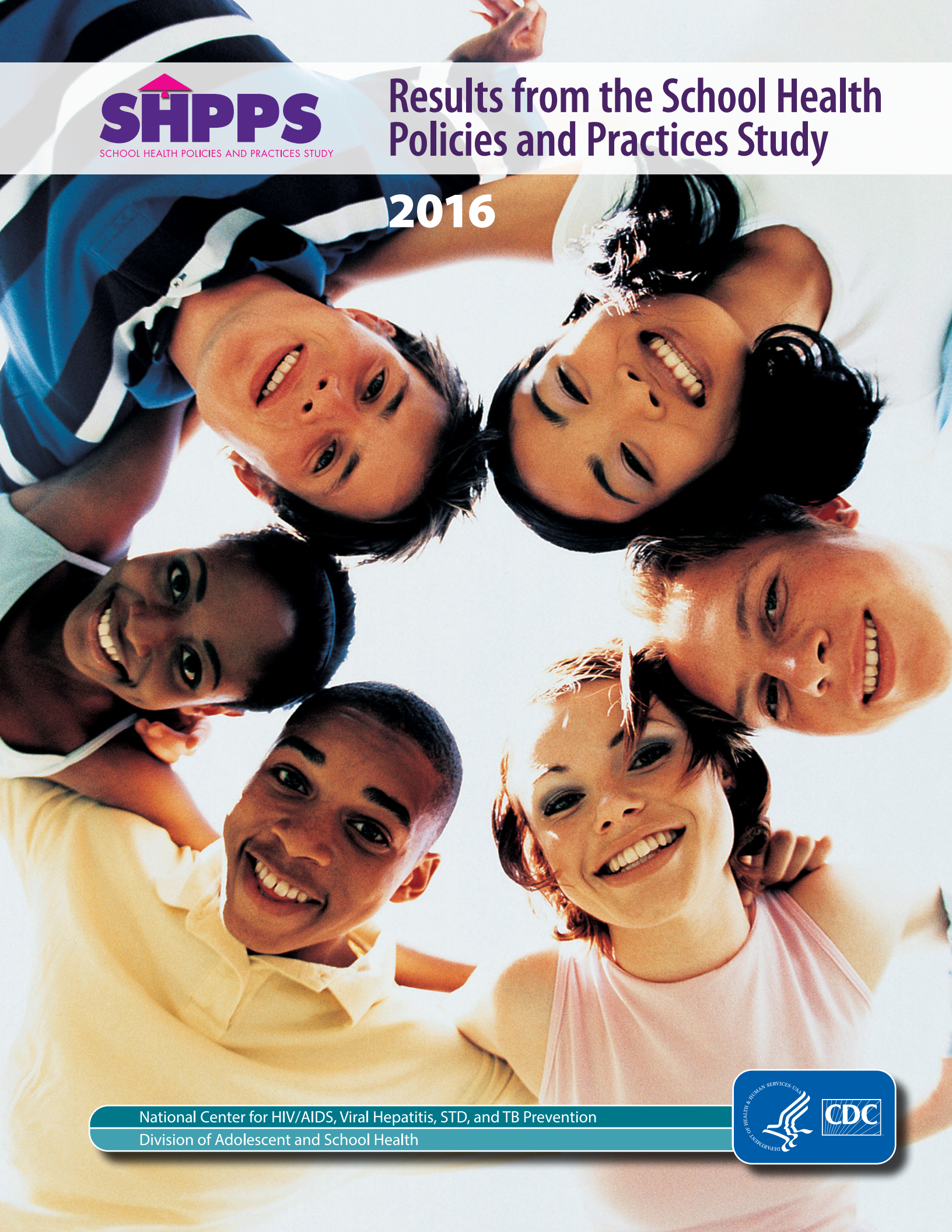
SHPPS
SCHOOL HEALTH POLICIES AND PRACTICES STUDY

Results from the School Health Policies and Practices Study

2016



National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of Adolescent and School Health

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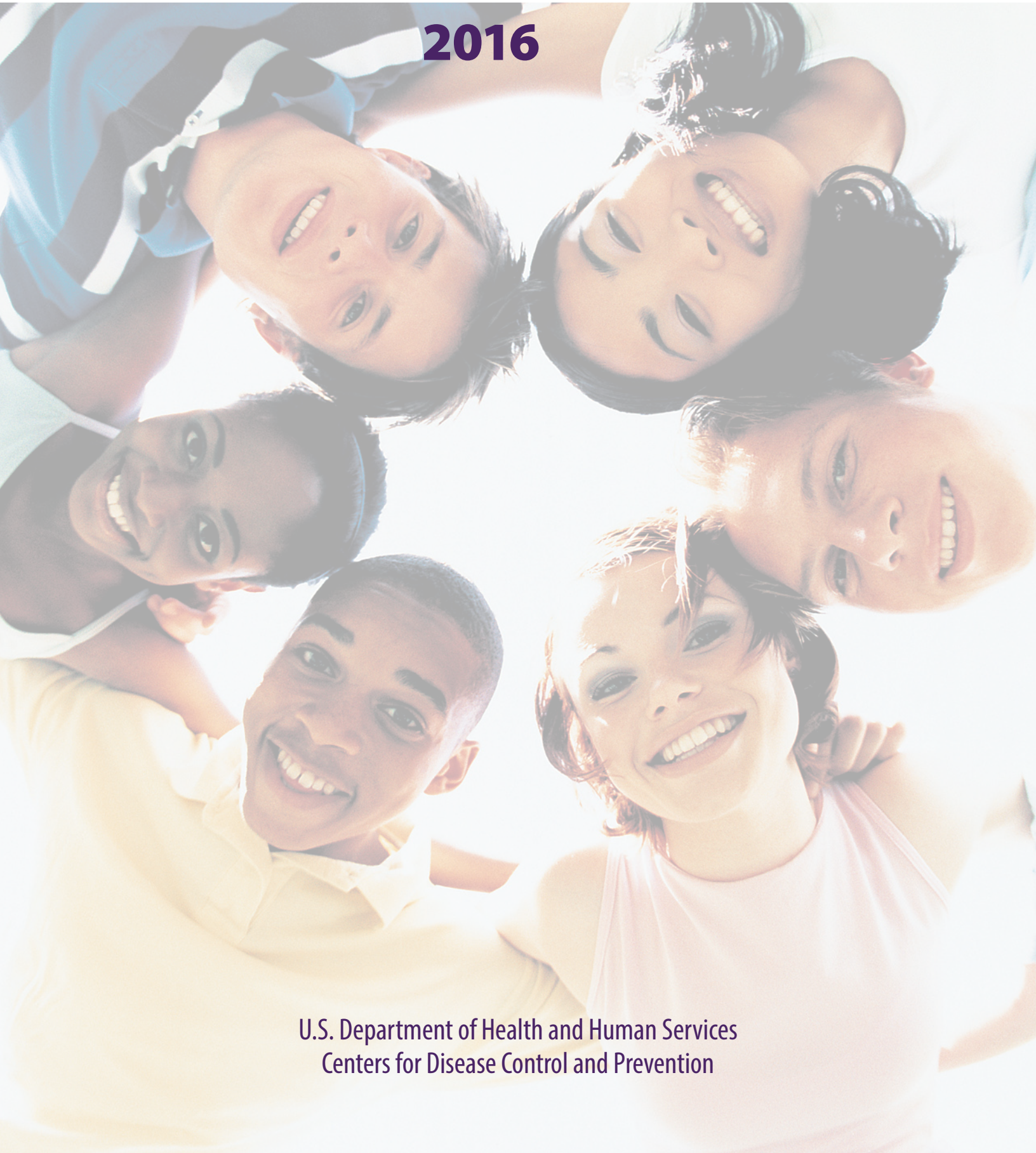

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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Background and Introduction

Students in the United States engage in behaviors that place them at risk for the leading causes of morbidity and mortality among youth and adults (1). These behaviors often are established during childhood and adolescence and extend into adulthood; therefore, it is important to prevent such behaviors at an early age. Because schools have direct contact with more than 95 percent of our nation's young people aged 5-17 years, they play a critical role in promoting the health and safety of young people and helping them establish lifelong healthy behavior patterns.

In 2014, the Association for Supervision and Curriculum Development (ASCD) and the Centers for Disease Control and Prevention (CDC) released the Whole School, Whole Community, Whole Child (WSCC) model (2). This model "incorporates the components of a coordinated school health program around the tenets of a whole child approach to education and provides a framework to address the symbiotic relationship between learning and health" (2, p. 6). The WSCC model contains 10 components: health education; physical education and physical activity; nutrition environment and services; health services; counseling, psychological and social services; social and emotional climate; physical environment; employee wellness; family engagement; and community involvement.

To monitor progress in each of these areas, it is critical to measure periodically the extent to which schools and school districts nationwide have policies and practices in place that address these components. In addition, data are needed to monitor national health objectives that pertain to schools and school districts, as well as to assist with program planning, help drive policy improvement, and track changes over time in these policies and practices. In response to these needs, CDC developed the School Health Policies and Practices Study (SHPPS). SHPPS is a national survey periodically conducted to assess school health policies and practices at multiple levels for each of the components of the WSCC model. SHPPS was conducted at the state, district, school, and classroom levels in 1994, 2000, and 2006. In 2012, SHPPS was conducted only at the state and district levels, and in 2014, it was conducted only at the school and classroom levels. SHPPS 2016 was conducted at the district level only; this report therefore provides district-level data on each of the components described below. Note that some components have been combined to reflect the organization of the study questionnaires (see Methods section).

Health Education

Health education is a fundamental part of an overall school health program and one of 10 components in the WSCC model (2) described above. The importance of health education is recognized by Healthy People 2020 which has established four relevant objectives (3):

> **EMC-4.** Increase the proportion of elementary, middle, and senior high schools that require school health education.
>
> **ECBP-2.** Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity.
>
> **ECBP-3.** Increase the proportion of elementary, middle, and senior high schools that have health education goals or objectives which address the knowledge and skills articulated in the National Health Education Standards (high school, middle, and elementary).
>
> **ECBP-4.** Increase the proportion of elementary, middle, and senior high schools that provide school health education to promote personal health and wellness in the following areas: hand washing or hand hygiene; oral health; growth and development; sun safety and skin cancer prevention; benefits of rest and sleep; ways to prevent vision and hearing loss; and the importance of health screenings and checkups.

Health instruction in schools is shaped, in large part, by the health education curriculum. Research has identified the following characteristics of effective health education curricula (4-17): focuses on clear health goals and related behavioral outcomes; is research-based and theory-driven; addresses individual values, attitudes, and beliefs; addresses individual and group norms that support health-enhancing behaviors; focuses on reinforcing protective factors and increasing perceptions of personal risk and harmfulness of engaging in specific unhealthy practices and behaviors; addresses social pressures and influences; builds personal competence, social competence, and self-efficacy by addressing skills; provided functional health knowledge that is basic, accurate, and directly contributes to health-promoting decisions and behaviors; uses strategies designed to personalize information and engage students; provides age-appropriate and developmentally appropriate information, learning strategies, teaching methods, and materials; incorporates learning strategies, teaching methods, and materials that are culturally inclusive; provides adequate time for instruction and learning; provides opportunities to reinforce skills and positive

health behaviors; provides opportunities to make positive connections with influential others; and includes teacher information and plans for professional development and training that enhance effectiveness of instruction and student learning. CDC has developed the Health Education Curriculum Analysis Tool (HECAT) to help schools identify curricula that feature these characteristics of effective health education curricula (18). In addition, the Registries of Programs Effective in Reducing Youth Risk Behavior (http://www.cdc.gov/healthyyouth/adolescenthealth/registries.htm) identify specific interventions and curricula determined to be worthy of recommendation on the basis of expert opinion or a review of design and research evidence.

The National Health Education Standards (NHES) (19) have been developed to further shape health instruction in schools. The NHES help establish, promote, and support health-enhancing behaviors for students in grades preK-12 and provide a framework for designing or selecting curricula, allocating instructional resources, and assessing student achievement. The NHES outline specific expectations for what students should know and be able to do by grades 2, 5, 8, and 12 to promote personal, family, and community health. The NHES also have become an accepted reference on health education and provide a framework for adoption of standards by most states.

Physical Education and Physical Activity

Physical education and physical activity in schools can positively impact students' health and academic achievement outcomes (e.g., grades, classroom behavior, and cognitive performance) (20-23). Districts can provide support to schools to help students attain the nationally recommended 60 minutes of daily physical activity. Through the WSCC model, districts and schools can develop policies and practices that promote a Comprehensive School Physical Activity Program (CSPAP) (24). The goal of a CSPAP is to increase physical activity opportunities before, during, and after school and increase students' overall physical activity and health (24). A CSPAP includes strong coordination across five components: physical education, physical activity during school, physical activity before and after school, staff involvement, and family and community engagement.

Physical education serves as the foundation of a CSPAP and is a K-12 academic subject that provides standards-based curricula and instruction that is part of a well-rounded education (25). Districts can support the four essential components that provide the structure for physical education. These include: policy and environment (e.g., daily minutes of physical education, not allowing exemptions, waivers, and substitutions); curriculum (e.g., written physical education curriculum for grades K–12 that is sequential and comprehensive); student assessment (e.g., evidence-based practices that measure student achievement in all areas of instruction, including physical fitness); and appropriate instruction (e.g., instructional practices and inclusion of all students) (26).

In addition, districts can help schools provide other opportunities for students to apply what they have learned in physical education, which can help increase their physical activity during the school day (22-24). One opportunity is through recess, which is a regularly scheduled period within the school day for physical activity and play that is monitored by trained staff and volunteers (27). Another way to increase physical activity during the school day is by encouraging the use of physical activity, such as stretching, jumping, and dancing in the classroom (22, 24). Physical activity before and after school also provides opportunities for all students to be physically active. Activities might include programs promoting or supporting walking or biking to and from school, physical activity clubs, intramural programs (i.e., sports organized by the school or community in which any child can participate), interscholastic sports (i.e., competitive sports between schools), and physical activity in before-school and after-school extended day programs (22, 24).

Nutrition Environment and Services

A school's nutrition environment and services include the foods and beverages that are available to students throughout the school day, and the information and messages about food, beverages, and nutrition that students encounter on school grounds (28). A school's nutrition environment and services can affect students' dietary choices and understanding about good nutrition. A healthy school nutrition environment makes it easier for students to make healthy choices by giving them access to nutritious and appealing foods and beverages, providing consistent and accurate messages about good nutrition, and offering ways for students to learn about and practice healthy eating.

School meal programs, including the National School Lunch Program (NSLP) and the School Breakfast Program (SBP), provide students with balanced meals that meet federal nutrition standards including a variety of fruits, vegetables, and whole grains; limits on saturated fat and sodium; and minimum and maximum calorie levels (29). All students can participate in school meal programs, and some students are eligible to receive free or reduced-price meals (25). Students may also have access to competitive foods, which are foods and beverages that are sold outside of the school meal programs, through fundraisers, school stores, vending machines, snack bars, and a la carte items. Competitive foods must meet federal Smart Snacks in School nutrition standards (30). In addition to

competitive foods and beverages that are sold during the school day, some schools may also offer students foods and beverages during classroom parties, school celebrations, and rewards for good behavior or academic performance. Although these foods and beverages that are offered are not required to meet Smart Snacks in School standards, all school districts that participate in a school meal program (e.g., NSLP) are required to establish nutrition standards for these items in their local school wellness policy. The district's local school wellness policy must also include goals for nutrition education and promotion, nutrition guidelines for all foods sold on each school campus during the school day, goals for physical activity, goals for other opportunities to promote student wellness, and nutrition standards for food and beverage marketing that allow marketing and advertising of only those foods and beverages that meet the Smart Snacks in School nutrition standards (31).

Health Services and Counseling, Psychological, and Social Services (includes Employee Wellness)

School health services and counseling, psychological, and social services support student health, broadly defined to include physical, mental, behavioral, and social-emotional health. By providing prevention and intervention services, schools can support students' educational success. Health services range from first aid and emergency care to the management of chronic conditions, such as asthma or diabetes, and also include wellness promotion. At school, health services are provided most frequently by registered school nurses. The importance of their role is apparent in multiple policy and position statements from the National Association of School Nurses (32) and the American Academy of Pediatrics (33). Further, school health services are "designed to ensure access and/or referrals to the medical home or private healthcare provider" (34, p. 733). Indeed, schools can play a valuable role in providing access to health care available in the community for students who might otherwise have difficulty obtaining access to such services (35).

Counseling, psychological, and social services include screenings, evaluations, and assessments; individual or group counseling and consultation as appropriate; and referrals to school and community support services when needed. In the school setting, professionals such as school counselors, school psychologists, and school social workers typically provide these services. School mental health services may be offered according to one of three models: 1) school-supported with a separate mental health unit in the school, 2) formal community connections and linkages through contracts with mental health professionals, and 3) comprehensive and integrated health and mental health services through school-based health centers and programs that address prevention, screening, referral, and direct care (36).

Students' health and academic success also can be supported by fostering school employees' physical and mental health through employee wellness programs. These programs are designed to address multiple risk factors (e.g., lack of physical activity, tobacco use) and health conditions (e.g., diabetes, depression) to meet the health and safety needs of those working in schools. When school employees are healthy, they are more productive, less likely to be absent, and can serve as positive role models for students. Employee wellness programs "can improve a district's bottom line by decreasing employee health insurance premiums, reducing employee turnover, and cutting costs of substitutes" (34). Ideally, such programs include a coordinated set of programs, policies, benefits, and environmental supports. The Directors of Health Promotion and Education developed *School Employee Wellness: A Guide for Protecting the Assets of Our Nation's Schools* to help school district staff establish, implement, and sustain effective school employee wellness programs (37).

Healthy and Safe School Environment (includes Social and Emotional Climate)

School districts promote a healthy and safe school environment through a variety of policies and practices that cover a wide range of issues, including transportation, unintentional injury and violence prevention, sun safety, tobacco use prevention, and crisis preparedness. A healthy and safe school environment also addresses the social and emotional climate, or "psychosocial aspects of students' educational experience that influence their social and emotional development" (34). A positive social and emotional climate encourages students to engage in school activities, fosters positive relationships in school and in the community, and promotes more effective teaching and learning (34).

Healthy and safe school environment policies and practices can be supported with professional development for staff and with a school health council, committee, or team. "Professional development is a systematic process that strengthens how professionals obtain and retain knowledge, skills, and attitudes" (38). When well executed, professional development enables school staff to transfer knowledge and skills to students or other staff (38). Thus, effective professional development that addresses the health and safety needs of students is an important aspect of a healthy and safe school environment. Such professional development can be enhanced by the work of a school health council, a diverse group of school staff and community members whose role is to make

health policy, program, and practice recommendations to schools or school districts that promote the health of students and staff (65). These councils take advantage of a variety of community resources and are an important aspect of creating healthy and safe schools (65).

Physical Environment

As defined in the WSCC model, the physical school environment component includes not only the school building and its contents, but also the land on which it is built and the area surrounding it. This component encompasses a wide range of issues such as ventilation, moisture, temperature, noise, lighting, traffic, pollution, and chemical and biological agents in the air, water, and soil (34, 39, 40). These issues influence the health and safety of students, staff, and visitors (39, 40), and as summarized by Michael et al., a growing body of literature supports the importance of addressing the physical school environment because of its influence on academic achievement (21).

Providing a healthy physical school environment can be difficult for many schools because of limited resources to address the unique and diverse challenges of maintaining healthy school buildings and grounds. For example, the range of activities that schools support include food preparation, physical activity and athletics, laboratory sciences, and traditional educational activities, to name a few. Each of these activities has its own environmental health and safety-related concerns such as indoor air quality, pest management, and chemical safety and management. And while some school districts are facing reductions in student enrollment, in others, regional residential growth has led to overcrowding with associated health and school performance issues (41). Districts with aging schools and overcrowding need to make decisions about renovations or capital investments in new schools. High property costs or lack of property options can lead to imperfect school location decisions. These school siting decisions affect traffic and traffic-related air pollution, busing, walkability, community use of school facilities or school use of community facilities, and sometimes exposure to poor soil or air quality (42). Trained custodial and maintenance staff and informed school personnel are important allies in promoting a healthy and safe school environment.

Overview of Report

This report provides results from the SHPPS conducted in 2016. Following a detailed Methods section, 2016 results are presented in a series of 90 tables organized around the components of the WSCC model described above. Tables 1.1 through 6.9 provide the percentage of districts with certain policies and practices in place. Results are shown separately by school level (elementary school, middle school, and high school) if the questions were asked separately by school level. For each variable, the prevalence estimate is shown along with a 95% confidence interval. Tables 7.1 through 7.6 then provide the results of trend analyses examining changes over time in selected school health policies and practices (see the Methods section for the criteria used to determine which variables are reported). Table 8.1 provides results for the 7 Healthy People 2020 objectives and sub-objectives monitored by SHPPS 2016 (3). Following the Results section is a Discussion section that highlights the key findings of the report.

Methods

The School Health Policies and Practices Study (SHPPS) 2016 was conducted by CDC through a contract with ICF Macro, Inc., an ICF Company. The study, formerly known as the School Health Policies and Programs Study, was previously conducted in 1994, 2000, 2006, 2012, and 2014. SHPPS 2016 examined seven components of school health among a nationally representative sample of public school districts. These components correspond to those in the Whole School, Whole Community, Whole Child (WSCC) model (2): health education; physical education and physical activity; nutrition environment and services; health services; counseling, psychological, and social services; healthy and safe school environment (including social and emotional climate); and physical school environment. SHPPS 2016 also included a limited number of questions on employee wellness, family engagement, and community involvement, which were integrated into the questionnaires assessing the other components.

Questionnaire Development

While previous cycles of SHPPS used seven questionnaires at the district level, SHPPS 2016 used only five: Health Education, Physical Education and Physical Activity, Nutrition Services, Health Services, and Healthy and Safe School Environment. Content from the two previously fielded questionnaires, Mental Health and Social Services (now called Counseling, Psychological, and Social Services in line with the WSCC model) and Faculty and Staff Health Promotion (now called Employee Wellness in line with the WSCC model) was incorporated into the Health Services and Healthy and Safe School Environment questionnaires.

The questionnaire development process for SHPPS 2016 began in March 2015. First, CDC convened a series of meetings with subject matter experts to complete a question-by-question review of the 2012 versions of the questionnaires. Questions were flagged for deletion or revision if the 2012 data revealed very high prevalence or a large number of missing responses. Subject matter experts also proposed deletion or revision of questions that were outdated or no longer of interest and proposed new questions to address data needs.

Next, all new questions and those that been revised substantially were subjected to cognitive testing. This testing was conducted by three trained interviewers who asked respondents to answer each question and then asked follow-up questions to ascertain the respondents' understanding of the question and response options. Interviews were conducted via telephone, but to simulate the Web-based administration used in SHPPS 2016, respondents viewed a PowerPoint presentation in which each slide contained a single question and its associated response options and "help" statements. Testing was conducted in eight districts selected to vary in geographic location, size, and urbanicity, but not included in the SHPPS 2016 sample. Between six and eight interviews were conducted for each questionnaire, resulting in a total of 42 interviews.

While the cognitive interviews were being conducted, CDC distributed the draft questionnaires to reviewers representing federal agencies, national nongovernmental organizations, foundations, universities, and businesses nationwide. Appendix 1 contains the list of reviewers who provided comments. Based on the comments received from the reviewers and the results of the cognitive testing, CDC revised the draft questionnaires and produced a final version. These questionnaires were then programmed into a Web-based survey system. Print versions of all questionnaires are available at www.cdc.gov/shpps.

Three of the final questionnaires were divided into modules: Health Education, Physical Education and Physical Activity, and Healthy and Safe School Environment. Modularization served two purposes. First, to reduce burden and improve reporting accuracy, related items were grouped together so that a single respondent could complete each module. Second, modularization allowed different respondents to complete one or more sections of each questionnaire based on their area of expertise. Table 1 shows the modules comprising each modularized questionnaire.

Table 1. Contents of modularized questionnaires—SHPPS 2016

Questionnaire	Module contents
Health Education	Module 1—Standards
	Module 2—Elementary School Instruction
	Module 3—Middle School Instruction
	Module 4—High School Instruction
	Module 5—Students with Disabilities, Staffing and Professional Development, Collaboration and Promotion, and Evaluation
	Module 6—Health Education Coordinator
Healthy and Safe School Environment	Module 1—General School Environment (Elementary Schools, Middle Schools, High Schools), Transportation, Joint Use Agreements, Violence Prevention, Tobacco Use Prevention, Student Drug Testing, Injury Prevention and Safety
	Module 2—Physical School Environment
	Module 3—Crisis Preparedness, Response, and Recovery
	Module 4—Community Service and Service Learning, Foods and Beverages Available Outside of the School Meal Programs, Professional Development, Employee Wellness, and School Health Coordination
Physical Education and Physical Activity	Module 1—Standards
	Module 2—Elementary School Instruction
	Module 3—Middle School Instruction
	Module 4—High School Instruction
	Module 5—Students with Disabilities, Physical Activity, Use of Protective Gear, Use of Physical Activity for Discipline, Staffing and Professional Development, Collaboration and Promotion, Evaluation, and Interscholastic Sports
	Module 6—Physical Education Coordinator

Sampling

SHPPS 2016 used a stratified random sample of public school districts in the United States to obtain nationally representative data. Unlike district samples drawn for previous cycles of SHPPS, the district sample did not need to provide a platform for a linked school sample, allowing for a simpler and more efficient sampling design than in previous cycles.

Sampling frame

The sampling frame was based on the October 2015 version of the Market Data Retrieval (MDR) database (43). The frame included 13,320 districts, including 12,628 regular districts, 504 districts that were sub-units of supervisory unions, 49 "main" districts (see description below), and 139 career/technical education districts. Districts were not included in the frame if they were supervisory unions, sub-districts, or special education districts. Supervisory unions were "parent" districts that contained sub-units, so they were excluded to ensure that each unit was included only once in the frame. "Main" districts were typically large districts broken down by school level or region into sub-districts; only the main districts were included in the frame to avoid duplication.

