Principal Item Rationale

2012 School Health Profiles Report
Item Rationale
Principal Survey

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 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.[2-6]

REFERENCES:

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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 objectives on any of the following topics?

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

RATIONALE:

These questions address the relationship between school improvement planning and 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]

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

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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. *The whole child and health and learning.* ASCD Adopted Positions. 2004. Available at: www.ascd.org/news_media/ASCD_Policy_Positions/All_Adopted_Positions.aspx#whole_child. Accessed June 10, 2009.

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] This individual coordinates school health activities, leads a school health committee or team, and integrates community-based programs with school-based programs.[2,3] Administration and management of school health programs requires devoted time, attention, training, and expertise.[4,5]

REFERENCES:

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

2. 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: Teachers College Press, 1998.

3. 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.

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

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

QUESTIONS:

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

6. Are each of the following groups represented on any school health council, committee, or team?

RATIONALE:

These questions assess whether the school has a health committee or team and the composition of that 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.[1,2] 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.[1-6] This includes parents and community members. Parent leaders help other parents understand and contribute ideas to issues and policies that affect the design and quality of school programs and opportunities for all children.[5]

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.

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6. Epstein LS. *School, Family, and Community Partnerships: Preparing Educators and Improving Schools.* Boulder, CO: Westview Press, 2001.

QUESTION:

7. During the past year, has any school health council, committee, or team at your school done any of the following activities?...Identified student health needs based on a review of relevant data?... Recommended new or revised health and safety policies and activities to school administrators or the school improvement team?...Sought funding or leveraged resources to support health and safety priorities for students and staff?... Communicated the importance of health and safety policies and activities to district administrators,

school administrators, parent-teacher groups, or community members?...Reviewed health-related curricula or instructional materials?

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, 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.[2-6]

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.

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7. 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.

QUESTION:

8. Has your school adopted a policy that addresses each of the following issues on human immunodeficiency virus (HIV) infection or AIDS?

RATIONALE:

This question assesses important components of school policies in place to address students and staff infected with HIV or AIDS. Students and staff infected with HIV or AIDS need policies protecting their rights.[1]

REFERENCE:

1. National Association of State Boards of Education. *Someone at school has AIDS: a complete guide to education policies concerning HIV infection*. Alexandria, VA: National Association of State Boards of Education, 2001.

QUESTION:

9. Are any school staff required to receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on HIV, STD, or pregnancy prevention issues and resources for the following groups?

RATIONALE:

This question assesses professional development requirements for school staff on HIV, STD, and pregnancy prevention, specifically for youth at high risk. Professional development has been described as a key component of effective prevention, since it creates opportunities for educators to learn about new developments in the field and innovative teaching techniques and to exchange ideas with colleagues.[1-2] Providing proper training and materials help ensure that effective programs also achieve the desired outcome.[3] In addition, when educators are trained to implement materials with fidelity to the original model, it is more likely that results can be replicated as well.[4]

Other components of effective programs include appropriateness for the age, sexual experience, gender, and culture of the youth.[4] High risk youth include racial/ethnic minorities and those who participate in drop-out prevention, alternative education, or GED programs. Studies show that racial/ethnic minority students are more likely than white students to engage in sexual risk behaviors that can lead to HIV, STDs, and unintended pregnancy. For example, black and Hispanic/Latino students are more likely than white counterparts to have ever had sexual intercourse, to have had sexual intercourse before age 13 years, and to have had sexual intercourse with 4 or more persons during their life. Black students are also more likely to be

currently sexually active (i.e., had sexual intercourse with 1 or more persons during the 3 months preceding the survey) than white or Hispanic students.[5] Other studies have shown that American Indians are at increased risk as well.[6] The prevalence of these same sexual risk behaviors is higher among alternative high school students than among all high school students nationally, based on comparable estimates from the 1998 national Alternative High School Youth Risk Behavior Survey (ALT-YRBS) and 1997 Youth Risk Behavior Survey (YRBS).[7]

REFERENCES:

1. Nation M, Crusto C, Wandersman A, et al. What works in prevention: principles of effective prevention programs. *American Psychologist* 2003;58(6-7):449-456.

