ITEM RATIONALE
2016 SCHOOL HEALTH PROFILES
SCHOOL PRINCIPAL QUESTIONNAIRE

QUESTION:

1. Has your school ever used the School Health Index or other self-assessment tool to assess your school's policies, activities, and programs in the following areas?

RATIONALE:

This question assesses whether the school has conducted an assessment or diagnosis as a critical first step in improving implementation of policies, programs, or environmental strategies to effect change or improvement in school health.[1] Studies confirm that the School Health Index[2] helps bring health issues to the school's attention, builds school commitment, identifies changes that do not require resources, encourages development of policy and action, raises awareness of federal policies, and helps schools set policies and standards that meet national health objectives.[3-7]

REFERENCES:

1. Goodman R, Steckler A, Kegler MC. Mobilizing organizations for health enhancement. In: Glantz K, Lewis FM, Rimer B, eds. *Health Behavior and Health Education.* San Francisco, CA: Jossey Bass Publishers, 1997, pp. 287-312.

2. Centers for Disease Control and Prevention. *School Health Index.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2014. Available at: www.cdc.gov/healthyyouth/shi. Accessed June 4, 2015.

3. Pearlman DN, Dowling E, Bayuk C, Cullinen K, Thacher AK. From concept to practice: using the School Health Index to create healthy school environments in Rhode Island elementary schools. *Preventing Chronic Disease* [serial online] 2005; 2(Special Issue):A09.

4. Staten LK, Teufel-Shone NI, Steinfelt VE, et al. The School Health Index as an impetus for change. *Preventing Chronic Disease* [serial online] 2005; 2(1):A19.

5. Austin SB, Fung T, Cohen-Bearak A, Wardle K, Cheung LWY. Facilitating change in school health: a qualitative study of schools' experiences using the School Health Index. *Preventing Chronic Disease* [serial online] 2006; 3(2):A35.

6. Sherwood-Puzzello CM, Miller M, Lohrmann D, Gregory P. Implementation of CDC's School Health Index in 3 midwest middle schools: motivation for change. *Journal of School Health* 2007; 77:285-293.

7. Geiger BF, Petri CJ, Barber C. A university-school system partnership to assess the middle school health program. *American Journal of Health Studies* 2004; 19(3):158-163.

QUESTIONS:

2. The Elementary and Secondary Education Act requires certain schools to have a written School Improvement Plan (SIP). Many states and school districts also require schools to have a written SIP. Does your school's written SIP include health-related objectives on any of the following topics?

3. During the past year, did your school review health and safety data such as Youth Risk Behavior Survey data or fitness data as part of your school's improvement planning process?

RATIONALE:

These questions address whether school improvement planning addresses student health. Education reform efforts are linked to student health; healthy students are present in school and ready to learn, while poor health is a barrier to learning and a frequent cause of underachievement.[1] In turn, academic success is an indicator of overall student well-being and a strong predictor of adult health outcomes.[2-4] A number of national education organizations recognize the close relationship between health and education and the need to embed health into the educational environment for all students.[5]

REFERENCES:

1. Basch CE. *Healthier Students Are Better Learners: A Missing Link in Efforts to Close the Achievement Gap*. New York, NY: Columbia University, 2010.

2. Grossman M, Kaestner R. Effects of education on health. In: Behrman JR, Stacey N, eds. *The Social Benefits of Education.* Ann Arbor, MI: University of Michigan Press, 1997.

3. Harper S, Lynch J. Trends in socioeconomic inequalities in adult health behaviors among U.S. states, 1990–2004. *Public Health Reports* 2007; 122(2):177–189.

4. Vernez G, Krop RA, Rydell CP. The public benefits of education. In: *Closing the Education Gap: Benefits and Costs.* Santa Monica, CA: RAND Corporation, 1999, pp. 13–32.

5. Association for Supervision and Curriculum Development, Centers for Disease Control and Prevention. *Whole School, Whole Child, Whole Community: A Collaborative Approach to Learning and Health*. Alexandria, VA: Association for Supervision and Curriculum Development, 2014. Available at:

http://www.ascd.org/ASCD/pdf/siteASCD/publications/wholechild/wscc-a-collaborative-approach.pdf. Accessed June 11, 2015.

QUESTION:

4. Currently, does someone at your school oversee or coordinate school health and safety programs and activities?

RATIONALE:

This question assesses whether the school has identified a person responsible for coordinating a school's health program. It is critical to have one person appointed to oversee the school health program.[1,2] This individual coordinates school health activities, leads a school health committee or team, and integrates community-based programs with school-based programs.[3,4] Administration and management of school health programs requires devoted time, attention, training, and expertise.[5,6]

REFERENCES:

1. Institute of Medicine. *Schools and Health: Our Nation's Investment.* Washington, DC: National Academy Press, 1997.

2. Lohrmann DK. A complementary ecological model of the coordinated school health program. *Journal of School Health* 2010; 80(1):1-9.

3. Fetro JV. Implementing coordinated school health programs in local schools. In: Marx E, Wooley S, eds. *Health Is Academic: A Guide to Coordinated School Health Programs.* New York, NY: Teachers College Press, 1998.

4. American Cancer Society. *School Health Program Elements of Excellence: Helping Children to Grow Up Healthy and Able to Learn.* Atlanta, GA: American Cancer Society, 2000.

5. National Association of State Boards of Education. *Fit, Healthy, and Ready to Learn: A School Health Policy Guide.* Washington, DC: National Association of State Boards of Education, 2000.

6. American Cancer Society. *Improving School Health: A Guide to the Role of School Health Coordinator.* Atlanta, GA: American Cancer Society, 1999.

QUESTION:

5. Is there one or more than one group (e.g., school health council, committee, team) at your school that offers guidance on the development of policies or coordinates activities on health topics?

RATIONALE:

This question assess whether the school has a health committee or team. The school health committee or team should represent a coalition of representatives from within and outside of the school community interested in improving the health of youth in schools.[1-3] Participation on such committees or teams can empower others through increased awareness and knowledge of the school health program, increase the chance of ownership and commitment, activate channels of communication, and increase involvement in decision making.[1-5]

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP13-1305: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.

REFERENCES:

1. National Association of State Boards of Education. *Fit, Healthy, and Ready to Learn: A School Health Policy Guide.* National Association of State Boards of Education. Washington, DC: NASBE, 2000.

2. Shirer K. *Promoting Healthy Youth, Schools and Communities: A Guide to Community-School Health Councils.* Atlanta, GA: American Cancer Society, 2003.

3. Lohrmann DK. A complementary ecological model of the coordinated school health program. *Journal of School Health* 2010; 80:1.

4. Fetro JV. Implementing coordinated school health programs in local schools. In: Marx E, Wooley S, eds. *Health Is Academic: A Guide to Coordinated School Health Programs.* New York, NY: Teachers College Press, 1998, pp. 15-42.

5. Green, LW, Kreuter MW. *Health Promotion and Planning: An Education and Environmental Approach.* 2nd edition. Palo Alto, CA: Mayfield Publishing Company, 1991, pp. 271-274.

QUESTION:

6. During the past year, has any school health council, committee, or team at your school done any of the following activities?...(a) Identified student health needs based on a

review of relevant data?...(b) Recommended new or revised health and safety policies and activities to school administrators or the school improvement team?...(c) Sought funding or leveraged resources to support health and safety priorities for students and staff?...(d) Communicated the importance of health and safety policies and activities to district administrators, school administrators, parent-teacher groups, or community members?...(e) Reviewed health-related curricula or instructional materials?...(f) Assessed the availability of physical activity opportunities for students?...(g) Developed a written plan for implementing a Comprehensive School Physical Activity Program (a multi-component approach that provides opportunities for students to be physically active before, during, and after school)?

Item 6f provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP13-1305: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.

RATIONALE:

This question assesses the major responsibilities of a school health committee or team. A school health council, committee, or team should regularly assess progress of school health activities and assist school leaders with oversight, planning, evaluation, and periodic revision of school health efforts.[1-4] Such a team can address major health issues facing students, assess availability of opportunities and resources, coordinate activities and resources, coordinate funding, support school health staff, and seek active involvement of students, families and the community in designing and implementing strategies to improve school health.[5]

The Centers for Disease Control and Prevention (CDC) and SHAPE America recommend a multi-component, school-wide approach to physical activity that provides opportunities for students to be physically active throughout the school environment.[6-8] One important step in achieving this comprehensive approach to physical activity is for schools to assess the availability of physical activity opportunities for students.[9-10]

REFERENCES:

1. National Association of State Boards of Education. *Fit, Healthy, and Ready to Learn: A School Health Policy Guide.* Washington, DC: National Association of State Boards of Education, 2012.

2. Shirer, K. *Promoting Healthy Youth, Schools, and Communities: A Guide to Community-School Health Councils.* Atlanta, GA: American Cancer Society, 2003.

3. Fetro JV. Implementing coordinated school health programs in local schools. In: Marx E, Wooley S, eds. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York, NY: Teachers College Press, 1998, pp. 15-43.

4. Institute of Medicine. *Schools and Health: Our Nation's Investment.* Washington, DC: National Academy Press, 1997.

5. North Carolina Department of Public Instruction. *Effective School Health Advisory Councils: Moving from Policy to Action.* Raleigh, NC: North Carolina Department of Public Instruction, 2003.

6. Lee S, Burgeson C, Fulton J, Spain C. Physical education and physical activity: Results from the School Health Policies and Programs Study 2006. *Journal of School Health* 2007; 77(8):435–463.

7. SHAPE America. *National Standards & Grade-level Outcomes for K-12 Physical Education*. Champaign, IL: Human Kinetics, 2014.

8. Centers for Disease Control and Prevention. *A Guide for Developing Comprehensive School Physical Activity Programs.* Atlanta, GA: U.S. Department of Health and Human Services; 2013.

9. Centers for Disease Control and Prevention. *School Health Index: A Self-Assessment and Planning Guide. Elementary school version.* Atlanta, GA: Centers for Disease Control and Prevention, 2014.

10. Centers for Disease Control and Prevention. *School Health Index: A Self-Assessment and Planning Guide. Middle school/high school version.* Atlanta, GA: Centers for Disease Control and Prevention, 2014.

QUESTIONS:

7. Does your school have any clubs that give students opportunities to learn about people different from them, such as students with disabilities, homeless youth, or people from different cultures?

8. During the past year, did your school offer each of the following activities for students to learn about people different from them, such as students with disabilities, homeless youth, or people from different cultures?

RATIONALE:

These questions address the extent to which schools provide opportunities to increase students' respect for diversity. Increasing understanding of similarities and differences can engender respect.[1] This practice is supported by CDC's *School Connectedness: Strategies for Increasing Protective Factors Among Youth*, which describes how schools can create trusting and caring relationships that promote open communication among administrators, teachers, staff, students,

families and communities.[2] School staff who promote mutual respect in the school foster a sense of safety and connectedness by reducing the threat of being embarrassed or teased.[3]

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Battistich V, Schaps E, Watson MS, Solomon D. Prevention effects of the Child Development Project: early findings from an ongoing multisite demonstration trial. *Journal of Adolescent Research* 1996; 11(1):12–35.

2. Centers for Disease Control and Prevention. *School Connectedness: Strategies for Increasing Protective Factors among Youth.* Atlanta, GA: U.S. Department of Health and Human Services, 2009.

3. Ryan AM, Patrick H. The classroom social environment and changes in adolescents' motivation and engagement during middle school. *American Educational Research Journal* 2001; 38(2):437–460.

SEXUAL ORIENTATION

QUESTION:

9. Does your school have a student-led club that aims to create a safe, welcoming, and accepting school environment for all youth, regardless of sexual orientation or gender identity? These clubs are sometimes called gay/straight alliances.

10. Does your school engage in each of the following practices related to lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth?

RATIONALE:

These questions assess whether the school implements activities and policies that are designed to create a safe and supportive school environment for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. Research shows that sexual minority youth are more likely than their heterosexual peers to be threatened or injured with a weapon on school property and to skip school because they felt unsafe.[1,2] In 2013, approximately 74% of LGBT students reported that they were verbally harassed at school during the past year because of their sexual orientation, while 36% were physically harassed at school, and 17% were physically assaulted at school.[3] Sexual minority youth who experience victimization at school are at a greater risk of attempting suicide than those who do not.[1] Gay/straight alliances or similar clubs are associated with greater safety for sexual minority youth. Sexual minority youth who attend schools with such a club are less likely than sexual minority youth who attend other schools to report dating violence, being threatened or injured with a weapon on school property, and skipping school because they felt unsafe.[1] In addition, sexual minority youth who attend schools with gay/straight alliances or similar clubs, those who attend schools with an anti-bullying policy, and those who feel that there is a school staff member who could be approached about a problem have a lower risk of suicidality than those who attend schools without these respective supports available.[1] The importance of improving the health, safety, and well-being of LGBT youth is underscored by the addition of goals related to LGBT health in *Healthy People 2020*,[4] such as Adolescent Health (AH-9), to increase the proportion of middle and high schools that prohibit harassment based on a student's sexual orientation or gender identity.

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Goodenow C, Szalacha L, Westheimer K. School support groups, other school factors, and the safety of sexual minority adolescents. *Psychology in the Schools* 2006; 45(3):573-589.

2. Kann L, Olsen E, McManus T, et al. Centers for Disease Control and Prevention. Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9–12 — Youth Risk Behavior Surveillance, Selected Sites, United States, 2001–2009. *MMWR* Early Release 2011; 60:1-133.

3. Kosciw JG, Greytak EA, Palmer NA, Boesen MJ. *The 2013 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in our Nation's Schools.* New York, NY: GLSEN, 2014. Available at: http://www.glsen.org/sites/default/files/2013%20National%20School%20Climate%20Survey%20Full%20Report_0.pdf. Accessed June 15, 2015.

4. U.S. Department of Health and Human Services. *Healthy People 2020.* Washington, DC: U.S. Department of Health and Human Services, 2010. Available at: www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25. Accessed June 15, 2015.

BULLYING AND SEXUAL HARASSMENT

QUESTIONS:

11. During the past year, did all staff at your school receive professional development on preventing, identifying, and responding to student bullying and sexual harassment, including electronic aggression?

12. Does your school have a designated staff member to whom students can confidentially report student bullying and sexual harassment, including electronic aggression?

13. Does your school use electronic (e.g., e-mails, school website), paper (e.g., flyers, postcards), or oral (e.g., phone calls, parent seminars) communication to publicize and disseminate policies, rules, or regulations on bullying and sexual harassment, including electronic aggression?