Sample selection

Stratification of the frame of school districts was based on locale codes developed by the National Center for Education Statistics (NCES) that were included in the MDR database. These NCES locales created 12 strata that classified districts based on urban status: city (divided into large, midsize, and small), suburb (divided into large, midsize, and small), town (divided into fringe, distant, and remote), and rural (divided into fringe, distant, and remote). The sample was allocated proportionally across the 12 strata, creating a nearly self-weighting sample of districts.

Initially, 972 districts were sampled. This sample included with certainty 17 districts funded for school-based HIV/STD prevention by the Division of Adolescent and School Health (DASH) at CDC at the time of the study, so that future analyses could examine how these districts might differ from those without this funding. The initial sample was validated to ensure that the sampled districts met eligibility criteria. Districts were considered ineligible if they served fewer than 30 students across all schools in the district, if they served only a special population of students, if they only contained schools that served students for whom primary education services were provided within schools in other districts (such as vocational schools), or if they only functioned for administrative purposes and did not contain schools. Of the 972 sampled districts, 14 were found to be ineligible during sample validation and were replaced by similar districts in the same stratum. An additional 15 districts were deemed ineligible for participation during recruitment. These districts were not subsequently replaced, resulting in a total of 957 districts in the sample.

Response rates

Response rates were calculated by questionnaire and module and are shown in Table 2. A total of 740 districts (77.3%) completed at least one module or one questionnaire. Not every district was eligible to complete every module. For example, if a district did not contain elementary schools, that district was not eligible to complete any elementary school modules.

Table 2. Summary of response rates—SHPPS 2016

Questionnaire/Module	# of eligible districts	# of ineligible districts	# of participating districts	Participation rate (%)
Health Education (overall)	957	0	619	64.7*
Standards, Professional Development, Collaboration, and Evaluation	957	0	561	58.6
Elementary School Instruction	942	15	527	55.9
Middle School Instruction	930	27	515	55.4
High School Instruction	863	94	472	54.7
Health Education Coordinator	957	0	535	55.9
Health Services	957	0	613	64.1
Healthy and Safe School Environment (overall)	957	0	613	64.1*
General School Environment	957	0	544	56.8
Physical School Environment	957	0	517	54.0
Crisis Preparedness	957	0	572	59.8
Nutrition Services	957	0	599	62.6
Physical Education and Physical Activity (overall)	957	0	589	61.6*
Standards, Professional Development, Collaboration, and Interscholastic Sports	957	0	541	56.5
Elementary School Instruction	942	15	506	53.7
Middle School Instruction	929	28	495	53.3
High School Instruction	862	95	444	51.5
Physical Education Coordinator	957	0	515	53.8

*Percentage of districts that completed at least 1 module in that questionnaire.

Recruitment and Data Collection

Recruitment began in June of 2015 with the solicitation of state support for the study. Contacts in each state were sent an information packet about SHPPS. These contacts, who worked in state education agencies and state departments of health, were asked to facilitate a letter of support for the study from the head of their agency. After a state sent a letter of support from one or both state agencies or made it clear that no letter of support would be forthcoming, a study invitation packet was mailed to the superintendent of each selected district in that state. The invitation packets and follow-up telephone calls sought each district's agreement to participate in the study. Participating districts then identified questionnaires and modules not applicable to the district and the most knowledgeable respondent for each questionnaire and module. These respondents were district staff such as superintendents, health and physical education coordinators, and school food authority directors.

After district contacts agreed that their district would participate in the study and identified respondents for each questionnaire and module, respondents were contacted directly by both e-mail and overnight mail. These e-mails and letters contained information about the study and provided respondents with instructions for accessing the secure data collection Web site, including a unique access code. When respondents logged into the Web site using their access code, they were asked to confirm their district's name and were then presented with an on-screen consent statement. After acknowledging consent, each respondent was presented with a home page that displayed their assigned questionnaire(s) and module(s). Respondents assigned to complete multiple questionnaires or modules could complete them in any

order. If respondents did not complete a questionnaire or module during a log-in session, their responses were saved and they could return to their stopping point the next time they logged in. Within each questionnaire or module, respondents could leave a question blank and still advance to the next question. Upon completing a questionnaire or module, respondents could review their responses, edit any previous responses, and fill in any missing responses before submitting the questionnaire or module.

Data collection began in October 2015 and concluded in August 2016. Respondents who had not submitted all of their questionnaires or modules received a reminder e-mail every 15 business days. In March 2016, data collection transitioned to a mixed mode of administration to increase response rates. Individuals who had been identified as respondents by their districts but had not yet submitted Web-based questionnaires received two rounds of mailings that offered them the option of completing paper-and-pencil versions of the questionnaires and returning them in pre-paid envelopes. In addition, districts that had not yet indicated a decision to participate received two rounds of paper-and-pencil questionnaires via mail that could be distributed to respondents in those districts. These mailings also included instructions for accessing the Web-based questionnaires if respondents preferred to submit their responses that way. In May 2016, a third round of correspondence in the form of a postcard was sent to respondents who had not yet submitted questionnaires. This postcard included a brief message encouraging respondents to go to the Web site to complete their assigned questionnaires. Recruiters followed up with district contacts and respondents by telephone after each mailing to answer any questions and elicit a commitment to participate.

At the end of the data collection period (August 2016), 94.2% of the completed questionnaires or modules were submitted via the Web-based system, and 5.8% were submitted as paper questionnaires that were subsequently entered into the Web-based system by project staff. In 97.8% of districts, at least one questionnaire or module was submitted via the Web-based system and in 23.6%, at least one questionnaire or module was submitted on paper via mail.

Incentives were offered at both the district level and at the individual respondent level. District contacts were offered incentives beginning in March 2016 in the form of an Amazon gift code. To receive this incentive, the district contact had to commit to district participation and complete and return a form identifying respondents for each questionnaire and module. Incentives also were introduced at the individual level in March 2016. Previously identified respondents who had not submitted questionnaires and newly identified respondents who had not submitted questionnaires within six weeks of being invited to participate were offered an Amazon gift code for each completed questionnaire.

Data Cleaning, Weighting, and Analysis

Cleaning

The Web-based data collection system contained built-in checks to limit invalid and out-of-range responses. For example, if a question was supposed to be skipped by a respondent based on the answer to a previous question, that question was never displayed, so the respondent did not have an opportunity to enter an invalid response. After verifying that all programming logic was implemented correctly, data were edited for logically inconsistent responses.

Weighting

SHPPS 2016 included a stratified random sample of school districts, plus 17 DASH-funded districts selected with certainty. Each of the DASH-funded districts had a sampling weight of 1.0. For the remaining districts, the base weight, or sampling weight, was computed as the inverse of the selection probability within each of the 12 strata defined by NCES locales. Base weights were then adjusted for non-response using a simple ratio adjustment, computed as the ratio of weighted totals within weight adjustment classes. The ratio used was the total of the base weights computed over all the sampled districts to the same total computed over all the participating districts. The weight adjustment classes were defined by census region, NCES locale, and poverty level. These variables were found to be the best predictors of response propensities in non-response analysis.

Because response rates were calculated for each questionnaire, the weight for nonresponse was calculated separately by questionnaire, resulting in a set of questionnaire-specific weights to be used for questionnaire-specific analyses. In addition, an overall weight was computed for use in analyses that merged data from two or more questionnaires. For this weight, the nonresponse adjustment was made based on an aggregated overall response indicator, in which a district was considered as responding if at least one module or questionnaire was completed.

As a final step, the district weights were post-stratified to control totals. Post-stratum cells were defined by census region and NCES locale, for which population totals are available from the MDR database. The adjustment made the final adjusted weights sum to the total number of districts in the post-stratum cell. Note that although each component was post-stratified independently, they shared a common set of control totals.

Analysis

Statistical analyses were conducted on weighted data using SAS and SUDAAN software to account for the sampling design. Prevalence estimates and 95% confidence intervals were computed for all variables. Unless otherwise indicated, the denominator for all analyses included all districts rather than a subset of districts. When analyzing changes between SHPPS 2000 and later cycles, many variables from SHPPS 2000 were recalculated so that the denominators used for all years of data were defined identically. As a result of this recalculation, percentages previously reported for SHPPS 2000 might differ from those provided in the trends over time section of this report. Only estimates that use the same denominator should be compared.

Secular trend analyses were performed using regression analysis to determine whether changes over time were statistically significant for variables that had at least two years of data. Time was treated as a continuous variable; orthogonal coefficients reflected a linear time component and spacing between the study years. Trend analyses took into account all available years of data for each variable.

Several criteria were used to determine which changes over time to present in this report. To account for multiple comparisons, changes were reported only if the p-value from the regression analysis was less than .01, and either the difference between the two endpoints was greater than 10 percentage points, or the 2016 estimate increased by at least a factor of two or decreased by at least half as compared to the baseline estimate.

Limitations and Future Plans

As in previous cycles, SHPPS 2016 is limited in its ability to provide data on the quality of the policies and practices measured. Respondents were asked only to report whether certain policies existed. It is possible that a policy could exist but not reflect best practices in its content or implementation. In addition, as with any study that relies on self-report, it is possible that the data reflect some amount of overreporting or underreporting, as well as lack of knowledge on the part of the respondents. For example, a content analysis of written policies might have resulted in different findings because self-report relies on both the knowledge of the respondents and their interpretation of existing policies.

Unlike previous cycles, SHPPS 2016 collected data at only the district level. As a result, the types of analyses that can be performed are limited, although the district-level data does contain state identifiers that allow the data to be linked to extant state-level data, such as state policy databases. No immediate plans exist for conducting future cycles of SHPPS.

Results

Health Education

Table 1.1. Percentage of districts that had adopted specific policies related to health education standards—SHPPS 2016

Policy	Districts (%)
Schools will follow any national, state, or district health education standards	81.7 (77.9–85.0)
Schools will follow standards based on the National Health Education Standards	63.0 (58.6–67.3)
Schools will follow standards based on the National Sexuality Education Standards	41.3 (36.8–45.9)

Table 1.2. Percentage of districts with specific health education policies and practices, by school level—SHPPS 2016

	Districts (%)		
Policy or practice	Elementary school	Middle school	High school
Requires schools to assess student achievement of health education standards used by district[1]	38.5 (33.6–43.7)	44.6 (39.7–49.6)	54.6 (49.5–59.7)
Requires schools to notify parents or guardians before students receive instruction on pregnancy prevention, HIV prevention, other STD prevention, or human sexuality[2]	79.4 (74.1–83.9)	75.2 (70.4–79.4)	66.3 (61.2–71.2)
Requires schools to require parental permission before children receive instruction on pregnancy prevention, HIV prevention, other STD prevention, or human sexuality[2]	66.4 (60.2–72.1)	61.7 (56.5–66.6)	53.1 (47.8–58.4)
Requires schools to allow parents or guardians to exclude their children from receiving instruction on pregnancy prevention, HIV prevention, other STD prevention, or human sexuality[2]	83.0 (77.9–87.2)	80.4 (75.9–84.2)	74.7 (69.7–79.0)
Ever used a curriculum analysis tool (e.g., the Health Education Curriculum Analysis Tool [HECAT]) to assess one or more health education curricula	11.3 (8.8–14.5)	15.3 (12.2–18.9)	17.7 (14.3–21.7)
Has specified time requirements for health education	32.0 (27.8–36.5)	52.3 (47.6–56.9)	72.3 (67.7–76.4)

[1] Among the 81.1%, 87.7%, and 93.4% of districts that follow standards for elementary, middle, and high school health education, respectively.
[2] Among the 57.9%, 82.5%, and 87.3% of districts requiring elementary, middle, and high schools, respectively, to teach about at least one of those topics.

Table 1.3. Percentage of districts with other specific health education policies and practices—SHPPS 2016

Policy or practice	Districts (%)
Requires each school to have someone to oversee or coordinate health education at the school	42.2 (37.8–46.6)
Requires those who teach health education to earn continuing education credits on health education topics or instructional strategies	39.6 (35.4–44.1)
Offered any health education to families of all students[1]	40.6 (36.2–45.1)
Provided district or school personnel (e.g., classroom teachers, administrators, or school board members) with information on school health education[1]	69.0 (64.8–73.0)
Sought positive media attention for school health education[1]	34.4 (30.3–38.8)
Reviewed or updated health education policies[2]	58.6 (54.0–63.0)
Reviewed or updated health education curricula[2]	62.8 (58.4–67.1)
Evaluated any health education professional development or in–service programs[2]	42.1 (37.6–46.7)
Has someone in district who oversees or coordinates health education	69.0 (64.6–73.0)

[1] During the 12 months before the study.
[2] During the 2 years before the study.

Table 1.4. Percentage of districts that follow specific standards for health education, by school level—SHPPS 2016

Standard	Districts (%)		
	Elementary school	Middle school	High school
Follows health education standards	81.1 (77.2–84.5)	87.7 (84.3–90.5)	93.5 (90.6–95.5)
Follows standards that specifically address:			
Accessing valid information, products, and services to enhance health	65.0 (60.5–69.3)	80.4 (76.3–83.9)	87.9 (84.5–90.7)
Advocating for personal, family, and community health	70.7 (66.3–74.7)	78.9 (74.7–82.5)	88.3 (84.9–91.0)
Analyzing the influence of family, peers, culture, media, technology, and other factors on health behaviors	70.9 (66.6–74.9)	84.5 (80.8–87.6)	90.7 (87.5–93.1)
Comprehending concepts related to health promotion and disease prevention to enhance health	77.3 (73.2–80.9)	86.0 (82.4–89.0)	92.2 (89.1–94.4)
Practicing health-enhancing behaviors to avoid or reduce health risks	77.1 (73.0–80.8)	85.0 (81.4–88.1)	92.2 (89.2–94.4)
Using decision-making skills to enhance health	77.1 (73.0–80.7)	86.5 (82.9–89.4)	92.6 (89.7–94.8)
Using goal-setting skills to enhance health	69.2 (64.8–73.3)	80.1 (76.1–83.7)	88.7 (85.2–91.4)
Using interpersonal communication skills to enhance health and avoid or reduce health risks	71.8 (67.5–75.8)	84.3 (80.5–87.5)	90.2 (86.9–92.7)

Table 1.5. Percentage of districts that had adopted a policy stating that schools will teach specific health topics, by school level—SHPPS 2016

Health topic	Districts (%)		
	Elementary school	Middle school	High school
Alcohol or other drug use prevention	63.9 (59.4–68.3)	79.7 (75.7–83.1)	86.0 (82.3–89.0)
Asthma	40.1 (35.6–44.8)	47.4 (42.7–52.1)	53.2 (48.3–58.0)
Chronic disease prevention (e.g., diabetes or obesity prevention)	48.4 (43.7–53.1)	65.8 (61.2–70.1)	76.5 (72.2–80.4)
Emotional and mental health	56.9 (52.2–61.5)	74.2 (70.0–78.0)	82.2 (78.3–85.6)
Food allergies	44.8 (40.2–49.4)	50.2 (45.5–54.8)	59.0 (54.1–63.7)
Foodborne illness prevention	34.6 (30.3–39.1)	47.9 (43.2–52.6)	59.6 (54.7–64.3)
Human immunodeficiency virus (HIV) prevention	29.0 (24.9–33.4)	70.6 (66.1–74.7)	82.4 (78.3–85.9)
Human sexuality	51.9 (47.2–56.6)	75.4 (71.2–79.1)	79.6 (75.4–83.2)
Infectious disease prevention (e.g., flu prevention)	55.1 (50.4–59.7)	63.4 (58.8–67.7)	71.6 (67.0–75.8)
Injury prevention and safety	66.9 (62.3–71.1)	71.3 (66.8–75.4)	77.1 (72.7–80.9)
Nutrition and dietary behavior	70.6 (66.2–74.7)	76.9 (72.8–80.6)	84.6 (80.7–87.8)
Oral health	57.7 (53.0–62.2)	54.9 (50.3–59.6)	56.1 (51.2–60.9)
Other sexually transmitted disease (STD) prevention	22.9 (19.1–27.1)	69.0 (64.6–73.1)	81.6 (77.6–85.1)
Physical activity and fitness	60.7 (56.1–65.1)	71.4 (67.0–75.4)	79.6 (75.5–83.2)
Pregnancy prevention	18.9 (15.6–22.8)	59.7 (55.0–64.3)	76.3 (71.8–80.2)
Suicide prevention	36.0 (31.6–40.6)	65.4 (60.8–69.7)	78.6 (74.4–82.3)
Tobacco use prevention	65.9 (61.4–70.2)	80.0 (76.1–83.4)	85.6 (81.9–88.7)
Violence prevention (e.g., bullying or fighting prevention)	86.3 (82.7–89.2)	85.0 (81.4–88.0)	87.3 (83.7–90.1)

Table 1.6. Percentage of districts that provided specific resources for health education,[1] by school level—SHPPS 2016

Resource	Districts (%)		
	Elementary school	Middle school	High school
Goals, objectives, and expected outcomes for health education	50.9 (46.3–55.5)	56.8 (52.1–61.3)	64.9 (60.2–69.4)
A chart describing the annual scope and sequence of instruction for health education	33.5 (29.2–38.0)	39.5 (35.1–44.2)	47.1 (42.3–52.0)
A list of one or more recommended health education curricula	44.1 (39.6–48.8)	50.7 (46.1–55.4)	56.6 (51.7–61.3)
Lesson plans or learning activities for health education	50.5 (45.9–55.1)	57.6 (52.9–62.2)	62.1 (57.3–66.7)
Plans for how to assess student performance in health education	36.9 (32.4–41.5)	48.8 (44.2–53.4)	53.7 (48.8–58.6)

[1]During the 2 years before the study.

Table 1.7. Percentage of districts that had adopted specific staffing policies for newly hired staff who teach health education, by school level[1]—SHPPS 2016

Policy	Districts (%)	
	Middle school	High school
Will have undergraduate or graduate training in health education	58.7 (54.0–63.3)	68.6 (63.8–73.1)
Will be certified, licensed, or endorsed by the state to teach health education	67.8 (63.2–72.1)	78.4 (74.0–82.2)
Will be Certified Health Education Specialists (CHES)	16.9 (13.6–20.7)	19.3 (15.7–23.5)

[1] Questions not asked for elementary school level.

Table 1.8. Percentage of districts with policies requiring schools to meet the health education needs of students with disabilities by using specific strategies—SHPPS 2016

Strategy	Districts (%)
Assigning a teacher or aide to assist students	90.3 (87.1–92.8)
Assigning note takers or readers for class work	80.1 (76.1–83.5)
Coordinating assignments with a special education teacher	90.6 (87.5–93.0)
Increasing skill modeling, practice, or repetition	90.8 (87.7–93.2)
Providing preferential seating	92.6 (89.7–94.8)
Simplifying instructional content or varying the amount or difficulty of material taught	91.9 (88.9–94.1)
Using modified assessments	94.3 (91.5–96.2)
Using modified instructional strategies	94.7 (92.1–96.5)

Table 1.9. Percentage of districts that had adopted a policy requiring those who teach health education to receive professional development on specific health topics, and the percentage of districts that provided funding for professional development or offered professional development on these topics to those who teach health education[1]—SHPPS 2016

	Districts (%)	
Health topic	**Required professional development**	**Provided funding for professional development or offered professional development[1]**
Alcohol or other drug use prevention	40.1 (35.8–44.6)	59.8 (55.3–64.1)
Asthma	32.5 (28.4–36.8)	44.7 (40.2–49.2)
Chronic disease prevention (e.g., diabetes or obesity prevention)	32.4 (28.3–36.7)	47.2 (42.7–51.8)
Emotional and mental health	41.2 (36.9–45.8)	63.6 (59.2–67.8)
Food allergies	34.0 (29.9–38.4)	46.5 (42.1–51.0)
Foodborne illness prevention	27.9 (24.0–32.0)	38.1 (33.8–42.6)
Human immunodeficiency virus (HIV) prevention	38.8 (34.5–43.3)	49.0 (44.5–53.5)
Human sexuality	37.1 (32.8–41.6)	50.4 (45.9–54.9)
Infectious disease prevention (e.g., flu prevention)	36.9 (32.7–41.3)	47.7 (43.3–52.3)
Injury prevention and safety	44.0 (39.6–48.5)	61.0 (56.5–65.3)
Nutrition and dietary behavior	38.1 (33.8–42.6)	56.0 (51.5–60.5)
Oral health	27.2 (23.3–31.4)	37.3 (33.1–41.8)
Other sexually transmitted disease (STD) prevention	37.2 (32.9–41.7)	48.9 (44.4–53.4)
Physical activity and fitness	37.8 (33.5–42.3)	60.1 (55.6–64.5)
Pregnancy prevention	32.6 (28.5–37.0)	44.5 (40.0–49.0)
Suicide prevention	47.9 (43.4–52.4)	68.8 (64.5–72.8)
Tobacco use prevention	39.2 (34.9–43.7)	55.1 (50.6–59.5)
Violence prevention (e.g., bullying or fighting prevention)	54.6 (50.1–59.0)	78.4 (74.5–81.9)

[1] During the 2 years before the study.

Table 1.10. Percentage of districts that provided funding for professional development or offered professional development on specific instructional strategy topics to those who teach health education[1]—SHPPS 2016

Instructional strategy topic	Districts (%)
Aligning health education standards to curriculum, instruction, or student assessment	69.6 (65.3–73.5)
Assessing or evaluating students in health education	61.2 (56.8–65.5)
Creating safe and supportive learning environments for all students, including students of different sexual orientations or gender identities	60.8 (56.3–65.2)
How to involve students' families in health education	41.5 (37.2–46.0)
How to involve the community in students' health education	41.0 (36.6–45.5)
Teaching online or distance education courses	27.6 (23.6–31.9)
Teaching skills for behavior change	62.2 (57.7–66.5)
Teaching students of various cultural backgrounds	62.0 (57.5–66.2)
Teaching students with limited English proficiency	61.9 (57.6–66.1)
Teaching students with long-term physical, medical, or cognitive disabilities	65.8 (61.4–70.0)
Using classroom management techniques (e.g., social skills training, environmental modification, conflict resolution and mediation, or behavior management)	76.3 (72.3–80.0)
Using data to plan or evaluate health education policies or practices	47.5 (43.0–52.1)
Using interactive teaching methods (e.g., role plays or cooperative group activities)	70.4 (66.1–74.3)
Using peer educators	47.8 (43.3–52.3)
Using technology (e.g., computers, the Internet, or social media) to enhance instruction or improve student learning	82.5 (79.0–85.6)
Using the Health Education Curriculum Analysis Tool (HECAT) to help assess health education curricula	15.1 (12.1–18.6)

[1] During the 2 years before the study.

Table 1.11. Percentage of districts in which health education staff worked on health education activities with other district-level and local agency or organization staff[1]—SHPPS 2016

Staff	Districts (%)
District staff	
Counseling, psychological, or social services	58.5 (54.1–62.9)
General curriculum coordinators or supervisors	66.8 (62.4–70.8)
Health services	58.0 (53.5–62.3)
Media or technology	53.7 (49.1–58.2)
Nutrition or food service	53.2 (48.7–57.7)
Physical education	64.0 (59.6–68.3)
Local agency or organization staff	
A community-based organization that provides sexual and reproductive health services	32.2 (28.1–36.6)
A health organization (e.g., the American Heart Association or the American Cancer Society)	59.8 (55.3–64.2)
A local business	37.5 (33.2–41.9)
A local college or university	41.4 (37.0–45.9)
A local dental or oral health association	44.3 (39.9–48.9)
A local health department	52.3 (47.7–56.8)
A local hospital	40.9 (36.6–45.4)
A local juvenile justice department	38.9 (34.6–43.4)
A local law enforcement agency	57.1 (52.6–61.5)
A local mental health or social services agency	57.3 (52.8–61.7)
A local service club (e.g., Rotary Club)	31.0 (27.0–35.4)
A local youth organization (e.g., the Boys and Girls Clubs)	27.7 (23.8–32.0)
A state affiliate of the American Association for Health Physical Education, Recreation, and Dance (AAHPERD)/ SHAPE America	29.3 (25.3–33.5)
Local fire or emergency medical services	53.0 (48.5–57.5)
The state health department	37.1 (32.8–41.6)

[1] During the 12 months before the study.

Physical Education and Physical Activity

Table 2.1. Percentage of districts that had adopted specific policies related to physical education standards—SHPPS 2016

Policy	Districts (%)
Schools will follow any national, state, or district physical education standards	85.6 (82.1–88.5)
Schools will follow standards based on the National Standards and Grade Level Outcomes for K-12 Physical Education from SHAPE America	60.0 (55.4–64.4)
Schools will assess student achievement of the physical education standards used by the district	58.9 (54.4–63.3)

Table 2.2. Percentage of districts that follow specific standards for physical education, by school level—SHPPS 2016

Standard	Districts (%)		
	Elementary school	Middle school	High school
Follows physical education standards	93.9 (91.2–95.9)	95.6 (93.4–97.1)	94.3 (91.7–96.1)
Follows standards that specifically address:			
Competency in a variety of motor skills and movement patterns	93.4 (90.6–95.4)	93.7 (91.1–95.6)	90.4 (87.2–92.9)
Knowledge and skills needed to achieve and maintain a health-enhancing level of physical activity and fitness	93.3 (90.5–95.4)	94.6 (92.2–96.3)	93.2 (90.5–95.2)
Knowledge of concepts, principles, strategies, and tactics related to movement and performance	93.1 (90.2–95.1)	94.3 (91.5–96.1)	92.1 (89.2–94.3)
Recognition of the value of physical activity for health, enjoyment, challenge, self-expression, and/or social interaction	93.1 (90.2–95.2)	93.3 (90.4–95.4)	93.5 (90.7–95.5)
Responsible personal and social behavior that respects self and others	92.6 (89.6–94.8)	94.1 (91.3–96.0)	91.2 (88.0–93.6)

Table 2.3. Percentage of districts that had adopted specific policies related to physical education requirements and exemptions from these requirements, by school level—SHPPS 2016

Policy	Districts (%)		
	Elementary school	Middle school	High school
Schools will teach physical education	92.6 (89.8–94.7)	89.7 (86.5–92.2)	92.9 (90.0–95.0)
The use of waivers, exemptions, or substitutions for physical education requirements[1] for students is prohibited[2]	13.6 (10.3–17.8)	13.3 (10.0–17.5)	18.0 (13.9–22.9)
Reasons that students may be excused from physical education requirements[1] through waivers, exemptions, or substitutions are described[2]	14.2 (10.9–18.3)	22.0 (17.6–27.1)	33.5 (28.2–39.3)
Students may be excused from physical education requirements[1,2] for:			
Achievement of positive, passing, or high physical fitness assessment scores	2.6 (1.3–4.9)	2.2 (1.1–4.4)	3.3 (1.9–6.0)
Cognitive disability	6.9 (4.7–10.2)	9.9 (7.1–13.6)	14.1 (10.6–18.5)
Enrollment in other courses (e.g., math or science)[3]	NA	1.8 (0.8–4.2)	4.3 (2.7–6.9)
Long-term physical or medical disability or chronic health condition	13.1 (9.9–17.1)	17.6 (13.7–22.4)	25.8 (21.0–31.3)
Participation in community service activities	0.7 (0.1–2.9)	0.7 (0.2–2.1)	1.0 (0.4–2.6)
Participation in community sports activities	0.7 (0.1–2.9)	2.0 (0.9–4.4)	2.3 (1.2–4.6)
Participation in school activities other than sports (e.g., band or chorus)	3.0 (1.7–5.3)	5.7 (3.6–8.9)	17.7 (13.7–22.4)
Participation in school sports[3]	NA	3.8 (2.2–6.5)	16.1 (12.4–20.7)
Participation in vocational training[3]	NA	1.0 (0.4–2.8)	2.6 (1.4–4.6)
Religious reasons	4.4 (2.7–6.9)	7.3 (4.8–10.8)	8.3 (5.7–12.0)
Students may be excused from one or more physical education class periods for additional instructional time, remedial work, or test preparation for other subjects[2]	14.3 (11.3–18.0)	19.2 (15.6–23.5)	11.3 (8.6–14.7)

[1] For one grading period or longer.
[2] Among the 92.6%, 89.6%, and 92.9% of districts requiring elementary, middle, and high schools, respectively, to teach physical education.
[3] Not asked about elementary schools.