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5. Centers for Disease Control and Prevention. Youth risk behavior surveillance—United States, 2009. *MMWR* 2010;59(SS-5):1–148.

6. Rutman S, Park A, Castor M, Taualii M, Forquera R. Urban American Indian and Alaska Native Youth: Youth Risk Behavior Survey 1997-2003. *Maternal and Child Health Journal.* 2008;12:S76-S81.

7. Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance – National Alternative High School Youth Risk Behavior Survey, United States, 1998. *MMWR* 1999;48(SS-7):1-44.

QUESTIONS:

10. 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.

11. 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] In 2009, almost 85% of LGBT students reported that they were verbally harassed at school during the past year because of their sexual orientation, while 40% were physically harassed at school, and 19% were physically assaulted at school.[2] 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*,[3] such as increasing access to supportive health and social services for LGBT youth and increasing the proportion of middle and high schools that prohibit harassment based on a student's sexual orientation or gender identity.

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.

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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: www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25. Accessed February 18, 2011.

QUESTIONS:

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

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

RATIONALE:

These questions measure 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, and confidence to adopt and maintain physically active lifestyles.[1-3] The importance of physical education in promoting the health of young people is supported by *Healthy People 2020* Objectives PA-4 and PA-5.[4]

REFERENCES:

1. National Association for Sport and Physical Education. *Moving into the Future: National standards for physical education.* 2nd ed. Reston, VA: National Association for Sport and Physical Education, 2004.

2. 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.

3. National Association for Sport and Physical Education. *Physical education is critical to a complete education.* Reston, VA: National Association for Sport and Physical Education, 2001.

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=33. Accessed June 22, 2011.

PHYSICAL EDUCATION AND PHYSICAL ACTIVITY

QUESTION:

14. During the past two years, 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?

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 the quality of physical education. 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.[1-3] Professional development for PE teachers provides skills to increase the quality of PE classes through student engagement in physical activity and the content of lessons taught.[4-6]

REFERENCES:

1. National Association for Sport and Physical Education. *National standards for beginning physical education teachers.* Reston, VA: National Association for Sport and Physical Education, 2001.

2. National Association for Sport and Physical Education. *Moving into the future: National standards for physical education.* Reston, VA: National Association for Sport and Physical Education, 2004.

3. 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.

4. 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.

5. 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.

6. 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:

15. 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. According to the National Association for Sport and Physical Education (NASPE), quality physical education is guided by and should include a written PE curriculum; goals, objectives, and expected outcomes; scope and sequence of instruction for PE; and plans for age-appropriate student assessment.[1-3]

REFERENCES:

1. National Association for Sport and Physical Education. *Moving into the future: National standards for physical education*. Reston, VA: National Association for Sport and Physical Education, 2004.

2. National Association for Sport and Physical Education. *What constitutes a quality physical education program?* Reston, VA: National Association for Sport and Physical Education, 2003. Available at: www.aahperd.org/naspe/pdf_files/pos_papers/qualityPePrograms.pdf. Accessed June 11, 2009.

3. Centers for Disease Control and Prevention. *Physical Education Curriculum Analysis Tool.* Atlanta, GA: U.S. Department of Health and Human Services, 2006.

QUESTION:

16. Outside of physical education, do students participate in physical activity breaks in classrooms during the school day? (Mark one response.)

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] Students can accumulate physical activity through classroom activity breaks and such participation can also enhance time on task, attentiveness, and concentration in the classroom.[3,4]

REFERENCES:

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

2. National Association for Sport and Physical Education. *Comprehensive school physical activity programs.* Reston, VA: National Association for Sport and Physical Education, 2008.

3. Barros RM, Silver EJ, Stein RE. School recess and group classroom behavior. *Pediatrics* 2009;123:431-6.

4. Caterino MC, Polak ED. Effects of two types of activity on the performance of second-, third-, and fourth-grade students on a test of concentration. *Perceptual and Motor Skills* 1999;89:245-8.

QUESTIONS:

17. Does your school offer opportunities for students to participate in intramural activities or physical activity clubs? (Intramural activities 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.)