RATIONALE:

These questions address actions schools can take to help prevent bullying and sexual harassment, including electronic aggression. The 2013 Youth Risk Behavior Survey found that 20% of high school students reported being bullied on school property in the prior 12 months, and 15% of high school students reported that they were bullied electronically.[1] Another nationally representative survey of middle and high school students found that nearly half (48%) experienced some form of sexual harassment during the 2010-11 academic year.[2] Adverse academic, psychological, and health consequences of bullying and sexual harassment have been documented, including absenteeism, depression and anxiety, and increased risk of violence involvement later in life.[2-4]

Although evaluations of school-based bullying prevention remain limited, promising practices have been identified, such as having a school-wide anti-bullying policy, enforcing it consistently, and promoting cooperation among school teachers, administrators, and parents.[5] Moreover, under Title IX of the Education Amendments of 1972, federally funded schools are required to distribute to students, parents, and employees a formal policy for addressing sexual harassment.[6] In addition to having policies in place, studies have also demonstrated the need for professional development to help school staff respond appropriately to bullying and sexual harassment.[7] Responding quickly and consistently to bullying and sexual harassment can help stop this behavior over time.[8]

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Centers for Disease Control and Prevention. Youth risk behavior surveillance—United States, 2013. *MMWR Surveillance Summaries* 2014; 63 (No. SS-4).

2. Hill C, Kearl H. *Crossing the Line*: *Sexual Harassment at School*. Washington, DC: American Association of University Women Educational Foundation, 2011.

3. Vreeman RC, Carroll AE. A systematic review of school-based interventions to prevent bullying. *Archives of Pediatrics & Adolescent Medicine* 2007; 161(1):78-88.

4. Smokowski P, Kopasz, KH. Bullying in school: an overview of types, effects, family characteristics, and intervention strategies. *Children & Schools* 2005; 27(2):101-110.

5. Farrington DP, Ttofi MM. School-based programs to reduce bullying and victimization. *Campbell Systematic Reviews* 2009; 6.

6. Office for Civil Rights, U.S. Department of Education. Revised Sexual Harassment Guidance: Harassment of Students by School Employees, Other Students, and Third Parties. 2001. Available at: http://www.ed.gov/about/offices/list/ocr/docs/shguide.pdf. Accessed June 15, 2015.

7. Charmaraman L, Jones AE, Stein N, Espelage DL. Is it bullying or sexual harassment? Knowledge, attitudes, and professional development experiences of middle school staff. *Journal of School Health* 2013; 83(6):438-44.

8. U.S. Department of Health and Human Services in partnership with the Department of Education and the Department of Justice. Respond to bullying. Available at: http://www.stopbullying.gov/respond/index.html. Accessed June 15, 2015.

REQUIRED PHYSICAL EDUCATION

QUESTION:

14. Is a required physical education course taught in each of the following grades in your school?

RATIONALE:

This question measures the extent to which physical education is required for students in grades 6 through 12. Physical education provides students with the knowledge, attitudes, skills, behaviors, enjoyment, and confidence to adopt and maintain physically active lifestyles.[1-5] The importance of physical education in promoting the health of young people is supported by *Healthy People 2020* Physical Activity objective-4 (PA-4): increase the proportion of the Nation's public and private schools that require daily physical education for all students and PA-5: increase the proportion of adolescents who participate in daily school physical education.[6]

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP13-1305: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.

REFERENCES:

1. SHAPE America. *National Standards & Grade-level Outcomes for K-12 Physical Education*. Champaign, IL: Human Kinetics, 2014.

2. SHAPE America. The Essential Components of Physical Education. Reston, VA: SHAPE America, 2015.

3. Lee SM, Burgeson CR, Fulton JE, Spain CG. Physical education and activity: results from the School Health Policies and Programs Study 2006. *Journal of School Health* 2007; 77(8):435-463.

4. Centers for Disease Control and Prevention. School health guidelines to promote healthy eating and physical activity. *MMWR* 2011; 60(No. RR-5).

5. Institute of Medicine. *Educating the Student Body: Taking Physical Activity and Physical Education to School*. Harold W. Kohl III and Heather D. Cook, eds; Committee on Physical Activity and Physical Education in the School Environment; Food and Nutrition Board; Institute of Medicine. Washington DC: The National Academies Press, 2013. Available at: http://www.nap.edu/catalog.php?record_id=18314. Accessed June 15, 2015.

6. U.S. Department of Health and Human Services. *Healthy People 2020.* Washington, DC: U.S. Department of Health and Human Services, 2010. Available at:

www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=33. Accessed June 15, 2015.

PHYSICAL EDUCATION AND PHYSICAL ACTIVITY

QUESTION:

15. During the past year, did any physical education teachers or specialists at your school receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on physical education or physical activity?

RATIONALE:

This question examines professional development for physical education (PE) teachers. PE teachers should have professional development opportunities that help them build new knowledge and skills to improve physical education and increase students' physical activity.[1-3] PE teachers who participate in staff development programs are more likely to use recommended teaching methods such as holding group discussions, implementing physical activity stations, videotaping student performances, testing students' knowledge related to PE, giving fitness tests, keeping students physically active the majority of PE class time, and explaining to students the meaning of fitness scores.[4] Professional development for PE teachers provides skills for improving PE classes through student engagement in physical activity and the content of lessons taught.[5-7]

REFERENCES:

1. SHAPE America. *National Standards & Grade-level Outcomes for K-12 Physical Education.* Champaign, IL: Human Kinetics, 2014.

2. SHAPE America. *The Essential Components of Physical Education*. Reston, VA: SHAPE America, 2015.

3. Centers for Disease Control and Prevention. School health guidelines to promote healthy eating and physical activity. *MMWR* 2011; 60(No. RR-5).

4. Davis K, Burgeson CR, Brener ND, McManus T, Wechsler H. The relationship between qualified personnel and self-reported implementation of recommended physical education practices and programs in U.S. schools. *Research Quarterly for Exercise and Sport* 2005; 76(2):202-211.

5. McKenzie TL, Feldman H, Woods SE, et al. Children's activity levels and lesson context during third-grade physical education. *Research Quarterly for Exercise and Sport* 1996; 66(3):184-193.

6. Kelder S, Mitchell PD, McKenzie TL, et al. Long-term implementation of the CATCH physical education program. *Health Education and Behavior* 2003; 30(4):463-475.

7. McKenzie TL, Marshall SJ, Sallis JF, Conway TL. Student activity levels, lesson context, and teacher behavior during middle school physical education. *Research Quarterly for Exercise and Sport* 2000; 71(3):249-259.

QUESTION:

16. Are those who teach physical education at your school provided with each of the following materials?

RATIONALE:

This question measures the type of information and support materials PE teachers are given in order to implement PE classes. Physical education should include opportunities to assess the knowledge and skills of students. Student assessment in physical education should be used to determine how well students meet national or state physical education standards, align with the content delivered through instruction, and allow teachers and schools to monitor and reinforce student learning.[1,2] According to SHAPE America, there are four essential components of physical education. These include 1) policy and environment; 2) curriculum; 3) appropriate instruction; and 4) student assessment.[3-5]

REFERENCES:

1. Centers for Disease Control and Prevention. School health guidelines to promote healthy eating and physical activity. *MMWR* 2011; 60(No. RR-5).

2. Institute of Medicine. *Educating the Student Body: Taking Physical Activity and Physical Education to School*. Harold W. Kohl III and Heather D. Cook, eds; Committee on Physical Activity and Physical Education in the School Environment; Food and Nutrition Board; Institute of Medicine. Washington DC: The National Academies Press, 2013. Available at: http://www.nap.edu/catalog.php?record_id=18314. Accessed June 15, 2015.

3. SHAPE America. *National Standards & Grade-level Outcomes for K-12 Physical Education.* Champaign, IL: Human Kinetics, 2014.

4. SHAPE America. *The Essential Components of Physical Education.* Reston, VA: SHAPE America, 2015.

5. Centers for Disease Control and Prevention. *Physical Education Curriculum Analysis Tool.* Atlanta, GA: U.S. Department of Health and Human Services, 2014. Available at http://www.cdc.gov/healthyyouth/PECAT/. Accessed June 11, 2015.

QUESTION:

17. Outside of physical education, do students participate in physical activity breaks in classrooms during the school day?

RATIONALE:

Schools play a critical role in helping students participate in the recommended 60 minutes of physical activity every day.[1] In order to achieve this recommendation, it is important to provide physical activity opportunities, such as classroom activity breaks, in addition to physical education.[2,3] Students can accumulate physical activity through classroom activity breaks and such participation can also enhance time on task, attentiveness, and concentration in the classroom.[4,5]

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP13-1305: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.

REFERENCES:

1. U.S. Department of Health and Human Services. *2008 Physical Activity Guidelines for Americans.* Washington, DC: U.S. Department of Health and Human Services, 2008.

2. Physical Activity Guidelines for Americans Midcourse Report Subcommittee of the President's Council on Fitness, Sports & Nutrition. *Physical Activity Guidelines for Americans Midcourse Report: Strategies to Increase Physical Activity among Youth.* Washington, DC: U.S. Department of Health and Human Services, 2012.

3. Centers for Disease Control and Prevention. *A Guide for Developing Comprehensive School Physical Activity Programs.* Atlanta, GA: US Department of Health and Human Services, 2013.

4. Rasberry CN, Lee SM, Robin L, et al. The association between school-based physical activity, including physical education, and academic performance: a systematic review of the literature. *Preventive Medicine* 2011; 52 Suppl 1:S10-20.

5. Centers for Disease Control and Prevention. *Health and Academic Achievement*. Atlanta, GA: Centers for Disease Control and Prevention, 2014. Available at http://www.cdc.gov/healthyyouth/health_and_academics/pdf/health-academic-achievement.pdf. Accessed June 11, 2015.

QUESTIONS:

18. Does your school offer opportunities for students to participate in intramural sports programs or physical activity clubs? (Intramural sports programs or physical activity clubs are any physical activity programs that are voluntary for students, in which students are given an equal opportunity to participate regardless of physical ability.)

19. Does your school offer interscholastic sports to students?

20. Does your school offer opportunities for students to participate in physical activity before the school day through organized physical activities or access to facilities or equipment for physical activity?

RATIONALE:

These questions measure the extent to which students are provided the opportunity to participate in physical activities before and after the school day, through intramural activities, physical activity clubs, and interscholastic sports. Offering a variety of opportunities can increase students' physical activity and help them attain their 60 minutes of daily activity.[1,2] According to SHAPE America, intramural activities, physical activity clubs, and recreation clubs contribute to young people's physical and social development. Additionally, intramural activities or physical activity clubs offer students the opportunity to be involved in planning and implementing such programs and offer safe and structured opportunities to be physically active.[3-10]

School or community-based sports programs provide structured time for students to accumulate minutes of physical activity, establish cooperative and competitive skills, and learn sport-specific and performance-based skills. Evidence indicates that participation in sports is related to higher levels of participation in overall physical activity.[11-13] Additionally, participation in sports programs has been associated with improved mental health and fewer risky health behaviors.[14,15]

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP13-1305: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.

REFERENCES:

1. Physical Activity Guidelines for Americans Midcourse Report Subcommittee of the President's Council on Fitness, Sports & Nutrition. *Physical Activity Guidelines for Americans Midcourse Report: Strategies to Increase Physical Activity among Youth.* Washington, DC: U.S. Department of Health and Human Services, 2012.

2. Centers for Disease Control and Prevention. School health guidelines to promote healthy eating and physical activity. *MMWR* 2011; 60(No. RR-5).

3. National Association for Sport and Physical Education. *Guidelines for After-school Physical Activity and Intramural Programs.* Reston, VA: National Association for Sport and Physical Education, 2002.

4. Hellison D. Physical activity programs for underserved youth. *Journal of Science & Medicine in Sport* 2000; 3(3):238-42.

5. Kelder S, Hoelscher DM, Barroso CS, et al. The CATCH Kids Club: a pilot after-school study for improving elementary students' nutrition and physical activity. *Public Health Nutrition* 2005; 8(2):133-40.

6. Pate RR, Saunders RP, Ward DS, Felton G, Trost SG, Dowda M. Evaluation of a community-based intervention to promote physical activity in youth: lessons from Active Winners. *American Journal of Health Promotion* 2003; 17(3):171-82.

7. Trevino RP, Yin Z, Hernandez A, Hale DE, Garcia OA, Mobley C. Impact of the Bienestar school-based diabetes mellitus prevention program on fasting capillary glucose levels: a randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine* 2004; 158(9):911-7.

8. Pate RR, O'Neill JR. After-school interventions to increase physical activity among youth. *British Journal of Sports Medicine* 2009; 43:14-18.

9. Beets M, Beighle A, Erwin H, Huberty J. After-school impact on physical activity and fitness. A meta-analysis. *American Journal of Preventive Medicine* 2009; 36(6):527-537.

10. National Association for Sport and Physical Education. Before- and after-school physical activity & intramural sport programs [Position statement]. Reston, VA: National Association for Sport and Physical Education, 2013. Available at: http://www.shapeamerica.org/admin/loader.cfm?csModule=security/getfile&pageid=4575. Accessed June 11, 2015.

11. Harrison PA, Gopalakrishnan N. Differences in behavior, psychological factors, and environmental factors associated with participation in school sports and other activities in adolescence. *Journal of School Health* 2003; 73:113-20.

12. Vilhjalmsson R, Kristjansdottir G. Gender differences in physical activity in older children and adolescents: the central role of organized sport. *Social Science & Medicine* 2003; 56:363-74.

13. Katzmarzyk PT, Malina R. Contribution of organized sports participation to estimated daily energy expenditure in youth. *Pediatric Exercise Science* 2000; 13:378-85.

14. Pate R, Trost S, Levin S, Dowda M. Sports participation and health-related behaviors among US youth. *Archives of Pediatrics & Adolescent Medicine* 2000; 154:904-11.

15. Rasberry CN, Lee SM, Robin L, et al. The association between school-based physical activity, including physical education, and academic performance: a systematic review of the literature. *Preventive Medicine* 2011;52 Suppl 1:S10-20.

QUESTION:

21. Does your school, either directly or through the school district, have a joint use agreement for shared use of school or community physical activity or sports facilities? (A joint use agreement is a formal agreement between a school or school district and another public or private entity to jointly use either school facilities or community facilities to share costs and responsibilities.)