Table 2.4. Percentage of districts with specific physical education policies and practices, by school level—SHPPS 2016

Policy or practice	Districts (%)		
	Elementary school	Middle school	High school
Has specified time requirements for physical education	73.5 (69.1–77.5)	70.5 (65.9–74.7)	76.4 (72.0–80.4)
Specifies a maximum student-to-teacher ratio for physical education	25.9 (22.0–30.2)	25.0 (21.1–29.3)	30.5 (26.2–35.2)
Requires that schools use one particular curriculum for physical education	20.9 (17.4–24.8)	19.3 (15.9–23.3)	20.7 (17.1–24.9)
Recommends that schools use one particular curriculum for physical education	25.1 (21.3–29.3)	26.8 (22.8–31.1)	27.7 (23.4–32.3)
Physical education curriculum required or recommended by district developed by:[1]			
College or university	5.3 (2.8–9.9)	5.2 (2.8–9.6)	3.3 (1.5–7.2)
Commercial company	19.1 (13.9–25.5)	9.1 (5.8–14.1)	9.1 (5.5–14.5)
National or state-level health organization (e.g., the American Heart Association or the American Cancer Society)	17.6 (12.9–23.4)	15.7 (11.3–21.5)	14.0 (9.9–19.6)
Other state agency	2.6 (1.0–6.6)	3.2 (1.6–6.7)	0.4 (0.1–2.9)
School district	62.6 (55.7–69.1)	66.3 (59.6–72.4)	72.4 (65.6–78.3)
State education agency	51.3 (44.4–58.2)	53.9 (47.0–60.7)	59.2 (52.1–66.0)
Other	12.8 (8.8–18.2)	12.1 (8.2–17.5)	10.5 (6.8–16.0)
Ever used a curriculum analysis tool (e.g., the Physical Education Curriculum Analysis Tool [PECAT]) to assess one or more physical education curricula	12.5 (9.7–15.9)	14.5 (11.5–18.2)	11.8 (9.0–15.3)
Requires schools to participate in the Presidential Youth Fitness Program (PYFP)	11.9 (9.2–15.3)	14.6 (11.6–18.3)	9.6 (7.1–12.9)
Recommends that schools participate in the Presidential Youth Fitness Program (PYFP)	34.4 (30.1–38.9)	33.2 (28.9–37.7)	28.7 (24.4–33.4)

[1] Among the 45.9%, 46.1%, and 48.4% of districts that required or recommended that elementary, middle, and high schools use one particular curriculum for physical education, respectively.

Table 2.5. Percentage of districts that provided specific resources for physical education,[1] by school level—SHPPS 2016

Resource	Districts (%)		
	Elementary school	Middle school	High school
Goals, objectives, and expected outcomes for physical education	66.2 (61.8–70.4)	67.1 (62.6–71.4)	67.5 (62.8–72.0)
A chart describing the annual scope and sequence of instruction for physical education	46.1 (41.6–50.7)	43.1 (38.6–47.8)	49.0 (44.1–53.9)
A list of one or more recommended physical education curricula	43.9 (39.3–48.5)	46.5 (41.8–51.2)	51.2 (46.2–56.2)
Lesson plans or learning activities for physical education	55.3 (50.6–59.9)	54.1 (49.4–58.8)	56.5 (51.5–61.3)
Plans for how to assess student performance in physical education	60.5 (55.9–65.0)	58.1 (53.3–62.7)	58.7 (53.7–63.5)
Resources for fitness assessment in schools	68.4 (63.9–72.6)	69.9 (65.4–74.1)	69.4 (64.6–73.8)
Physical activity monitoring devices (e.g., pedometers or heart rate monitors) for physical education	41.4 (36.9–46.0)	42.3 (37.7–47.0)	48.4 (43.6–53.3)

[1] During the 2 years before the study.

Table 2.6. Percentage of districts with specific requirements and recommendations related to assessments, by school level—SHPPS 2016

Requirement or recommendation	Districts (%)		
	Elementary school	Middle school	High school
Requires schools to give written assessments of students' knowledge related to physical education	13.0 (10.1–16.5)	17.8 (14.5–21.7)	21.8 (18.0–26.2)
Recommends that schools give written assessments of students' knowledge related to physical education	27.7 (23.8–32.0)	38.2 (33.7–42.9)	39.5 (34.7–44.4)
Requires schools to give skill performance assessments of students' knowledge related to physical education	24.6 (20.7–29.0)	18.7 (15.3–22.6)	25.3 (21.2–29.9)
Recommends that schools give skill performance assessments of students' knowledge related to physical education	39.5 (35.1–44.1)	45.7 (41.0–50.5)	41.9 (37.1–46.9)
Requires schools to assess students' physical activity levels (e.g., through the use of physical activity logs or pedometers)	7.1 (5.0–9.9)	7.5 (5.4–10.4)	10.7 (8.0–14.3)
Recommends that schools assess students' physical activity levels (e.g., through the use of physical activity logs or pedometers)	33.2 (28.9–37.7)	39.6 (35.1–44.4)	41.6 (36.8–46.6)
Requires schools to assess students' fitness levels	30.6 (26.5–35.0)	32.0 (27.8–36.5)	30.0 (25.7–34.6)
Recommends that schools assess students' fitness levels	40.0 (35.5–44.6)	39.6 (35.1–44.3)	38.1 (33.4–43.0)
Requires schools to use Fitnessgram	27.3 (23.3–31.7)	26.9 (22.9–31.3)	21.9 (18.1–26.2)
Recommends that schools use Fitnessgram	26.1 (22.3–30.3)	27.9 (23.9–32.3)	25.5 (21.4–30.0)
Requires schools to use the Physical Fitness Test from the President's Challenge	11.3 (8.7–14.6)	10.7 (8.1–14.1)	8.6 (6.2–11.9)
Recommends that schools use the Physical Fitness Test from the President's Challenge	25.9 (22.1–30.2)	26.4 (22.5–30.7)	25.0 (20.9–29.5)
Requires schools to use any other fitness assessment	9.2 (6.7–12.4)	5.7 (3.9–8.2)	8.1 (5.8–11.3)
Recommends that schools use any other fitness assessment	15.3 (12.3–18.8)	20.2 (16.7–24.3)	21.9 (18.1–26.3)
Requires schools to submit students' fitness assessment results to the state or district	44.9 (39.5–50.5)	40.4 (35.0–46.0)	42.4 (36.5–48.5)
Requires schools to share the results of students' fitness assessments with students' parents or guardians	20.4 (16.2–25.5)	14.6 (11.0–19.1)	14.7 (10.8–19.8)
Recommends that schools share the results of students' fitness assessments with students' parents or guardians	40.2 (35.0–45.7)	44.8 (39.3–50.5)	44.9 (38.9–51.1)

Table 2.7. Percentage of districts that had adopted specific staffing policies for newly hired staff who teach physical education, by school level—SHPPS 2016

Policy	Districts (%)		
	Elementary school	Middle school	High school
Will have undergraduate or graduate training in physical education or a related field	70.6 (66.1–74.7)	74.2 (69.8–78.2)	81.2 (77.1–84.7)
Will be certified, licensed, or endorsed by the state to teach physical education	78.2 (74.0–81.9)	86.0 (82.3–89.0)	89.6 (86.2–92.3)

Table 2.8. Percentage of districts with policies requiring schools to meet the physical education needs of students with disabilities by using specific strategies—SHPPS 2016

Strategy	Districts (%)
Including accommodations in physical education in 504 plans or Individualized Education Programs (IEPs)	97.6 (95.6–98.7)
Mainstreaming into regular physical education as appropriate	97.2 (95.2–98.4)
Providing adapted physical education as appropriate	91.0 (88.0–93.3)
Using modified assessments	94.2 (91.7–96.0)
Using modified equipment or facilities in regular physical education	89.4 (86.4–91.8)
Using modified instructional strategies	95.5 (93.2–97.0)
Using teaching assistants in regular physical education	78.6 (74.6–82.1)

Table 2.9. Percentage of districts with requirements and recommendations related to recess—SHPPS 2016

Requirement or recommendation	Districts (%)
Requires that elementary schools provide students with regularly scheduled recess	64.8 (60.3–69.0)
Recommends that elementary schools provide students with regularly scheduled recess	31.3 (27.3–35.7)
Required or recommended number of minutes per day of recess for elementary school students:[1]	
Less than 10 minutes	0.6 (0.2–1.8)
10 to 19 minutes	18.7 (15.3–22.6)
20 to 29 minutes	35.1 (30.8–39.6)
30 or more minutes	30.2 (26.0–34.6)
No specified time requirements or recommendations	15.5 (12.3–19.4)
Requires that elementary schools provide recess before students eat lunch[1]	7.8 (5.5–10.8)
Recommends that elementary schools provide recess before students eat lunch[1]	22.6 (19.0–26.6)

[1] Among the 96.1% of districts that required or recommended that elementary schools provide regularly scheduled recess.

Table 2.10. Percentage of districts with requirements and recommendations related to physical activity, by school level—SHPPS 2016

Requirement or recommendation	Districts (%)		
	Elementary school	Middle school	High school
Requires that schools provide regular classroom physical activity breaks[1] during the school day	10.7 (8.2–13.8)	7.5 (5.3–10.4)	2.2 (1.1–4.3)
Recommends that schools provide regular classroom physical activity breaks[1] during the school day	49.6 (45.0–54.2)	38.7 (34.4–43.3)	27.6 (23.6–32.0)
Requires that schools provide opportunities for physical activity before the school day	2.6 (1.5–4.5)	1.2 (0.5–2.7)	0.8 (0.3–2.1)
Recommends that schools provide opportunities for physical activity before the school day	28.6 (24.6–32.9)	25.2 (21.4–29.4)	24.0 (20.1–28.3)
Requires that schools provide opportunities for physical activity after the school day	2.1 (1.1–3.9)	4.7 (3.0–7.3)	6.8 (4.7–9.8)
Recommends that schools provide opportunities for physical activity after the school day	38.2 (33.9–42.7)	50.9 (46.3–55.5)	47.7 (42.9–52.5)

[1] For elementary schools, this is defined as "outside of physical education class and recess." For middle schools and high schools, this is defined as "outside of physical education class."

Table 2.11. Percentage of districts with other physical education and physical activity policies and practices—SHPPS 2016

Policy or practice	Districts (%)
Requires students to wear appropriate protective gear:	
During physical education	38.9 (34.6–43.4)
When engaged in physical activity clubs or intramural sports	51.6 (47.0–56.1)
When engaged in interscholastic sports	83.7 (80.0–86.8)
Prohibits or actively discourages elementary schools from excluding students from all or part of recess as punishment for inappropriate behavior or failure to complete class work	52.1 (47.4–56.7)
Prohibits or actively discourages schools from using physical activity to punish students for inappropriate behavior in physical education	62.3 (57.8–66.6)
Prohibits or actively discourages schools from using physical activity to punish students for poor performance or inappropriate behavior in interscholastic sports	57.7 (53.1–62.1)
Prohibits or actively discourages schools from excluding students from all or part of physical education class to punish students for inappropriate behavior or failure to complete class work in another class	68.1 (63.6–72.2)
Prohibits or actively discourages schools from excluding students from all or part of physical education class to punish students for inappropriate behavior in physical education class	57.6 (53.0–62.1)
Requires each school to have someone to oversee or coordinate physical education at the school	46.9 (42.4–51.4)
Requires each school to have someone to oversee or coordinate a Comprehensive Physical Activity Program (CSPAP) at the school	15.4 (12.4–18.9)
Requires each school to have a written plan for a Comprehensive School Physical Activity Program (CSPAP)	12.5 (9.9–15.7)
Requires those who teach physical education to earn continuing education credits on physical education topics or instructional strategies	45.5 (41.0–50.1)
Provided district or school personnel (e.g., classroom teachers, administrators, or school board members) with information on school physical education[1]	68.4 (64.0–72.4)
Provided district or school personnel (e.g., classroom teachers, administrators, or school board members) with information on school physical activity[1]	65.8 (61.3–70.0)
Sought positive media attention for school physical education[1]	45.5 (41.1–50.0)
Sought positive media attention for school physical activity[1]	49.3 (44.8–53.8)
Provided awards or recognition for outstanding implementation of school physical activity programs (e.g., physical activity clubs or intramural sports programs)	40.3 (35.9–44.8)
Reviewed or updated physical education policies[2]	56.3 (51.7–60.8)
Reviewed or updated physical education curricula[2]	65.2 (60.8–69.4)
Evaluated any physical education professional development or in-service programs	44.0 (39.6–48.5)
Requires schools to report:	
Number of minutes of physical education required in each grade	59.0 (54.4–63.5)
Number of minutes of elementary school recess	50.3 (45.6–55.0)
Number of minutes of classroom physical activity breaks	14.5 (11.6–18.1)
Has someone in the district who oversees or coordinates physical education	66.6 (62.2–70.7)

[1]During the 12 months before the survey.
[2]During the 2 years before the survey.

Table 2.12. Percentage of districts that provided funding for professional development or offered professional development on specific topics to those who teach physical education[1]—SHPPS 2016

Topic	Districts (%)
Administering or using fitness assessments	67.6 (63.1–71.7)
Aligning physical education standards to curriculum, instruction, or student assessment	74.3 (70.0–78.1)
Assessing or evaluating student performance in physical education	69.4 (65.0–73.5)
Assessing student weight status using body mass index (BMI), skinfolds, or bioelectric impedance	43.2 (38.8–47.8)
Chronic health conditions (e.g., asthma or diabetes), including recognizing and responding to severe symptoms or reducing triggers	56.8 (52.2–61.3)
Developing and using student portfolios for physical education	34.9 (30.7–39.4)
Developing, implementing, and evaluating a Comprehensive School Physical Activity Program (CSPAP)	22.7 (19.1–26.7)
Encouraging family involvement in physical activity	49.8 (45.3–54.4)
Establishing walking or biking to school programs	30.2 (26.2–34.5)
Helping classroom teachers integrate physical activity into their classrooms	43.6 (39.1–48.2)
Helping students develop individualized physical activity plans	49.1 (44.6–53.7)
How to prevent, recognize, and respond to concussions among students	81.5 (77.6–84.8)
Implementing the Presidential Youth Fitness Program (PYFP)	39.6 (35.3–44.2)
Injury prevention and first aid	78.6 (74.5–82.1)
Methods for developing, implementing, and evaluating physical activity clubs or intramural sports programs	32.4 (28.3–36.8)
Methods to increase the amount of time students are engaged in moderate-to-vigorous physical activity during physical education class	62.4 (57.8–66.7)
Methods to promote gender equity in physical education and sports	51.2 (46.7–55.8)
Providing Physical Activity Leader (PAL) training through Let's Move! Active Schools	22.1 (18.6–26.1)
Teaching individual or paired activities or sports	60.4 (55.8–64.8)
Teaching methods to promote inclusion and active participation of overweight and obese children during physical education	46.5 (42.0–51.1)
Teaching movement skills and concepts	64.1 (59.6–68.5)
Teaching online or distance education courses	20.3 (16.8–24.2)
Teaching physical education to students with long-term physical, medical, or cognitive disabilities	59.9 (55.3–64.4)
Teaching team or group activities or sports	66.3 (61.7–70.5)
Using data to plan or evaluate physical education policies or practices	52.2 (47.6–56.8)
Using physical activity monitoring devices (e.g., pedometers or heart rate monitors) for physical education	57.5 (53.0–62.0)
Using technology (e.g., computers, the Internet, or social media) to enhance instruction or improve student learning	78.5 (74.5–82.0)
Using the Physical Education Curriculum Analysis Tool (PECAT) to help assess physical education curricula	15.0 (12.0–18.5)

[1] During the 2 years before the survey.

Table 2.13. Percentage of districts in which physical education staff worked on physical education activities with other district-level and local agency or organization staff[1]—SHPPS 2016

Staff	Districts (%)
District staff	
Counseling, psychological, or social services	39.3 (34.9–43.9)
General curriculum coordinators or supervisors	56.5 (51.9–61.0)
Health education	52.2 (47.7–56.7)
Health services	42.1 (37.7–46.7)
Media or technology	43.6 (39.1–48.1)
Nutrition or food service	41.3 (36.8–45.9)
Local agency or organization staff	
A health organization (e.g., the American Heart Association or the American Cancer Society)	59.0 (54.5–63.4)
A local business	29.8 (25.8–34.2)
A local college or university	31.1 (27.1–35.4)
A local department of transportation or public works	9.3 (7.0–12.3)
A local health department	39.0 (34.7–43.6)
A local health or fitness club	27.1 (23.2–31.3)
A local hospital	27.1 (23.2–31.4)
A local law enforcement agency	31.8 (27.7–36.2)
A local mental health or social services agency	33.2 (29.0–37.7)
A local parks or recreation department	39.6 (35.3–44.2)
A local professional sports team	10.3 (7.9–13.3)
A local service club (e.g., Rotary Club)	22.1 (18.5–26.2)
A local youth organization (e.g., the Boys and Girls Clubs)	28.4 (24.4–32.7)
A state affiliate of the American Association for Health Physical Education, Recreation, and Dance (AAHPERD)/ SHAPE America	31.8 (27.7–36.1)
The state health department	27.0 (23.1–31.2)

[1] During the 12 months before the study.

Table 2.14. Percentage of districts with specific policies and practices related to interscholastic sports—SHPPS 2016

Policy or practice	Districts (%)
Requires head coaches of interscholastic sports to	
Be certified in cardiopulmonary resuscitation (CPR)	76.0 (71.9–79.7)
Be certified in first aid	72.5 (68.3–76.4)
Be employed by the school or school district	43.7 (39.2–48.3)
Complete a coaches[1] training course	73.8 (69.6–77.6)
Complete a sports safety course	76.0 (71.7–79.7)
Have a teaching certificate	29.4 (25.5–33.7)
Have previous coaching experience in any sport	25.0 (21.2–29.2)
Have previous coaching experience in the sport(s) they will be coaching	27.0 (23.1–31.3)
Have training on how to prevent, recognize, and respond to concussions among students	90.3 (87.1–92.8)
Requires assistant coaches or volunteer athletic aides to complete a coaches[1] training course	60.9 (56.4–65.3)
Provided any funding for professional development or offered professional development to coaches of interscholastic sports[1]	65.6 (61.1–69.8)

[1] During the 2 years before the study.

Table 2.15. Percentage of districts with specific policies and practices related to concussions during interscholastic sports—SHPPS 2016

Policy or practice	Districts (%)
Provided educational materials to student athletes or their parents on preventing, recognizing, and responding to concussions[1]	87.4 (84.0–90.2)
Provided educational sessions to student athletes or their parents on preventing, recognizing, and responding to concussions[1]	71.3 (67.0–75.3)
Provides student athletes returning to class after a suspected concussion with necessary academic accommodations (i.e., a return-to-learn protocol)	78.8 (74.8–82.3)
Requires clearance by a healthcare provider before allowing student athletes to further participate in practice or competition after a suspected concussion	91.4 (88.4–93.7)
Requires schools to conduct neurocognitive testing of student athletes before participation in interscholastic sports	41.4 (37.0–46.0)
Requires student athletes suspected of having a concussion to be removed immediately from practice or competition	90.9 (87.8–93.2)
Requires student athletes who required medical clearance by a healthcare provider after a suspected concussion to successfully return to the classroom before returning to athletic participation	67.8 (63.3–71.9)

[1] During the 12 months before the study.

Nutrition Environment and Services

Table 3.1. Percentage of districts with specific school nutrition services policies and practices—SHPPS 2016

Policy or practice	Districts (%)
Participates in the:	
National School Lunch Program (NSLP)	98.0 (96.3–99.0)
National School Lunch Program After-School Snack Program	32.9 (29.0–37.0)
School Breakfast Program (SBP)	91.1 (88.3–93.3)
After-School Supper Program	9.0 (6.9–11.7)
Sponsored the USDA Summer Food Service Program in any schools[1]	34.5 (30.7–38.6)
Nutrition services program operated by:	
School district	77.1 (73.3–80.5)
Food service management company	19.9 (16.7–23.5)
Other	3.0 (1.8–4.9)
Nutrition services program has primary responsibility for deciding which foods to order for schools	94.1 (91.7–95.8)
Nutrition services program has primary responsibility for cooking foods for schools (e.g., in a central kitchen)	81.6 (78.0–84.7)
Requires all schools to offer breakfast to students	82.9 (79.3–85.9)
Requires some categories of schools[2] to offer breakfast to students	5.9 (4.2–8.4)
Requires schools to encourage breakfast consumption by serving breakfast to students:	
On the school bus	1.5 (0.7–3.1)
In the classroom	27.1 (23.4–31.1)
As grab-and-go meals	41.5 (37.2–45.8)
After first period or during a morning break	20.8 (17.5–24.6)
Requires schools to offer lunch to students	96.3 (94.4–97.7)
Requires a minimum amount of time students will be given to eat breakfast once they receive their meal	19.4 (16.2–23.0)
Recommends a minimum amount of time students will be given to eat breakfast once they receive their meal	32.7 (28.7–36.9)
Minimum required or recommended amount of time students given to eat breakfast once they receive their meal[3] is:	
Less than 5 minutes	0 (. – .)
5 to 9 minutes	11.7 (8.2–16.5)
10 to 14 minutes	37.5 (32.0–43.4)
15 to 19 minutes	25.8 (20.9–31.4)
20 or more minutes	25.0 (20.3–30.4)
Requires a minimum amount of time students will be given to eat lunch once they receive their meal	35.5 (31.4–39.7)
Recommends a minimum amount of time students will be given to eat lunch once they receive their meal	40.2 (36.0–44.6)
Minimum required or recommended amount of time students given to eat lunch once they receive their meal[3] is:	
Less than 10 minutes	0.4 (0.1–1.5)
10 to 19 minutes	33.9 (29.3–38.8)
20 to 29 minutes	53.8 (48.8–58.8)
30 or more minutes	11.9 (9.1–15.4)
Has a district-level plan for feeding students who rely on the school meal programs in the event of an unplanned school dismissal or school closure	33.8 (29.7–38.2)
Purchases foods from local or regional growers or producers	68.7 (64.7–72.3)
Has someone in the district who oversees or coordinates nutrition services (e.g., a district food service director or school food authority director)	93.6 (91.2–95.3)

[1] During the summer of 2015.
[2] Such as those with a certain percentage of students eligible for free or reduced-price meals.
[3] Among districts with a required or recommended minimum time.

