

Item Rationale

2012 School Health Profiles Report

Item Rationale

Elementary School 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:

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.
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3. Staten LK, Teufel-Shone NI, Steinfeldt VE, et al. The School Health Index as an impetus for change. *Preventing Chronic Disease* [serial online] 2005;2(1):A19.
4. 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.
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6. 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.

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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 health-related objectives on any of the following topics?
3. During the past year, did your school review health and safety data such as fitness data as part of your school's improvement planning process?

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

REFERENCES:

1. McKenzie FD, Richmond JB. Linking Health and Learning: An Overview of Coordinated School Health Programs. In: Marx E, Wooley S, eds. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York: Teachers College Press, 1998, pp. 1-14.
 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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 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.
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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?

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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.
 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: Teachers College Press, 1998, pp. 15-42.
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 6. Epstein LS. *School, Family, and Community Partnerships: Preparing Educators and Improving Schools*. Boulder, CO: Westview Press, 2001.
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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.²⁻⁷

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.
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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.
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QUESTION:

9. Is health education instruction required for students in any of grades K through 6 in your school? (Mark one response.)

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

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QUESTION:

10. Is required health education taught in each of the following grades in your school? (For each grade, mark yes or no, or if your school does not have that grade, mark “grade not taught in your school.”)

RATIONALE:

These questions measure the extent to which health education courses are required for students in grades K through 6. 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 and that age-appropriate health education be taught during elementary grade levels also.¹ The benefits of a health education curriculum increase when students receive at least three consecutive years of a quality health curriculum.²

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: Teachers College Press, 1998, pp. 43–66.

QUESTION:

11. Are those who teach health education at your school provided with each of the following materials? (Mark yes or no for each material.)

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

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

12. Is physical education required for students in any of grades K through 6 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 K through 6. 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.
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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.
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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.

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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.

QUESTIONS:

16. Do students in each of the following grades participate in recess during every school day? (Do not include physical education.)
17. On average, how many minutes each day do students spend in recess?

RATIONALE:

CDC's School Health Guidelines to Promote Healthy Eating and Physical Activity recommend that schools implement a comprehensive physical activity program, which includes physical education, physical activity breaks, walk/bike to school programs, after school physical activity clubs and sports, and recess.¹ This type of approach offers students multiple opportunities to enjoy physical activity and increase daily physical activity participation. Recess periods are a critical time for elementary school students to participate in unstructured or structured play. CDC

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and the National Association for Sport and Physical Education (NASPE) recommend that all elementary schools provide at least one daily 20-minute recess period for all students in all grades.^{1,2} Regularly scheduled recess enables students to accumulate a portion of their recommended 60 minutes of daily physical activity.³⁻⁵ It also allows children to apply skills learned in physical education (e.g., motor skill development, decision-making, cooperation, conflict resolution, and negotiation).^{2,6} Participation in recess is associated with many academic benefits as well, such as improved attentiveness, concentration, behavior, and time on task in the classroom.^{2,7-12}

REFERENCES:

1. Centers for Disease Control and Prevention. School Health Guidelines to Promote Healthy Eating and Physical Activity. *MMWR* 2011;60(No. RR5): 28-31.
2. National Association for Sport and Physical Education. Recess for elementary school students. Reston, VA: National Association for Sport and Physical Education; 2006. Available at <http://www.aahperd.org/naspe/standards/upload/Recess-for-Elementary-School-Students-2006.pdf>.
3. Ridgers ND, Stratton G, Fairclough SJ. Physical activity levels of children during school playtime. *Sports Med* 2006;36:359-71.
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7. Jarrett OS, Maxwell DM, Dickerson C, Hoge P, Davies G, Yetley A. Impact of recess on classroom behavior: group effects and individual differences. *J Educ Res* 1998; 92:121-6.
8. Pellegrini AD, Davis PD. Relations between children’s playground and classroom behavior. *Br J Educ Psychol* 1993;63:89-95.
9. Sluckin A. Growing up in the playground: the social development of children. London, England: Routledge & Kegan Paul; 1981.
10. Barros RM, Silver EJ, Stein RE. School recess and group classroom behavior. *Pediatr* 2009;123:431-6.

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11. 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. *Percept Mot Skills* 1999;89:245-8.
 12. Pelligrini AD, Kato K, Blatchford P, Baines E. A short-term longitudinal study of children's playground games across the first year of school: implications for social competence and adjustment to school. *Am Educ Res J* 2002;39:991-1015.
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QUESTION:

18. Outside of physical education and recess, 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.
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QUESTION:

19. 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.)

RATIONALE:

This question measures 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.

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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.
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QUESTION:

20. 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⁾

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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.
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 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.
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TOBACCO-USE PREVENTION POLICIES

QUESTIONS:

21. Has your school adopted a policy prohibiting tobacco use?
22. 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?
23. Does the tobacco-use prevention policy specifically prohibit tobacco use during each of the following times for each of the following groups?
24. Does the tobacco-use prevention policy specifically prohibit tobacco use in each of the following locations for each of the following groups?
25. Does your school have procedures to inform each of the following groups about the tobacco-use prevention policy that prohibits their use of tobacco?
26. Does your school's tobacco-use prevention policy include guidelines on what actions the school should take when students are caught smoking cigarettes?
27. At your school, who is responsible for enforcing your tobacco-use prevention policy?
28. Do each of the following criteria help determine what actions your school takes when students are caught smoking cigarettes?
29. When students are caught smoking cigarettes, how often are each of the following actions taken?
30. 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}

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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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QUESTIONS:

31. Does your school provide tobacco cessation services for faculty and staff?
32. Does your school have arrangements with any organizations or health care professionals not on school property to provide tobacco cessation services for faculty and staff?

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 Providing a brief clinical intervention has been shown to encourage cessation among adults.⁴

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NUTRITION-RELATED POLICIES AND PRACTICES

QUESTIONS:

33. When foods or beverages are offered at school celebrations, how often are fruits or non-fried vegetables offered?
34. 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?
35. 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 canteens¹ 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:

36. 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 gardens⁸ 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,

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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:

37. 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?
38. 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:

39. Are students permitted to have a drinking water bottle with them during the school day?
40. Does your school offer a free source of drinking water in the cafeteria during meal times?

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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:

41. 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:

42. 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

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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:

43. 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:

44. 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:

45. 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:

46. Has your school adopted a policy stating that students are permitted to carry and self-administer asthma medications?
47. 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?
48. 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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