RATIONALE:

This question measures the extent to which schools and communities have an agreement to share physical activity facilities. School spaces and facilities should be available to young people before, during, and after the school day, on weekends, and during summer and other vacations.[1,2] Access to these facilities increases visibility of schools, provides youth, their families, and community members a safe place for physical activity, and might increase partnerships with community-based physical activity programs.[1,2] Community resources can expand existing school programs by providing program staff as well as intramural and club activities on school grounds. For example, community agencies and organizations can use school facilities for after-school physical fitness programs for children and adolescents, weight management programs for overweight or obese young people, and sports and recreation programs for young people with disabilities or chronic health conditions.[1-5]

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP13-1305: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.

REFERENCES:

1. Centers for Disease Control and Prevention. School health guidelines to promote healthy eating and physical activity. *MMWR* 2011; 60(No. RR-5).

2. Institute of Medicine. *Educating the Student Body: Taking Physical Activity and Physical Education to School*. Harold W. Kohl III and Heather D. Cook, eds; Committee on Physical Activity and Physical Education in the School Environment; Food and Nutrition Board; Institute of Medicine. Washington, DC: The National Academies Press, 2013. Available at: http://www.nap.edu/catalog.php?record_id=18314. Accessed June 8, 2015.

3. Baker T, Masud H. Liability risks for afterhours use of public school property to reduce obesity. *Journal of School Health* 2010; 80(10):508-513.

4. Sallis JF, Conway TL, Prochaska JJ, et al. The association of school environments with youth physical activity. *American Journal of Public Health* 2001; 91:618-20.

5. Choy LB, McGurk MD, Tamashiro R, Nett B, Maddock JE. Increasing access to places for physical activity through a joint use agreement: a case study in urban Honolulu. *Preventing Chronic Disease* [serial online] 2008; 5(3).

TOBACCO-USE PREVENTION POLICIES

QUESTIONS:

22. Has your school adopted a policy prohibiting tobacco use?

23. Does the tobacco-use prevention policy specifically prohibit use of each type of tobacco for each of the following groups during any school-related activity?

24. Does the tobacco-use prevention policy specifically prohibit tobacco use during each of the following times for each of the following groups?

25. Does the tobacco-use prevention policy specifically prohibit tobacco use in each of the following locations for each of the following groups?

26. Does your school post signs marking a tobacco-free school zone, that is, a specified distance from school grounds where tobacco use is not allowed?

RATIONALE:

These questions measure the extent to which schools develop, implement, and enforce a policy that creates a totally tobacco-free environment within the school experience for both young people and adults, as outlined in the CDC *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*[1] to achieve the *Healthy People 2020* objective Tobacco Use-15 (TU-15) of increasing tobacco-free environments in schools, including all school facilities, property, vehicles, and school events.[2] The Pro-Children Act of 1994, reauthorized under the No Child Left Behind Act of 2001, prohibits smoking in facilities where federally funded educational, health, library, daycare, or child development services are provided to children under the age of 18.[3,4]

Because tobacco use is the most preventable contributor to mortality in the United States, it is important to restrict use of or exposure to tobacco products at an early age.[5] The existence and enforcement of a school policy creates a tobacco-free environment that models acceptable behavior and sends a clear message to students, teachers, staff, parents, and visitors that the use of tobacco is socially unacceptable.[6] Environmental interventions aimed at reducing use of tobacco in homes, public places, and worksites lead to reduction of tobacco use.[7] Likewise, tobacco-free school policies are associated with lower rates of student smoking.[6,8-10]

Prohibiting any use of any tobacco product at all times, whether or not school is in session, and regardless of whether students are present, protects students and staff from the harmful effects of secondhand smoke (a mixture of smoke from the burning end of tobacco products and the smoke exhaled by smokers). The 2006 U.S. Surgeon General's report, *The Harmful Effects of Involuntary Exposure to Tobacco Smoke*, outlines a large body of research findings which demonstrate that breathing secondhand smoke is harmful to health.[11] Evidence shows that there is no safe level of secondhand smoke exposure, and even the most advanced ventilation systems cannot eliminate secondhand smoke or its harmful effects.[11] A complete ban of indoor smoking

at all times in a facility (such as a school building) is the only effective approach to controlling involuntary inhalation of secondhand smoke.[11]

REFERENCES:

1. Centers for Disease Control and Prevention. Guidelines for school health programs to prevent tobacco use and addiction. *MMWR* 1994; 43(No. RR-2):1-18.

2. U.S. Department of Health and Human Services. *Healthy People 2020*. Office of Disease Prevention and Health Promotion. November 2010. Available at: www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=11. Accessed June 15, 2015.

3. Pro-Children Act of 1994. 20 U.S.C. §6081-6084, 1994.

4. No Child Left Behind Act or Pro-Children Act of 2001. Public Law No. 107-110, 115 Stat. 1773. § 4301-4304, 2001.

5. U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012.

6. Brownson RC, Koffman DM, Novotny TE, Hughes RG, Eriksen MP. Environmental and policy interventions to control tobacco use and prevent cardiovascular disease. *Health Education Quarterly* 1995; 22(4):478-98.

7. Levy DT. The effects of tobacco control policies on smoking rates: a tobacco control scorecard. *Journal of Public Health Management and Practice* 2004; 10(4):338-53.

8. Wakefield MA, Chaloupka FJ, Kaufman NJ, et al. Effect of restrictions on smoking at home, at school, and in public places in teenage smoking: cross sectional study. *British Medical Journal* 2000; 321:310-311.

9. Charlton A, While D. Smoking prevalence among 16-19 year olds related to staff and student smoking policies in sixth forms and further education. *Health Education Journal* 1994; 53:191-215.

10. Pentz MA, Brannon BR, Carlin VL, et al. The power of policy: the relationship of smoking policy to adolescent smoking. *American Journal of Public Health* 1989; 79:857–62.

11. U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and

Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

QUESTIONS:

27. Does your school provide tobacco cessation services for each of the following groups?

28. Does your school have arrangements with any organizations or health care professionals not on school property to provide tobacco cessation services for each of the following groups?

RATIONALE:

These questions measure the extent to which schools provide access to tobacco-use cessation services, as outlined in the *CDC Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*[1] to achieve the *Healthy People 2020* objectives TU-4.1 and TU-7 of increasing tobacco-use cessation attempts among adult and adolescent smokers.[2,3] Nicotine addiction can occur at an early age for some adolescent tobacco users.[4] People who begin using tobacco at an early age are more likely to develop higher levels of addiction in adulthood.[4] Adolescent tobacco users suffer similar symptoms of withdrawal to those of adults when attempting to quit.[4,5] Many young people want to quit but have tried and failed.[6] Some are unaware of or do not have access to cessation services. Others underestimate the power of addiction and do not feel that quitting would require professional assistance; therefore recruitment into formal programs can be difficult.[7] School health providers as a routine part of care should assess the tobacco-use status of students, and if they identify a student's use of tobacco, they should provide self-help materials and refer them to a tobacco-use cessation program provided on site or in the community.[8-10] Also, providing a brief clinical intervention has been shown to encourage cessation among both adults and adolescents.[10]

REFERENCES:

1. Centers for Disease Control and Prevention. Guidelines for school health programs to prevent tobacco use and addiction. *MMWR* 1994; 43(RR-2):1-18.

2. U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000.

3. *Healthy People 2020*. Office of Disease Prevention and Health Promotion. November 2010. Available at: www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=11. Accessed June 15, 2015.

4. U.S. Department of Health and Human Services. *Preventing Tobacco Use among Youth and Young Adults: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012.

5. Centers for Disease Control and Prevention. Reasons for tobacco use and symptoms of nicotine withdrawal among adolescent and young adult tobacco users—United States, 1993. *MMWR* 1994; 43:746-750.

6. Centers for Disease Control and Prevention. Youth risk behavior surveillance—United States, 2009. *MMWR* 2010; 59(No. SS-5):1–148.

7. Milton MH, Maule CO, Yee SL, et al. *Youth Tobacco Cessation: A Guide for Making Informed Decisions*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2004.

8. Allensworth DD. Guidelines for adolescent preventive services: a role for the school nurse. *Journal of School Health* 1996; 66(8):281-285.

9. Donovan KA. Smoking cessation programs for adolescents. *Journal of School Nursing* 2000; 16(4):36-43.

10. Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline.* Rockville, MD: U.S. Department of Health and Human Services. Public Health Service, May 2008.

NUTRITION-RELATED POLICIES AND PRACTICES

QUESTIONS:

29. When foods or beverages are offered at school celebrations, how often are fruits or non-fried vegetables offered?

30. Can students purchase snack foods or beverages from one or more vending machines at the school or at a school store, canteen, or snack bar?

31. Can students purchase each of the following snack foods or beverages from vending machines or at the school store, canteen, or snack bar?

RATIONALE:

These questions address the extent to which schools are making more nutritious foods available to students and not offering less nutritious foods and beverages. Many schools offer foods and beverages in vending machines, school stores, snack bars, and canteens, and during celebrations.[1] These foods and beverages, called competitive foods because they compete with school meals as a source of nutrition for students, are often relatively low in nutrient density and relatively high in fat, added sugars, and calories.[2,3] Competitive foods are widely available in many elementary schools, in most middle schools, and in almost all high schools.[1,4-7] Given that schools offer numerous and diverse opportunities for young people to learn and make consumption choices about healthful eating, schools should provide a consistent environment that is conducive to healthful eating behaviors.[8] To help improve dietary behavior and reduce overweight among youth, schools should offer appealing and nutritious foods in school stores, snack bars, and vending machines and discourage sale of foods and beverages high in fat, sodium, added sugars, and caffeine on school grounds.[2,9-13] Schools can also ensure that healthful foods (e.g., fruits and vegetables) are available when foods and beverages are offered during school celebrations. Because students' food choices are influenced by the total food environment, the simple availability of healthful foods such as fruits and vegetables may not be sufficient to prompt the choice of fruits and vegetables when other high-fat or high-sugar foods are easily accessible.[14,15] However, offering a wider range of healthful foods can be an effective way to promote better food choices among high school students.[16] Restricting access to snack foods is associated with higher frequency of fruit and vegetable consumption in elementary school aged children.[17] Taken together, such findings suggest that restricting the availability of high-calorie, energy dense foods in schools while increasing the availability of healthful foods might be an effective strategy for promoting more healthful choices among students at school.[8,18] The United States Department of Agriculture recently established Smart Snacks in Schools nutrition standards for competitive foods sold during the school day.[19] The Smart Snacks standards will help ensure that foods and beverages sold outside of the school meal programs are consistent with national dietary recommendations.

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP13-1305: State Public Health

Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.

REFERENCES:

1. O'Toole T, Anderson S, Miller C, Guthrie J. Nutrition services and foods and beverages Available at: school: results from the School Health Policies and Programs Study. *Journal of School Health* 2007; 77(8):500-521.

2. Institute of Medicine. *Nutrition Standards for Foods in Schools: Leading the Way Toward Healthier Youth.* Washington, DC: Institute of Medicine of the National Academies, 2007.

3. U.S. Department of Agriculture. *Foods Sold in Competition with USDA School Meal Programs: A Report to Congress*. Washington, DC: U.S. Department of Agriculture, 2001.

4. Brener ND, Kann L, O'Toole TP, Wechsler H, Kimmons J. Competitive foods and beverages available for purchase in secondary schools – selected sites, United States, 2006. *MMWR* 2008; 57(34):935-938.

5. U.S. Government Accountability Office. *School meal programs: Competitive foods are widely available and generate substantial revenues*. Report to Congressional Requesters GAO-05-563, 2005. Available at: www.gao.gov/new.items/d05563.pdf. Accessed June 10, 2015.

6. Fox MK, Gordon A, Nogales R, Wilson A. Availability and consumption of competitive foods in US public schools. *Journal of the American Dietetic Association* 2009a; 109:S57-S66.

7. U.S. Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis. *School Nutrition Dietary Assessment Study IV, Vol. I: School Foodservice Operations, School Environments, and Meals Offered and Served*. Alexandria, VA: November 2012.

8. Food and Nutrition Board, Institute of Medicine, Committee on Prevention of Obesity of Children and Youth. Schools. In: JP Koplan, CT Liverman, VI Kraak, eds. *Preventing Childhood Obesity: Health in the Balance.* Washington, DC: National Academy Press, 2005, pp. 237–284.

9. Wechsler H, McKenna ML, Lee SM, Dietz WH. The role of schools in preventing childhood obesity. *The State Education Standard* 2004; 5(2):4-12.

10. American Dietetic Association. Position of the American Dietetic Association: local support for nutrition integrity in schools. *Journal of the American Dietetic Association* 2010; 110(8):1244-1254.

11. Fox MK, Dodd AH, Wilson A, Gleason PM. Association between school food environment and practices and body mass index of US public school children. *Journal of the American Dietetic Association* 2009b; 109(2 suppl):S108–S17.

12. Briefel RR, Crepinsek MK, Cabili C, Wilson A, Gleason PM. School food environments and practices affect dietetic behaviors of US public school children. *Journal of the American Dietetic Association* 2009; 109 (Suppl 1):S91–S107.

13. Institute of Medicine. *Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation*. Washington, DC: The National Academies Press, 2012.

14. Cullen KW, Eagan J, Baranowski T, Owens E, deMoor C. Effect of a la carte and snack bar foods at school on children's lunchtime intake of fruits and vegetables. *Journal of the American Dietetic Association* 2000; 100:1482–1486.

15. Kubik MY, Lytle LA, Hannan PJ, Perry CL, Story M. The association of the school food environment with dietary behaviors of young adolescents. *American Journal of Public Health* 2003; 93:1168–1173.

16. French SA, Story M, Fulkerson JA, Hannan P. An environmental intervention to promote lower fat food choices in secondary schools. Outcomes of the TACOS study. *American Journal of Public Health* 2004; 94(9):1507-1512.

17. Gonzalez W, Jones SJ, Frongillo EA. Restricting snacks in US elementary schools is associated with higher frequency of fruit and vegetable consumption. *Journal of Nutrition* 2009; 139:142-4.

18. Story, M, Nanney MS, and Schwartz MB. Schools and obesity prevention: creating school environments and policies to promote healthy eating and physical activity. *Milbank Quarterly* 2009; 87(1):71-100.

19. National School Lunch Program and School Breakfast Program: Nutrition Standards for All Foods Sold in School as Required by the Healthy, Hunger-Free Kids Act of 2010, 7 CFR Section 210 and 220.