Table 3.2. Percentage of districts with food procurement contracts that address specific issues—SHPPS 2016

Issue	Districts (%)
Cooking methods for precooked items (e.g., baked instead of deep fried)	89.3 (86.3–91.7)
Food safety	97.0 (95.1–98.1)
Hazard Analysis and Critical Control Points (HACCP)	95.1 (93.0–96.6)
Limiting artificial colors, sweeteners, and preservatives	76.8 (72.8–80.4)
Nutritional standards for a la carte foods	85.4 (82.1–88.3)
Preference for locally or regionally grown foods	59.8 (55.4–64.0)
Use of low-sodium canned products	92.3 (89.4–94.5)
Use of whole grain-rich foods	97.7 (95.6–98.8)

Table 3.3. Percentage of districts[1] that almost always or always used healthy food preparation practices[2]—SHPPS 2016

Practice	Districts (%)
Substitution techniques	
Used canned fruit packed in light syrup or juice instead of canned fruit packed in heavy syrup	93.9 (91.4–95.7)
Used cooked dried beans, canned beans, soy products, or other meat extenders instead of meat	5.6 (3.8–8.3)
Used fresh or frozen fruit instead of canned	37.5 (33.0–42.2)
Used fresh or frozen vegetables instead of canned	55.6 (50.9–60.1)
Used ground turkey or lean ground beef instead of regular ground beef	57.9 (53.2–62.5)
Used low-fat or nonfat yogurt, mayonnaise, or sour cream instead of regular mayonnaise, sour cream, or creamy salad dressings	70.3 (65.9–74.3)
Used low-sodium canned vegetables instead of regular canned vegetables	75.8 (71.6–79.6)
Used non-stick spray or pan liners instead of grease or oil	91.5 (88.6–93.8)
Used olive or canola oil instead of shortening, butter, or margarine	49.0 (44.3–53.8)
Used other seasonings instead of salt	67.9 (63.3–72.1)
Used part-skim or low-fat cheese instead of regular cheese	81.5 (77.6–84.9)
Used skim, low-fat, soy, or nonfat dry milk instead of whole milk	89.0 (85.7–91.6)
Used whole grain-rich foods instead of non-whole grain-rich foods	94.0 (91.5–95.8)
Reduction techniques	
Reduced the amount of salt called for in recipes or used low-sodium recipes	76.4 (72.1–80.1)
Reduced the amount of saturated fats and oils called for in recipes	64.8 (60.1–69.2)
Reduced the amount of sugar called for in recipes or used low-sugar recipes	55.2 (50.5–59.9)
Meat/poultry preparation techniques	
Drained fat from browned meat[3]	70.7 (66.1–74.8)
Removed skin from poultry or used skinless poultry[3]	46.8 (42.1–51.6)
Roasted meat or poultry on a rack so fat would drain[3]	44.3 (39.7–49.1)
Roasted, baked, or broiled meat rather than fried it[3]	66.0 (61.4–70.3)
Skimmed fat off warm broth, soup, stew, or gravy	73.1 (68.6–77.2)
Spooned solid fat from chilled meat or poultry broth	76.2 (71.8–80.1)
Trimmed fat from meat or used lean meat[3]	58.5 (53.8–63.1)
Vegetable preparation techniques	
Boiled, mashed, or baked potatoes rather than fried or deep fried them	86.8 (83.1–89.8)
Prepared vegetables without using butter, margarine, or a cheese or creamy sauce	74.3 (70.0–78.1)
Rinsed canned vegetables and/or beans	56.5 (51.7–61.2)
Steamed or baked other vegetables	86.2 (82.6–89.2)

[1] Among the 81.6% of districts that have primary responsibility for cooking foods for schools in the district.
[2] During the 30 days before the study.
[3] An additional 31.0% of districts used only precooked meat/poultry.

Table 3.4. Percentage of districts in which nutrition services staff worked on school nutrition services activities with other district-level and local agency or organization staff[1]—SHPPS 2016

Staff	Districts (%)
District staff	
Counseling, psychological, or social services	29.0 (25.1–33.1)
Health education	47.6 (43.3–52.0)
Health services	55.8 (51.4–60.0)
Physical education	38.4 (34.2–42.7)
Local agency or organization staff	
A county cooperative extension office	27.2 (23.5–31.2)
A food commodity organization (e.g., the Dairy Council or produce growers association)	44.3 (40.0–48.6)
A food policy council	21.4 (18.1–25.3)
A health organization (e.g., the American Heart Association or the American Cancer Society)	16.9 (14.0–20.3)
A local anti-hunger organization (e.g., a food bank)	34.6 (30.7–38.8)
A local business	29.1 (25.2–33.3)
A local college or university	19.3 (16.1–22.9)
A local health department	56.4 (52.1–60.5)
A local hospital	9.0 (6.8–11.9)
A local mental health or social services agency	9.7 (7.3–12.7)
A local or state chapter of the School Nutrition Association	53.0 (48.7–57.2)
A local service club (e.g., Rotary Club)	11.6 (9.1–14.8)
A local youth organization (e.g., the Boys and Girls Clubs)	13.3 (10.6–16.6)
A non-governmental organization promoting farm to school activities	24.1 (20.5–28.0)
A Supplemental Nutrition Assistance Program-Education (SNAP-Ed) implementing agency	21.6 (18.2–25.4)
The state agriculture department	33.4 (29.4–37.6)
The state health department	35.4 (31.4–39.7)

[1] During the 12 months before the study.

Table 3.5. Percentage of districts that used specific practices[1] to promote school nutrition services—SHPPS 2016

Practice	Districts (%)
Made menus available to students	98.6 (97.2–99.3)
Made information available to students on the nutrition and caloric content of foods available to them	74.0 (70.2–77.4)
Made menus available to families of all students	98.8 (97.5–99.5)
Made information available to families of all students on the nutrition and caloric content of foods available to students	63.1 (59.0–67.1)
Made information about school nutrition services available at community events	47.6 (43.4–51.9)
Led an activity about healthy eating for students	49.0 (44.8–53.3)
Recommended that schools:	
Make healthful foods more visible	92.6 (90.2–94.4)
Improve the presentation of healthful foods in the cafeteria	89.4 (86.6–91.7)
Improve the lunchroom atmosphere	83.2 (79.7–86.2)
Offer grab-and-go meals	64.7 (60.7–68.5)
Involve students in menu development and promotion	55.9 (51.7–60.1)
Involve students in taste tests of new menu items	67.5 (63.5–71.2)
Provided ideas to schools:	
On how to involve school nutrition services staff in classrooms	35.9 (31.8–40.2)
On how to use the cafeteria as a place where students might learn about food safety, food preparation, or other nutrition-related topics	41.4 (37.1–45.8)
For nutrition-related special events	38.8 (34.8–43.1)

[1] During the 12 months before the study.

Table 3.6. Percentage of districts with other practices related to school nutrition services—SHPPS 2016

Practice	Districts (%)
Uses direct certification to determine students' eligibility for free school meals	96.7 (94.8–97.9)
Uses the community eligibility provision to offer free school meals to all students	30.8 (27.0–34.8)
Used Hazard Analysis and Critical Control Points (HACCP)-based recipes:[1]	
Never	2.9 (1.7–4.8)
Rarely	2.0 (1.1–3.7)
Sometimes	13.0 (10.3–16.3)
Almost always or always	82.1 (78.5–85.2)
Participates in any farm to school activities	37.9 (33.9–42.1)
Provided assistance[2] to schools for providing meals for students:	
With food allergies, sensitivities, or intolerances	89.3 (86.4–91.6)
With chronic health conditions that require dietary modification (e.g., diabetes)	79.4 (75.9–82.6)
Who are vegetarians	62.3 (58.2–66.1)
Measured or monitored:[3]	
The number of students participating in the nutrition services program	96.6 (94.7–97.8)
The nutritional quality of school meals	95.0 (93.0–96.5)
The nutritional quality of meals and snacks served in after-school or extended day programs	46.2 (42.0–50.4)
The amount of plate waste	65.6 (61.4–69.6)
Food safety procedures	96.2 (94.3–97.5)
Evaluated any professional development or in-service programs for nutrition services staff[3]	69.6 (65.5–73.5)
Limits the sale of foods and beverages that do not meet Smart Snacks standards during the school day for fundraising purposes by:	
Following state policy that does not allow the sale of such foods and beverages	40.0 (35.6–44.5)
Following limits set by the state on the number of days schools can sell such foods and beverages	52.5 (48.0–57.0)
Setting more restrictive limits than the state on the number of days schools can sell such foods and beverages	7.5 (5.5–10.3)
Prohibits or actively discourages schools from using food or food coupons as a reward for good behavior or good academic performance	50.3 (45.8–54.8)
Prohibits or actively discourages schools from withholding food or restricting the types of foods available as a form of punishment for students' behavior	70.0 (65.7–73.9)

[1] During the 30 days before the survey.
[2] During the 12 months before the survey.
[3] During the 2 years before the survey.

Table 3.7. Percentage of districts with practices related to local wellness policies—SHPPS 2016

Practice	Districts (%)
Policy made available to the public by:	
Posting on the district or school web sites	87.0 (83.9–89.5)
Sending home with students	27.0 (23.1–31.2)
Mailing to families	13.9 (11.0–17.5)
Emailing to families	11.4 (8.7–15.0)
Posting in schools	49.3 (44.8–53.9)
Publishing in the local newspaper or other media outlets	13.1 (10.2–16.6)
Sharing through social media	19.9 (16.5–23.7)
Sharing during meetings where parents are in attendance	49.5 (45.0–54.0)
Publishing in the district newsletter or in school publications	37.8 (33.4–42.3)
Including in the student handbook	50.1 (45.6–54.7)
Individual identified as responsible for ensuring compliance with policy:	
No single individual is identified	31.3 (27.3–35.6)
Superintendent	27.4 (23.6–31.6)
Assistant superintendent	3.3 (2.1–5.3)
District food service director (school food authority director)	15.6 (12.6–19.2)
Other district-level staff member	7.6 (5.6–10.3)
A school administrator	11.3 (8.8–14.5)
A school-level faculty or staff member	3.4 (2.2–5.2)
Policy last reviewed:	
Never	2.1 (1.1–4.0)
During the 12 months before the survey	64.3 (60.0–68.4)
Between 1 and 3 years before the survey	25.7 (22.1–29.6)
More than 3 years before the survey	7.9 (5.8–10.6)
Policy last updated:	
Never	2.5 (1.4–4.4)
During the 12 months before the survey	53.6 (49.1–58.0)
Between 1 and 3 years before the survey	30.6 (26.7–34.8)
More than 3 years before the survey	13.3 (10.6–16.6)
Groups involved during last review or update of policy:[1]	
Students	35.1 (30.9–39.6)
Students' parents or guardians	52.9 (48.4–57.4)
Representatives of the school food authority	73.7 (69.6–77.4)
School board members	51.0 (46.6–55.5)
School administrators	86.9 (83.5–89.6)
Community members	43.4 (39.0–47.9)
Physical education teachers	58.8 (54.3–63.2)
Other classroom teachers	38.4 (34.1–42.9)
Other school health professionals, such as health educators, school nurses, or school counselors	65.8 (61.4–70.0)

continued

Practice	Districts (%)
Tools and resources used during last review or update of policy:	
WellSAT or WellSAT 2.0	8.6 (6.3–11.8)
Action for Healthy Kids Wellness Policy Tool	32.0 (27.6–36.8)
Any other standardized tool	25.4 (21.4–29.9)
CDC's School Health Guidelines to Promote Healthy Eating and Physical Activity	32.6 (28.2–37.4)
State's model wellness policy	83.6 (79.8–86.8)
Another organization's model wellness policy (e.g., Alliance for a Healthier Generation)	34.5 (30.2–39.2)
Another district's wellness policy	42.4 (37.8–47.2)
Made results of last evaluation or assessment of implementation of wellness policy available to the public[2]	65.9 (61.0–70.4)

[1]Among the 99.0% of districts that have either reviewed or updated their policy.
[2]Among the 83.5% of districts that have evaluated or assessed the implementation of their policy.

Table 3.8. Percentage of districts with specific staffing policies for nutrition services staff—SHPPS 2016

Policy	Districts (%)
Requires a newly hired district food service director to have as minimum education level:	
High school diploma or GED	33.1 (29.2–37.3)
Associate's degree in nutrition or a related field	13.8 (11.1–17.2)
Undergraduate degree in nutrition or a related field	20.8 (17.5–24.6)
Graduate degree in nutrition or a related field	8.5 (6.3–11.5)
No specific education requirements	23.7 (20.1–27.8)
Requires a newly hired district food service director to have:	
A Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) credential from the Commission on Dietetic Registration	6.0 (4.2–8.5)
A School Nutrition Specialist credential from the School Nutrition Association	9.8 (7.3–13.0)
A School Nutrition Association certification	21.4 (17.9–25.3)
Successfully completed a school nutrition services training program provided or sponsored by the state	50.5 (46.0–54.9)
ServSafe or other food safety certification	76.2 (72.3–79.8)
Requires a newly hired district food service director to be certified, licensed, or endorsed by the state	23.4 (19.7–27.5)
Requires the district food service director is required to earn continuing education credits on nutrition topics	49.1 (44.7–53.5)
Requires each school to have someone to oversee or coordinate nutrition services at the school (e.g., a school food service manager)	64.4 (59.9–68.6)
Requires newly hired district school food service managers to have as minimum education level:	
High school diploma or GED	59.6 (55.1–64.0)
Associate's degree in nutrition or a related field	8.2 (6.1–11.1)
Undergraduate degree in nutrition or a related field	4.3 (2.9–6.4)
Graduate degree in nutrition or a related field	2.2 (1.1–4.4)
No specific education requirements	25.6 (21.8–29.8)
Requires newly hired school food service managers to have:	
A Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) credential from the Commission on Dietetic Registration	1.7 (0.9–3.4)
A School Nutrition Specialist credential from the School Nutrition Association	4.9 (3.3–7.2)
A School Nutrition Association certification	15.8 (12.7–19.5)
Successfully completed a school nutrition services training program provided or sponsored by the state	47.1 (42.6–51.6)
ServSafe or other food safety certification	77.1 (73.2–80.6)
Requires newly hired school food service managers to be certified, licensed, or endorsed by the state	18.6 (15.3–22.3)
Requires school food service managers to earn continuing education credits on nutrition topics	50.5 (46.1–54.9)

Table 3.9. Percentage of districts that provided funding for professional development or offered professional development on specific topics to nutrition services staff—SHPPS 2016

Topic	Districts (%)
Access to free drinking water	72.3 (68.2–76.0)
Competitive food policies that meet or exceed Smart Snacks in School standards	78.8 (75.0–82.2)
Culinary skills	50.6 (46.3–55.0)
Cultural diversity in meal planning	40.5 (36.2–44.9)
Customer service	71.3 (67.3–75.0)
Decreasing marketing of less nutritious foods	55.6 (51.3–59.9)
Facility design and layout, including equipment selection	38.0 (33.8–42.4)
Financial management	59.3 (54.8–63.6)
Food preparation methods for students with food allergies, sensitivities, or intolerances	78.1 (74.2–81.5)
Food safety	91.8 (89.1–93.9)
Healthy food preparation methods	80.9 (77.1–84.1)
Implementing local wellness policies at the school level	68.1 (63.9–72.1)
Implementing the updated USDA requirements for school meals	92.2 (89.6–94.3)
Increasing the percentage of students participating in school meals	72.2 (68.1–75.9)
Involving students in menu development and promotion	53.1 (48.7–57.4)
Making school meals more appealing	84.0 (80.4–87.0)
Menu planning for healthful meals	82.4 (78.8–85.4)
Nutrition services for students with special dietary needs other than food allergies	77.3 (73.5–80.8)
Nutrition standards for foods and beverages served in after-school or extended day programs	51.1 (46.7–55.5)
Personal safety for nutrition services staff	83.5 (80.0–86.5)
Personnel management	60.0 (55.6–64.2)
Procedures for handling severe food allergy reactions	76.1 (72.1–79.6)
Procedures for responding to food recalls	69.5 (65.3–73.4)
Program regulations and procedures	85.2 (81.9–88.0)
Promoting vegetables and salads	86.5 (83.2–89.1)
Selecting and ordering food	74.7 (70.7–78.3)
Sourcing foods locally or regionally	51.5 (47.1–55.8)
Strategies to improve the lunchroom atmosphere	73.1 (69.0–76.8)
Strategies to improve the presentation of healthful foods in the cafeteria	78.3 (74.5–81.7)
Using Hazard Analysis and Critical Control Points (HACCP)	82.6 (79.1–85.7)
Using produce from school gardens	19.5 (16.3–23.2)
Using the cafeteria for nutrition education	51.1 (46.6–55.5)

Table 3.10. Percentage of districts that require or recommend that schools implement specific nutrition practices—SHPPS 2016

	Districts (%)	
Practice	**Require**	**Recommend**
Offer students whole grain-rich foods each day for breakfast	78.9 (75.1–82.3)	10.0 (7.7–12.9)
Offer a choice between the following items each day for lunch:		
2 or more different entrees or main courses	33.7 (29.7–37.8)	32.4 (28.5–36.6)
2 or more different non-fried vegetables	37.8 (33.7–42.0)	36.9 (32.9–41.2)
2 or more different fruits	39.9 (35.7–44.2)	39.4 (35.2–43.7)
Offer a vegetarian entrée or main course each day for lunch	11.0 (8.4–14.1)	25.5 (21.9–29.5)
Offer students whole grain-rich foods each day for lunch	79.9 (76.2–83.1)	14.0 (11.3–17.2)
Offer self-serve salad bars	15.5 (12.7–18.9)	28.9 (25.0–33.0)
Prohibit offering foods and beverages that do not meet Smart Snacks standards:		
At classroom parties	31.9 (27.9–36.1)	39.2 (35.0–43.6)
In after-school or extended day programs	31.1 (27.2–35.4)	23.3 (19.8–27.2)
At staff meetings	3.1 (1.9–5.1)	23.1 (19.6–26.9)
At meetings attended by students' family members	5.8 (4.0–8.4)	25.7 (22.0–29.8)
In school stores, canteens, or snack bars not during the school day	29.2 (25.4–33.4)	19.7 (16.4–23.5)
In vending machines not during the school day	47.9 (43.6–52.3)	17.1 (14.1–20.5)
At concession stands not during the school day	8.3 (6.0–11.2)	26.1 (22.4–30.2)
Restrict the availability of deep-fried foods	58.9 (54.5–63.2)	17.9 (14.9–21.4)
Prohibit offering brand-name fast foods as part of school meals or as a la carte items	35.3 (31.1–39.6)	12.0 (9.4–15.2)
Prohibit sales of beverages containing caffeine (e.g., coffee, tea, or energy drinks)	37.8 (33.7–42.2)	18.4 (15.3–22.1)
Make fruits or vegetables available to students whenever other food is offered or sold1	16.3 (13.2–20.0)	29.4 (25.5–33.6)
Make whole grain-rich foods available to students whenever other food is offered or sold1	19.7 (16.4–23.5)	29.6 (25.7–33.9)
Make healthful beverages (e.g., plain water or nonfat milk) available to students whenever other beverages are offered or sold[1]	23.3 (19.8–27.2)	34.1 (30.1–38.4)
Intentionally price healthful foods (e.g., fruits, vegetables, and whole grains) at a lower cost than other foods	8.5 (6.3–11.4)	22.6 (19.1–26.4)
Intentionally price healthful beverages (e.g., nonfat milk) at a lower cost than other beverages (e.g., sugar-sweetened beverages)[2]	7.9 (5.9–10.5)	10.1 (7.8–13.0)
Have written plans for:		
Implementation of a risk-based approach to food safety (e.g., a HACCP- based program)	83.0 (79.5–85.9)	8.0 (6.0–10.6)
Feeding students with food allergies, sensitivities, or intolerances	65.9 (61.6–69.9)	22.5 (19.0–26.3)
Feeding students who rely on the school meal programs in the event of an unplanned school dismissal or closure	25.5 (21.7–29.6)	22.5 (19.0–26.4)

[1] For example, at classroom parties or in school stores.
[2] An additional 54.2% of districts do not sell sugar-sweetened beverages.

Table 3.11. Percentage of district food service directors[1] with specific qualifications—SHPPS 2016

Qualification	Districts (%)
Works for:	
School district	86.6 (82.8–89.7)
Food service management company	13.7 (10.6–17.6)
Other	1.1 (0.4–2.6)
Has degree[2] in:	
Business	20.9 (17.0–25.4)
Culinary arts	8.5 (6.2–11.7)
Family and consumer sciences	3.7 (2.3–5.9)
Food service management	17.9 (14.3–22.1)
Foods and nutrition	27.2 (23.0–31.8)
Nutrition education	12.2 (9.3–15.8)
Public/school administration	7.0 (4.9–10.1)
None of these	43.4 (38.7–48.3)
Holds the following credentials:	
Licensed Nutritionist or Dietitian	6.6 (4.6–9.4)
Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) credential from the Commission on Dietetic Registration	8.7 (6.4–11.9)
A School Nutrition Association certification	31.8 (27.3–36.6)
A School Nutrition Specialist credential from the School Nutrition Association	11.0 (8.2–14.7)
State food service certificate	19.1 (15.4–23.5)
ServSafe or other food safety certification	78.9 (74.7–82.6)
Health department certification	15.2 (11.8–19.2)
Certified dietary manager	4.6 (2.9–7.2)
Dietetic Technician, Registered (DTR)	1.2 (0.6–2.8)
Other	9.6 (6.9–13.1)
None of the above	9.4 (7.0–12.5)

[1] Among the 76.8% of districts that had a food service director who served as the respondent to the nutrition services questionnaire.
[2] Associate's degree, undergraduate major or minor, or graduate degree.

Table 3.12. Percentage of districts with specific policies and practices related to beverages available outside the school meal program—SHPPS 2016

Policy or practice	Districts (%)
Adopted a policy that allows students to have a drinking water bottle with them during the school day	51.8 (47.3–56.4)
Requires schools to provide free drinking water to students in:	
The cafeteria during breakfast	60.6 (56.1–64.9)
The cafeteria during lunch	64.2 (59.8–68.4)
The gymnasium or other indoor physical activity facilities	63.2 (58.7–67.4)
Outdoor physical activity facilities and sports fields	55.5 (51.0–59.9)
Hallways throughout the school	65.9 (61.5–70.1)
Allows schools to sell soft drinks[1] to students after the official school day in any venue	60.9 (56.5–65.2)
District receives a specified percentage of soft drink sales receipts	38.1 (33.9–42.6)
District receives incentives from soft drink sales (e.g., cash awards or donations of equipment, supplies, or other donations) once receipts total a specified amount	9.1 (6.9–12.0)
District prohibited from selling soft drinks produced by more than one company	18.4 (15.1–22.1)

[1]Such as sports drinks, soda pop, or fruit drinks that are not 100% juice.

Table 3.13. Percentage of districts that require or recommend that schools prohibit specific practices related to foods and beverages available outside of the school meal program—SHPPS 2016

	Districts (%)	
Prohibited practice	**Require**	**Recommend**
Student access to vending machines during the school day:		
Elementary schools[1]	38.4 (34.1–42.9)	2.1 (1.2–3.8)
Middle schools[2]	43.6 (39.1–48.2)	8.5 (6.3–11.5)
High schools[3]	44.2 (39.5–49.0)	14.4 (11.4–18.1)
Marketing of fast food restaurants and foods and beverages that do not meet Smart Snack standards[4] in the following places:		
In school buildings	51.4 (46.8–55.9)	17.4 (14.2–21.1)
On school grounds, on the outside of the school building, on playing fields, or other areas of the campus	39.9 (35.6–44.5)	23.2 (19.5–27.2)
On school buses or other vehicles used to transport students	41.6 (37.2–46.2)	19.0 (15.7–22.9)
In school publications (e.g., newsletters, newspapers, web sites, or other school publications)	33.0 (28.8–37.3)	20.9 (17.3–24.9)
In curricula or other educational materials (including assignment books, school supplies, book covers, and electronic media)	30.0 (26.0–34.3)	23.3 (19.6–27.4)
Through the distribution of products to students (e.g., t-shirts or hats)	25.5 (21.8–29.6)	19.1 (15.7–23.0)
Sale of foods and beverages that do not meet Smart Snack standards as part of fundraising for school organizations	33.2 (29.0–37.6)	27.5 (23.6–31.7)
Fundraiser nights at fast food restaurants where a portion of the sales made during a particular night benefit the school	5.9 (4.1–8.5)	16.9 (13.9–20.5)

[1] An additional 53.9% of districts have no elementary schools with vending machines.
[2] An additional 31.8% of districts have no middle schools with vending machines.
[3] An additional 11.4% of districts have no high schools with vending machines.
[4] Such as soft drinks or candy.