18. Does your school offer interscholastic sports to students?

RATIONALE:

These questions measure the extent to which students are provided the opportunity to participate in physical activities and interscholastic sports outside of the regular school day. According to NASPE, 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.[1-7]

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.[8-10] Additionally, participation in sports programs has been associated with improved mental health and fewer risky health behaviors.[11-12]

REFERENCES:

1. 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. Available at www.aahperd.org/naspe/pdf_files/pos_papers/intramural_guidelines.pdf. Accessed June 11, 2009.

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

3. 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.

4. 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.

5. 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.

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

7. 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.

8. 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.

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

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

11. 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.

12. Seefeldt V, Ewing ME. Youth Sports in America. *The President's Council on Physical Fitness and Sports Research Digest* 1997;2:1-12.

QUESTION:

19. 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. Does your school, either directly or through the school district, have a joint use agreement for shared use of school or community physical activity facilities?

RATIONALE:

This question measures the extent to which schools and communities 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. 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. 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.[1-4]

REFERENCES:

1. Centers for Disease Control and Prevention. Guidelines for school and community programs to promote lifelong physical activity among young people. *MMWR* 1997;46(RR-6).

2. Sallis JF, Conway TL, Prochaska JJ, et al. The association of school environments with youth physical activity. *American Journal of Public Health* 2001;1:618-20.

3. Evenson KR, McGinn AP. Availability of school physical activity facilities to the public in four U.S. communities. *American Journal of Health Promotion* 2004;18:243-50.

4. 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* 2008;5.

TOBACCO-USE PREVENTION POLICIES

QUESTIONS:

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

21. 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?

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

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

24. Does your school have procedures to inform each of the following groups about the tobacco-use prevention policy that prohibits their use of tobacco?

25. Does your school's tobacco-use prevention policy include guidelines on what actions the school should take when students are caught smoking cigarettes?

26. At your school, who is responsible for enforcing your tobacco-use prevention policy?

27. Do each of the following criteria help determine what actions your school takes when students are caught smoking cigarettes?

28. When students are caught smoking cigarettes, how often are each of the following actions taken?

29. 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* Tobacco Use Objective-15 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 or exposure to tobacco products at an early age.[1] 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.[5] Environmental interventions aimed at reducing use of tobacco in homes, public places, and worksites lead to reduction of tobacco use.[6] Likewise, tobacco-free school policies are associated with lower rates of student smoking.[5,7-9]

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.[10] 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.[10] 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.[10]

REFERENCES:

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6. 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.

7. 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.

8. 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.

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QUESTIONS:

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

31. 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* Tobacco Use Objectives 4.1 and 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.[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]

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NUTRITION-RELATED POLICIES AND PRACTICES

QUESTIONS:

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

33. 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?

34. 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 after-school programs, school stores, snack bars, or canteens[1] and these foods sold in competition to school meals are often relatively low in nutrient density and relatively high in fat, added sugars and calories.[2] Competitive foods are widely available in many elementary schools, in most middle schools, and in almost all secondary schools.[1,3-5] 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.[6] To help improve dietary behavior and reduce overweight among youths, schools should offer appealing and nutritious foods in school snack bars and vending machines and discourage sale of foods high in fat, sodium, and added sugars, and beverages and foods containing caffeine on school grounds.[7-11] 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.[12,13] However, offering a wider range of healthful foods can be an effective way to promote better food choices among high school students.[14] Restricting access to snack foods is associated with higher frequency of fruit and vegetable consumption in elementary school aged children.[15] 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.[6,16]

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QUESTION:

35. During this school year, has your school done any of the following?...Priced nutritious foods and beverages at a lower cost while increasing the price of less nutritious foods and beverages? Collected suggestions from students, families, and school staff on nutritious food preferences and strategies to promote healthy eating? Provided information to students or families on the nutrition and caloric content of foods available? Conducted taste tests to determine food preferences for nutritious items? Provided opportunities for students to visit the cafeteria to learn about food safety, food preparation, or other nutrition-related topics? Served locally or regionally grown foods in the cafeteria or classrooms? Planted a school food or vegetable garden? Placed fruit and vegetables near the cafeteria cashier, where they are easy to access? Used attractive displays for fruits and vegetables in the cafeteria? Offered a self-serve salad bar to students? Labeled healthful foods with appealing names (e.g., crunchy carrots)?