QUESTION:

32. During this school year, has your school done any of the following?...(a) Priced nutritious foods and beverages at a lower cost while increasing the price of less nutritious foods and beverages?...(b) Collected suggestions from students, families, and school staff on nutritious food preferences and strategies to promote healthy eating?...(c) Provided information to students or families on the nutrition and caloric content of foods available?...(d) Conducted taste tests to determine food preferences for nutritious

items?...(e) Provided opportunities for students to visit the cafeteria to learn about food safety, food preparation, or other nutrition-related topics?...(f) Served locally or regionally grown foods in the cafeteria or classrooms?...(g) Planted a school food or vegetable garden?...(h) Placed fruit and vegetables near the cafeteria cashier, where they are easy to access?...(i) Used attractive displays for fruits and vegetables in the cafeteria?...(j) Offered a self-serve salad bar to students?...(k) Labeled healthful foods with appealing names (e.g., crunchy carrots)?...(l) Encouraged students to drink plain water?...(m) Prohibited school staff from giving students food or food coupons as a reward for good behavior or good academic performance?...(n) Prohibited less nutritious foods and beverages (e.g., candy, baked goods) from being sold for fundraising purposes?

RATIONALE:

This question addresses the variety of methods schools can use to promote healthy eating. Students' food choices are influenced by the total food environment. The simple availability of fruits and vegetables may not be sufficient to prompt the choice of these items when items high in fat and/or added sugar are also available.[1] Even when healthful foods (e.g. fruits and vegetables) are available, they compete in the context of a vast array of other food items, mostly high in fat and sugar, that are competitively priced.[2] Schools should employ effective or promising strategies in the school setting to promote healthy eating, such as pricing strategies,[3,4] input from stakeholders,[5] provision of nutrition information,[6] taste tests, using the cafeteria as a learning laboratory,[7] school gardens[8] and serving locally or regionally grown foods in the cafeteria or classrooms.[9] Additional promising strategies include placing fruit and vegetables near the cafeteria cashier, where they are easy to access,[10] using attractive displays for fruits and vegetables in the cafeteria,[10] labeling healthful foods with appealing names,[10] offering a self-serve salad bar to students,[11,12] and encouraging students to drink plain water.[13-15] Additionally schools can implement practices that limit access to less healthful foods and beverages including prohibiting school staff from giving students food or food coupons as a reward for good behavior or good academic performance,[15,16] and prohibiting less nutritious foods and beverages (e.g., candy, baked goods) from being sold for fundraising purposes[15,16]

Items 32 a, c, and h provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP13-1305: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.

REFERENCES:

1. Kubik MY, Lytle LA, Hannan PJ, Perry CL, Story M. The association of the school food environment with dietary behaviors of young adolescents. *American Journal of Public Health* 2003; 93:1168–1173.

2. Cullen KW, Eagan J, Baranowski T, Owens E, deMoor C. Effect of a la carte and snack bar foods at school on children's lunchtime intake of fruits and vegetables. *Journal of the American Dietetic Association* 2000; 100:1482–1486.

3. French SA, Story M, Jeffery RW, Snyder P, Eisenberg M, Sidebottom A. Pricing strategy to promote fruit and vegetable purchase in high school cafeterias. *Journal of the American Dietetic Association* 1997; 97:1008–1010.

4. French SA, Jeffery RW, Story M, et al. Pricing and promotion effects on lowfat vending snack purchases: the CHIPS study. *American Journal of Public Health* 2001; 91:112–117.

5. Food and Nutrition Service, U.S. Department of Agriculture, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, and U.S. Department of Education. *Making It Happen: School Nutrition Success Stories*. Alexandria, VA: U.S. Department of Agriculture, 2005.

6. Food and Nutrition Board, Institute of Medicine, Committee on Prevention of Obesity of Children and Youth. Schools. In: JP Koplan, CT Liverman, VI Kraak, eds. *Preventing Childhood Obesity: Health in the Balance.* Washington, DC: National Academy Press; 2005, pp. 237–284.

7. American Dietetic Association. Position of the American Dietetic Association, Society for Nutrition Education, and American School Food Service Association – Nutrition services: an essential component of comprehensive school health programs. *Journal of the American Dietetic Association* 2003; 103:505–514.8.

8. Robinson-Obrien R, Story M, Heim S. Impact of garden-based youth nutrition intervention programs: a review. *Journal of the American Dietetic Association* 2009; 109:273-80.

9. Joshi A, Misako Azuma A, Feenstra G. Do farm-to-school programs make a difference? Findings and future research needs. *Journal of Hunger and Environmental Nutrition* 2008; 3:2-3.

10. Just DR, Mancino L, Wansink B. *Could Behavioral Economics Help Improve Diet Quality for Nutrition Assistance Program Participants?* Economic Research Report no. 43. Washington, DC: US Department of Agriculture, Economic Research Service 2007.

11. Slusser WM, Cumberland WG, Browdy BL, et al. A school salad bar increases frequency of fruit and vegetable consumption among children living in low-income households. *Public Health Nutrition* 2007; 10(12):1490-1496.

12. Adams MA, Pelletier RL, Zive MM, Sallis JF. Salad bars and fruit and vegetable consumption in elementary schools: a plate waste study. *Journal of the American Dietetic Association* 2005; 105(11):1789-1792.

13. American Academy of Pediatrics, Committee on Nutrition and the Council of Sports Medicine and Fitness. Clinical Report-Sports drinks and energy drinks for children and adolescents: Are they appropriate? *Pediatrics* 2011; 127:1182-1189.

14. Patel AI, Bogart LM, Elliott MN, et al. Increasing the availability and consumption of drinking water in schools: a pilot study. *Preventing Chronic Disease* [serial online] 2011; 8(3):A60.

15. Institute of Medicine. *Nutrition Standards for Foods in Schools: Leading the Way toward Healthier Youth*. Washington, DC: Institute of Medicine of the National Academies, 2007.

16. Centers for Disease Control and Prevention. School health guidelines to promote healthy eating and physical activity. *MMWR* 2011; 60(RR05):1–76.

QUESTION:

33. Does your school prohibit advertisements for candy, fast food restaurants, or soft drinks in each of the following locations?

RATIONALE:

This question addresses prohibiting marketing of less nutritious foods to students while at school or at school-sponsored events. Marketing and promotion of foods and beverages in schools occur in many forms including posters, coupons, commercials during educational programming (e.g., Channel One television), and the sale of branded foods and beverages.[1] In 2006, 23.3% of schools allowed the promotion of candy, meals from fast food restaurants, or soft drinks through the distribution of coupons for free or reduced price, 14.3% allowed the promotion of these products through sponsorship of school events, and 7.7% did so through publications such as a school newsletter or newspaper.[2] Many contracts for soft drink or other vending products have provisions to increase the percentage of profits schools receive when sales volume increases, and this is a substantial incentive for schools to promote soft drink consumption by adding vending machines, increasing the times they are available, and marketing the products to students.[3,4] In some districts, these incentives have led schools to aggressively promote student purchases of soft drinks.[4] Research suggests that exposure to advertisements may have adverse effects on children's eating habits.[5] Food advertisements have been found to trigger food purchase by parents, have effects on children's product and brand preferences, and have an effect on consumption behavior.[6] Further, younger children do not generally understand the difference between information and advertising,[7] such that children may interpret school-based advertising to mean that teachers or other adults endorse the use of the advertised product. More than $149 million is spent on marketing of foods and beverages in schools annually, with carbonated beverages and noncarbonated beverages making up the majority of in-school marketing expenditures.[1] Given that schools provide a captive audience of students, the Institute of Medicine report on food marketing to children and youth recommends that schools should promote healthful diets for children and youth in all aspects of the school environment (e.g., commercial sponsorships, meals and snacks, curriculum).[8]

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP13-1305: State Public Health

Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.

REFERENCES:

1. Federal Trade Commission. *Marketing Food to Children and Adolescents: Follow-Up Report*. Washington, DC: Federal Trade Commission, 2012.

2. O'Toole T, Anderson S, Miller C, Guthrie J. Nutrition services and foods and beverages Available at: school: results from the School Health Policies and Programs Study. *Journal of School Health* 2007; 77(8):500-521.

3. U.S. Department of Agriculture. *Foods Sold in Competition with USDA School Meal Programs: A Report to Congress.* Washington, DC: U.S. Department of Agriculture, 2001.

4. Nestle M. Soft drink "pouring rights:" marketing empty calories to children. *Public Health Reports* 2000; 115:308-319.

5. Horgen KB, Choate M, Brownell KK. Television and food advertising: targeting children in a toxic environment. In: Sinder DG, Singer JL, eds. *Handbook of Children and the Media.* Thousand Oaks, CA: Sage Publications, 2001, pp. 447-461.

6. Hastings G, Stead M, McDermott L, et al. *Review of Research on the Effects of Food Promotion to Children*. Glasgow, UK: Center for Social Marketing, University of Strathclyde, 2003. Available at: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.134.1856&rep=rep1&type=pdf Accessed June 12, 2015.

7. Wilcox BL, Kunkel D, Cantor J, Dowrick P, Linn S, Palmer E. *Report of the APA Task Force on Advertising and Children.* Washington, DC: American Psychological Association, 2004.

8. Institute of Medicine, Committee on Food Marketing and the Diets of Children and Youth. *Food Marketing to Children and Youth: Threat or Opportunity?* Washington, DC: The National Academies Press, 2006.

QUESTIONS:

34. Are students permitted to have a drinking water bottle with them during the school day?

35. Does your school offer a free source of drinking water in the following locations?

RATIONALE:

These questions address the importance of drinking water and access to free drinking water throughout the school day and during school meals. The United States Department of Agriculture requires that schools participating in the National School Lunch Program and School Breakfast Program make drinking water available free of charge where school meals are served.[1,2] However, schools should ensure that students have access to safe, free, and well-maintained drinking water fountains or dispensers throughout the school day.[3] This provides a healthy alternative to sugar-sweetened beverages (SSBs) and can help increase students' overall water consumption and maintain adequate hydration.[4,5] Adequate hydration is associated with improved cognitive function in children and adolescents which is important for learning.[6-9] Drinking tap water instead of SSBs can help protect against tooth decay, reduce calorie intake, and prevent childhood obesity.[5,10,11,12]

Bottled water may not be affordable for all students. In addition, free drinking water is not always readily accessible or available in schools. Barriers may include concerns (real and/or perceived) about the safety and quality of drinking water, students' preference for beverages other than tap water, the costs of improving drinking water access and quality, and a lack of sound policies promoting the availability of drinking water.[13,14] School districts and schools can encourage students to drink tap water by including provisions in their local wellness policies that emphasize safe, free drinking water as an essential component of student health and wellness.[13]

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP13-1305: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.

REFERENCES:

1. Healthy, Hunger-Free Kids Act of 2010, Pub L 111-296, 124 Stat 3183, Sec 203.

2. National School Lunch Program and School Breakfast Program: Nutrition Standards for All Foods Sold in School as Required by the Healthy, Hunger-Free Kids Act of 2010, 7 C.F.R. Section 210 and 220.

3. Institute of Medicine, Committee on Nutrition Standards for Foods in Schools. *Nutrition Standards for Foods in Schools: Leading the Way toward Healthier Youth*. Washington, DC: The National Academies Press, 2007.

4. Kaushik A, Mullee MA, Bryant TN, Hill CM. A study of the association between children's acess to drinking water in primary schools and their fluid intake: can water be 'cool' in school? *Child: Care, Health & Development* 2007; 33:409-15.

5. Muckelbauer R, Libuda L, Clausen K, Toschke AM, Reinehr T, Kersting M. Promotion and provision of drinking water in schools for overweight prevention: randomized, controlled cluster trial. *Pediatrics* 2009; 123:e661-36676.

6. Kempton MJ, Ettinger U, Foster R, Williams SCR, Calvert GA, Hampshire A, et al. Dehydration affects brain structure and function in healthy adolescents. *Human Brain Mapping* 2011; 32:71–79.

7. Edmonds CJ, Jeffes B. Does having a drink help you think? 6-7-year-old children show improvements in cognitive performance from baseline to test after having a drink of water. *Appetite* 2009; 53:469–472.

8. Edmonds CJ, Burford D. Should children drink more water? The effects of drinking water on cognition in children. *Appetite* 2009; 52:776–779.

9. Benton D, Burgess N. The effect of the consumption of water on the memory and attention of children. *Appetite* 2009; 53:143–146.

10. US Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

11. Dietary Guidelines Advisory Committee. *Report of the Dietary Guidelines Advisory Committee on the Dietary Guidelines for Americans 2010, to the Secretary of Agriculture and the Secretary of Health and Human Services.* U.S. Department of Agriculture, Agricultural Research Service, Washington, DC. 2010.

12. Wang Y C, Ludwig DS, Sonneville K, Gortmaker SL. Impact of change in sweetened caloric beverage consumption on energy intake among children and adolescents. *Archieves of Pediatric & Adolescent Medicine* 2009; 163(4):336–343.

13. National Policy & Legal Analysis Network to Prevent Childhood Obesity (NPLAN). *Model Wellness Policy Language for Water Access in Schools*. Public Health Law and Policy, Oakland, CA. Oct 2010. Available at: http://changelabsolutions.org/publications/wellness-policy-water. Accessed June 11, 2015.

14. Patel AI, Bogart LM, Klein DJ, et al. Middle school student attitudes about school drinking fountains and water intake. *Academic Pediatrics* 2014;14:471–477.

HEALTH SERVICES

QUESTION:

36. Is there a full-time registered nurse who provides health services to students at your school? (A full-time nurse means that a nurse is at the school during all school hours, 5 days per week.)

37. Is there a part-time registered nurse who provides health services to students at your school? (A part-time nurse means that a nurse is at the school less than 5 days a week, less than all school hours, or both.)

RATIONALE:

These questions examine the degree to which schools are being staffed by school nurses. Because a school nurse is an essential component of a healthy school, *Healthy People 2020* Educational and Community-Based Program objective-5 calls to increase the proportion of the Nation's elementary, middle, and senior high schools that have a full-time registered school nurse-to-student ratio of at least 1:750.[1] School nurses, whether part- or full-time can link students and schools to physician and community resources in addition to providing services to students in schools.

REFERENCE:

1. U.S. Department of Health and Human Services. *Healthy People 2020*. Office of Disease Prevention and Health Promotion. November 2010. Available at: www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=11. Accessed June 11, 2015.

QUESTION:

38. Does your school have a school-based health center that offers health services to students? (School-based health centers are places on school campus where enrolled students can receive primary care, including diagnostic and treatment services. These services are usually provided by a nurse practitioner or physician's assistant.)