Health Services and Counseling, Psychological, and Social Services

Table 4.1. Percentage of districts with specific policies and practices related to health services and counseling, psychological, and social services—SHPPS 2016

Policy or practice	Districts (%)
Has someone in the district who oversees or coordinates health services	79.3 (75.4–82.7)
Has someone in the district who oversees or coordinates counseling, psychological, or social services	79.5 (75.5–82.9)
Has arrangements to provide health services or counseling, psychological, or social services to students in the district at other sites not on school property	48.4 (44.0–52.9)
Requires students entering kindergarten or first grade to have:	
A hearing screening	79.5 (75.7–82.8)
A vision screening	82.7 (79.1–85.9)
An oral health examination	41.4 (37.2–45.7)
A physical examination	59.1 (54.9–63.2)
A developmental examination assessing readiness to learn	68.6 (64.3–72.6)
Allows standing orders for administration of:	
Quick-relief inhalers	60.6 (56.4–64.6)
Epinephrine auto-injectors (e.g., Epi-Pen)	82.7 (79.3–85.7)
Insulin	50.0 (45.8–54.2)
Receives Medicaid reimbursement for eligible health services[1] provided to:	
Students with Individualized Education Programs or 504 plans	67.8 (63.4–71.8)
Other eligible students	33.6 (29.5–38.0)
Requires schools to submit student injury report data to the school district or local health department	70.6 (66.7–74.3)
Requires schools to complete a report when a student experiences a serious illness at school	71.3 (67.2–75.0)
Requires schools to submit information on student weight status to the state, school district, or local health department	27.6 (24.1–31.5)
Has real-time access to student attendance or absenteeism information for all schools in the district	75.1 (71.2–78.7)
Requires schools to submit information to the school district or local health department on the reasons for student absences	53.0 (48.7–57.3)
Recommends that schools in the district use a specified electronic system for reporting student attendance or absenteeism information	91.6 (88.8–93.8)
Requires schools in the district to close or dismiss all students when the percentage of absent students or staff reaches a specified level	33.7 (29.6–38.0)
Requires supplies for applying standard or universal precautions to be available:	
In all classrooms	59.7 (55.3–63.8)
In the gymnasium, on playgrounds, or on playing fields	63.4 (59.1–67.5)
In the cafeteria	66.7 (62.5–70.6)
On school buses or in other vehicles used to transport students	68.4 (64.2–72.4)
Requires student assistance programs to be offered to all students	58.7 (54.3–63.0)
Requires schools to create and maintain student support teams	69.4 (65.1–73.4)
Requires the following staff to participate in the development of Individualized Education Programs when indicated:	
School nurses	71.5 (67.4–75.3)
School counseling, psychological, or social services staff	86.6 (83.4–89.3)
Requires the following staff to participate in the development of 504 plans when indicated:	
School nurses	76.5 (72.6–79.9)
School counseling, psychological, or social services staff	87.0 (83.6–89.7)
Requires school counseling, psychological, or social services staff to participate in the development of Individualized Health Plans when indicated	69.3 (65.0–73.3)
Requires health services staff to follow Do Not Resuscitate orders	23.1 (19.5–27.2)

Table 4.2. Percentage of districts that had adopted a policy stating that schools will obtain and keep certain information in any type of student record—SHPPS 2016

Type of information	Districts (%)
A physical health history	84.5 (81.1–87.3)
An authorization for emergency treatment	85.6 (82.4–88.4)
An emotional or mental health history	45.7 (41.5–50.0)
Asthma action plans	86.9 (83.7–89.6)
Dietary needs or restrictions	86.4 (83.3–89.1)
Emergency contact information	95.6 (93.4–97.0)
Insurance coverage information	49.6 (45.4–53.8)
Medication needs	94.0 (91.8–95.7)
Other screening records (e.g., vision or hearing)	93.0 (90.5–94.8)
Physical activity restrictions	83.6 (80.1–86.5)
Reasons for absences	86.1 (82.8–88.8)
Severe food or other allergies	93.7 (91.2–95.5)
Tuberculosis screening results	38.4 (34.4–42.6)
Weight status (e.g., body mass index)	38.7 (34.7–42.8)

Table 4.3. Percentage of districts with specific policies and practices related to immunizations—SHPPS 2016

Policy or practice	Districts (%)
Requires students to receive an influenza vaccine annually	4.0 (2.6–6.0)
Allows students to be exempted from required immunizations for:	
Medical reasons	97.0 (95.1–98.2)
Religious reasons	90.8 (87.8–93.1)
Personal beliefs	49.2 (45.0–53.4)
Exclusion policies for students entering kindergarten or first grade	
Students who have not received the required immunizations are immediately excluded from attending classes	26.6 (23.1–30.6)
Students who have not received the required immunizations are allowed to attend classes for a specified number of days and then excluded	60.7 (56.5–64.8)
Does not have a policy that excludes students from attending classes if they have not received the required immunizations	12.7 (10.1–15.8)
Exclusion policies for students entering middle school	
Students who have not received the required immunizations are immediately excluded from attending classes	27.6 (23.9–31.6)
Students who have not received the required immunizations are allowed to attend classes for a specified number of days and then excluded	58.8 (54.6–63.0)
Does not have a policy that excludes students from attending classes if they have not received the required immunizations	13.6 (11.0–16.7)
Exclusion policies for students entering high school	
Students who have not received the required immunizations are immediately excluded from attending classes	24.6 (20.9–28.7)
Students who have not received the required immunizations are allowed to attend classes for a specified number of days and then excluded	57.7 (53.2–62.1)
Does not have a policy that excludes students from attending classes if they have not received the required immunizations	17.7 (14.5–21.3)

Table 4.4. Percentage of districts that had adopted a policy stating specific immunization requirements for school entry—SHPPS 2016

Policy	Districts (%)
Requirements for kindergarten or first grade entry	
A hepatitis A vaccine series	37.0 (33.0–41.1)
A hepatitis B vaccine series	89.0 (86.1–91.3)
A pertussis vaccine series	93.6 (91.2–95.3)
A polio vaccine series	95.6 (93.7–97.0)
A second chicken pox or varicella vaccine	84.5 (81.1–87.4)
A second measles vaccine	94.4 (92.2–96.1)
A tetanus vaccine series	93.6 (91.2–95.4)
Requirements for middle school entry	
A hepatitis A vaccine series	27.4 (23.8–31.3)
A hepatitis B vaccine series	84.0 (80.6–86.9)
A human papillomavirus (HPV) vaccine series	7.4 (5.4–10.0)
A meningococcal conjugate vaccine	47.2 (42.9–51.5)
A second chicken pox or varicella vaccine	75.3 (71.3–78.9)
A second measles vaccine	87.0 (83.8–89.6)
A tetanus-diphtheria-pertussis (Tdap) vaccine series	89.5 (86.5–91.9)
Requirements for high school entry	
A hepatitis A vaccine series	23.1 (19.6–27.0)
A hepatitis B vaccine series	83.9 (80.5–86.9)
A human papillomavirus (HPV) vaccine series	6.6 (4.7–9.3)
A meningococcal conjugate vaccine	44.9 (40.4–49.4)
A second chicken pox or varicella vaccine	68.2 (63.8–72.3)
A second measles vaccine	84.9 (81.5–87.8)
A tetanus-diphtheria-pertussis (Tdap) vaccine series	85.0 (81.5–87.9)

Table 4.5. Percentage of districts with specific practices related to tuberculosis (TB) screening and testing—SHPPS 2016

Practice	Districts (%)
Screens[1] students for TB prior to entry into kindergarten or first grade	15.0 (12.2–18.4)
TB testing[2] prior to entry into kindergarten or first grade:	
Required based on the result of TB screening	11.8 (9.3–14.9)
Required for all students	5.8 (4.0–8.2)
Not required for any students	82.4 (78.8–85.5)
Periodic TB testing after school entry	
Required for all students	1.9 (1.0–3.6)
Required for students previously identified through screening	3.6 (2.3–5.4)
Not required for any students	94.5 (92.3–96.1)
Methods accepted as evidence that a student does not have TB:[3]	
PPD skin test done by Mantoux method	71.8 (61.7–80.0)
A negative skin test not otherwise specified	39.3 (30.0–49.5)
A negative chest x-ray	55.5 (45.6–65.0)
A negative blood test	41.9 (32.5–52.0)
Letter from a physician stating that the student is free of TB	59.7 (49.6–69.1)

[1] Defined as the identification of individuals meeting certain risk criteria. Students meeting these criteria would then be referred for TB testing or required to provide evidence of medical clearance.
[2] Defined as a clinical test for TB.
[3] Among the 18.8% of districts that require any TB testing.

Table 4.6. Percentage of districts that had adopted policies related to student medications—SHPPS 2016

Policy	Districts (%)
Some students may carry and self-administer:	
A prescription quick-relief inhaler	91.2 (88.6–93.3)
An epinephrine auto-injector (e.g., Epi-Pen)	82.7 (79.3–85.6)
Insulin or other injected medications	69.2 (65.1–72.9)
Any other prescribed medications	23.2 (19.8–27.1)
Any over-the-counter medications	22.6 (19.2–26.5)
Who may administer:	
Prescription medications to a student at school	95.7 (93.6–97.1)
Over-the-counter medications to a student at school	94.8 (92.6–96.4)
When someone who is not a licensed healthcare professional administers prescription medications to students, they must be:	
Licensed or certified to administer medications	30.2 (26.4–34.3)
Trained to administer medications	83.4 (80.0–86.3)
When someone who is not a licensed healthcare professional administers over-the-counter medications to students, they must be:	
Licensed or certified to administer medications	26.7 (23.1–30.7)
Trained to administer medications	77.6 (73.8–80.9)
Schools will have written instructions from the physician or prescriber before school nurses, teachers, or any other school staff may administer:	
Prescription medications to a student	92.8 (90.2–94.7)
Over-the-counter medications to a student	59.0 (54.8–63.2)
Schools will have a written request from the parent or guardian before school nurses, teachers, or any other school staff may administer:	
Prescription medications to a student	92.7 (90.0–94.7)
Over-the-counter medications to a student	91.4 (88.5–93.6)
Schools will have written information on possible side effects before school nurses, teachers, or any other school staff may administer:	
Prescription medications to a student	44.0 (39.7–48.4)
Over-the-counter medications to a student	32.3 (28.3–36.6)

Table 4.7. Percentage of districts in which health services staff worked on school health services activities with other district-level and local agency or organization staff[1]—SHPPS 2016

Staff	Districts (%)
District staff	
Counseling, psychological, or social services	82.6 (78.9–85.8)
Health education	74.0 (69.8–77.9)
Nutrition or food service	77.7 (73.7–81.3)
Physical education	72.3 (68.0–76.2)
School-based health center	34.4 (30.0–39.1)
Local agency or organization staff	
A community healthcare provider	62.9 (58.7–66.9)
A community-based organization that provides sexual and reproductive health services	34.2 (30.2–38.5)
A health organization (e.g., the American Heart Association or the American Cancer Society)	60.9 (56.6–65.1)
A local business	39.0 (34.8–43.4)
A local child welfare agency	57.9 (53.6–62.1)
A local college or university	38.1 (34.0–42.3)
A local health department	78.7 (74.8–82.1)
A local hospital	49.4 (45.2–53.7)
A local juvenile justice department	38.2 (34.0–42.6)
A local mental health or social services agency	64.3 (60.0–68.4)
A local service club (e.g., Rotary Club)	50.9 (46.5–55.2)
The state health department	56.2 (51.9–60.5)

[1] During the 12 months before the study.

Table 4.8. Percentage of districts in which counseling, psychological, or social services staff worked on school counseling, psychological, or social services activities with other district-level and local agency or organization staff[1]—SHPPS 2016

Staff	Districts (%)
District staff	
Health education	65.7 (61.0–70.2)
Health services	81.1 (77.2–84.4)
Nutrition or food service	51.5 (46.7–56.4)
Physical education	57.6 (52.7–62.3)
School-based health center	32.8 (28.4–37.5)
Local agency or organization staff	
A dropout prevention organization (e.g., Communities in Schools)	32.2 (28.1–36.6)
A health organization (e.g., the American Heart Association or the American Cancer Society)	33.5 (29.2–38.0)
A local business	37.1 (32.7–41.7)
A local child welfare agency	69.7 (65.4–73.7)
A local college or university	42.5 (38.1–47.1)
A local health department	50.7 (46.0–55.3)
A local hospital	46.3 (41.8–50.8)
A local juvenile justice department	58.3 (53.7–62.7)
A local law enforcement agency	68.8 (64.4–72.8)
A local mental health or social services agency	75.6 (71.5–79.2)
A local service club (e.g., Rotary Club)	39.6 (35.3–44.2)
The state health department	34.2 (29.9–38.7)

[1] During the 12 months before the study.

Table 4.9. Percentage of districts that reviewed, measured, or evaluated aspects of school health services and school counseling, psychological, or social services[1]—SHPPS 2016

Aspects reviewed, measured, or evaluated	Districts (%)
Reviewed or updated:	
District's health services policies	80.0 (76.3–83.3)
District's counseling, psychological, or social services policies	65.0 (60.3–69.4)
Measured or monitored:	
Student use of school health services in the district	61.8 (57.5–65.9)
Student use of school counseling, psychological, or social services in the district	59.6 (54.8–64.2)
Student or family satisfaction with school health services in the district	20.8 (17.4–24.5)
Student or family satisfaction with school counseling, psychological, or social services in the district	34.4 (30.0–39.2)
Evaluated any professional development or in-service programs for:	
Health services staff	47.9 (43.6–52.2)
Counseling, psychological, or social services staff	51.8 (47.0–56.7)

[1] During the 2 years before the study.

Table 4.10. Percentage of districts that had adopted policies related to student health screening—SHPPS 2016

	Districts (%)			
Type of screening	Policy that schools will screen students	Policy that parents or guardians will be notified[1]	Policy that teacher will be notified[1]	Policy that schools must provide referrals[1]
Hearing problems	87.5 (84.4–90.1)	97.4 (95.7–98.5)	74.4 (70.2–78.2)	64.1 (59.7–68.4)
Mental health problems	12.3 (9.6–15.6)	96.5 (89.9–98.9)	84.3 (72.7–91.5)	78.3 (65.5–87.3)
Oral health problems	26.0 (22.5–30.0)	95.8 (90.3–98.2)	60.9 (52.5–68.7)	76.2 (68.5–82.6)
Vision problems	88.0 (84.9–90.5)	97.5 (95.8–98.5)	75.1 (70.9–78.8)	64.1 (59.7–68.3)
Weight status using BMI	30.1 (26.4–34.0)	60.0 (52.3–67.1)	NA	28.0 (21.8–35.2)

NA = Question not asked.
[1] If screening indicates a potential problem, among districts requiring schools to screen students for that problem.

Table 4.11. Percentage of districts that had adopted a policy that schools will provide specific health and prevention services to students—SHPPS 2016

Service	Districts (%)
Health service	
Administration of medications	94.5 (92.0–96.3)
Administration of sports physicals	37.0 (33.0–41.2)
Administration of topical fluorides (e.g., mouthrinses, varnish, or supplements)	12.2 (9.8–15.1)
Alcohol or other drug use treatment	19.0 (15.8–22.7)
Application of dental sealants	7.7 (5.8–10.2)
Assistance with accessing benefits for students with disabilities	53.4 (49.0–57.8)
Assistance with enrolling in Medicaid or SCHIP	33.1 (29.0–37.4)
Assistance with enrolling in WIC or SNAP or accessing food stamps or food banks	28.5 (24.7–32.7)
Assistance with securing temporary or permanent housing	26.8 (23.0–30.9)
Cardiopulmonary resuscitation (CPR)	86.3 (83.0–89.0)
Case management for students with chronic health conditions (e.g., asthma or diabetes)	65.7 (61.4–69.7)
Case management for students with disabilities	76.5 (72.5–80.0)
Counseling after a natural disaster or other emergency or crisis situation	64.8 (60.4–68.9)
Counseling for emotional or behavioral disorders (e.g., anxiety, depression, or ADHD)	60.3 (55.8–64.6)
Crisis intervention for personal problems	69.6 (65.4–73.6)
First aid	90.8 (88.0–93.0)
HIV testing[1]	0.3 (0.1–1.2)
Human papillomavirus (HPV) vaccine	2.3 (1.3–4.0)
Identification of eating disorders	20.8 (17.4–24.6)
Identification of emotional or behavioral disorders (e.g., anxiety, depression, or ADHD)	56.0 (51.5–60.3)
Identification of oral health problems	27.7 (24.0–31.6)
Identification of physical, sexual, or emotional abuse	68.0 (63.7–72.0)
Identification of students with family problems (e.g., parental divorce, substance abuse, or violence)	52.7 (48.3–57.2)
Identification or school-based management of acute illnesses	68.4 (64.2–72.2)
Identification or school-based management of chronic health conditions (e.g., asthma or diabetes)	76.2 (72.4–79.7)
Immunizations other than human papillomavirus (HPV) and seasonal influenza	6.5 (4.7–8.9)
Instruction on self-management of chronic health conditions (e.g., asthma or diabetes)	66.5 (62.3–70.5)
Job readiness skills programs[1]	51.1 (46.5–55.7)
Pregnancy testing[1]	1.1 (0.6–2.3)
Provision of condom-compatible lubricant[1]	1.0 (0.4–2.5)
Provision of contraceptives other than condoms[1]	1.1 (0.5–2.4)
Seasonal influenza vaccine	8.3 (6.3–10.9)
STD testing[1]	0.5 (0.2–1.4)
STD treatment[1]	0.6 (0.3–1.6)
Stress management	34.8 (30.7–39.1)
Tobacco use cessation	18.8 (15.7–22.4)
Tracking of students with chronic health conditions (e.g., asthma or diabetes)	69.4 (65.2–73.3)
Weight management	9.2 (7.0–12.0)

continued

Service	Districts (%)
Prevention service[2]	
Alcohol or other drug use prevention	57.8 (53.2–62.2)
HIV prevention	31.7 (27.6–36.0)
Injury prevention and safety counseling	52.7 (48.1–57.2)
Nutrition and dietary behavior counseling	24.8 (21.2–28.9)
Physical activity and fitness counseling	30.5 (26.5–34.7)
Pregnancy prevention	31.2 (27.2–35.5)
STD prevention	32.2 (28.1–36.5)
Suicide prevention	56.1 (51.5–60.5)
Tobacco use prevention	52.7 (48.1–57.2)
Violence prevention (e.g., bullying, fighting, or dating violence prevention)	77.4 (73.4–80.9)

[1] Not asked among districts containing only elementary schools.
[2] Provided in one-on-one or small group sessions, not as part of classroom instruction.

Table 4.12. Percentage of districts with specific policies related to condom availability, by school level[1]—SHPPS 2016

Policy	Districts (%)	
	Middle school	High school
Required to make condoms available to students	0.2 (0.0–0.8)	1.0 (0.4–2.4)
Neither required nor prohibited from making condoms available to students	49.3 (44.7–53.9)	49.0 (44.2–53.7)
Prohibited from making condoms available to students	50.6 (46.0–55.2)	50.1 (45.3–54.9)

[1] Not asked among districts containing only elementary schools.

Table 4.13. Percentage of districts that had adopted a policy that schools will provide referrals for specific services or conditions to students—SHPPS 2016

Service or condition	Districts (%)
Acute illnesses	47.5 (43.3–51.9)
Administration of topical fluorides (e.g., mouthrinses, varnish, or supplements)	13.5 (10.9–16.7)
After-school programs for students (e.g., supervised recreation)	40.2 (35.9–44.7)
Alcohol or other drug use treatment	44.7 (40.3–49.1)
Application of dental sealants	12.7 (10.2–15.8)
Assistance with accessing benefits for students with disabilities	52.0 (47.5–56.5)
Assistance with enrolling in Medicaid or SCHIP	35.5 (31.3–40.0)
Assistance with enrolling in WIC or SNAP or accessing food stamps or food banks	32.5 (28.5–36.8)
Assistance with securing temporary or permanent housing	32.8 (28.8–37.2)
Child care for teen parents	17.6 (14.4–21.4)
Chronic health conditions (e.g., asthma or diabetes)	50.6 (46.3–54.9)
Condom-compatible lubricant[1]	7.2 (5.2–9.9)
Condoms[1]	9.1 (6.8–12.1)
Contraceptives other than condoms[1]	10.2 (7.8–13.3)
Counseling after a natural disaster or other emergency or crisis situation	57.0 (52.5–61.3)
Crisis intervention for personal problems	57.7 (53.2–62.0)
Eating disorders	30.7 (26.8–34.9)
Emotional or behavioral disorders (e.g., anxiety, depression, or ADHD)	57.3 (52.7–61.7)
HIV testing[1]	14.8 (11.9–18.3)
HIV treatment[1]	13.1 (10.4–16.5)
Human papillomavirus (HPV) vaccine	12.2 (9.7–15.3)
Immunizations other than human papillomavirus (HPV) and seasonal influenza	38.4 (34.3–42.6)
Job readiness skills programs[1]	42.3 (37.8–46.9)
nPEP (non-occupational post-exposure prophylaxis for HIV)	9.0 (6.7–11.9)
Oral healthcare	36.5 (32.5–40.8)
Physical, sexual, or emotional abuse	58.9 (54.4–63.3)
Pregnancy testing[1]	19.1 (15.7–22.9)
Prenatal care[1]	21.5 (18.1–25.4)
Seasonal influenza vaccine	18.9 (15.8–22.4)
Services for students with family problems (e.g., parental divorce, substance abuse, or violence)	52.2 (47.6–56.6)
Sports physicals	55.8 (51.4–60.1)
STD testing[1]	15.8 (12.8–19.4)
STD treatment[1]	14.8 (11.8–18.3)
Stress management	36.7 (32.5–41.1)
Tobacco use cessation	23.1 (19.6–27.0)
Weight management	16.8 (13.8–20.4)

[1] Not asked among districts containing only elementary schools.

Table 4.14. Percentage of districts that had adopted a policy specifying education and certification requirements for health services and counseling, psychological, or social services staff—SHPPS 2016

Policy	Districts (%)
Health services staff	
Requires a newly hired school nurse to have as minimum education level:	
Undergraduate/baccalaureate degree in nursing (e.g., BSN)	26.0 (22.4–30.0)
Graduate degree in nursing	3.6 (2.3–5.7)
Associate's degree in nursing	23.6 (20.2–27.5)
Other	26.0 (22.4–30.1)
No specific education requirements	20.7 (17.3–24.4)
Requires a newly hired school nurse to have:	
A Licensed Practical Nurse's (LPN) license	27.0 (23.0–31.3)
A Registered Nurse's (RN) license	79.0 (75.3–82.2)
A national school nurse certification from the National Board for Certification of School Nurses	7.3 (5.2–10.0)
A state school nurse certification	39.1 (34.9–43.5)
Counseling, psychological, and social services staff	
Requires a newly hired school counselor to have as minimum education level:	
Undergraduate degree in counseling	26.5 (22.4–31.0)
Master's degree in counseling	53.7 (48.8–58.6)
Other degree	5.7 (3.7–8.7)
No specific education requirements	14.1 (11.1–17.8)
Requires a newly hired school psychologist to have as minimum education level:	
Undergraduate degree in psychology	12.9 (9.8–16.7)
Master's degree in psychology	50.0 (44.9–55.1)
Doctoral degree in psychology	4.2 (2.6–6.7)
Other degree	10.7 (8.0–14.3)
No specific education requirements	22.2 (18.4–26.6)
Requires a newly hired school social worker to have as minimum education level:	
Undergraduate degree in social work	24.3 (20.1–29.1)
Master's degree in social work	36.9 (32.0–42.1)
Other degree	11.3 (8.2–15.3)
No specific education requirements	27.5 (23.2–32.3)
Requires the following newly hired staff to be licensed, certified, or credentialed by a state agency or board:	
School counselor	77.6 (73.1–81.4)
School psychologist	73.7 (69.1–77.8)
School social worker	59.2 (54.1–64.1)
Requires school counseling, psychological, or social services staff to earn continuing education credits on counseling, psychological, or social services topics	64.6 (59.5–69.3)

Table 4.15. Percentage of districts with specific staffing policies and practices for health services and counseling, psychological, or social services staff—SHPPS 2016

Policy or practice	Districts (%)
Health services staff	
Requires each school to have someone to oversee or coordinate health services at the school	57.5 (53.1–61.9)
Specifies a maximum student-to-school nurse ratio	10.9 (8.6–13.7)
Requires each school to have a full-time school nurse	33.7 (29.8–37.8)
Requires each school to have a specified ratio of school nurses to students	8.2 (6.2–10.7)
Requires each school to have at least a part-time school nurse	18.1 (15.0–21.7)
Employs or contracts with physician or nurse practitioner who can be contacted to consult as needed during the school day	37.9 (33.9–42.1)
Requires school health aides to work under the supervision of a Registered Nurse (RN) at all times[1]	65.5 (59.3–71.2)
School nurses employed by:	
School district	79.7 (76.0–83.0)
Schools	21.0 (17.7–24.7)
Local health departments	7.6 (5.6–10.3)
Some other organization or agency	13.1 (10.2–16.6)
Counseling, psychological, and social services staff	
Requires schools at each level to have a specified ratio of counselors to students:	
Elementary schools	16.2 (13.0–19.9)
Middle schools	16.8 (13.6–20.7)
High schools	19.8 (16.1–24.1)
Requires each school to have someone to oversee or coordinate counseling, psychological, or social services at the school	56.3 (51.6–60.9)
School counseling, psychological, and social services staff employed by:	
School district	89.4 (86.3–91.8)
Schools	25.3 (21.6–29.4)
Local mental health and social services agencies	19.9 (16.5–23.8)
Some other organization or agency	20.9 (17.4–24.8)

[1]Among the 48.3% of districts that employ school health aides.

Table 4.16. Percentage of districts that provided funding for professional development or offered professional development[1] to school health services staff or counseling, psychological, or social services staff on specific services[2] or topics—SHPPS 2016

Service or topic	Districts (%)
Health service or counseling, psychological, or social service topic	
Accessing benefits for students with disabilities	42.2 (37.7–46.8)
Accurately measuring student height and weight	30.9 (27.0–35.0)
Administration of medications	62.9 (58.6–67.0)
After-school programs for students (e.g., supervised recreation)	38.7 (34.4–43.3)
Alcohol or other drug use treatment	39.0 (34.8–43.4)
Calculating student weight status using body mass index (BMI)	28.4 (24.6–32.4)
Case management for students with chronic health conditions (e.g., asthma or diabetes)	57.3 (52.9–61.6)
Case management for students with disabilities	59.3 (54.9–63.6)
Child care options for teen parents	14.8 (11.7–18.5)
Counseling after a natural disaster or other emergency or crisis situation	49.6 (45.2–54.1)
Counseling for emotional or behavioral disorders (e.g., anxiety, depression, or ADHD)	63.2 (58.7–67.4)
CPR or use of AED equipment	88.2 (85.1–90.7)
Crisis intervention for personal problems	56.5 (52.0–60.9)
Dental sealants	11.4 (8.9–14.6)
Emergency preparedness	74.8 (70.7–78.5)
Enrolling in Medicaid or SCHIP	26.1 (22.2–30.4)
Enrolling in WIC or SNAP or accessing food stamps or food banks	20.3 (16.8–24.3)
Federal laws that protect the privacy of student health information (e.g., HIPAA or FERPA)	68.1 (63.8–72.1)
First aid	78.1 (74.2–81.5)
HIV testing	11.2 (8.6–14.4)
HIV treatment	10.4 (7.9–13.6)
How to identify a teen-friendly health service provider	17.7 (14.5–21.5)
Human papillomavirus (HPV) vaccine	11.0 (8.6–14.0)
Identification of emotional or behavioral disorders (e.g., anxiety, depression, or ADHD)	64.2 (59.8–68.4)
Identification of students with family problems (e.g., parental divorce, substance abuse, or violence)	51.8 (47.2–56.3)
Identification or school-based management of acute illnesses	53.1 (48.7–57.4)
Identification or school-based management of chronic health conditions (e.g., asthma or diabetes)	64.1 (59.8–68.1)
Immunizations other than seasonal influenza and human papillomavirus (HPV)	33.0 (29.0–37.2)
Infectious disease outbreak detection and response	50.7 (46.3–55.1)
Infectious disease prevention (e.g., hand hygiene or food safety)	58.6 (54.1–62.9)
Job readiness skills programs	38.8 (34.4–43.4)
Meeting the unique health-related needs of lesbian, gay, bisexual, or transgender students	34.6 (30.4–39.0)
nPEP (non-occupational post-exposure prophylaxis for HIV)	8.5 (6.3–11.4)
Oral health services	25.2 (21.6–29.2)
Pregnancy testing	11.8 (9.2–15.1)
Prenatal care	11.6 (9.0–14.9)
PrEP (pre-exposure prophylaxis for HIV)	8.3 (6.1–11.2)
Provision of condom-compatible lubricant	6.5 (4.6–9.1)
Provision of condoms	7.6 (5.5–10.3)
Provision of contraceptives other than condoms	7.0 (5.0–9.6)

continued

Service or topic	Districts (%)
Seasonal influenza vaccine	32.9 (29.0–37.2)
Securing temporary or permanent housing	20.6 (17.1–24.6)
Services for eating disorders	30.2 (26.2–34.5)
Services for physical, sexual, or emotional abuse	56.4 (51.8–60.9)
Sports physicals	26.9 (23.3–30.9)
STD testing	12.8 (10.1–16.1)
STD treatment	14.0 (11.2–17.5)
Stress management	42.0 (37.6–46.5)
Teaching self-management of chronic health conditions (e.g., asthma or diabetes)	55.2 (50.9–59.5)
Tobacco use cessation	26.9 (23.2–31.0)
Topical fluorides (e.g., mouthrinses, varnish, or supplements)	14.9 (12.1–18.2)
Tracking students with chronic health conditions (e.g., asthma or diabetes)	55.0 (50.7–59.4)
Weight management	18.8 (15.6–22.5)
Prevention services topic	
Alcohol or other drug use prevention	53.4 (48.9–58.0)
HIV prevention	27.9 (24.0–32.1)
Injury prevention and safety counseling	50.7 (46.2–55.3)
Nutrition and dietary behavior counseling	31.3 (27.3–35.6)
Physical activity and fitness counseling	38.4 (34.1–42.9)
Pregnancy prevention	26.7 (22.9–30.9)
STD prevention	27.7 (23.8–31.8)
Suicide prevention	67.9 (63.6–72.0)
Tobacco use prevention	41.2 (36.8–45.8)
Violence prevention (e.g., bullying, fighting, or dating violence prevention)	75.5 (71.5–79.2)
Counseling, psychological, or social services topic	
Case management for students with emotional or behavioral problems	60.2 (55.4–64.7)
Comprehensive assessment or intake evaluation	39.1 (34.5–43.9)
Family counseling	33.5 (29.2–38.0)
Group counseling	38.9 (34.3–43.6)
Individual counseling	52.6 (47.8–57.3)
Peer counseling or mediation	41.4 (36.7–46.2)
Self-help or support groups	37.1 (32.6–41.9)
Student assistance programs	47.4 (42.7–52.1)
Student support teams	47.2 (42.5–52.0)

[1] During the 2 years before the study.
[2] Includes professional development about the service or referral for the service.

