oct. 30, 2004].''

FINDINGS OF 2004 AMENDMENT

Pub. L. 108–377, § 2, Oct. 30, 2004, 118 Stat. 2202, provided that: ''The Congress finds the following:

''(1) Asthma is a chronic condition requiring lifetime, ongoing medical intervention.

''(2) In 1980, 6,700,000 Americans had asthma.

''(3) In 2001, 20,300,000 Americans had asthma; 6,300,000 children under age 18 had asthma.

''(4) The prevalence of asthma among African-American children was 40 percent greater than among Caucasian children, and more than 26 percent of all asthma deaths are in the African-American population.

''(5) In 2000, there were 1,800,000 asthma-related visits to emergency departments (more than 728,000 of these involved children under 18 years of age).

''(6) In 2000, there were 465,000 asthma-related hospitalizations (214,000 of these involved children under 18 years of age).

''(7) In 2000, 4,487 people died from asthma, and of these 223 were children.

''(8) According to the Centers for Disease Control and Prevention, asthma is a common cause of missed school days, accounting for approximately 14,000,000 missed school days annually.

''(9) According to the New England Journal of Medicine, working parents of children with asthma lose an estimated $1,000,000,000 a year in productivity.

''(10) At least 30 States have legislation protecting the rights of children to carry and self-administer asthma metered-dose inhalers, and at least 18 States expand this protection to epinephrine auto-injectors.

''(11) Tragic refusals of schools to permit students to carry their inhalers and auto-injectable epineph-

rine have occurred, some resulting in death and spawning litigation.

''(12) School district medication policies must be developed with the safety of all students in mind. The immediate and correct use of asthma inhalers and auto-injectable epinephrine are necessary to avoid serious respiratory complications and improve health care outcomes.

''(13) No school should interfere with the patient-physician relationship.

''(14) Anaphylaxis, or anaphylactic shock, is a systemic allergic reaction that can kill within minutes. Anaphylaxis occurs in some asthma patients. According to the American Academy of Allergy, Asthma, and Immunology, people who have experienced symptoms of anaphylaxis previously are at risk for subsequent reactions and should carry an epinephrine auto-injector with them at all times, if prescribed.

''(15) An increasing number of students and school staff have life-threatening allergies. Exposure to the affecting allergen can trigger anaphylaxis. Anaphylaxis requires prompt medical intervention with an injection of epinephrine.''

§ 280g–1. Early detection, diagnosis, and treatment regarding hearing loss in newborns and infants

(a) Statewide newborn and infant hearing screening, evaluation and intervention programs and systems

The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall make awards of grants or cooperative agreements to develop statewide newborn and infant hearing screening, evaluation, diagnosis, and intervention programs and systems, and to assist in the recruitment, retention, education, and training of qualified personnel and health care providers, for the following purposes:

(1) To develop and monitor the efficacy of statewide programs and systems for hearing screening of newborns and infants; prompt evaluation and diagnosis of children referred from screening programs; and appropriate educational, audiological, and medical interventions for children identified with hearing loss. Early intervention includes referral to and delivery of information and services by schools and agencies, including community, consumer, and parent-based agencies and organizations and other programs mandated by part C of the Individuals with Disabilities Education Act [20 U.S.C. 1431 et seq.], which offer programs specifically designed to meet the unique language and communication needs of deaf and hard of hearing newborns, infants, toddlers, and children. Programs and systems under this paragraph shall establish and foster family-to-family support mechanisms that are critical in the first months after a child is identified with hearing loss.

(2) To collect data on statewide newborn and infant hearing screening, evaluation and intervention programs and systems that can be used for applied research, program evaluation and policy development.

(3) Other activities may include developing efficient models to ensure that newborns and infants who are identified with a hearing loss through screening receive follow-up by a qualified health care provider, and State agencies shall be encouraged to adopt models that effectively increase the rate of occurrence of such follow-up.

(b) Technical assistance, data management, and applied research

(1) Centers for Disease Control and Prevention

The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall make awards of grants or cooperative agreements to provide technical assistance to State agencies to complement an intramural program and to conduct applied research related to newborn and infant hearing screening, evaluation and intervention programs and systems. The program shall develop standardized procedures for data management and program effectiveness and costs, such as—

(A) to ensure quality monitoring of newborn and infant hearing loss screening, evaluation, diagnosis, and intervention programs and systems;

(B) to provide technical assistance on data collection and management;

(C) to study the costs and effectiveness of newborn and infant hearing screening, evaluation and intervention programs and systems conducted by State-based programs in order to answer issues of importance to State and national policymakers;

(D) to identify the causes and risk factors for congenital hearing loss;

(E) to study the effectiveness of newborn and infant hearing screening, audiologic and medical evaluations and intervention programs and systems by assessing the health, intellectual and social developmental, cognitive, and language status of these children at school age; and

(F) to promote the sharing of data regarding early hearing loss with State-based birth defects and developmental disabilities monitoring programs for the purpose of identifying previously unknown causes of hearing loss.

(2) National Institutes of Health

The Director of the National Institutes of Health, acting through the Director of the National Institute on Deafness and Other Communication Disorders, shall for purposes of this section, continue a program of research and development on the efficacy of new screening techniques and technology, including clinical studies of screening methods, studies on efficacy of intervention, and related research.

(c) Coordination and collaboration

(1) In general

In carrying out programs under this section, the Administrator of the Health Resources and Services Administration, the Director of the Centers for Disease Control and Prevention, and the Director of the National Institutes of Health shall collaborate and consult with other Federal agencies; State and local agencies, including those responsible for early intervention services pursuant to title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] (Medicaid Early and Periodic Screening, Diagnosis and Treatment Program); title XXI of