RATIONALE:

This question assesses if schools have a school-based health center (SBHC). SHBCs provide a range of age-appropriate health services to students including screening, early intervention, risk reduction, counseling, and treatment for both mental and physical conditions.[1] Schools typically partner with community health organizations to provide these services.[1] The type and range of services provided by the SHBC depends on community needs and resources.[1] SHBCs are well suited to provide care for youth without some of the associated burdens of the traditional health

care model.[2] There is evidence that SBHC usage may not only improve the health of children and adolescents, but also may reduce health care costs and improve school outcomes.[2]

REFERENCES:

1. U.S. Department of Health and Human Services, Health Resources and Services Administration. School-based health centers. Available at: http://www.hrsa.gov/ourstories/schoolhealthcenters/. Accessed June 15, 2015.

2. American Academy of Pediatrics Council on School Health. School-based health centers and pediatric practice. [Policy Statement]. *Pediatrics* 2012; 129(2):387-393.

QUESTIONS:

39. Does your school provide the following services to students?

40. Does your school provide students with referrals to any organizations or health care professionals not on school property for the following services?

RATIONALE:

These questions address students' access to sexual health services either provided on-site or through referrals to health care professionals not on school property. Many adolescents engage in sexual risk behaviors that can result in unintended health outcomes. In 2013, among U.S. high school students, almost half reported ever having had sex. Of those sexually active in the previous 3 months, about a third did not use a condom.[1] In 2010, young people aged 13-24 accounted for 26% of all new HIV infections in the United States.[2] Of the 19.7 million incident sexually transmitted infections in 2008, nearly 50% (9.8 million) were acquired by young women and men aged 15 to 24 years.[3] Several official and national guidelines for adolescent preventive care specifically include recommendations for the provision of sexual health services for adolescents.[4-7] Schools in the United States have a critical role to play in facilitating delivery of such needed preventive services for adolescents; schools have direct daily contact with 31.7 million students ages 10-17.[8] Many U.S. schools already have health care service infrastructure in place and can play an important role in providing adolescents access to sexual health services.

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Centers for Disease Control and Prevention. Youth risk behavior surveillance—United States, 2013. *MMWR* 2014;63(No. SS-4).

2. Centers for Disease Control and Prevention. Vital Signs: HIV infection, testing, and risk behaviors among youth – United States. *MMWR* 2012;61(47):971–976.

3. Satterwhite CL, Torrone E, Meites E, Dunne EF, Mahajan R, et al. Sexually transmitted infections among U.S. women and men: prevalence and incidence estimates, 2008. *Sexually Transmitted Diseases* 2013; 40(3): 187-193.

4. U.S. Public Health Service. *Clinician's Handbook of Preventive Services: Put Prevention into Practice*. 2nd edition. Alexandria, VA: International Medical Publishing, 1998.

5. Elster AB, Kuznets NJ, editors. *AMA Guidelines for Adolescent Preventive Services (GAPS): Recommendations and Rationale*. Baltimore, MD: Williams & Wilkins, 1994.

6. Green M, Palfrey JS, editors. Bright Futures: *Guidelines for Health Supervision of Infants, Children and Adolescents.* 2nd edition. Arlington, VA: National Center for Education in Maternal and Child Health, 2000.

7. U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services.* 2nd edition. Alexandria, VA: International Medical Publishing, 1996.

8. United States Census Bureau. *School Enrollment*. U.S. Department of Commerce, Census Bureau Web site. Available at: http://www.census.gov/hhes/school. Accessed June 9, 2015.

QUESTIONS:

41. Does your school have a protocol that ensures students with a chronic condition that may require daily or emergency management (e.g., asthma, diabetes, food allergies) are enrolled in private, state, or federally funded insurance programs if eligible?

42. Does your school routinely use school records to identify and track students with a current diagnosis of the following chronic conditions? School records might include student emergency cards, medication records, health room visit information, emergency care and daily management plans, physical exam forms, or parent notes.

RATIONALE:

Chronic health conditions such as epilepsy or seizure disorder, diabetes, asthma, obesity, high blood pressure/hypertension and food allergies may affect students' physical and emotional well-being, school attendance, academic performance, and social participation. Given the clustering of chronic conditions, many students face the added burden of living with two conditions. The opportunity for academic success is increased when communities, schools, families, and students work together to meet the needs of students with chronic health conditions and provide safe and supportive learning environments.[1,2]

The first question acknowledges and supports the role schools can play in ensuring that students with chronic conditions have access to appropriate clinical care and disease management through a primary care provider and medical home. In 2011, 5 million children had no health insurance coverage. Approximately 1.3 million children were unable to get needed medical care because the family could not afford it, and medical care for 2.5 million children was delayed because of worry about the cost. Schools can support the needs of students with chronic conditions by ensuring they have access to quality clinical care through a primary care provider and medical home. School health personnel should establish systematic protocols and processes for determining the health insurance status of students with chronic conditions and if necessary, assist parents and families in enrolling eligible students into private, state, or federally funded insurance programs.[3,4]

The second question examines the type of information schools use to identify and track students with a known chronic health condition, such as asthma, food allergies, diabetes, obesity, high blood pressure/hypertension, and epilepsy or seizure disorder. Collecting this information for students with chronic conditions will also help to assess the potential need for additional case management of these students. Assessment of successful school-based chronic disease management programs, such as school-based asthma management programs, reveal that this type of tracking and case management can contribute to improved medical management, such as symptom management, of students with chronic conditions.[5-10]

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP13-1305: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.

REFERENCES:

1. National Asthma Education and Prevention Program, National School Boards Association, American School Health Association, American Diabetes Association, American Academy of Pediatrics, Food Allergy and Anaphylaxis Network, Epilepsy Foundation. Students with chronic illnesses: Guidance for families, schools, and students. *Journal of School Health* 2003; 73(4):131-132.

2. Taras H, Brennan JJ. Students with chronic diseases: Nature of school physician support. *Journal of School Health* 2008; 78(7):389-396.

3. Bloom B, Cohen RA, Freeman G. Summary health statistics for U.S. children: National Health Interview Survey, 2011. National Center for Health Statistics. *Vital Health Statistics* 2012; 10(254).

4. Homer CJ, Klatka K, Romm D, Kuhlthau K, Bloom S, Newacheck P, Van Cleave J, Perrin JM. A review of the evidence for the medical home for children with special health care needs. *Pediatrics* 2008 Oct;122(4):e922-37.

5. Levy M., Heffner B, Stewart T, Beeman G. The efficacy of asthma case management in an urban school district in reducing school absences and hospitalizations for asthma. *Journal of School Health*. 2006; 76(6):320-324.

6. Taras H, Wright S, Brennan J, Campana J, Lofgren R. Impact of school nurse case management on students with asthma. *Journal of School Health* 2004; 74(6):213-219.

7. Erickson CD, Splett PL, Mullett SS, Jensen C, Belseth SB. The healthy learner model for student chronic condition management-Part II: The Asthma Initiative. *Journal of School Nursing*. 2006; 22(6):319-329.

8. Splett PL, Erickson CD, Belseth SB, Jensen C. Evaluation and sustainability of the healthy learners asthma initiative. *Journal of School Health*. 2006; 76(6):276-282.

9. Halterman JS, Szilagyi PG, Fisher SG, et al. Randomized controlled trial to improve care for urban children with asthma: results of the School-Based Asthma Therapy trial. *Archives of Pediatrics & Adolescent Medicine*. 2011; 165(3):262-268.

10. Rodriguez E, Rivera DA, Perlroth D, Becker E, Wang NE, Landau M. School Nurses' Role in Asthma Management, School Absenteeism, and Cost Savings: A Demonstration Project. *Journal of School Health*. 2013; 83(12):842-850.

QUESTION:

43. Does your school provide referrals to any organizations or health care professionals not on school property for students diagnosed with or suspected to have any of the following chronic conditions? Include referrals to school-based health centers, even if they are located on school property.

RATIONALE:

This question addresses referrals to community providers for students with chronic conditions. Community resources can address health, mental health, and social service gaps that the school might not have the resources or expertise to address adequately. School health personnel should establish systematic processes and criteria for referring students to external primary health care providers. Students with signs of asthma, food allergies, diabetes, epilepsy or seizure disorder, obesity, or hypertension/high blood pressure should be referred to a primary health care provider for diagnosis, and, if needed, establishment of management or treatment plans. Health, mental health, and social services staff members play an important role in developing and marketing a referral system for students and families. The recipients of these referrals could include school-based health centers, local health departments, outside health care providers (e.g., private physicians, hospitals, psychologists and other mental health workers, community health clinics, and management care organizations).[1-5]

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP13-1305: State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.

REFERENCES:

1. Taras H, Duncan P, Luckenbill D, Robinson J, Wheeler L, Wooley S. *Health, Mental Health, and Safety Guidelines for Schools*. 2004. Available at: http://www.nationalguidelines.org. Accessed June 9, 2015.

2. Centers for Disease Control and Prevention. Strategies for Addressing Asthma Within a Coordinated School Health Program, With Updated Resources. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2006. Available at: www.cdc.gov/HealthyYouth/asthma/pdf/strategies.pdf. Accessed June 9, 2015.

3. Centers for Disease Control and Prevention. School health guidelines to promote healthy eating and physical activity. *MMWR* 2011; 60(5):2011.

4. National Association of School Nurses. Position statement: role of the school nurse. Silver Spring, MD: National Association of School Nurses; 2011. Available at: http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/87/Role-of-the-School-Nurse-Revised-2011. Accessed June 9, 2015.

5. Rose BL, Mansour M, Kohake K. Building a partnership to evaluate school-linked health services: the Cincinnati School Health Demonstration Project. *Journal of School Health* 2005; 75:363-93.

QUESTION:

44. Which of the following best describes your school's practices regarding parental consent and notification when sexual or reproductive health services, such as STD testing or pregnancy testing, are provided by your school?

45. Which of the following best describes your school's practices regarding parental consent and notification when sexual or reproductive health services, such as STD testing or pregnancy testing, are referred by your school?

RATIONALE:

Little is currently known about provider practices in terms of parental notification after minor consent to sensitive services, and misconceptions about state minor consent and confidentiality

laws are widespread. Although most states allow minors to consent to health services without parental permission, policies can vary with regard to the type of service and age of the minor seeking that service.[1] The Health Insurance Portability and Accountability Act (HIPAA) protects identifiable health information from being disclosed. The Federal Educational Rights and Privacy Act (FERPA) also applies to health services that are a part of a school record. Under FERPA, parents may obtain access to and control disclosure of student health records.[2] Exceptions could apply under state laws that govern mandated reporting. It is therefore crucial that schools and districts ensure that staff providing health services or making referrals understand all relevant laws and policies. Further, strict parental consent laws can result in fewer adolescents seeking out sexual health services.[3-5]

REFERENCES:

1. Guttmacher Institute. State Policies in Brief as of June 1, 2015: An Overview of Minors' Consent Law; 2015. Available at: http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf. Accessed June 3, 2015.

2. U.S. Department of Health and Human Services and U.S. Department of Education. Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records; 2008. Available at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/hipaaferpajointguide.pdf. Accessed June 15, 2015.

3. Brewin D, Koren A, Morgan B, Shipley S, Hardy RL. Behind closed doors: school nurses and sexual education. *Journal of School Nursing* 2014; 30:31-41.

4. Reddy DM, Fleming R, Swain C. Effect of mandatory parental notification on adolescent girls' use of sexual health care services. *JAMA* 2002; 288:710-4.

5. Goodwin KD, Taylor MM, Brown EC, et al. Protecting adolescents' right to seek treatment for sexually transmitted diseases without parental consent: the Arizona experience with Senate Bill 1309. *Public Health Reports* 2012; 127:253-8.

FAMILY AND COMMUNITY INVOLVEMENT

QUESTIONS:

46. During this school year, has your school done any of the following activities?... (a) Provided parents and families with information about how to communicate with their child about sex…(b) Provided parents with information about how to monitor their child (e.g., setting parental expectations, keeping track of their child, responding when their child breaks the rules)…(c) Involved parents as school volunteers in the delivery of health education activities and services…(d) Linked parents and families to health services and programs in the community

47. Does your school use electronic (e.g., e-mails, school web site), paper (e.g., flyers, postcards), or oral (e.g., phone calls, parent seminars) communication to inform parents about school health services and programs?

RATIONALE:

These questions assess several different ways to involve parents and community members in school-based health activities and programs. Implementing a variety of activities can increase the likelihood of engaging more parents in the health and education of their children in all grade levels.[1] These different ways to engage parents as they relate to school health are supported by CDC's *Parent Engagement: Strategies for Involving Parents in School Health*:[2]

1) *Provide parenting support:* School staff can use seminars, workshops, and digital and print resources to build parents' skills to support the development of positive health attitudes and behaviors among students. Information should be provided on the following two parenting practices: parental monitoring and communication. Research shows that adolescents whose parents use effective monitoring practices are less likely to make poor decisions, such as having sex at an early age, smoking cigarettes, drinking alcohol, being physically aggressive, or skipping school.[3–7] Clear communication about sex and parental expectations is also important. Research shows that parent communication with their adolescents reduces the likelihood that adolescents will begin having sex at an early age.[7] Generally, adolescents who believe their parents disapprove of risky behaviors are less likely to choose those behaviors.[7]
2) *Provide a variety of volunteer opportunities:* Involving parent members as school volunteers can enrich health and physical education classes, improve the delivery of health services, and help create safe and healthy environments for students.[1,8]
3) *Collaborate with the community:* Schools that work with community groups and organizations can help parents obtain useful information and resources from these groups and organizations and give parents access to community programs, services, and resources.[9]
4) *Communicate with parents:* Research shows that two-way communication (school-to-home and home-to-school) can help ensure parents receive educational materials about different health topics, learn how they can be involved in school health activities, receive feedback and recommendations about health activities, and stay in constant communication with teachers, administrators, counselors, and other staff about their children's health.[1]

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Epstein JL. *School, Family, and Community Partnerships: Preparing Educators and Improving Schools.* 2nd edition. Boulder, CO: Westview Press, 2011.

2. Centers for Disease Control and Prevention. *Parent Engagement: Strategies for Involving Parents in School Health*. Atlanta, GA: U.S. Department of Health and Human Services, 2012.

3. Brendgen M, Vitaro R, Tremblay RE, et al. Reactive and proactive aggression: predictions to physical violence in different contexts and moderating effects of parental monitoring and caregiving behavior. *Journal of Abnormal Child Psychology* 2001; 29(4):293–304.