Table 4.17. Percentage of districts that provided funding for training or offered training to any teachers, administrators, and school staff other than school nurses and counseling, psychological, and social services staff on specific topics[1]—SHPPS 2016

Topic	Districts (%)
CPR or use of AED equipment	90.7 (87.6–93.1)
HIV infection	37.1 (32.9–41.4)
Severe food or other allergies	74.8 (70.8–78.4)
Chronic health conditions (e.g., asthma or diabetes), including chronic disease management, recognizing and responding to severe symptoms, or reducing triggers	74.8 (70.8–78.5)
Infectious disease prevention (e.g., hand hygiene or food safety)	72.8 (68.6–76.6)
Making appropriate referrals for health services providers	41.6 (37.1–46.2)
Recognizing signs and symptoms of:	
Physical, sexual, or emotional abuse	70.7 (66.3–74.8)
Substance abuse	58.3 (53.6–62.8)
Depression and suicidal behavior	69.5 (65.0–73.6)
Bullying victimization	83.5 (79.8–86.6)
Dating violence[2]	44.0 (39.4–48.7)
Making appropriate referrals to a school counselor, psychologist, or social worker	69.9 (65.5–74.0)
Managing students with emotional or behavioral problems	74.0 (69.7–77.8)

[1]During the 2 years before the study.
[2]Not asked among districts containing only elementary schools.

Table 4.18. Mean number of school-based health centers per district that offer specific types of services to students in the district—SHPPS 2016

Type of service	Districts (%)
Primary care	0.5 (0.3–0.6)
Counseling, psychological, or social services	0.6 (0.4–0.7)
Oral health services	0.3 (0.2–0.4)

Table 4.19. Percentage of districts that had arrangements with specific organizations or healthcare professionals to provide health services or counseling, psychological, or social services to students in the district—SHPPS 2016

Organization or healthcare professional	Districts (%)
A community health clinic or health center	20.3 (17.0–24.0)
A dental or dental hygiene school	6.1 (4.3–8.4)
A local health department	31.7 (27.7–35.9)
A local hospital	17.3 (14.2–20.8)
A local mental health or social services agency	35.9 (31.9–40.2)
A managed care organization	2.5 (1.5–4.2)
A private counselor	8.6 (6.4–11.4)
A private dentist	6.7 (4.8–9.1)
A private nurse practitioner	3.4 (2.2–5.3)
A private physician	15.0 (12.2–18.4)
A private psychiatrist	4.8 (3.3–7.0)
A private psychologist	6.7 (4.9–9.2)
A private social worker	5.2 (3.5–7.6)
A school-linked health center	10.2 (7.9–13.0)
A university, medical school, or nursing school	11.7 (9.2–14.7)

Table 4.20. Percentage of districts that had arrangements with organizations or healthcare professionals to provide specific health services, prevention services, and counseling, psychological, or social services to students in the district—SHPPS 2016

Service	Districts (%)
Health service	
Administration of sports physicals	24.8 (21.3–28.7)
Administration of topical fluorides (e.g., mouthrinses, varnish, or supplements)	19.4 (16.2–23.0)
After-school programs for students (e.g., supervised recreation)	26.4 (22.7–30.5)
Alcohol or other drug use treatment	14.7 (11.8–18.1)
Application of dental sealants	19.2 (16.0–22.8)
Assistance with accessing benefits for students with disabilities	24.0 (20.4–28.1)
Assistance with enrolling in Medicaid or SCHIP	17.7 (14.6–21.4)
Assistance with enrolling in WIC or SNAP, or accessing food stamps or food banks	16.7 (13.6–20.3)
Assistance with securing temporary or permanent housing	17.4 (14.2–21.1)
Case management for students with chronic health conditions (e.g., asthma or diabetes)	15.7 (12.8–19.2)
Case management for students with disabilities	20.0 (16.7–23.8)
Child care for teen parents	8.0 (5.9–10.8)
Counseling after a natural disaster or other emergency or crisis situation	26.6 (22.9–30.7)
Counseling for emotional or behavioral disorders (e.g., anxiety, depression, or ADHD)	27.4 (23.6–31.5)
Crisis intervention for personal problems	28.1 (24.2–32.3)
HIV testing	8.1 (5.9–10.9)
HIV treatment	7.3 (5.2–10.0)
Human papillomavirus (HPV) vaccine	8.8 (6.7–11.5)
Identification of emotional or behavioral disorders (e.g., anxiety, depression, or ADHD)	25.6 (21.9–29.7)
Identification or school-based management of acute illnesses	13.4 (10.8–16.5)
Identification or school-based management of chronic health conditions (e.g., asthma or diabetes)	14.0 (11.3–17.2)
Immunizations other than seasonal influenza and human papillomavirus (HPV)	15.8 (12.9–19.2)
Job readiness skills programs	23.9 (20.3–27.9)
Lab tests other than for HIV, other STDs, or pregnancy	7.9 (5.8–10.6)
nPEP (non-occupational post-exposure prophylaxis for HIV)	5.8 (4.1–8.3)
Oral healthcare	23.6 (20.2–27.5)
Pregnancy testing	10.5 (8.1–13.6)
Prenatal care	8.4 (6.3–11.2)
Prescriptions for medications	8.6 (6.4–11.3)
Primary care	10.0 (7.7–12.9)
Provision of condom-compatible lubricant	4.6 (3.1–6.8)
Provision of condoms	6.2 (4.4–8.7)
Provision of contraceptives other than condoms	5.5 (3.8–7.9)
Seasonal influenza vaccine	25.6 (22.0–29.5)
Services for eating disorders	9.2 (6.9–12.1)
Services for physical, sexual, or emotional abuse	22.9 (19.4–26.8)
Services for students with family problems (e.g., parental divorce, substance abuse, or violence)	23.0 (19.4–27.0)
STD testing	9.2 (6.9–12.2)
STD treatment	8.8 (6.6–11.8)
Stress management	18.7 (15.4–22.4)

continued

Service	Districts (%)
Tobacco use cessation	10.8 (8.4–13.8)
Weight management	6.6 (4.7–9.1)
Prevention service	
Alcohol or other drug use prevention	20.4 (17.0–24.3)
HIV prevention	12.5 (9.8–15.9)
Injury prevention and safety counseling	15.5 (12.5–19.1)
Nutrition and dietary behavior counseling	10.0 (7.6–13.0)
Physical activity and fitness counseling	10.2 (7.8–13.2)
Pregnancy prevention	12.1 (9.5–15.4)
STD prevention	13.1 (10.3–16.5)
Suicide prevention	19.9 (16.6–23.7)
Tobacco use prevention	17.3 (14.2–20.9)
Violence prevention (e.g., bullying, fighting, or dating violence prevention)	20.9 (17.5–24.8)
Counseling, psychological, or social service	
Case management for students with emotional or behavioral problems	29.3 (25.4–33.5)
Comprehensive assessment or intake evaluation	25.4 (21.7–29.5)
Family counseling	21.2 (17.8–25.1)
Group counseling	20.8 (17.4–24.7)
Individual counseling	31.1 (27.1–35.3)
Peer counseling or mediation	16.6 (13.5–20.3)
Self-help or support groups	18.4 (15.2–22.2)

Table 4.21. Percentage of districts with specific employee wellness policies and practices—SHPPS 2016

Policy or practice	Districts (%)
Requires schools to have an employee wellness program	54.0 (49.5–58.5)
Has someone in the district who oversees or coordinates employee wellness programs throughout the district	59.9 (55.4–64.1)
Requires each school to have someone to oversee or coordinate employee wellness programs	30.6 (26.6–35.0)
Provided funding for an Employee Assistance Program (EAP) or offered an Employee Assistance Program for employees[1]	43.3 (39.0–47.7)
Provided funding for health risk appraisals or offered health risk appraisals for employees[1]	40.7 (36.3–45.2)
Employees receive subsidies or discounts for off-site health promotion activities	34.5 (30.4–38.9)
Provided funding for incentives for employee participation or goal achievement in employee wellness programs[1,2]	27.8 (23.9–32.0)

[1] During the 12 months before the study.
[2] An additional 26.4% of districts do not have employee wellness programs.

Table 4.22. Percentage of districts that provided funding for or offered specific screenings or services for employees[1]—SHPPS 2016

Screening or service	Districts (%)
Blood pressure screening	41.4 (37.1–45.7)
Body mass index (BMI) screening	24.8 (21.2–28.8)
Diabetes screening	22.0 (18.6–25.9)
Immunizations (e.g., influenza vaccines)	60.8 (56.4–64.9)
Physical fitness assessment	14.7 (11.7–18.2)
Serum cholesterol screening	25.6 (22.0–29.7)

[1] During the 12 months before the survey, regardless of what is covered through employees' health insurance.

Table 4.23. Percentage of district health services coordinators[1] with an undergraduate major or minor or graduate degree in specific areas—SHPPS 2016

Area	Districts (%)
Biology	1.8 (0.9–3.8)
Counseling	3.0 (1.5–5.9)
Education	23.4 (18.9–28.7)
Healthcare administration or business	5.0 (3.0–8.2)
Nursing	80.3 (75.4–84.5)
Other science	4.4 (2.5–7.4)
Psychology	6.8 (4.3–10.4)
Public health	7.1 (4.6–10.8)
Social work	1.8 (0.7–4.3)
None of these	3.5 (2.0–6.1)

[1]Among the 59.6% of districts that had a health services coordinator who served as the respondent to the health services questionnaire.

Healthy and Safe School Environment (includes Social and Emotional Climate)

Table 5.1. Percentage of districts with specific policies related to keeping the school environment safe and secure, by school level—SHPPS 2016

Policy	Districts (%)		
	Elementary school	Middle school	High school
Requires schools to maintain closed campuses[1]	83.0 (79.4–86.1)	82.6 (78.8–85.7)	62.9 (58.2–67.4)
Requires schools to assign staff or adult volunteers to monitor:			
School halls during classes	40.3 (36.0–44.8)	43.8 (39.3–48.4)	49.3 (44.6–54.1)
School halls between classes	69.0 (64.6–73.1)	76.2 (72.0–80.0)	77.5 (73.1–81.4)
Restrooms	49.6 (45.1–54.2)	43.4 (38.9–47.9)	42.8 (38.2–47.6)
School grounds	76.1 (71.9–79.8)	73.7 (69.5–77.6)	72.0 (67.5–76.1)
Cafeterias	86.0 (82.4–89.0)	87.7 (84.2–90.5)	85.5 (81.5–88.7)
Requires schools to routinely conduct locker searches[2]	NA	51.3 (46.7–55.8)	64.2 (59.4–68.7)
Requires students to wear school uniforms	5.6 (4.0–7.8)	5.6 (4.0–7.8)	5.2 (3.5–7.7)
Requires schools to enforce student dress code[3]	77.2 (73.0–80.8)	86.5 (82.9–89.4)	89.4 (85.9–92.1)
Requires the following groups to wear identification badges:			
Students	1.5 (0.8–2.9)	4.7 (3.2–7.0)	8.7 (6.3–11.9)
Faculty and staff	60.0 (55.8–64.1)	60.1 (55.8–64.2)	60.5 (56.1–64.7)
Visitors[4]	86.9 (83.7–89.6)	86.0 (82.5–88.9)	86.9 (83.3–89.8)
Requires schools to use:			
Security or surveillance cameras, either inside or outside the building	75.9 (71.7–79.6)	83.0 (79.2–86.2)	85.5 (81.8–88.5)
Metal detectors	3.5 (2.3–5.4)	4.7 (3.2–6.7)	6.4 (4.5–9.1)
Communication devices for security purposes (e.g., cell phones, 2-way radios, walkie-talkies, or intercoms)	82.2 (78.5–85.4)	82.5 (78.7–85.7)	82.4 (78.4–85.8)
Requires schools to keep all entrances locked during the school day	76.0 (71.7–79.8)	75.7 (71.4–79.5)	71.6 (67.2–75.7)
Requires students to refrain from using personal communication devices (e.g., cell phones) during the school day[5]	78.9 (74.8–82.4)	74.6 (70.5–78.4)	58.8 (54.0–63.4)
Requires schools to use police, school resource officers, or security guards during the regular school day	35.4 (31.3–39.7)	42.7 (38.5–47.1)	54.1 (49.7–58.5)

[1] Students are not allowed to leave school during the school day, including during lunchtime.
[2] Question not asked regarding elementary schools.
[3] Among districts that do not require school uniforms.
[4] Can include adhesive stickers with hand-written names.
[5] Does not include the use of smart phones, tablets, or computers for educational purposes.

Table 5.2. Percentage of districts with specific practices related to school start times, by school level[1]—SHPPS 2016

	Districts (%)	
Practice	**Middle school**	**High school**
School start times are set by the district, not by individual schools	90.2 (87.2–92.5)	88.2 (84.7–90.9)
School start times are set by individual schools, but the district requires schools start no earlier than a specific time	3.8 (2.5–5.9)	4.4 (2.8–6.7)
School start times are set by individual schools, but the district recommends schools start no earlier than a specific time	1.6 (0.8–3.1)	2.2 (1.1–4.1)
School start times are set by individual schools and the district does not require or recommend an earliest start time	4.4 (2.9–6.7)	5.3 (3.5–8.0)
Earliest start time set, required, or recommended by district is 8:30am or later[2]	9.4 (6.8–12.9)	7.7 (5.3–11.1)

[1] Questions not asked about elementary school start times.
[2] Among the 95.6% and 94.7% of districts that set, require, or recommend an earliest start time for middle schools and high schools, respectively.

Table 5.3. Percentage of districts in which students must live a standard distance from their school to be eligible for riding a school bus, by school level[1]—SHPPS 2016

	Districts (%)		
Distance	**Elementary school**	**Middle school**	**High school**
More than ½ mile	8.7 (6.4–11.6)	7.5 (5.4–10.3)	9.4 (6.9–12.7)
More than ¾ mile	3.3 (2.0–5.5)	3.5 (2.1–5.9)	2.4 (1.3–4.5)
More than 1 mile	23.0 (19.3–27.2)	22.0 (18.4–26.2)	21.4 (17.6–25.7)
More than 1½ miles	9.4 (7.0–12.5)	10.6 (8.0–13.8)	9.0 (6.5–12.2)
More than 2 miles	16.3 (13.2–20.0)	18.2 (14.9–22.1)	18.9 (15.2–23.1)
No minimum distance	39.3 (35.0–43.7)	38.2 (34.0–42.6)	39.0 (34.5–43.7)

[1]Does not include students with special needs or those eligible for hazard busing.

Table 5.4. Percentage of districts that support or promote transportation-related practices—SHPPS 2016

Practice	**Districts (%)**
Walking or biking to and from school	32.9 (28.8–37.3)
The use of public transportation for its students to travel to and from school[1]	13.4 (10.5–16.9)
The use of public transportation for its faculty and staff to travel to and from school[1]	4.1 (2.6–6.4)

[1] An additional 67.4% of districts had no public transportation available.

Table 5.5. Percentage of districts with specific policies and practices related to bullying and harassment—SHPPS 2016

Policy or practice	Districts (%)
Prohibits bullying:	
On school property	99.7 (98.7–99.9)
At any locations on the way to and from school (e.g., school bus stops)	97.0 (95.2–98.2)
At off-campus, school-sponsored events	95.7 (93.4–97.1)
Has a policy prohibiting bullying that lists (or enumerates) groups with specific traits or characteristics	71.9 (67.7–75.7)
Has the following student traits listed or enumerated in the district's bullying policy:[1]	
Age	53.7 (49.2–58.1)
Disability	70.5 (66.2–74.4)
Gender identity or expression	58.9 (54.5–63.2)
Race or ethnicity	71.1 (66.9–74.9)
Religion	70.1 (65.8–74.0)
Sex	69.5 (65.2–73.5)
Sexual orientation	63.5 (59.1–67.7)
Socio-economic status	56.0 (51.5–60.4)
Other traits or characteristics	33.6 (29.5–38.0)
Prohibits electronic aggression or cyber-bullying that interferes with the educational environment, even if it does not occur on school property or at school-sponsored events	93.2 (90.6–95.1)
Prohibits sexual harassment:	
On school property	99.4 (97.8–99.8)
At any locations on the way to and from school (e.g., school bus stops)	95.0 (92.6–96.6)
At off-campus, school-sponsored events	96.1 (93.9–97.5)

[1] Among districts with a policy that prohibits bullying.

Table 5.6. Percentage of districts with specific policies and practices related to gang activity, drug testing, and suicide prevention—SHPPS 2016

Policy or practice	Districts (%)
Prohibits gang activity (e.g., recruiting or wearing gang colors, symbols, or other gang attire)	75.9 (71.9–79.5)
Has adopted a student drug-testing policy	37.5 (33.3–42.0)
Requires schools to have a plan for the actions to be taken when a student at risk for suicide is identified	79.5 (75.6–82.9)
Requires the student's family to be informed[1]	96.7 (94.2–98.1)
Requires that the student be referred to a mental health provider[1]	83.5 (79.4–86.9)
Requires a visit with a mental health provider to be documented before the student returns to school[1]	59.9 (54.9–64.8)

[1] Among districts that require schools to have a plan for the actions to be taken when a student at risk for suicide is identified.

Table 5.7. Percentage of districts with specific tobacco-use prevention policies—SHPPS 2016

Policy	Districts (%)
For students	
Prohibits cigarette smoking	99.2 (97.9–99.7)
In school buildings	99.2 (97.9–99.7)
Outside on school grounds, including parking lots and playing fields	99.2 (97.9–99.7)
On school buses or other vehicles used to transport students	98.3 (96.6–99.2)
At off-campus, school-sponsored events	95.9 (93.8–97.4)
Prohibits smokeless tobacco use	97.4 (95.7–98.5)
In school buildings	96.9 (95.0–98.1)
Outside on school grounds, including parking lots and playing fields	96.9 (95.0–98.1)
On school buses or other vehicles used to transport students	96.1 (94.0–97.5)
At off-campus, school-sponsored events	94.3 (91.9–96.0)
Prohibits cigar or pipe smoking	95.1 (92.8–96.7)
Prohibits the use of electronic vapor products (e.g., e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens)	81.8 (78.1–85.1)
For faculty and staff during any school-related activity	
Prohibits cigarette smoking	95.9 (93.5–97.4)
In school buildings	95.9 (93.5–97.4)
Outside on school grounds, including parking lots and playing fields	95.0 (92.6–96.7)
On school buses or other vehicles used to transport students	95.7 (93.3–97.3)
At off-campus, school-sponsored events	91.9 (89.0–94.1)
Prohibits smokeless tobacco use	92.9 (90.1–95.0)
In school buildings	93.0 (90.2–95.0)
Outside on school grounds, including parking lots and playing fields	92.3 (89.4–94.4)
On school buses or other vehicles used to transport students	93.0 (90.2–95.0)
At off-campus, school-sponsored events	90.3 (87.2–92.8)
Prohibits cigar or pipe smoking	92.9 (90.1–94.9)
Prohibits the use of electronic vapor products (e.g., e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens)	77.3 (73.3–80.9)
For school visitors	
Prohibits cigarette smoking	96.6 (94.5–97.9)
In school buildings	96.5 (94.4–97.8)
Outside on school grounds, including parking lots and playing fields	93.0 (90.4–95.0)
On school buses or other vehicles used to transport students	95.8 (93.6–97.3)
At off-campus, school-sponsored events	82.2 (78.5–85.5)
Prohibits smokeless tobacco use	90.8 (87.8–93.1)
In school buildings	90.0 (86.9–92.5)
Outside on school grounds, including parking lots and playing fields	87.3 (84.0–90.0)
On school buses or other vehicles used to transport students	90.0 (86.9–92.5)
At off-campus, school-sponsored events	79.1 (75.2–82.6)
Prohibits cigar or pipe smoking	93.1 (90.5–95.1)
Prohibits the use of electronic vapor products (e.g., e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens)	75.7 (71.6–79.4)

continued

Policy	Districts (%)
Marketing	
Prohibits marketing of tobacco or other products containing nicotine	
In school buildings	93.3 (90.8–95.2)
Outside on school grounds, including parking lots and playing fields	92.8 (90.1–94.7)
On school buses or other vehicles used to transport students	92.0 (89.2–94.1)
In school publications	90.5 (87.4–92.8)
Through sponsorship of school events	89.9 (86.8–92.3)
Prohibits students from wearing tobacco brand-name apparel or carrying merchandise with tobacco company names, logos, or cartoon characters on it	82.9 (79.2–86.0)

Table 5.8. Percentage of districts with specific injury prevention and safety policies and the percentage of districts that have ever been sued because of an injury—SHPPS 2016

Policy	Districts (%)
Requires inspection or maintenance of:	
Automated external defibrillators (AEDs)	86.1 (82.4–89.0)
Fire extinguishers	94.8 (92.3–96.5)
Indoor athletic facilities and equipment (e.g., playing surfaces, benches, tumbling mats, and weight lifting equipment)	76.2 (72.2–79.8)
Lighting inside school buildings	79.3 (75.5–82.7)
Lighting outside school buildings	78.6 (74.8–82.0)
Other school areas (e.g., halls, stairs, and regular classrooms)	79.5 (75.8–82.8)
Outdoor athletic facilities and equipment (e.g., playing fields and bleachers)	78.6 (74.8–82.0)
Playground facilities and equipment (e.g., playing surfaces, benches, monkey bars, and swings)[1]	77.3 (73.3–80.8)
Smoke alarms	91.0 (88.1–93.3)
Special classroom areas (e.g., chemistry labs, workshops, and art rooms)	79.0 (75.1–82.4)
Sprinkler systems	83.8 (80.3–86.7)
Requires students to wear appropriate protective gear when engaged in:	
Classes such as wood shop or metal shop[2]	73.5 (69.3–77.4)
Lab activities for photography, chemistry, biology, or other science classes[3]	84.9 (81.2–87.9)
Requires students to use hearing protection devices during classes or activities where they are exposed to potentially unsafe noise levels	61.3 (56.7–65.7)
Ever been sued because of an injury that occurred on school property or at an off-campus, school-sponsored event	26.5 (22.6–30.7)

[1] Question asked only among districts containing elementary schools.
[2] An additional 22.7% of districts did not have these types of classes.
[3] An additional 8.7% of districts did not have these types of activities.

Table 5.9. Percentage of districts with specific playground safety policies and practices[1]—SHPPS 2016

Policy or practice	Districts (%)
Has adopted a policy addressing:	
A discipline procedure for students who are not following the rules	86.2 (82.7–89.0)
A procedure for what to do in case of an injury	90.1 (87.0–92.5)
Criteria for selecting playground monitors	38.5 (34.1–43.0)
Criteria for the selection, placement, and installation of playground surfacing materials	61.6 (57.1–66.0)
Criteria for the selection, placement, and installation of playground equipment	61.5 (57.0–65.9)
Duties of playground monitors	65.3 (60.9–69.6)
Ratio of playground monitors to students	40.9 (36.5–45.5)
The identification of an individual responsible for enforcing the policy	62.9 (58.3–67.2)
The posting of rules for the safe use of specific types of equipment (e.g., swings, slides, or climbing structures)	44.5 (40.0–49.1)
Training for playground monitors	44.2 (39.7–48.9)
Provided training for playground monitors[2]	41.9 (37.4–46.6)

[1] Question asked only among districts containing elementary schools.
[2] During the 2 years before the study.

