immunization status to ensure the optimal well-being of all children in camps.

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Abbreviations: DTaP, diphtheria, tetanus, and whooping cough; Hep, hepatitis; Hib, haemophilus influenzae type B; HPV, human papillomavirus; IPV, inactivated polio vaccine; Men, meningitis; MMR, measles, mumps, rubella; PCV, pneumococcal conjugate vaccine; PPSV, pneumococcal polysaccharide vaccine.

### Table. Percentage of Camps Requiring Various Immunizations

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>No. (%) Required</th>
<th>Not required</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td>195 (52)</td>
<td>86 (23)</td>
<td>97 (26)</td>
</tr>
<tr>
<td>DTaP</td>
<td>191 (50)</td>
<td>85 (22)</td>
<td>102 (27)</td>
</tr>
<tr>
<td>Tdap or Td</td>
<td>190 (50)</td>
<td>82 (22)</td>
<td>106 (28)</td>
</tr>
<tr>
<td>IPV</td>
<td>156 (41)</td>
<td>10 (27)</td>
<td>121 (32)</td>
</tr>
<tr>
<td>Hep B</td>
<td>147 (39)</td>
<td>106 (28)</td>
<td>125 (33)</td>
</tr>
<tr>
<td>Varicella</td>
<td>139 (29)</td>
<td>110 (29)</td>
<td>129 (34)</td>
</tr>
<tr>
<td>Hib</td>
<td>108 (28)</td>
<td>139 (37)</td>
<td>131 (34)</td>
</tr>
<tr>
<td>Hep A</td>
<td>108 (28)</td>
<td>141 (37)</td>
<td>129 (34)</td>
</tr>
<tr>
<td>Meningococcal A</td>
<td>99 (26)</td>
<td>137 (36)</td>
<td>142 (37)</td>
</tr>
<tr>
<td>Men B</td>
<td>80 (21)</td>
<td>153 (41)</td>
<td>145 (38)</td>
</tr>
<tr>
<td>PCV13 or PPSV 23</td>
<td>67 (18)</td>
<td>164 (43)</td>
<td>147 (39)</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>69 (18)</td>
<td>166 (44)</td>
<td>143 (38)</td>
</tr>
<tr>
<td>HPV</td>
<td>44 (12)</td>
<td>194 (51)</td>
<td>140 (37)</td>
</tr>
<tr>
<td>Influenza</td>
<td>41 (11)</td>
<td>202 (53)</td>
<td>135 (36)</td>
</tr>
</tbody>
</table>


COMMENT & RESPONSE

**Children With Disabilities Must Be More Than an Afterthought in School Reopening**

To the Editor: The Individuals With Disabilities Education Act, adopted in 1975, mandates that all children have a right to appropriate and free public education services. Fourteen percent of public school enrollees (7.1 million children) receive special education services.1 Many children served by the Individuals With Disabilities Education Act are at high risk for severe illness if they contract coronavirus disease 2019. Thus, the US Centers for Disease Control and Prevention identifies this group for special consideration when reopening schools.2 A JAMA Pediatrics Editorial correctly asserted that issues related to school reopening were not getting adequate attention.3 A critical part of this planning is being proactive for children with disabilities.

Three factors should drive the discussion on reintegrating children with disabilities into schools during phased reopening. First, the default position of school districts should not be automatically confining these children to home. Those who require specialized instruction, specific
equipment, and/or therapy services to learn best are not well served by exclusively remote education. Second, individual education plans are important tools for equity. To assure that children with disabilities receive quality education and are appropriately accommodated, individual education plans should proactively account for limitations on class sizes, minimization of group activities, and truncation of the school day. Education in the least restrictive environment, the legal standard, is the goal while assuring safety and mitigating risk. Third, retention of therapy and paraprofessional support in schools has to be prioritized as budget cuts tighten operating margins for school districts. A large-scale exodus of these professionals from the education sector would be catastrophic for children with disabilities.

In addition to those operational realities, 2 truisms should drive planning to reopen schools. First, keeping children with disabilities safe in schools will necessitate effort. Schools should plan for those who require specialized transportation, those who cannot wear a mask, and those who need cleaning of specialized equipment. Next, there should be creative approaches to replace the socialization and integration that children with disabilities receive in mainstream academic activities such as art, physical education, and field trips, which are slated to be minimized as schools reopen. Children with disabilities are more isolated than their peers, and reopening plans must not exacerbate that reality.

Even before the pandemic, budget cuts made it difficult for schools to implement adaptations critical to optimize learning for children with disabilities. However, these children are not disposable and future legislative and operational efforts should focus on child health and well-being for all children.

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Editorial Note: This letter was shown to the corresponding author of the original article, who declined to reply on behalf of the authors.


Ways to Support Low-Income, At-Risk Young Children During and After Coronavirus Disease 2019

To the Editor In an issue of JAMA Pediatrics, Dooley et al1 bring up the important issue of supporting low-income children during coronavirus disease 2019 (COVID-19) and suggest that US Congress should increase investments in evidence-based programs (eg, home visiting and Head Start) and digital learning. Expanding evidence-based programs in the early intervention (EI) and preschool school systems may be more challenging than we thought, even before COVID-19. For instance, approximately 170,000 low-socioeconomic status (SES) children aged 3 or 4 years who were eligible for state-run preschools in California were not enrolled in state-run preschools. Governor Newsom wanted to expand 10,000 preschool spots2 after he took office but unfortunately did not, in part because of limited school facility capacities and teacher shortage. As a result, a large fraction of $100 million of education funds remain unused.

The EI and preschool systems for low-SES and at-risk children will face 2 challenges in the upcoming years owing to the likely repercussions of COVID-19: (1) a high rate of parent unemployment rate that contributes to family instability and (2) the need to support young children at home without the presence of a specialist/teacher owing to social distancing. To turn this pandemic crisis into an opportunity, we need to think beyond expanding existing evidence-based programs but instead ideating new ways to deliver such programs in a family-centered manner with the consideration of the larger economic environment.

One intriguing, related question is whether we can systematically teletrain and pay low-SES parents to deliver part-time preschool education or EI at home. Training and paying low-SES parents to deliver EI/part-time preschool education at home solves 2 major problems. First, it offers employment to many jobless parents. Approximately 26 million people have already lost their jobs during the pandemic crisis; many of these low-income parents are now jobless. Directly paying parents who want to and are capable of delivering EI/preschool education at home may provide a more stable environment for both the children and parents.

Second, many research studies have already shown that, with support, parents can successfully learn and implement EI strategies at home.3,4 Training parents to deliver EI and preschool curriculums for at-risk children at home could decrease the demand for space and support personnel and enable continual support for at-risk children in face of social distancing.


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