4. Choquet M, Hassler C, Morin D, et al. Perceived parenting styles and tobacco, alcohol and cannabis use among French adolescents: gender and family structure differentials. *Alcohol & Alcoholism* 2008; 43(1):73–80.

5. Cota-Robles S, Gamble W. Parent-adolescent processes and reduced risk for delinquency: the effect of gender for Mexican American adolescents. *Youth & Society* 2006; 37(4):375–392.

6. Li X, Feigelman S, Stanton B. Perceived parental monitoring and health risk behaviors among urban low-income African-American children and adolescents. *Journal of Adolescent Health* 2000; 27(1):43–48.

7. Markham CM, Lormand D, Gloppen KM, et al. Connectedness as a predictor of sexual and reproductive health outcomes for youth. *Journal of Adolescent Health* 2010; 46(3 Suppl 1):S23–S41.

8. Michael S, Dittus P, Epstein J. Family and community involvement in schools: results from the School Health Policies and Programs Study 2006. *Journal of School Health* 2007; 77:567–579.

9. Gold E, Simon E, Brown C. *Successful Community Organizing for School Reform.* Chicago, IL: Cross City Campaign for Urban School Reform, 2002.

QUESTION:

48. Does your school participate in a program in which family or community members serve as role models to students or mentor students, such as the Big Brothers Big Sisters program?

RATIONALE:

This question assesses whether schools involve parents and community members in programs that provide support, guidance, and opportunities to help students succeed in life and meet their goals.[1] Children and adolescents who feel supported by important adults in their lives are likely to be more engaged in school and learning.[2] This is also supported by the *Healthy People 2020* Adolescent Health objective-3 (AH-3): increase the proportion of adolescents who are connected to a parent or other positive adult caregiver.[3]

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. DuBois DL, Karcher, MJ, eds. *Handbook of Youth Mentoring*. Thousand Oaks, CA: Sage, 2005.

2. Croninger RG, Lee VE. Social capital and dropping out of high school: benefits to at-risk students of teachers' support and guidance. *Teachers College Record* 2001; 103(4):548–581.

3. U.S. Department of Health and Human Services. *Healthy People 2020*. Office of Disease Prevention and Health Promotion. November 2010. Available at: www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=2. Accessed June 15, 2015.

QUESTIONS:

49. Service learning is a particular type of community service that is designed to meet specific learning objectives for a course. Does your school provide service-learning opportunities for students?

50. Does your school provide peer tutoring opportunities for students?

RATIONALE:

These questions assess the extent to which schools foster pro-social behavior by engaging students in activities such as service learning and peer tutoring. These activities are supported by CDC's *School Connectedness: Strategies for Increasing Protective Factors Among Youth.*[1] Service learning integrates volunteering and community service into academic coursework and provides mutually beneficial partnerships between students and the community.[2] Peer tutoring provides an opportunity for students to explore empathy, personal strengths, fairness, kindness, and social responsibility.[3]

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Centers for Disease Control and Prevention. *School Connectedness: Strategies for Increasing Protective Factors among Youth.* Atlanta, GA: U.S. Department of Health and Human Services, 2009.

2. Muscott, H. An introduction to service-learning for students with emotional and behavioral disorders: answers to frequently asked questions. *Beyond Behavior* 2001; 10(3), 8-15.

3. Flay BR, Allred CG. Long-term effects of the Positive Action Program. *American Journal of Health Behavior* 2003; 27(1):S6–S21.

QUESTION:

51. During the past two years, have students' families helped develop or implement policies and programs related to school health?

RATIONALE:

This question assesses whether schools have included parents as participants in school decisions, school activities, and/or advocacy activities through the Parent Teacher Association (PTA) or Parent Teacher Organization (PTO), school health council, school action teams to plan special health related events, and/or other school groups and organizations. Studies show that parent engagement in schools, which includes encouraging parents to be part of decision making, is linked to better student behavior,[1-4] higher academic achievement,[5-7] and enhanced social skills.[4,8] This specific strategy for involving parents is supported by CDC's *Parent Engagement: Strategies for Involving Parents in School Health*.[9]

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Epstein J, Sheldon S. Present and accounted for: improving student attendance through family and community involvement. *The Journal of Educational Research* 2002; 95(5):308–318.

2. Sheldon SB. Parents' social networks and beliefs as predictors of parent involvement. *Elementary School Journal* 2002; 102(4):301–316.

3. Flay BR, Allred CG. Long-term effects of the Positive Action Program. *American Journal of Health Behavior* 2003; 27(1):S6–S21El

4. Nokali NE, Bachman HJ, Votruba-Drzal E. Parent involvement and children's academic and social development in elementary school. *Child Development* 2010; 81(3):988–1005.

5. Fan X, Chen M. Parental involvement and students' academic achievement: a meta-analysis. *Educational Psychology Review* 2001; 13(1):1–22.

6. Jeynes WH. A meta-analysis: the effects on parental involvement on minority children's academic achievement. *Education and Urban Society* 2003; 35:202–218.

7. Jeynes WH. The relationship between parental involvement and urban secondary school student academic achievement: a meta-analysis. *Urban Education* 2007; 42:82–110.

8. Hawkins JD, Catalano RF, Kosterman R, Abbott R, Hill KG. Preventing adolescent health-risk behaviors by strengthening protection during childhood. *Archives of Pediatrics & Adolescent Medicine* 1999; 153:226–234.

9. Centers for Disease Control and Prevention. *Parent Engagement: Strategies for Involving Parents in School Health*. Atlanta, GA: U.S. Department of Health and Human Services; 2012.

ITEM RATIONALE
2016 SCHOOL HEALTH PROFILES
LEAD HEALTH EDUCATION TEACHER QUESTIONNAIRE

REQUIRED HEALTH EDUCATION COURSES

QUESTIONS:

1. How many required health education courses do students take in grades 6 through 12 in your school?

2. Is a required health education course taught in each of the following grades in your school?

3. If students fail a required health education course, are they required to repeat it?

RATIONALE:

These questions measure the extent to which health education courses are required for students in grades 6 through 12 and the importance of these requirements. School health education could be one of the most effective means to reduce and prevent some of the most serious health problems in the United States, including cardiovascular disease, cancer, motor-vehicle crashes, homicide, and suicide.[1] The Institute of Medicine has recommended that schools require a one-semester health education course at the secondary school level;[1] however, the benefits of a health education curriculum increase when students receive at least three consecutive years of a quality health curriculum.[2] The importance of school health education is supported by the establishment of *Healthy People 2020* Early and Middle Childhood objective-4 (EMC-4): increase the proportion of elementary, middle, and senior high schools that require school health education.[3]

REFERENCES:

1. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.

2. Lohrmann DK, Wooley SF. Comprehensive school health education. In: Marx E, Wooley SF, eds. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York, NY: Teachers College Press, 1998, pp. 43–66.

3. U.S. Department of Health and Human Services. *Healthy People 2020.* Washington, DC: U.S. Department of Health and Human Services, 2010. Available at: http://www.healthypeople.gov/2020/topics-objectives/topic/early-and-middle-childhood/objectives. Accessed June 15, 2015.

HEALTH EDUCATION MATERIALS

QUESTION:

4. Are those who teach health education at your school provided with each of the following materials?

RATIONALE:

This question addresses the types of information and support materials health education teachers are given in order to implement health education classes. According to the Joint Committee on National Health Education Standards, quality health education is guided by access and equity principles that call for clear curriculum direction, including goals, objectives, and expected outcomes; a written curriculum; clear scope and sequence of instruction for health education content; and plans for age-appropriate student assessment.[1]

REFERENCE:

1. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence.* 2nd edition. Atlanta, GA: American Cancer Society, 2007.

QUESTION:

5. Does your health education curriculum address each of the following skills?

RATIONALE:

This question addresses the extent to which schools have a health education curriculum that is based on, or is consistent with, current national health education standards.[1] *Healthy People 2020* objective Educational and Community Based Programs-3 (ECBP-3) calls for an increase in the proportion of elementary, middle, and senior high schools that address the knowledge and skills articulated in these standards.[2]

REFERENCES:

1. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence.* 2nd edition. Atlanta, GA: American Cancer Society, 2007.

2. U.S. Department of Health and Human Services. *Healthy People 2020.* Washington, DC: U.S. Department of Health and Human Services, 2010. Available at: www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=11. Accessed June 15, 2015.

QUESTION:

6. Are those who teach sexual health education at your school provided with each of the following materials?

RATIONALE:

This question reflects the characteristics of exemplary sexual health education (ESHE), which is a systematic, evidence-informed approach to sexual health education that includes the use of grade-specific, evidence-based interventions, but also emphasizes sequential learning across elementary, middle, and high school grade levels.[1-3] ESHE provides adolescents the essential knowledge and critical skills needed to avoid HIV, other STD, and unintended pregnancy.[2] ESHE is delivered by well-qualified and trained teachers, uses strategies that are relevant and engaging, and consists of elements that are medically accurate, developmentally and culturally appropriate, and consistent with the scientific research on effective sexual health education.[1,3,4] The items in this question also align with the Health Education Curriculum Analysis Tool[3] and the National Health Education Standards.[5]

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Lohrmann DK, Wooley SF. Comprehensive school health education. In: Marx E, Wooley S, Northrop D, eds. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York, NY: Teachers College Press, 1998, pp. 43–45.

2. Kirby D, Coyle K, Alton F, Rolleri L, Robin L. *Reducing Adolescent Sexual Risk: A Theoretical Guide for Developing and Adapting Curriculum-Based Programs*. Scotts Valley, CA: ETR Associates, 2011.

3. Centers for Disease Control and Prevention. HECAT: Module SH. Sexual health curriculum. 2012. Available at: http://www.cdc.gov/healthyyouth/hecat/pdf/HECAT_Module_SH.pdf. Accessed June 15, 2015.

4. Centers for Disease Control and Prevention. Characteristics of an effective health education curriculum. Available at: www.cdc.gov/healthyyouth/sher/characteristics/index.htm. Accessed June 15, 2015.

5. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence.* 2nd edition. Atlanta, GA: American Cancer Society, 2007.

QUESTION:

7. Does your school provide curricula or supplementary materials that include HIV, STD, or pregnancy prevention information that is relevant to lesbian, gay, bisexual, transgender, and questioning youth (e.g., curricula or materials that use inclusive language or terminology)?

RATIONALE:

This question assesses whether the school uses inclusive curricula or supplementary materials for lesbian, gay, bisexual, transgender, and questioning youth (i.e., sexual minority youth). In a recent report that presented data from 14 states and large urban school districts on sexual minority youth, the percentage of students self-identifying as gay or lesbian, bisexual, or not sure ranged from 1.0-2.6, 2.9-5.2, and 1.3-4.7, respectively.[1] The percentage of students reporting sexual contact with same sex only or both sexes was 0.7-3.9 and 1.9-4.9, respectively.[1] Results from this report and other studies have found that sexual minority students more often participate in behaviors that put them at greater risk for HIV, STD, and unintended pregnancy, including not using a condom during last sexual intercourse.[1-4] Furthermore, the percentage of sexual minority students reporting they were taught in school about AIDS or HIV was lower than that of heterosexual students.[1] Research indicates reduced risk behaviors for some lesbian, gay, and bisexual youth when using inclusive HIV instruction in schools.[5]

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Kann L, Olsen E, McManus T, et al. Centers for Disease Control and Prevention. Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9–12 — Youth Risk Behavior Surveillance, Selected Sites, United States, 2001–2009. *MMWR* Early Release 2011; 60:1-133.

2. Garofalo R, Katz E. Health care issues of gay and lesbian youth. *Current Opinion in Pediatrics* 2001; 13(4):298-302

3. Pathela P, Schillinger J. Sexual behaviors and sexual violence: adolescents with opposite-, same-, or both-sex partners. *Pediatrics* 2010; 126(5):879-886.

4. Goodenow C, Szalacha L, Robin L, Westheimer K. Dimensions of sexual orientation and HIV-related risk among adolescent females: evidence from a statewide survey. *American Journal of Public Health* 2008; 98(6):1051-1058.

5. Blake SM, Ledsky R, Lehman T, Goodenow C, Sawyer R, Hact T. Preventing sexual risk behaviors among gay, lesbian, and bisexual adolescents: the benefits of gay-sensitive HIV instruction in schools. *American Journal of Public Health* 2001; 91(6):940-946.

REQUIRED HEALTH EDUCATION

QUESTION:

8. Is health education instruction required for students in any of grades 6 through 12 in your school?

RATIONALE:

Not all health education instruction takes place in health education courses.[1] This question addresses whether schools require any classroom instruction on health topics, including instruction that occurs outside of health education courses.

REFERENCE:

1. Kann L, Telljohann SK, Wooley SF. Health education: results from the School Health Policies and Programs Study 2006. *Journal of School Health* 2007; 77(8): 408-434.

QUESTION:

9. During this school year, have teachers in your school tried to increase student knowledge on each of the following topics in a required course in any of grades 6 through 12?

RATIONALE:

This question addresses the extent to which traditional health content areas and the prevention of health risk behaviors are taught in required courses in grades 6 through 12. *Healthy People 2020* objective ECBP-2 calls for an increase in the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent morbidity and mortality

resulting from unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity.[1]

Additionally, chronic health conditions such as epilepsy or seizure disorder, diabetes, asthma, and food allergies may affect students' physical and emotional well-being, school attendance, academic performance, and social participation. Given the clustering of chronic conditions, many students face the added burden of living with two conditions. The opportunity for academic success is increased when communities, schools, families, and students work together to meet the needs of students with chronic health conditions and provide safe and supportive learning environments.[2,3] Providing health education in these areas contribute to raising awareness of these chronic health conditions within the broader school community.

REFERENCES:

1. U.S. Department of Health and Human Services. *Healthy People 2020.* Washington, DC: U.S. Department of Health and Human Services, 2010. Available at: www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=11. Accessed June 11, 2015.

2. National Asthma Education and Prevention Program, National School Boards Association, American School Health Association, American Diabetes Association, American Academy of Pediatrics, Food Allergy and Anaphylaxis Network, Epilepsy Foundation. Students with chronic illnesses: Guidance for families, schools, and students. *Journal of School Health* 2003; 73(4):131-132.

3. Taras H, Brennan JJ. Students with chronic diseases: Nature of school physician support. *Journal of School Health* 2008; 78(7):389-396.