Table 5.10. Percentage of districts that require or recommend that schools implement specific sun safety practices—SHPPS 2016

	Districts (%)	
Practice	**Require**	**Recommend**
Allow students to apply sunscreen while at school	2.6 (1.5–4.6)	46.9 (42.4–51.4)
Encourage students to apply sunscreen while at school	1.5 (0.7–2.9)	44.3 (39.8–48.9)
Encourage students to wear hats or visors when in the sun during the school day	0.5 (0.1–1.8)	38.5 (34.1–43.0)
Encourage students to wear protective clothing (e.g., long sleeve shirts or long pants) when in the sun during the school day	1.3 (0.5–3.0)	39.3 (34.9–43.8)
Encourage students to wear sunglasses when in the sun during the school day	0.5 (0.1–1.8)	24.1 (20.4–28.2)
Schedule outdoor activities to avoid times when the sun is at peak intensity during the school day	3.9 (2.5–6.2)	33.2 (29.0–37.6)

Table 5.11. Percentage of districts with specific policies and practices related to crisis preparedness, response, and recovery—SHPPS 2016

Policy or practice	Districts (%)
Ever used any materials from the U.S. Department of Education to develop policies or plans related to crisis preparedness, response, and recovery	71.8 (67.8–75.5)
Has a comprehensive district-level plan to address crisis preparedness, response, and recovery in the event of a natural disaster or other emergency or crisis situation	94.6 (92.3–96.2)
Requires schools to have a comprehensive plan to address crisis preparedness, response, and recovery in the event of a natural disaster or other emergency or crisis situation	86.4 (83.2–89.0)
Provided funding for training or offered training on the crisis preparedness, response, and recovery plan[1,2] to:	
School faculty and staff	89.6 (86.4–92.0)
Students	59.5 (55.0–63.7)
Students' families	17.4 (14.2–21.0)
Offered education on crisis preparedness, response, and recovery to students' families[2]	21.6 (18.1–25.5)
Evaluated or assessed district's crisis preparedness, response, and recovery plan[1,3]	85.4 (81.9–88.2)
Is a member of a local emergency planning committee or emergency management team[4]	54.5 (50.1–58.7)
Has schools designated to serve as staging areas or community shelters during local emergencies	77.4 (73.6–80.8)
Conducted any district-level crisis response or emergency drills other than fire drills[3]	83.4 (80.0–86.4)
Requires all schools to have a National Oceanic and Atmospheric Administration (NOAA) weather radio	38.0 (33.9–42.3)

[1] Among the 95.9% of districts with either a district-level plan or a requirement for schools to have a plan.
[2] During the 2 years before the study.
[3] During the 12 months before the study.
[4] Defined as a group of local agencies that coordinates crisis preparedness, response, and recovery efforts in a community.

Table 5.12. Percentage of districts with crisis preparedness, response, and recovery plans that include specific elements—SHPPS 2016

Topic	Districts (%)
Establishment of an incident command system	88.5 (85.5–91.0)
Evacuation protocols for crises involving more than one school	85.4 (82.1–88.1)
Mechanisms for communicating with parents or guardians of students	93.6 (91.1–95.4)
Mechanisms for communicating with school personnel	94.0 (91.6–95.7)
Mechanisms for evaluating outside offers of assistance during or after a crisis	57.6 (53.2–61.8)
Plans for serving as a community shelter or coordinating center during a community-wide crisis	76.9 (73.1–80.3)
Plans for supplying food, water, and medical supplies to schools in extended shelter-in-place	62.9 (58.7–66.9)
Plans for training school staff (e.g., in triage or first aid skills)	70.4 (66.3–74.2)
Plans to resume normal activities after buildings or facilities have been damaged	65.7 (61.5–69.6)
Procedures for ensuring the continuity of education (e.g., online classes or prepackaged assignments) during unplanned school closure	43.0 (38.8–47.4)
Procedures for implementing unplanned school dismissal or school closure	88.7 (85.5–91.2)
Procedures for responding to media inquiries	92.0 (89.4–94.0)
Procedures for responding to pandemic influenza (flu) or other infectious disease outbreaks	73.6 (69.7–77.2)
Protocols for communicating with building-level managers during a crisis	92.6 (90.1–94.6)
Provision of mental health services for students, faculty, and staff after a crisis has occurred	84.5 (81.2–87.3)
Requirements to conduct district-level crisis-response drills	86.3 (83.0–89.0)
Requirements to periodically review and revise emergency response plans	90.9 (88.1–93.0)

Table 5.13. Percentage of districts that require schools to include specific topics in their crisis preparedness, response, and recovery plans—SHPPS 2016

Topic	Districts (%)
Establishment of an incident command system	79.5 (75.9–82.7)
Evacuation plans	85.1 (81.9–87.8)
Family reunification procedures	74.4 (70.5–77.9)
Mechanisms for communicating the plan to students' families	78.7 (75.0–81.9)
Mechanisms for communicating with parents or guardians of students	83.3 (80.0–86.2)
Mechanisms for communicating with school personnel	83.7 (80.4–86.6)
Plans to resume normal activities after buildings or facilities have been damaged	63.0 (58.8–67.0)
Plans to seek immediate shelter and remain in that area during a chemical, biological, or radiological emergency rather than evacuating, or shelter-in-place plans	77.9 (74.2–81.2)
Procedures for ensuring the continuity of education (e.g., online classes or prepackaged assignments) during unplanned school closure	43.8 (39.5–48.2)
Procedures for implementing unplanned school dismissal or school closure	80.8 (77.2–84.0)
Procedures for responding to media inquiries	81.2 (77.7–84.3)
Procedures for responding to pandemic influenza (flu) or other infectious disease outbreaks	65.3 (61.2–69.3)
Procedures to control the exterior of the building and school grounds	77.8 (74.1–81.1)
Procedures to stop people from leaving or entering school buildings (i.e., lock down plans)	83.8 (80.5–86.7)
Provision of mental health services for students, faculty, and staff after a crisis has occurred	77.6 (73.9–80.9)
Provisions for students and staff with special needs	79.9 (76.2–83.0)
Requirements to conduct regular emergency drills, other than fire drills	84.0 (80.6–86.8)
Requirements to periodically review and revise emergency response plans	82.4 (79.0–85.3)

Table 5.14. Percentage of districts that worked with specific groups to develop their crisis preparedness, response, and recovery plans[1]—SHPPS 2016

Group	Districts (%)
A local fire department	93.0 (90.5–94.9)
A local health department	54.4 (50.0–58.8)
A local homeland security office or emergency management agency[2]	49.5 (45.1–53.9)
A local hospital	35.5 (31.4–39.8)
A local law enforcement agency	97.8 (96.1–98.8)
A local mental health or social services agency	43.6 (39.2–48.0)
Local emergency medical services	81.9 (78.2–85.1)
Other community members	71.3 (67.2–75.1)
Staff from individual schools within your district	97.8 (96.1–98.8)
Students	42.6 (38.3–47.1)
Students' families	33.9 (29.7–38.3)
The local public transportation department[3]	16.7 (13.6–20.3)

[1] Among the 95.9% districts with either a district-level plan or a requirement for schools to have a plan.
[2] An additional 22.4% of districts did not have a local homeland security office or emergency management agency.
[3] An additional 62.2% of districts did not have a local public transportation department.

Table 5.15. Percentage of districts with specific policies related to community service and service learning—SHPPS 2016

Policy	Districts (%)
Requires students at any school level to participate in community service	30.4 (26.4–34.8)
Requires that schools provide service-learning opportunities to students	10.3 (8.0–13.3)
Recommends that schools provide service-learning opportunities to students	54.4 (49.9–58.9)
Requires schools at the following levels to participate in programs in which family or community members serve as role models to students or mentor students:	
Elementary schools	15.9 (12.8–19.6)
Middle schools	14.4 (11.4–18.1)
High schools	17.4 (14.0–21.5)

Table 5.16. Percentage of districts that provided funding for professional development or offered professional development for school faculty and staff on how to implement school-wide policies and programs related to specific topics[1]—SHPPS 2016

Topic	Districts (%)
Alcohol use prevention	58.9 (54.3–63.3)
Classroom management	87.6 (84.2–90.3)
Community involvement	63.2 (58.6–67.5)
Crisis preparedness, response, and recovery	88.8 (85.7–91.4)
Dating violence prevention	57.9 (53.4–62.3)
Drinking water quality	19.2 (15.8–23.1)
Electronic aggression or cyber-bullying prevention	87.3 (84.0–90.1)
Employee wellness	73.8 (69.6–77.6)
Family engagement	62.8 (58.4–67.1)
Green cleaning products and practices	43.1 (38.7–47.7)
Illegal drug use prevention	63.8 (59.3–68.1)
Indoor air quality	27.4 (23.5–31.6)
Injury prevention and safety	75.1 (71.0–78.7)
Integrated pest management	43.9 (39.4–48.5)
Mercury exposure prevention	23.0 (19.3–27.1)
Other bullying prevention	94.4 (91.8–96.2)
Other violence prevention	74.6 (70.5–78.3)
Radon testing and mitigation	22.7 (19.0–26.8)
Sexual harassment prevention	83.5 (79.8–86.6)
Sun safety	19.7 (16.2–23.7)
Tobacco use prevention	56.7 (52.2–61.2)

[1] During the 2 years before the study.

Table 5.17. Percentage of districts with specific practices related to school health coordination—SHPPS 2016

Practice	Districts (%)
Has a district-level school health council, committee, or team[1]	61.0 (56.6–65.2)
Number of times group met[2]	
0 times	1.6 (0.7–3.9)
1 or 2 times	39.1 (33.5–45.1)
3 or 4 times	37.6 (32.0–43.5)
5 or 6 times	9.5 (6.6–13.6)
More than 6 times	12.2 (8.7–16.7)
Provided any funding or offered to help schools establish a school health council, committee, or team[1,3]	30.7 (26.6–35.2)
Ever used a self-assessment tool to assess the district's health and safety policies and activities	43.2 (38.7–47.9)
Requires that schools use a self-assessment tool (e.g., the School Health Index)	6.1 (4.3–8.8)
Recommends that schools use a self-assessment tool (e.g., the School Health Index)	25.7 (21.8–30.1)
Has a district-level school improvement plan that includes health and safety objectives[4]	59.4 (54.8–63.8)
Requires schools to include health and safety objectives in their written School Improvement Plan[5]	44.5 (39.9–49.2)
Has someone in the district who oversees or coordinates the district's health and safety policies and activities (e.g., a district health coordinator)	57.8 (53.2–62.2)

[1] Defined as a group that offers guidance on the development of policies or coordinates activities that are health-related.
[2] During the 12 months before the study, among districts with a school health council, committee, or team.
[3] During the 2 years before the study.
[4] An additional 13.1% of districts do not have a district-level School Improvement Plan.
[5] In an additional 15.8% of districts, schools do not have a written School Improvement Plan.

Table 5.18. Percentage of districts that had one or more district-level school health councils, committees, or teams that addressed specific school health program components and health topics and engaged in specific activities[1]—SHPPS 2016

Component, topic, or activity	Districts (%)
School health program component	
Community involvement in school health programs	59.0 (53.1–64.8)
Counseling, psychological, and social services	71.3 (65.8–76.3)
Employee wellness	76.8 (71.6–81.2)
Family engagement in school health programs	56.5 (50.5–62.3)
Health education	85.4 (80.9–88.9)
Health services	77.6 (72.4–82.0)
Nutrition environment and services	92.4 (88.8–94.9)
Physical education and physical activity	90.9 (86.9–93.8)
Physical school environment	72.4 (66.9–77.2)
Social and emotional school climate	73.3 (68.0–78.1)
Topic	
Alcohol or other drug use prevention	69.6 (64.0–74.8)
Crisis preparedness, response, and recovery	79.1 (74.0–83.3)
Human immunodeficiency virus (HIV) prevention	49.2 (43.2–55.1)
Injury prevention and safety	71.6 (66.0–76.5)
Local wellness policies	83.9 (79.1–87.8)
Management of chronic health conditions (e.g., asthma or diabetes)	58.5 (52.5–64.2)
Management of food allergies	70.1 (64.5–75.2)
Management of foodborne illnesses	52.4 (46.4–58.3)
Management of infectious diseases (e.g., influenza [flu])	64.3 (58.4–69.7)

continued

Component, topic, or activity	Districts (%)
Other sexually transmitted disease (STD) prevention	51.6 (45.7–57.5)
Pregnancy prevention	46.2 (40.3–52.2)
Tobacco use prevention	70.6 (65.0–75.6)
Violence prevention (e.g., bullying, fighting, or dating violence prevention)	70.2 (64.6–75.3)
Activities	
Communicate the importance of health and safety policies and activities to the school board, district administrators, school administrators, or community members	85.5 (81.1–89.1)
Identify student health needs based on a review of relevant data	67.2 (61.4–72.4)
Recommend new or revised health and safety policies and activities to district administrators or the school board	88.5 (84.3–91.6)
Review health-related curricula or instructional materials	71.1 (65.5–76.2)
Seek funding or leverage resources to support health and safety priorities for students and staff	67.2 (61.5–72.5)

[1] Among the 61.0% of districts with a district-level school health council, committee, or team.

Table 5.19. Percentage of districts that had one or more school health councils that included representatives from specific school groups and local agencies or organizations[1]—SHPPS 2016

Group	Districts (%)
School group	
District administrators	95.6 (92.8–97.4)
Health education teachers	80.7 (75.5–85.1)
Health services staff (e.g., school nurses)	90.1 (86.1–93.0)
Library or media center staff	32.9 (27.4–38.8)
Maintenance staff	46.5 (40.7–52.4)
Mental health and social services staff	70.1 (64.7–75.0)
Nutrition or food service staff	87.2 (82.6–90.7)
Physical education teachers	88.0 (83.4–91.5)
School-level administrators	93.2 (89.6–95.6)
Students	56.0 (50.1–61.8)
Students' parents or families	74.0 (68.6–78.8)
Technology staff	39.7 (34.0–45.6)
Transportation staff	35.6 (30.2–41.5)
Agency or organization	
Businesses	33.0 (27.6–38.9)
Community members	78.4 (73.3–82.8)
Faith-based organizations	24.7 (19.8–30.3)
Health department	40.9 (35.2–46.9)
Health organizations (e.g., the local Red Cross chapter)	20.4 (15.9–25.8)
Healthcare providers (e.g., pediatricians or dentists)	36.5 (30.9–42.4)
Hospitals	32.3 (26.9–38.1)
Mental health or social services agencies	44.7 (38.9–50.6)
Other local government agencies	33.7 (28.2–39.7)
Public safety agencies (e.g., police, fire, or emergency services)	55.7 (49.8–61.4)
School board members	48.2 (42.4–54.2)
Service clubs (e.g., the Rotary Club)	25.2 (20.1–30.9)
Youth organizations (e.g., the Boys and Girls Clubs)	16.5 (12.5–21.5)

[1]Among the 61.0% of districts with a school health council, committee, or team.

Physical Environment

Table 6.1. Percentage of districts with specific policies and practices related to the physical school environment—SHPPS 2016

Policy or practice	Districts (%)
Has at least one school with a main instructional building that was constructed before 1980	92.1 (89.3–94.1)
Requires schools constructed before 1980 to inspect for lead in cracked or peeling paint[1,2]	37.2 (32.6–42.0)
Requires schools constructed before 1980 to inspect for PCBs in caulking around windows and doors[3]	24.1 (20.2–28.5)
Requires schools constructed before 1980 to inspect for PCBs in fluorescent light ballasts[4]	21.4 (17.7–25.6)
Requires schools to purchase mercury-free products for use in and around school buildings	52.4 (47.7–57.0)
Requires district approval before products are used by teachers, administrative or custodial staff, or contractors at a school:	
Cleaning and maintenance products (e.g., disinfectants, air fresheners, polishes, or waxes)	68.4 (64.0–72.4)
Pesticides	79.2 (75.3–82.6)
Chemicals or other potentially hazardous materials used in science labs, vocational education, art, or other classes	77.2 (73.1–80.8)
Requires Phase I environmental site assessments prior to constructing a new school facility	30.4 (26.3–34.9)
Requires a newly hired person who oversees custodial, maintenance, and environmental issues to have any formal training in issues related to the physical environment of buildings and health hazards likely to be encountered in schools	57.6 (53.0–62.1)

[1] Among districts that have at least one school with a main instructional building that was constructed before 1980.
[2] In an additional 36.6% of districts, lead paint in schools was previously identified and remediated.
[3] In an additional 32.0% of districts, PCBs in caulking in schools were previously identified and remediated.
[4] In an additional 45.8% of districts, PCBs in fluorescent light ballasts in schools were previously identified and remediated.

Table 6.2. Percentage of districts with specific policies and practices related to indoor and outdoor air quality and drinking water quality—SHPPS 2016

Policy or practice	Districts (%)
Indoor and outdoor air quality	
Has an indoor air quality management program	48.9 (44.3–53.5)
Has an indoor air quality management program based on the Environmental Protection Agency's Indoor Air Quality Tools for Schools	39.3 (34.9–44.0)
Requires schools to conduct periodic inspections:	
For appropriate cleaning of the school facility	83.0 (79.3–86.2)
For condensation in and around the school facilities	58.4 (53.7–62.8)
For mold	69.1 (64.7–73.2)
Of the building foundation, walls, and roof for cracks, leaks, or past water damage	71.3 (66.9–75.3)
Of the heating, ventilation, and air conditioning (HVAC) system	77.0 (73.0–80.6)
Of the plumbing system	65.3 (60.8–69.5)
Has a policy regarding how schools should address mold problems	54.6 (50.0–59.2)
Requires schools to respond to moisture-related issues within 48 hours or less	54.1 (49.4–58.7)
Requires schools to test for radon	33.2 (28.9–37.7)
Implemented an engine idling reduction program for:	
School buses	49.2 (44.7–53.8)
Commercial vehicles (e.g., delivery trucks)	25.2 (21.5–29.4)
Personal vehicles (e.g., cars)	16.5 (13.4–20.2)
Provided bus drivers with training related to the engine idling reduction program[1]	82.4 (76.6–87.0)
Requires purchase of low-emitting products[2] for use and around the school and school grounds	33.9 (29.6–38.4)

continued

Policy or practice	Districts (%)
Drinking water quality	
Requires schools to conduct periodic inspections that test drinking water outlets for lead	50.0 (45.4–54.7)
Requires schools to test drinking water at least once per year for:[3]	
Bacteria	30.1 (25.5–35.1)
Coliforms	29.6 (25.1–34.6)
Other contaminants	31.4 (26.7–36.4)
Requires schools to flush drinking water outlets after periods of non-use (e.g., after weekends or school vacations)	18.3 (15.0–22.2)

[1] During the 2 years before the study, among districts that have implemented such a program.
[2] Defined as products designed to give off little to no chemical fumes or vapors.
[3] Among the 83.0% of districts that have schools served by community water systems for which water testing is voluntary.

Table 6.3. Percentage of districts with specific pest management policies and practices—SHPPS 2016

Policy or practice	Districts (%)
Uses integrated pest management[1]	87.4 (83.9–90.2)
Requires schools to conduct a campus-wide inspection for pests at least monthly	54.5 (49.9–59.0)
Requires schools to notify staff, students, and families prior to each application of pesticides	43.2 (38.7–47.8)
Requires schools to:	
Allow eating only in designated areas to control pests	52.9 (48.3–57.5)
Keep vegetation, shrubs, and wood mulch at least 1 foot away from buildings to control pests	54.5 (49.9–59.1)
Mark indoor and outdoor areas that have been treated with pesticides	55.4 (50.8–60.0)
Remove infested or diseased plants	77.0 (72.8–80.6)
Repair cracks in pavement and sidewalks	69.1 (64.6–73.2)
Seal openings in walls, floors, doors, and windows with caulk or weather stripping	80.3 (76.4–83.7)
Store food in plastic, glass, or metal containers with tight lids so that it is inaccessible to pests	78.3 (74.2–81.9)
Store food waste in plastic, glass, or metal containers with tight lids so that it is inaccessible to pests	72.3 (68.0–76.2)
Use spot treatments and baiting rather than widespread applications of pesticides	80.4 (76.5–83.8)

[1] Defined as an approach to pest control that seeks to address safety concerns when using pesticides and to use methods that focus on eliminating pest access to food, water, and shelter in and around the school.

Table 6.4. Percentage of districts that provided funding for training or offered training to custodial or maintenance staff on specific topics[1]—SHPPS 2016

Topic	Districts (%)
Disposal of hazardous materials	80.1 (76.2–83.6)
Green cleaning products and practices	61.9 (57.4–66.3)
How to address mold problems	59.1 (54.5–63.5)
How to reduce the use of hazardous materials	63.3 (58.7–67.6)
Indoor air quality	52.1 (47.5–56.7)
Integrated pest management	63.2 (58.7–67.5)
Labeling of hazardous materials	80.6 (76.7–84.0)
Mercury spill cleanup	27.3 (23.2–31.8)
School drinking water quality	36.7 (32.3–41.3)
Storage of hazardous materials	82.2 (78.4–85.5)
Use of hazardous materials	78.3 (74.3–81.8)

[1] During the 2 years before the study.

Table 6.5. Percentage of districts that have adopted specific green building policies—SHPPS 2016

Policy	Districts (%)
Includes green design when building new school buildings or renovating existing buildings	28.0 (24.0–32.4)
Requires the use of a third party green building certification, labeling, or rating system[1]	54.0 (44.9–62.8)
Addresses the following practices for new school campuses or renovations:	
Conservation of water (e.g., using rainwater or plumbing fixtures that conserve water)	37.2 (32.8–41.9)
Creating a system for managing arrivals and departures of pedestrians and bicycles	35.6 (31.2–40.2)
Implementation of recycling programs	61.5 (56.9–65.9)
Orienting buildings to optimize energy conservation, use of daylight, and noise reduction	31.7 (27.5–36.1)
Preservation of green space or protection of the existing landscape	32.5 (28.3–37.1)
Use of alternative transportation including public transportation, walking, or biking	19.1 (15.7–23.1)
Use of building materials (e.g., floor and wall coverings, paints, sealants, caulk, adhesives, or furniture) that are low- or no-volatile organic compound (VOC) emitting materials	45.6 (41.0–50.2)
Use of energy efficient lighting and electrical systems	65.4 (60.9–69.7)
Use of landscaping that includes only native planting materials	25.8 (21.9–30.2)
Use of natural light for visual comfort or energy conservation	40.3 (35.8–44.9)
Use of procedures or systems to protect indoor air quality	54.3 (49.7–58.9)
Use of radon resistant new construction practices	34.0 (29.7–38.7)
Use of renewable energy (e.g., solar or wind power)	22.4 (18.7–26.6)

[1]Among districts with a green building design policy.

Table 6.6. Percentage of districts that found specific factors influential in deciding to build a new school facility rather than renovate an existing facility[1]—SHPPS 2016

	Districts (%)		
Factor	Not a factor	Somewhat influential	Very influential
Cost of repairing existing facility	31.8 (23.5–41.3)	15.6 (9.9–23.7)	52.6 (43.0–62.0)
Desire to accommodate community use of the school facility or campus (e.g., an auditorium, classrooms, or athletic fields)	28.5 (20.7–37.9)	29.8 (21.8–39.3)	41.7 (32.5–51.5)
Desire to have a more energy-efficient facility	22.9 (15.9–32.0)	27.8 (20.0–37.1)	49.3 (39.8–58.9)
Ease of obtaining approvals to construct a new school rather than renovate an existing school	39.7 (30.7–49.4)	33.0 (24.7–42.5)	27.4 (19.3–37.2)
Ease of obtaining funding to construct a new school rather than renovate an existing school	37.5 (28.6–47.3)	30.3 (22.3–39.7)	32.2 (23.7–42.1)
Need to accommodate population growth	20.1 (13.6–28.7)	26.5 (18.9–35.9)	53.4 (43.8–62.8)
Need to support current or future educational programs	6.6 (3.6–12.1)	28.6 (20.8–38.0)	64.7 (55.3–73.1)
School consolidation policy	57.7 (48.0–66.9)	25.0 (17.3–34.6)	17.4 (11.4–25.6)

[1]Among the 23.4% of districts that had initiated the construction of a school facility on a new school site during the 5 years before the study.

Table 6.7. Percentage of districts that found specific factors influential in deciding where to build a new school facility[1]—SHPPS 2016

Factor	Districts (%)		
	Not a factor	Somewhat influential	Very influential
Ability for students to walk or bike to school	54.8 (45.1–64.1)	31.3 (23.1–40.8)	14.0 (8.4–22.2)
Availability or design of existing roads and infrastructure	35.1 (26.4–44.9)	45.3 (35.9–55.0)	19.6 (13.1–28.4)
Compatibility with local community growth plan related to future residential development	40.8 (31.8–50.4)	31.2 (23.0–40.7)	28.1 (20.2–37.6)
Demographic characteristics (e.g., race, ethnicity, and poverty status) of students who would attend that school	71.6 (61.8–79.6)	14.3 (8.8–22.4)	14.1 (8.2–23.2)
Desire to accommodate community use of the school facility or campus (e.g., an auditorium, classrooms, or athletic fields)	36.9 (28.2–46.6)	27.1 (19.3–36.5)	36.1 (27.3–45.9)
Environmental concerns related to on-site contamination or potential nearby sources of pollution	66.7 (56.8–75.4)	14.0 (8.3–22.6)	19.3 (12.7–28.3)
Land prices	51.5 (41.9–60.9)	23.8 (16.8–32.7)	24.7 (17.2–34.1)
Local government officials' input	47.9 (38.5–57.4)	31.3 (23.2–40.7)	20.8 (13.8–30.2)
Need for athletic facilities	47.4 (38.0–57.0)	32.3 (24.2–41.7)	20.3 (13.5–29.3)
Need for parking	44.1 (34.8–53.8)	39.8 (30.9–49.5)	16.1 (10.2–24.6)
Potential clean-up costs of contaminated sites	75.8 (66.4–83.3)	9.3 (4.9–16.7)	14.9 (9.1–23.5)
Site already owned	36.7 (28.0–46.3)	13.3 (7.8–21.7)	50.1 (40.6–59.6)
Site donated	84.0 (75.4–90.0)	8.7 (4.5–16.2)	7.3 (3.6–14.1)

[1] Among the 23.4% of districts that had initiated the construction of a school facility on a new school site during the 5 years before the study.