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 fruit and vegetable items 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] and offering a self-serve salad bar to students.[11-12]

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QUESTIONS:

36. At your school, are candy, meals from fast food restaurants, or soft drinks promoted through the distribution of products, such as t-shirts, hats, and book covers to students?

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

RATIONALE:

These questions address prohibiting marketing of less nutritious foods to students while at school or at school-sponsored events. 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.[1] 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.[2,3] 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. Given that schools provide a captive audience of students, the Institute of Medicine (IOM) 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), and outlines the importance of prohibiting advertising of less nutritious foods.[8]

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QUESTIONS:

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

39. Does your school offer a free source of drinking water in the cafeteria during meal times?

RATIONALE:

These questions address the importance of drinking water and access to free drinking water throughout the school day and during school meals. Schools should ensure that students have access to safe, free, and well-maintained drinking water fountains or dispensers throughout the school day.[1] This provides a healthy alternative to sugar-sweetened beverages (SSBs) and can help increase students' overall water consumption.[2,3] The Healthy, Hunger-Free Kids Act of 2010 requires all schools to make drinking water available free of charge where school meals are served beginning 2011-12 school year. Drinking tap water (and in particular, fluoridated water), instead of SSBs, could help protect against tooth decay and prevent childhood obesity.[3-5]

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.[6] 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.[6]

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QUESTION:

40. 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.)

RATIONALE:

This question examines the degree to which schools are being adequately 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 can link students and schools to physician and community resources.

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QUESTION:

41. At your school, how many students with known asthma have an asthma action plan on file? (Students with known asthma are those who are identified by the school to have a current diagnosis of asthma as reported on student emergency cards, medication records, health room visit information, emergency care plans, physical exam forms, parent notes, and other forms of health care clinician notification.)

RATIONALE:

This question addresses the need for clear, written guidance about the needs of individual students with asthma. Assessment of successful school-based asthma management programs suggest these plans play an important role in providing school staff, students, and families with an understanding of an individual student's asthma management needs at school, including how to respond in an emergency. Additionally, the use of an asthma action plan at school results in affected students experiencing significant improvement in several health-related outcomes, including a decrease in the frequency of asthma-related nighttime awakenings, number of days of restricted activity, and frequency of acute medical treatment.[1,2] Schools should have asthma action plans on file for all students with known asthma. These plans help schools meet the needs of students with asthma during the school day and at school-related activities. Based upon

current research, federal agencies and other national organizations have provided additional guidance and recommendations related to the collection and implementation of individualized plans. Plans should be developed by a primary care provider and be provided by parents. They should include individualized emergency protocol, medications, environmental triggers and emergency contact information. School staff should actively solicit copies of asthma action plans from families and/or asthma care providers. When necessary, school nurses can construct asthma action plans based on information from the family and medication orders. A constructed plan should be sent to the asthma care provider for confirmation that it is appropriate.[3-7]

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QUESTION:

42. At your school, which of the following events are used to identify students with poorly controlled asthma?

RATIONALE:

This question examines the type of information schools use to monitor and then assess the need for additional case management of students with known asthma. Assessment of successful school-based asthma management programs reveal that this type of tracking and case management can contribute to the medical management of students with asthma.[1-4] This information can subsequently be used by schools to focus their asthma programs on students with poorly managed asthma as demonstrated by frequent school absences, school health office visits, emergency department visits, or hospitalizations.[5,6]

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QUESTION:

43. Does your school provide each of the following services for students with poorly controlled asthma?

RATIONALE:

This question examines whether schools provide intensive case management for students with poorly controlled asthma. Schools should ensure that case management is provided by a trained professional for students with frequent school absences, school health office visits, emergency department visits, or hospitalizations due to asthma.[1-7] Assessment of successful school-based asthma management programs reveal that monitoring and then providing case management can contribute to the medical management of students with asthma.[3,8] Case management activities help students better manage their asthma, and have been shown to decrease hospitalizations, emergency department visits, and school absences among students with severe, persistent, or poorly controlled asthma.[9,10]

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QUESTION:

44. How often are school staff members required to receive training on recognizing and responding to severe asthma symptoms?