QUESTION:

10. During this school year, did teachers in your school teach each of the following tobacco-use prevention topics in a required course for students in any of grades 6 through 12?

RATIONALE:

This question measures the tobacco-use prevention curricula content, and relates to the *Healthy People 2020* ECBP-2: Increasing the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems including tobacco use and addiction.[1] Since most smoking is initiated by persons less than 18 years old, programs that prevent onset of smoking during the school years are crucial. When implemented in conjunction with broader community-based mass media campaigns that show strong evidence of their effectiveness in reducing tobacco use among adolescents, school-based tobacco

prevention programs that address multiple psychosocial factors related to tobacco use among youth and that teach the skills necessary to resist those influences have demonstrated consistent and significant reductions or delays in adolescent smoking.[2-10] Social influence programming has reduced smoking onset by as much as 50%, with effects lasting up to 6 years, and with effects including reduction of the use of other tobacco products as well.[4]

In addition, this question measures the extent to which schools are complying with the components of the National Health Education Standards, which provide a framework for decisions about the lessons, strategies, activities, and types of assessment to include in a health education curriculum.[11] It also measures the extent to which the content aligns with the Health Education Curriculum Analysis Tool.[12]

REFERENCES:

1. U.S. Department of Health and Human Services. *Healthy People 2020*. Office of Disease Prevention and Health Promotion. November 2010. Available at: www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=11. Accessed June 11, 2015.

2. U.S. Department of Health and Human Services. *Preventing Tobacco Use among Youth and Young Adults: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012.

3. U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000.

4. Sussman S. School-based tobacco use prevention and cessation: where are we going? *American Journal of Health Behavior* 2001; 25(3):191-9.

5. Dent CW, Sussman S, Stacy AW, Craig S, Burton D, Flay BR. Two-year behavior outcomes of project towards no tobacco use. *Journal of Consulting and Clinical Psychology* 1995; 63(4):676-677.

6. Botvin GJ, Baker E, Dusenbury L, Botvin EM, Diaz T. Long-term follow-up results of a randomized drug abuse prevention trial in a white middle-class population. *Journal of the American Medical Association* 1995; 273(14):1106-1112.

7. Lantz PM, Jacobson PD, Warner KE, Wasserman J, Pollack HA, Berson J, Ahlstrom A. Investing in youth tobacco control: a review of smoking prevention and control strategies. *Tobacco Control* 2000; 9:47-63.

8. Rooney BL, Murray DM. A meta-analysis of smoking prevention programs after adjustment for errors in the unit of analysis. *Health Education Quarterly* 1996; 23(1):48-64.

9. Bruvold WH. A meta-analysis of adolescent smoking prevention programs. *American Journal of Public Health* 1993; 83(6):872-80.

10. Guide to Community Preventive Services. Reducing Tobacco Use Initiation: Mass Media Campaigns when Combined with Other Interventions (1999 archived review). Available at: www.thecommunityguide.org/tobacco/massmediaeducation_archive.html. Accessed June 11, 2015.

11. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence.* 2nd edition. Atlanta, GA: American Cancer Society, 2007.

12. Centers for Disease Control and Prevention. Health Education Curriculum Analysis Tool. 2013. Available at: http://www.cdc.gov/healthyyouth/hecat/index.htm. Accessed June 11, 2015.

QUESTION:

11. During this school year, did teachers in your school teach each of the following sexual health topics in a required course for students in each of the grade spans below?

RATIONALE:

This question measures sexual health education curricula content. The National Health Education Standards outline knowledge and skills that should be attained by students following the completion of a high-quality health education program.[1]

Sexual health education programs can increase knowledge and skills to prevent unintended pregnancy and decrease risk of HIV and STD infection.[2-4] Given variability among adolescents in cognition, social maturity, and sexual experience, curricula should be tailored to meet the unique needs of younger, as well as older adolescents.[5,6] To coincide with the maturity level and cognitive abilities of the learner, the progression of sexual health education concepts and skills increase in complexity as the sequence advances up grade levels. The Centers for Disease Control and Prevention's Health Education Curriculum Analysis Tool is aligned with the National Health Education Standards and provides a guide to developmentally appropriate topics for sexual health education within schools for pre-K-12th grade.[7]

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence.* 2nd edition. Atlanta, GA: American Cancer Society, 2007.

2. Goesling B, Colman S, Trenholm C, Terzian M, Moore K. Programs to reduce teen pregnancy, sexually transmitted infections, and associated sexual risk behaviors: a systematic review. *Journal of Adolescent Health* 2014; 54 (5):499–507.

3. Kirby D. *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Siseases*. Washington, DC: The National Campaign to Prevent Teen Pregnancy, 2007. Available at: http://thenationalcampaign.org/sites/default/files/resource-primary-download/EA2007_full_0.pdf. Accessed June 8, 2015.

4. Robin L, Dittus P, Whitaker D, et al. Behavioral interventions to reduce incidence of HIV, STD, and pregnancy among adolescents: a decade in review. *Journal of Adolescent Health* 2004; 34(1):3-26.

5. Kirby D, Coyle K, Alton F, Rolleri L, Robin L. *Adolescent Sexual Risk: A Theoretical Guide for Developing and Adapting Curriculum-Based Programs.* Scotts Valley, CA: ETR Associates, 2011. Available at: http://go.etr.org/reducing-adolescent-sexual-risk. Accessed June 8, 2015.

6. Pedlow CT, Carey MP. Developmentally appropriate sexual risk reduction interventions for adolescents: rationale, review of interventions, and recommendations for research and practice. *Annals of Behavioral Medicine* 2004; 27(3):172-184.

7. Centers for Disease Control and Prevention. Health Education Curriculum Analysis Tool. 2013. Available at: www.cdc.gov/Healthyyouth/HECAT/index.htm. Accessed June 8, 2015.

QUESTION:

12. During this school year, did teachers in your school assess the ability of students to do each of the following in a required course for students in each of the grade spans below?

RATIONALE:

This question measures the extent to which students were assessed on their skills to perform behaviors associated with reduced sexual risk behaviors. When adolescents are confident in their ability to perform behaviors (called self-efficacy) and when they have practice in implementing behaviors, they are more likely to engage in protective behaviors and to refrain from sexual risk behaviors.[1,2] The skills listed are part of exemplary sexual health education and are based on the characteristics of sexual health education curricula as listed in the Health Education Curriculum Analysis Tool (HECAT)[3] and the National Health Education Standards.[4]

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Kirby D, Coyle K, Forrest A, et al. *Reducing Adolescent Sexual Risk: A Theoretical Guide for Developing and Adapting Curriculum-Based Programs.* Scotts Valley, CA: ETR Associates, 2011.

2. Gavin LE, Catalano RF, Corinne David-Ferdon C, et al. A review of positive youth development programs that promote adolescent sexual and reproductive health. *Journal of Adolescent Health* 2010; 46(3):S75–S91.

3. Centers for Disease Control and Prevention. HECAT Module SH. Sexual Health Curriculum. 2012. Available at: http://www.cdc.gov/healthyyouth/hecat/pdf/HECAT_Module_SH.pdf. Accessed June 11, 2015.

4. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence.* 2nd edition. Atlanta, GA: American Cancer Society, 2007.

QUESTION:

13. During this school year, did teachers in your school teach each of the following nutrition and dietary behavior topics in a required course for students in any of grades 6 through 12?

RATIONALE:

This question measures the curricula content related to nutrition and dietary behavior. Comprehensive, sequential nutrition education using the classroom and the lunchroom can reinforce healthful eating behaviors.[1,2] Nutrition education should be part of a comprehensive

school health education curriculum that is aligned with the National Health Education Standards[3,4] and includes concepts and skills to promote healthy eating.[4-7] This list of 20 nutrition topics is based on the Dietary Guidelines for Americans, 2010,[8] CDC guidelines,[7] the School Health Index,[9] and the Health Education Curriculum Analysis Tool (HECAT).[4] *Healthy People 2020* objective ECBP-2.8 calls for an increase in the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in unhealthy dietary patterns.[10] In addition to understanding healthy eating, students should also understand how to assess their weight status using body mass index. An individual's weight status is linked to nutrition and their overall health.[11] *Healthy People 2020* objective ECBP-4.3 calls for an increase in the proportion of elementary, middle, and senior high schools that provide health education in growth and development to promote personal health and wellness.[10]

REFERENCES:

1. Food and Nutrition Board, Institute of Medicine, Committee on Prevention of Obesity of Children and Youth, Schools. In: JP Koplan, CT Liverman and VI Kraak, eds. *Preventing Childhood Obesity: Health in the Balance*. Washington, DC: National Academy Press, 2005, pp. 237–284.

2. Briggs M, Mueller CG, Fleischhacker S. Position of the American Dietetic Association, School Nutrition Association, and Society for Nutrition Education: Comprehensive school nutrition services. *Journal of the American Dietetic Association* 2010; 110:1738-1749.

3. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence.* 2nd edition. Atlanta, GA: American Cancer Society, 2007.

4. Centers for Disease Control and Prevention. Health Education Curriculum Analysis Tool. 2013. Available at: www.cdc.gov/healthyyouth/hecat/index.htm. Accessed June 10, 2015.

5. Ralston K, Buzby J, Guthrie J. *A Healthy School Meal Environment.* US Department of Agriculture, Economic Research Service, Food Assistance and Nutrition Research Report Number 34-5, 2003. Available at: http://www.ers.usda.gov/publications/fanrr-food-assistance-nutrition-research-program/fanrr34-5.aspx. Accessed June 10, 2015.

6. U.S. Department of Agriculture. *Changing the Scene: Improving the School Nutrition Environment.* 2000. Available at: http://www.fns.usda.gov/changing-scene-improving-school-nutrition-environment. Accessed June 10, 2015.

7. Centers for Disease Control and Prevention. School health guidelines to promote healthy eating and physical activity. *MMWR* 2011; 60(5).

8. U.S. Department of Agriculture, U.S. Department of Health and Human Services. *Dietary Guidelines for Americans, 2010*. 7th edition. Washington, DC: U.S. Government Printing Office, 2010.

9. Centers for Disease Control and Prevention. *School Health Index.* 2014. Available at: www.cdc.gov/healthyyouth/shi. Accessed June 11, 2015.

10. U.S. Department of Health and Human Services. *Healthy People 2020.* Washington, DC: U.S. Department of Health and Human Services, 2010. Available at: www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=11. Accessed June 11, 2015.

11. Barlow SE and the Expert Committee. Expert Committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: summary report. *Pediatrics* 2007; 120:S164-S192.

QUESTION:

14. During this school year, did teachers in your school teach each of the following physical activity topics in a required course for students in any of grades 6 through 12?

RATIONALE:

This question measures the extent to which physical activity concepts are taught in a required course. Health education that includes physical activity concepts increases the likelihood of students increasing their participation in physical activity,[1-3] reinforces what has been taught in physical education,[4] and assists students in achieving the National Health Education Standards.[5] The content also aligns with the Health Education Curriculum Analysis Tool (HECAT).[6]

REFERENCES:

1. Hoelscher D, Feldman H, Johnson C, et al. School-based health education programs can be maintained over time: results from the CATCH institutionalization study. *Preventive Medicine* 2004; 38(5):594-606.

2. Nader P, Stone E, Lytle L, Perry C, Osganian S, Kelder S et al. Three-year maintenance of improved diet and physical activity: the CATCH cohort. Child and Adolescent Trial for Cardiovascular Health. *Archives of Pediatrics & Adolescent Medicine* 1999; 153:695-704.

3. Marcoux MF, Sallis JF, McKenzie TL, Marshall S, Armstrong CA, Goggin K. Process evaluation of a physical activity self-management program for children: SPARK. *Psychology and Health* 1999; 14:659-77.

4. Pate RR, Davis MG, Robinson TN, Stone EJ, McKenzie TL, Young JC. Promoting physical activity in children and youth: a leadership role for schools. *Circulation* 2006; 114:1-11.

5. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence.* 2nd edition. Atlanta, GA: American Cancer Society, 2007.

6. Centers for Disease Control and Prevention. Health Education Curriculum Analysis Tool. 2013. Available at: http://www.cdc.gov/healthyyouth/hecat/index.htm. Accessed June 8, 2015.

COLLABORATION

QUESTION:

15. During this school year, have any health education staff worked with each of the following groups on health education activities?

RATIONALE:

This question measures the extent to which health education staff work cooperatively with other components of the school health program (school health services, school mental health or social services, food service, and physical education staff) and with a school health council, committee, or team. An integrated school and community approach is an effective strategy to promote adolescent health and well-being.[1-3]

REFERENCES:

1. Allensworth D, Kolbe L. The comprehensive school health program: state of the art. *Journal of School Health* 1987; 63:14–20.

2. Kann L, Telljohann SK, Wooley SF. Health education: results from the School Health Policies and Programs Study 2006. *Journal of School Health* 2007; 77:408–434.

3. Lohrmann DK. A complementary ecological model of the coordinated school health program. *Journal of School Health* 2010; 80:1-9.

QUESTION:

16. During this school year, did your school provide parents and families with health information designed to increase parent and family knowledge of each of the following topics?

RATIONALE:

This question measures whether schools are providing health information to students' families. School programs that engage parents and link with the community yield stronger positive results. Studies aimed at preventing childhood overweight, treating childhood overweight, and promoting physical activity and healthy eating have demonstrated more success when targeting the parent and child versus targeting the child alone.[1-4] School-based tobacco prevention programs and community interventions involving parents and community organizations have a stronger impact over time when working in tandem rather than as separate, stand-alone interventions.[5] Assessments of successful school-based asthma management programs indicate that with increased knowledge, parents can assist their children in better managing their asthma.[4-8] Parents also are teenagers' primary sex educators, able to capitalize on teachable moments

when youth may be more open to learning new information.[9] Parents can continue prevention messages delivered in school, thereby enhancing the likelihood of sustained behavioral changes.[10] Increased communication affects both parenting and health practices of parents. Communicating information on healthy lifestyles aims to reinforce the child's coursework at school, facilitate communication with parents about school activities, and increase parent knowledge of healthy living.[11,12] An estimated 4% to 6% of U.S. children of children under age 18 have food allergies.[13-15] Ensuring that parents have the knowledge to help keep their children safe from potential exposure to all foods that might trigger an allergic reaction is an important role schools can play in addressing the needs of students with food allergies. In 2010, 0.26% of youth under the age of 20 had been diagnosed with type 1 or type 2 diabetes.[16] In 2005-2006 NHANES, 16% (overall) of youth 12-19 years and 30% of obese youth 12-19 years had prediabetes, a condition in which blood glucose levels indicate a high risk for development of diabetes.[17] In addition, between 1995 and 2010, the prevalence of diagnosed diabetes in adults increased 50% or more in 42 states, and by 100% or more, in 18 states.[18] Therefore, creating awareness among parents about diabetes may increase knowledge about the extent of the disease and appropriate activities for prevention.

Item 16i provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Golan M, Crow S. Targeting parents exclusively in the treatment of childhood obesity: long-term results. *Obesity Research* 2004; 12:357-361.

2. Ransdell LB, Taylor A, Oakland D, Schmidt J, Moyer-Mileur L, Shultz B. Daughters and mothers exercising together: effects of home- and community-based programs. *Medicine & Science in Sports & Exercise* 2003; 35:286–96.

3. McLean N, Griffin S, Toney K, Hardeman W. Family involvement in weight control, weight maintenance and weight-loss interventions: a systematic review of randomised trials. *International Journal of Obesity Related Metabolic Disorders* 2003; 27:987–1005.

4. Wang Y, Wu Y, Wilson RF, et al. *Childhood Obesity Prevention Programs: Comparative Effectiveness Review and Meta-Analysis.* Comparative Effectiveness Review No. 115. (Prepared by the Johns Hopkins University Evidence-based Practice Center under Contract No. 290-2007-10061-I.) AHRQ Publication No. 13-EHC081-EF. Rockville, MD: Agency for Healthcare Research and Quality; 2013. Available at: http://www.effectivehealthcare.ahrq.gov/ehc/products/330/1524/obesity-child-report-130610.pdf. Accessed June 15, 2015.

5. Lantz PM, Jacobson PD, Warner KE, Wasserman J, Pollack HA, Berson J, Ahlstrom A. Investing in youth tobacco control: a review of smoking prevention and control strategies. *Tobacco Control* 2000; 9:47-63.

6. Splett PL, Erickson CD, Belseth SB, Jensen C. Evaluation and sustainability of the healthy learners asthma initiative. *Journal of School Health* 2006; 76(6):276-282.

7. Erickson, CD, Splett PL, Mullett SS, Jensen C, Belseth SB. The healthy learner model for student chronic condition management-Part II: The Asthma Initiative. *Journal of School Nursing* 2006; 22(6):319-329.

8. Levy M, Heffner B, Stewart T, Beeman G. The efficacy of asthma case management in an urban school district in reducing school absences and hospitalizations for asthma. *Journal of School Health* 2006; 76(6):320-324.

9. Szapocznik J, Coatsworth JD. An ecodevelopmental framework for organizing risk and protection for drug abuse: A developmental model of risk and protection. In: Glantz M, Hartel CR, eds. *Drug Abuse: Origins and Interventions*. Washington, DC: American Psychological Association, 1999, pp. 331-366.

10. Pequegnat W, Szapocznik J. The role of families in preventing and adapting to HIV/AIDS: Issues and answers. In: Pequegnat W, Szapocznik J, eds. *Working with Families in the Era of HIV/AIDS*. Thousand Oaks, CA: Sage Publications, 2000.

11. Nader PR, Sellers DE, Johnson CC, et al. The effect of adult participation in a school-based family intervention to improve children's diet and physical activity: The Child and Adolescent Trial for Cardiovascular Health. *Preventive Medicine* 1996; 25:455-464.

12. Perry CL, Luepker RV, Murray DM, Kurth C, Mullis R, Crockett S, Jacobs DR. Parent involvement with children's health promotion: The Minnesota Home Team. *American Journal of Public Health* 1988; 78(9):1156-1160.

13. Branum AM, Lukacs SL. Food allergy among US children: trends in prevalence and hospitalizations. *NCHS Data Brief*, No. 10. Hyattsville, MD: National Center for Health Statistics; 2008. Available at: http://www.cdc.gov/nchs/data/databriefs/db10.pdf Accessed June 8, 2015.

14. Liu AH, Jaramillo R, Sicherer SH, et al. National prevalence and risk factors for food allergy and relationship to asthma: results from the National Health and Nutrition Examination Survey 2005-2006. *Journal of Allergy and Clinical Immunology* 2010; 126(4):798-806 e13.

15. National Institute of Allergy and Infectious Diseases, National Institutes of Health. *Report on the Expert Panel on Food Allergy Research*. 2003. Available at: http://www.niaid.nih.gov/about/organization/dait/documents/june30_2003.pdf. Accessed June 8, 2015.

16. Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011.

Atlanta, GA: Centers for Disease Control and Prevention, 2011. Available at: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf. Accessed June 8, 2015.

17. Li C, Ford ES, Zhao G, Mokdad AH. Prevalence of pre-diabetes and its association with clustering of cardiometabolicy risk factors and hyperinsulinemia among U.S. adolescents: NHANES 2005-2006. *Diabetes Care* 2009; 32:342-7.

18. Geiss LS, Li Y, Kirtland K, Barker L, Burrows NR, Gregg EW. Increasing prevalence of diagnosed diabetes – United States and Puerto Rico, 1995-2010. *MMWR* 2012; 61(45):918-921.

QUESTION:

17. During this school year, have teachers in this school given students homework assignments or health education activities to do at home with their parents?

RATIONALE:

This question assesses whether teachers develop family-based education strategies that involve parents in discussions about health topics with their children. Supporting learning at home is a type of involvement promoted in CDC's *Parent Engagement: Strategies for Involving Parents in School Health.*[1] Engaging parents in homework assignments or other health activities at home can increase the likelihood that students receive consistent messages at home and in school as well as decrease the likelihood that they engage in health-risk behaviors.[2-4]

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Centers for Disease Control and Prevention. *Parent Engagement: Strategies for Involving Parents in School Health*. Atlanta, GA: U.S. Department of Health and Human Services; 2012.

2. Weiss HB, Kreider H, Lopez ME, Chatman CM, eds. *Preparing Educators to Involve Families.* Thousand Oaks, CA: Sage Publications, Inc., 2005.

3. Hoover-Dempsey KV, Battiato AC, Walker JMT, Reed RP, DeJong JM, Jones KP. Parental involvement in homework. *Educational Psychologist* 2001; 36(3):195–209.

4. Hawkins JD, Catalano RF, Kosterman R, Abbott R, Hill KG. Preventing adolescent health-risk behaviors by strengthening protection during childhood. *Archives of Pediatrics & Adolescent Medicine* 1999; 153:226–234.

PROFESSIONAL DEVELOPMENT

QUESTIONS:

18. During the past two years, did you receive professional development (e.g., workshops, conferences, continuing education, any other kind of in-service) on each of the following topics?

21. Would you like to receive professional development on each of the following topics?

RATIONALE:

These questions address the importance of professional development for teachers. It is vitally important that teachers be well prepared when they begin teaching and that they continue to improve their knowledge and skills throughout their careers.[1] Educators who have received professional development in health education report increases in the number of health lessons taught and their confidence in teaching.[2] Professional development increases educators' confidence in teaching subject matter and provides opportunities for educators to learn about new developments in the field and innovative teaching techniques, and to exchange ideas with colleagues.[3,4] Districts that have made improvements in their professional development activities have seen a rise in student achievement.[5,6] Staff development is associated with increased teaching of important health education topics.[7] The Institute of Medicine's Committee on Comprehensive School Health Programs in Grades K-12 recommended that health education teachers should be expected to participate in ongoing, discipline-specific in-service programs in order to stay abreast of new developments in their field.[3]

REFERENCES:

1. Public Education Network. *Teacher Professional Development: A Primer for Parents and Community Members*. Washington, DC: Public Education Network, 2004.

2. Hausman A, Ruzek S. Implementation of comprehensive school health education in elementary schools: focus on teacher concerns. *Journal of School Health* 1995; 65(3):81-86.

3. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.

4. U.S. Department of Education. Why is professional development so important? *Reading First Notebook*. Summer 2005. Available at: http://www.sedl.org/pubs/reading100/RF-NB-2005-Summer.pdf. Accessed June 15, 2015.

5. Togneri W, Anderson SE. *Beyond Islands of Excellence: What Districts Can Do to Improve Instruction and Achievement in all Schools*. Washington, DC: Learning First Alliance, 2003.

6. Miles KH, Darling-Hammond L. *Rethinking the Allocation of Teaching Resources: Some Lessons from High-Performing Schools.* Philadelphia: Consortium for Policy Research in Education, 1997.

7. Jones SE, Brener ND, McManus T. The relationship between staff development and health instruction in schools in the United States. *American Journal of Health Education* 2004; 35:2-10.

QUESTIONS:

19. During the past two years, did you receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on each of the following topics?

22. Would you like to receive professional development on each of the following topics?

(a) Teaching students with physical, medical, or cognitive disabilities…(b) Teaching students of various cultural backgrounds…(c) Teaching students with limited English proficiency…(d) Teaching students of different sexual orientations or gender identities…(e) Using interactive teaching methods (e.g., role plays, cooperative group activities)…(f) Encouraging family or community involvement…(g) Teaching skills for behavior change…(h) Classroom management techniques (e.g., social skills training, environmental modification, conflict resolution and mediation, behavior management)…(i) Assessing or evaluating students in health education.

RATIONALE:

These questions address the importance of professional development for teachers. It is vitally important that teachers be well prepared when they begin teaching and that they continue to improve their knowledge and skills throughout their careers.[1] Educators who have received professional development in health education report increases in the number of health lessons taught and their confidence in teaching.[2] Professional development increases educators' confidence in teaching subject matter and provides opportunities for educators to learn about new developments in the field and innovative teaching techniques, and to exchange ideas with colleagues.[3,4] Districts that have made improvements in their professional development activities have seen a rise in student achievement.[5,6] Staff development is associated with increased teaching of important health education topics.[7] The Institute of Medicine's Committee on Comprehensive School Health Programs in Grades K-12 recommended that health education teachers should be expected to participate in ongoing, discipline-specific in-service programs in order to stay abreast of new developments in their field.[3]

Item 19h provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Public Education Network. *Teacher Professional Development: A Primer for Parents and Community Members*. Washington, DC: Public Education Network, 2004.

2. Hausman A, Ruzek S. Implementation of comprehensive school health education in elementary schools: focus on teacher concerns. *Journal of School Health* 1995; 65(3):81-86.

3. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.

4. U.S. Department of Education. Why is professional development so important? *Reading First Notebook*. Summer 2005. Available at: http://www.sedl.org/pubs/reading100/RF-NB-2005-Summer.pdf. Accessed June 15, 2015.

5. Togneri W, Anderson SE. *Beyond Islands of Excellence: What Districts Can Do to Improve Instruction and Achievement in all Schools.* Washington, DC: Learning First Alliance, 2003.

6. Miles KH, Darling-Hammond L. *Rethinking the Allocation of Teaching Resources: Some Lessons from High-Performing Schools.* Philadelphia: Consortium for Policy Research in Education, 1997.

7. Jones SE, Brener ND, McManus T. The relationship between staff development and health instruction in schools in the United States. *American Journal of Health Education* 2004; 35:2-10.

QUESTION:

20. During the past two years, did you receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on each of the following topics related to teaching sexual health education?

23. Would you like to receive professional development on each of the following topics related to teaching sexual health education?

RATIONALE:

This question measures the extent to which professional development about sexual health education and HIV, other STD, or pregnancy prevention has been received by the lead health education teacher. As new information and research on prevention is available, those responsible for teaching about sexual health should periodically receive continuing education to ensure they have the most current information on effective prevention and health education intervention

strategies and priority populations identified as most at-risk for pregnancy and HIV/STD infection.[1-3]

Effective implementation of school health education and sexual health education are linked directly to adequate teacher training programs.[4-6] School health education designed to decrease students' participation in risk behaviors requires that teachers have appropriate training to develop and implement school health education curricula.[4,5] Staff development activities for health education teachers need to focus on teaching strategies that both actively engage students and facilitate their mastery of critical health information and skills and should include information about district and state policies related to sexual health education.[7]

REFERENCES:

1. Kirby D, Laris BA, Rolleri L. *Sex and HIV Education Programs for Youth: Their Impact and Important Characteristics.* Washington, DC: Family Health International, 2006. Available at: http://recapp.etr.org/recapp/documents/programs/SexHIVedProgs.pdf. Accessed June 11, 2015.

2. Center for AIDS Prevention Studies (CAPS) and the AIDS Research Institute, University of California, San Francisco. *What Works Best in Sex/HIV Education?* San Francisco, CA: University of California San Francisco, 2006. Available at: http://caps.ucsf.edu/uploads/pubs/FS/pdf/revsexedFS.pdf. Accessed June 11, 2015.

3. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence.* 2nd edition. Atlanta, GA: American Cancer Society, 2007.

4. Kirby DB. *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent Teen and Unwanted Pregnancy, 2007. Available at: http://thenationalcampaign.org/sites/default/files/resource-primary-download/EA2007_full_0.pdf. Accessed June 11, 2015.

5. LaChausse RG, Clark KR, Chapple S. Beyond teacher training: The critical role of professional development in maintaining curriculum fidelity. *Journal of Adolescent Health* 2014; 54:S53-S-58.

6. Barr EM, Goldfarb ES, Russell S, Seabert D, Wallen M, Wilson KL. Improving sexuality education: The development of teacher-preparation standards. *Journal of School Health* 2014; 84:396-415.

7. Institute of Medicine. *Schools and Health: Our Nation's Investment.* Allensworth D, Lawson E, Nicholson L, Wyche J, eds. Washington, DC: National Academy Press; 1997.

PROFESSIONAL PREPARATION

QUESTIONS:

24. What was the major emphasis of your professional preparation?

25. Currently, are you certified, licensed, or endorsed by the state to teach health education in middle school or high school?

26. Including this school year, how many years of experience do you have teaching health education courses or topics?

RATIONALE:

These questions measure the extent to which lead health education teachers are formally trained in the topic of health education as well as the teaching experience and credentials of the lead health education teacher. Health education teachers need to be academically prepared and specifically qualified on the subject of health.[1] In addition, pre-service training in health education is associated with increased teaching of important health education topics.[2]

REFERENCES:

1. National Commission on the Role of the School and the Community to Improve Adolescent Health. *Code Blue: Uniting for Healthier Youth*. Alexandria, VA: National Association of State Boards of Education, 1990.

2. Jones SE, Brener ND, McManus T. The relationship between staff development and health instruction in schools in the United States. *American Journal of Health Education* 2004; 35:2-10.