RATIONALE:

This question examines professional development for school staff. Because asthma can be life-threatening, it is essential to assist those involved in monitoring and managing children with asthma at school to provide timely, appropriate care. Therefore, all school staff members should be provided with basic information about asthma so that they can support students' asthma management and appropriately respond to asthma emergencies.[1-7]

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QUESTIONS:

45. Has your school adopted a policy stating that students are permitted to carry and self-administer asthma medications?

46. Does your school have procedures to inform each of the following groups about your school's policy permitting students to carry and self-administer asthma medications?

47. At your school, who is responsible for implementing your school's policy permitting students to carry and self-administer asthma medication?

RATIONALE:

These questions address the need for schools to have policies and procedures to support students in receiving the asthma medications they may need at school. Many students with asthma require preventive or quick-relief medicine at school. Students with asthma have had serious episodes and have died at school when they did not have access to quick-relief medicine.[1] Access to medications is critical and it must meet usual safety guidelines for medication storage.[2,3] To ensure compliance with federal, state, and many local laws and guidelines, schools should ensure that students have immediate access to asthma medications, as prescribed by a physician and approved by parents.[4] Several national guidance documents, along with evaluations of successful school-based asthma programs, have provided additional information that addresses the process and methods for self-carry policies. Policies should include medication storage in a safe, controlled, and accessible location, and appropriate attention should be given to expiration dates and safe disposal.[5-8]

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QUESTIONS:

48. Does your school provide the following services to students?... HIV counseling and testing? STD testing and treatment? Pregnancy testing? Condoms? Contraceptives other than condoms (e.g., birth control pill, birth control shot, intrauterine device [IUD])? Prenatal care? Human papillomavirus (HPV) vaccine?

49. Does your school provide students with referrals to any organizations or health care professionals not on school property for the following services?... HIV counseling and testing? STD testing and treatment? Pregnancy testing? Condoms? Contraceptives other than condoms (e.g., birth control pill, birth control shot, intrauterine device [IUD])? Prenatal care? Human papillomavirus (HPV) vaccine?

RATIONALE:

These questions address the provision of sexual and reproductive health care to students at school. Pregnancy care and prescription contraceptive services are the two largest health care expenditures among female adolescents nationally.[1] In addition to the need for reproductive health care services, high STD rates among female adolescents[2] and relatively low numbers of adolescents who have been tested for HIV[3] underscore the need to provide testing, counseling, and treatment for sexually transmitted diseases and HIV. However, assuring adolescent access to such services, may be difficult.[4] Provision of such health care services is more effective in assuring adolescents' access to care when provided at diverse venues, including schools,[1] and use of schools for reproductive and sexual health care services is acceptable to youth.[5] The number of school-based health centers operating in the United States is low and the majority of those are prohibited from providing school-based sexual and reproductive health care services.[6] Therefore, schools have a need for strong sexual and reproductive health care service referral systems.

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FAMILY AND COMMUNITY INVOLVEMENT

QUESTIONS:

50. During the past two years, have students' families helped develop or implement policies and programs related to HIV, STD, or teen pregnancy prevention?

51. During the past two years, have community members helped develop or implement policies and programs related to HIV, STD, or teen pregnancy prevention?

RATIONALE:

This question emphasizes the importance of engaging family and community members in school health programs related to HIV, STD, or teen pregnancy prevention. Parent leaders help other parents understand and contribute ideas to issues and policies that affect the design and quality of school programs and opportunities for all children.[1] School programs that link with the community yield strong positive results in reducing sexual risk behaviors,[2] including those that provide community service learning opportunities.[3] Collaboration with parent groups, community organizations, and other agencies can help to build broad-based support for school health programs and provide service integration and coordination with schools as well as programs increase the quality of experiences for students.[4] Parent support of education programs and policies as decision-makers in partnership with schools is an important factor in providing effective and sustained programs.[1]

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