Table 6.8. Percentage of districts that required formal consultation or input from groups on new school construction—SHPPS 2016

Group	Districts (%)		
	Whether to construct a new school	Where to construct a new school	Environmental review of candidate sites
Local government land use or community planning officials	47.1 (42.4–51.9)	45.4 (40.8–50.1)	40.1 (35.5–44.8)
Local government transportation officials	30.6 (26.3–35.2)	28.8 (24.6–33.4)	22.9 (19.0–27.2)
Local health department or environmental health officials	42.7 (38.1–47.3)	37.8 (33.4–42.5)	36.8 (32.3–41.5)
State government officials	49.7 (45.1–54.4)	41.9 (37.3–46.6)	40.3 (35.8–45.1)
The public	67.5 (63.0–71.7)	55.8 (51.1–60.4)	38.2 (33.6–42.9)

Table 6.9. Percentage of districts with specific policies and practices related to joint use agreements[1]—SHPPS 2016

Policy or practice	Districts (%)
Has a formal written joint use agreement	59.4 (55.0–63.6)
Has a formal written joint use agreement that allows:	
Community members or groups to use school facilities	54.6 (50.1–58.9)
Students to use community facilities (e.g., a park or recreation center)	29.3 (25.5–33.5)
Has a formal written joint use agreement that applies to community member or community group use of school facilities for:	
Adult education programs	28.6 (24.7–32.9)
Before- or after-school programs for school-aged children	38.4 (34.1–42.8)
Education-based programs hosted by universities, colleges, or technical schools	32.5 (28.5–36.9)
Emergency response (e.g., emergency food or shelter)	42.9 (38.5–47.4)
Healthcare services	13.6 (10.7–17.0)
Indoor recreation, sports, or physical activity	47.5 (43.1–52.0)
Library services	12.6 (10.0–15.9)
Meeting or office space for local government use	19.6 (16.2–23.4)
Meeting space for civic or community groups (e.g., the Lions Club, League of Women Voters, historical society, or music or theater group)	34.4 (30.3–38.8)
Mental health or social services	16.9 (13.8–20.6)
Outdoor recreation, sports, or physical activity	44.2 (39.8–48.6)
Performances, such as dance, theater, or music	36.0 (31.8–40.4)
Preschool or infant child care programs	25.5 (21.8–29.6)
Has a written formal joint use agreement with:	
A civic or community group (e.g., the Lions Club, League of Women Voters, historical society, or music or theater group)	24.5 (20.8–28.6)
A faith-based organization	14.5 (11.6–18.1)
A health club	5.2 (3.6–7.5)
A healthcare facility, practice, or group	8.7 (6.5–11.6)
A library system	9.2 (6.9–12.1)
A local government department, office, or program	29.0 (25.1–33.3)
A mental health or social services facility, practice, or group	16.8 (13.7–20.4)
A sports program or league not operated by local government	32.2 (28.1–36.6)
A university, college, or technical school	21.5 (18.0–25.4)
A youth group or organization (e.g., the Boys or Girls Clubs, the Boy Scouts or Girl Scouts, or 4H Clubs)	34.7 (30.5–39.0)
Any other public or private entity	6.4 (4.5–9.0)
Allow community members or groups to use the following types of school facilities without a formal joint use agreement:	
Indoor facilities only	2.7 (1.6–4.5)
Outdoor facilities only	14.6 (11.6–18.2)
Both indoor and outdoor facilities	40.8 (36.6–45.2)
No facilities allowed to be used without a formal joint agreement	41.9 (37.6–46.3)

[1] Defined as a formal written agreement between the school district and another public or private entity to jointly use or share either school facilities or community facilities to share costs and responsibilities.

Trends Over Time

Health Education

Table 7.1. Significant trends over time[1] in the percentage of districts with specific health education policies and practices, SHPPS 2000, 2006, 2012, and 2016

Policy or practice	2000	2006	2012	2016	Trend
Requires schools to follow any national, state, or district health education standards	68.8	79.3	82.4	81.7	Increased
Requires elementary schools to teach the following health topics:					
Alcohol or other drug use prevention	81.3	79.0	78.4	63.9	Decreased
HIV prevention	58.6	48.6	40.1	29.0	Decreased
Infectious disease prevention	NA	NA	70.5	55.1	Decreased
STD prevention	39.4	32.8	29.1	22.9	Decreased
Tobacco use prevention	79.9	81.1	79.7	65.9	Decreased
Violence prevention	73.4	83.6	85.8	86.3	Increased
Requires middle schools to teach the following health topics:					
HIV prevention	81.9	79.0	75.7	70.6	Decreased
Suicide prevention	53.8	62.3	65.1	65.4	Increased
Violence prevention	71.6	83.8	86.3	85.0	Increased
Has specified time requirements for middle school health education	NA	66.9	58.7	52.3	Decreased
Requires high schools to teach violence prevention	74.5	85.0	88.3	87.3	Increased
Provided funding for professional development or offered professional development to those who teach health education on the following health topics:[2]					
Emotional and mental health	44.0	58.6	59.8	63.6	Increased
Infectious disease prevention	NA	NA	59.1	47.7	Decreased
Injury prevention and safety	40.0	66.2	63.6	61.0	Increased
Nutrition and dietary behavior	43.3	65.3	62.9	56.0	Increased
Physical activity and fitness	43.3	75.3	74.6	60.1	Increased
Suicide prevention	41.5	56.1	62.6	68.8	Increased
Violence prevention	62.1	77.6	82.7	78.4	Increased
Provided funding for professional development or offered professional development to those who teach health education on the following instructional strategy topics:[2]					
Assessing or evaluating students in health education	NA	49.9	49.8	61.2	Increased
Teaching students of various cultural backgrounds	37.9	46.1	52.6	62.0	Increased
Teaching students with limited English proficiency	27.7	44.8	51.0	61.9	Increased
Teaching students with long-term physical, medical, or cognitive disabilities	47.0	58.5	60.0	65.8	Increased
Using interactive teaching methods (e.g., role plays or cooperative group activities)	55.2	66.1	60.0	70.4	Increased
Health education staff worked on health education activities with:					
A local business	24.2	26.8	35.4	37.4	Increased
District-level counseling, psychological, or social services staff	36.8	38.9	43.0	58.5	Increased
Provided district or school personnel (e.g., classroom teachers, administrators, or school board members) with information on school health education[3]	NA	79.2	66.5	69.0	Decreased

NA = Data not available.

[1] Significant linear trends based on regression analyses with all years of available data. Trends are presented if $p < .01$ and the difference between the two endpoints (2000 and 2016, 2006 and 2016, or 2012 and 2016) was greater than 10 percentage points or showed an increase of at least a factor of 2 or a decrease of at least half.

[2] During the 2 years before the study.

[3] During the 12 months before the study.

Physical Education and Physical Activity

Table 7.2. Significant trends over time[1] in the percentage of districts with specific physical education and physical activity policies and practices, SHPPS 2000, 2006, 2012, and 2016

Policy or practice	2000	2006	2012	2016	Trend
Requires elementary schools to teach physical education	82.6	93.3	93.6	92.6	Increased
Requires or recommends elementary schools use one particular curriculum developed by a commercial company	NA	4.8	11.6	19.1	Increased
Requires or recommends that schools at each level use Fitnessgram:					
Elementary schools	12.8	21.5	36.5	53.4	Increased
Middle schools	9.5	24.1	40.2	54.8	Increased
High schools	8.3	21.2	40.3	47.3	Increased
Requires or recommends that schools at each level use any other fitness assessment:[2]					
Elementary schools	NA	NA	8.7	24.4	Increased
Middle schools	NA	NA	9.4	26.0	Increased
High schools	NA	NA	12.4	30.0	Increased
Requires schools to meet the physical education needs of students with disabilities by using the following strategies:					
Mainstreaming into regular physical education as appropriate	82.3	98.5	97.8	97.2	Increased
Providing adapted physical education as appropriate	74.6	92.7	92.8	91.0	Increased
Using modified equipment or facilities in regular physical education	65.0	93.2	91.5	89.4	Increased
Using teaching assistants in regular physical education	57.2	86.5	79.2	78.6	Increased
Requires students to wear appropriate protective gear:					
When engaged in interscholastic sports	73.4	84.2	83.7	83.7	Increased
When engaged in physical activity clubs or intramural sports	40.8	44.8	57.9	51.6	Increased
Provided funding for professional development or offered professional development to those who teach physical education on the following topics:[3]					
Administering or using fitness assessments	49.8	62.5	71.1	67.6	Increased
Assessing or evaluating student performance in physical education	48.0	62.2	66.3	69.4	Increased
Developing, implementing, and evaluating a Comprehensive School Physical Activity Program (CSPAP)	NA	NA	42.2	22.7	Decreased
Encouraging family involvement in physical activity	28.0	51.0	53.9	49.8	Increased
Helping students develop individualized physical activity plans	35.1	47.2	52.9	49.1	Increased
Injury prevention and first aid	62.6	72.0	81.0	78.6	Increased
Methods to promote gender equity in physical education and sports	35.4	48.9	46.1	51.2	Increased
Teaching individual or paired activities or sports	46.4	59.7	60.1	60.4	Increased
Teaching movement skills and concepts	51.6	62.8	61.9	64.1	Increased
Teaching physical education to students with long-term physical, medical, or cognitive disabilities	45.5	55.9	54.7	59.9	Increased
Teaching team or group activities or sports	54.9	68.9	66.0	66.3	Increased
Physical education staff worked on school physical education activities with district-level:[4]					
Counseling, psychological, or social services staff	12.5	27.1	30.9	39.3	Increased
Health education staff	41.1	54.8	56.3	52.2	Increased
Health services staff	29.9	48.1	44.8	42.1	Increased
Nutrition or food service staff	12.1	46.0	41.5	41.3	Increased

continued

Policy or practice	2000	2006	2012	2016	Trend
Physical education staff worked on school physical education activities with:					
A health organization (e.g., the American Heart Association or the American Cancer Society)	46.4	59.2	62.4	59.0	Increased
A local business	15.9	21.5	30.0	29.8	Increased
A local health department	24.1	34.3	48.3	39.0	Increased
A local mental health or social services agency	14.1	22.5	33.2	33.2	Increased
A local parks or recreation department	26.2	31.2	35.4	39.6	Increased
A local youth organization (e.g., the Boys and Girls Clubs)	15.3	24.4	25.2	28.3	Increased
Requires schools to report number of minutes of classroom physical activity breaks	NA	NA	30.1	14.5	Decreased
Requires head coaches of interscholastic sports to:					
Be certified in cardiopulmonary resuscitation (CPR)	NA	57.7	68.6	76.0	Increased
Be certified in first aid	NA	61.3	68.0	72.5	Increased
Be employed by the school or school district	NA	56.8	50.2	43.7	Decreased
Complete a coaches' training course	48.5	61.5	70.5	73.8	Increased
Complete a sports safety course	NA	NA	65.2	76.0	Increased
Have a teaching certificate	47.1	46.0	35.0	29.4	Decreased
Have training on how to prevent, recognize, and respond to concussions among students	NA	NA	77.0	90.3	Increased
Provided educational materials to student athletes or their parents on preventing, recognizing, and responding to concussions[4]	NA	NA	73.4	87.4	Increased
Provided educational sessions to student athletes or their parents on preventing, recognizing, and responding to concussions[4]	NA	NA	58.7	71.3	Increased

NA = Data not available.

[1] Significant linear trends based on regression analyses with all years of available data. Trends are presented if $p < .01$ and the difference between the two endpoints (2000 and 2016, 2006 and 2016, or 2012 and 2016) was greater than 10 percentage points or showed an increase of at least a factor of 2 or a decrease of at least half.

[2] Other than Fitnessgram and the Physical Fitness Test from the President's Challenge. 3 During the 2 years before the study.

[4] During the 12 months before the study.

Nutrition Environment and Services

Table 7.3. Significant trends over time[1] in the percentage of districts with specific nutrition environment and services policies and practices, SHPPS 2000, 2006, 2012, and 2016

Policy or practice	2000	2006	2012	2016	Trend
Has food procurement contracts that address:					
Cooking methods for precooked items (e.g., baked instead of deep fried)	NA	77.7	84.0	89.3	Increased
Food safety	NA	83.5	93.6	97.0	Increased
Hazard Analysis and Critical Control Points (HACCP)	NA	74.1	92.1	95.1	Increased
Nutritional standards for a la carte foods	NA	55.1	73.5	85.4	Increased
Almost always or always used healthy food preparation practices:[2,3]					
Boiled, mashed, or baked potatoes rather than fried or deep fried them	NA	74.1	78.7	86.8	Increased
Drained fat from browned meat	93.7	91.4	79.0	70.7	Decreased
Prepared vegetables without using butter, margarine, or a cheese or creamy sauce	59.1	48.4	63.5	74.3	Increased
Reduced the amount of salt called for in recipes or used low-sodium recipes	32.6	28.3	46.1	76.4	Increased
Reduced the amount of sugar called for in recipes or used low-sugar recipes	12.7	17.5	30.3	55.2	Increased
Roasted meat or poultry on a rack so fat would drain	33.2	34.4	41.7	44.3	Increased
Roasted, baked, or broiled meat rather than fried it	NA	86.7	76.2	66.0	Decreased
Skimmed fat off warm broth, soup, stew, or gravy	60.2	64.9	70.8	73.1	Increased
Steamed or baked other vegetables	59.5	77.7	83.7	86.2	Increased
Used ground turkey or lean ground beef instead of regular ground beef	35.1	40.5	44.1	57.9	Increased
Used low-fat or nonfat yogurt, mayonnaise, or sour cream instead of regular mayonnaise, sour cream, or creamy salad dressings	26.8	39.8	53.1	70.3	Increased
Used low-sodium canned vegetables instead of regular canned vegetables	7.4	14.3	34.4	75.8	Increased
Used other seasonings instead salt	33.0	32.5	46.9	67.8	Increased
Used part-skim or low-fat cheese instead of regular cheese	34.1	50.3	69.4	81.5	Increased
Used skim, low-fat, soy, or nonfat dry milk instead of whole milk	67.4	77.9	90.7	89.0	Increased
Nutrition services staff worked on school nutrition services activities with district-level:[4]					
Counseling, psychological, or social services staff	8.8	23.3	22.1	29.0	Increased
Health education staff	26.0	59.9	51.1	47.6	Increased
Health services staff	23.9	55.1	51.4	55.8	Increased
Physical education staff	13.9	44.3	39.9	38.4	Increased
Nutrition services staff worked on school nutrition services activities with:[4]					
A local anti-hunger organization (e.g., a food bank)	NA	NA	24.1	34.6	Increased
A local business	8.8	19.9	20.9	29.1	Increased
A local college or university	8.7	11.8	17.9	19.2	Increased
A local health department	37.6	45.2	52.0	56.3	Increased
Made information available to students on the nutrition and caloric content of foods available to them	46.0	49.4	68.2	74.0	Increased
Provided assistance to schools for providing meals for students who are vegetarians[4]	NA	NA	45.4	62.3	Increased
Made results of last evaluation or assessment of implementation of wellness policy available to the public[5]	NA	NA	53.0	65.9	Increased
Newly hired district food service director required to have ServSafe or other food safety certification	NA	54.0	70.1	76.2	Increased

continued

Policy or practice	2000	2006	2012	2016	Trend
Newly hired food service manager required to:					
Have a high school diploma or GED	95.3	74.1	58.4	59.6	Decreased
Have an undergraduate degree	0.7	1.5	4.2	4.3	Increased
Have ServSafe or other food safety certification	NA	53.9	70.5	77.1	Increased
Be certified, licensed, or endorsed by the state	33.8	16.0	15.8	18.6	Decreased
Provided funding for professional development or offered professional development to nutrition services staff on nutrition services for students with special dietary needs other than food allergies[6]	NA	NA	62.7	77.3	Increased
Requires schools to restrict the availability of deep-fried foods	NA	42.1	48.0	58.9	Increased
Requires schools to have a written plan for implementation of a risk-based approach to food safety (e.g., a HACCP-based program)	NA	58.2	78.3	83.0	Increased
District receives a specified percentage of soft drink sales receipts	NA	64.4	41.6	38.1	Decreased
District receives incentives from soft drink sales (e.g., cash awards or donations of equipment, supplies, or other donations) once receipts total a specified amount	NA	32.5	13.9	9.1	Decreased
District prohibited from selling soft drinks produced by more than one company	NA	43.0	24.7	18.4	Decreased

NA = Data not available.

[1] Significant linear trends based on regression analyses with all years of available data. Trends are presented if $p < .01$ and the difference between the two endpoints (2000 and 2016, 2006 and 2016, or 2012 and 2016) was greater than 10 percentage points or showed an increase of at least a factor of 2 or a decrease of at least half.

[2] During the 30 days before the study.

[3] Among the districts that have primary responsibility for cooking foods for schools in the district.

[4] During the 12 months before the study.

[5] Among the districts that have evaluated or assessed the implementation of their policy.

[6] During the 2 years before the study.

Health Services and Counseling, Psychological, and Social Services

Table 7.4. Significant trends over time[1] in the percentage of districts with specific health services and counseling, psychological, and social services policies and practices, SHPPS 2000, 2006, 2012, and 2016

Policy or practice	2000	2006	2012	2016	Trend
Requires schools to obtain and keep the following information in any type of student record:					
Dietary needs/restrictions	69.9	84.2	88.5	86.4	Increased
TB screening results	48.9	47.7	40.4	38.4	Decreased
Weight status (e.g., body mass index)	NA	NA	51.5	38.7	Decreased
Requires the following vaccines:					
A meningococcal conjugate vaccine for middle school entry	NA	NA	33.2	47.2	Increased
A meningococcal conjugate vaccine for high school entry	NA	NA	27.2	44.8	Increased
A second measles vaccine for high school entry	66.8	73.2	84.5	84.9	Increased
Has adopted a policy that some students may carry and self-administer:					
An epinephrine auto-injector (e.g., EpiPen)	46.6	55.2	75.6	82.6	Increased
Insulin or other injected medications	58.8	45.1	60.9	69.2	Increased
Any other prescribed medications	36.8	15.6	22.8	23.2	Decreased
Any over-the-counter medications	35.1	15.9	21.3	22.6	Decreased
Health services staff worked on school health services activities with:[1]					
Counseling, psychological, or social services staff	56.6	58.7	60.9	82.6	Increased
Nutrition or food service staff	49.5	71.3	69.3	77.7	Increased
Physical education staff	59.9	63.8	63.1	72.3	Increased
Requires schools to submit injury report data to the school district or local health department	53.2	69.1	67.8	70.6	Increased
Requires schools to complete a report when a student experiences a serious illness at school	48.6	63.1	60.0	71.3	Increased
Requires supplies for applying standard or universal precautions to be available in the gymnasium, on playgrounds, or on playing fields	73.5	68.6	64.6	63.4	Decreased
Requires teachers to be notified when screening indicates hearing problems	85.5	79.7	77.4	74.4	Decreased
Requires schools to provide referrals to community healthcare providers when screening indicates oral health problems	NA	NA	62.9	76.2	Increased
Requires schools to provide the following health services:					
Alcohol or other drug use treatment	46.2	33.6	30.4	19.0	Decreased
Assistance with enrolling in Medicaid or SCHIP	44.4	38.9	34.9	33.0	Decreased
Identification or school-based management of acute illnesses	50.0	68.8	70.9	68.4	Increased
Identification or school-based management of chronic health conditions (e.g., asthma or diabetes)	46.5	76.0	80.5	76.2	Increased
Instruction on self-management of chronic health conditions	NA	44.7	48.6	66.5	Increased
Tobacco use cessation	42.1	36.9	26.9	18.8	Decreased
Requires schools to provide the following prevention services:					
HIV prevention	47.4	46.6	39.5	31.7	Decreased
STD prevention	45.0	44.9	36.7	32.2	Decreased
Violence prevention	59.2	70.0	77.9	77.4	Increased

continued

Policy or practice	2000	2006	2012	2016	Trend
Requires health services staff to follow Do Not Resuscitate orders	9.2	23.8	17.7	23.1	Increased
Requires a newly hired school nurse to have a Registered Nurse's license	95.6	75.1	86.1	79.0	Decreased
School nurses employed by school district	93.7	81.3	83.3	79.7	Decreased
Has arrangements with a university, medical school, or nursing school to provide services to students in the district	NA	NA	4.7	11.7	Increased
Has arrangements with other sites not on school property to provide:					
Administration of topical fluorides (e.g., mouthrinses, varnish, or supplements)	NA	NA	9.1	19.4	Increased
Alcohol or other drug use treatment	42.9	43.0	35.1	14.7	Decreased
Application of dental sealants	NA	6.9	9.1	19.2	Increased
Assistance with accessing benefits for students with disabilities	NA	NA	40.7	24.0	Decreased
Assistance with enrolling in Medicaid or SCHIP	30.8	32.3	29.1	17.7	Decreased
Assistance with enrolling in WIC or SNAP or accessing food stamps or food banks	28.9	32.2	28.4	16.7	Decreased
Case management for students with emotional or behavioral problems	NA	46.9	48.1	29.3	Decreased
Comprehensive assessment or intake evaluation	40.4	40.6	42.4	25.4	Decreased
Counseling for emotional or behavioral disorders (e.g., anxiety, depression, or ADHD)	NA	47.4	44.1	27.4	Decreased
Crisis intervention for personal problems	49.1	51.2	42.0	28.1	Decreased
Family counseling	41.7	39.2	39.4	21.2	Decreased
Group counseling	37.3	35.7	34.7	20.8	Decreased
Identification of emotional or behavioral disorders (e.g., anxiety, depression, or ADHD)	NA	48.0	41.8	25.6	Decreased
Individual counseling	49.0	47.4	48.8	31.1	Decreased
Job readiness skills programs	36.9	37.7	38.3	23.9	Decreased
Seasonal influenza vaccine	NA	NA	12.5	25.6	Increased
Self-help or support groups	32.1	30.0	28.0	18.4	Decreased
Suicide prevention	NA	NA	9.6	19.9	Increased
Tobacco use cessation	29.0	33.8	26.1	10.8	Decreased
Counseling, psychological, or social services staff worked on counseling, psychological, or social services activities with district-level:					
Health education staff	45.3	59.9	57.3	65.7	Increased
Health services staff	50.7	58.8	62.6	81.1	Increased
Nutrition services staff	11.2	39.3	37.6	51.5	Increased
Physical education staff	32.4	41.7	46.8	57.6	Increased
Requires schools to create and maintain student support teams	NA	NA	80.1	69.4	Decreased
Requires school counseling, psychological, or social services staff to participate in the development of Individualized Health Plans when indicated	38.5	58.6	57.2	69.3	Increased
Requires a newly hired school counselor to have as minimum education level:					
Undergraduate degree in counseling	NA	NA	15.2	26.5	Increased
Master's degree in counseling	NA	NA	70.7	53.7	Decreased
Requires a newly hired school psychologist to have an undergraduate degree in psychology	NA	NA	4.6	12.8	Increased
Requires school counseling, psychological, or social services staff to earn continuing education credits on counseling, psychological, or social services topics	NA	NA	51.4	64.6	Increased

continued

Policy or practice	2000	2006	2012	2016	Trend
Requires schools at each level to have a specified ratio of counselors to students:					
Elementary schools	NA	NA	26.4	16.2	Decreased
Middle schools	NA	NA	28.1	16.8	Decreased
High schools	NA	NA	32.0	19.8	Decreased
Provided funding for professional development or offered professional development to counseling, psychological, or social services staff on the following topics:[2]					
Peer counseling or mediation	56.6	56.1	45.2	41.4	Decreased
Student support teams	NA	NA	60.7	47.2	Decreased
Has someone in the district who oversees or coordinates counseling, psychological, or social services	62.6	71.9	63.1	79.5	Increased
Employee wellness					
Requires each school to have someone to oversee or coordinate employee wellness programs	NA	18.0	15.7	30.6	Increased
Provided funding for health risk appraisals or offered health risk appraisals for employees[3]	NA	12.3	25.9	40.6	Increased

NA = Data not available.

[1] Significant linear trends based on regression analyses with all years of available data. Trends are presented if $p < .01$ and the difference between the two endpoints (2000 and 2016, 2006 and 2016, or 2012 and 2016) was greater than 10 percentage points or a factor of 2.

[2] During the 2 years before the study.

[3] During the 12 months before the study.

Healthy and Safe School Environment (includes Social and Emotional Climate)

Table 7.5. Significant trends over time[1] in the percentage of districts with specific school environment policies and practices, SHPPS 2000, 2006, 2012, and 2016

Policy or practice	2000	2006	2012	2016	Trend
Safety and security measures					
Requires schools at each level to assign staff or adult volunteers to monitor school halls during classes					
Elementary schools	NA	51.7	43.4	40.3	Decreased
Middle schools	NA	55.9	47.1	43.8	Decreased
Requires schools at each level to assign staff or adult volunteers to monitor school restrooms					
Middle schools	57.5	54.1	47.6	43.4	Decreased
High schools	59.3	52.7	47.5	42.8	Decreased
Requires faculty and staff at each level to wear identification badges					
Elementary schools	NA	33.0	49.9	60.0	Increased
Middle schools	NA	33.9	51.4	60.1	Increased
High schools	NA	34.8	52.2	60.5	Increased
Requires visitors at each level to wear identification badges					
Elementary schools	NA	66.7	83.6	86.9	Increased
Middle schools	NA	71.3	82.4	86.0	Increased
High schools	NA	68.3	80.4	86.9	Increased
Requires high school students to wear identification badges	3.5	5.2	9.9	8.7	Increased
Requires schools at each level to use security or surveillance cameras[2]					
Elementary schools	11.0	29.1	59.0	75.9	Increased
Middle schools	16.4	37.2	68.6	82.9	Increased
High schools	19.2	46.4	74.9	85.4	Increased
Requires students at each level to refrain from using personal communication devices (e.g., cell phones) during the school day					
Middle schools	NA	NA	88.4	74.6	Decreased
High schools	NA	NA	82.4	58.8	Decreased
Requires high school students to wear school uniforms	1.3	1.9	5.1	5.2	Increased
Requires high schools to enforce student dress code[4]	77.5	90.4	83.5	89.4	Increased
Supports or promotes walking or biking to and from school	NA	17.5	30.2	32.9	Increased
Violence prevention					
Prohibits gang activity (e.g., recruiting or wearing gang colors, symbols, or other gang attire)	62.5	78.5	73.0	75.9	Increased
Prohibits electronic aggression or cyber-bullying that interferes with the educational environment[5]	NA	NA	82.0	93.2	Increased
Tobacco use prevention					
Prohibits students from wearing tobacco brand-name apparel or carrying merchandise with tobacco company names, logos, or cartoon characters on it	70.5	80.5	82.3	82.9	Increased
Prohibits faculty and staff from					
Cigarette smoking outside on school grounds, including parking lots and playing fields	78.3	86.8	92.4	95.0	Increased
Cigarette smoking at off-campus, school-sponsored events	75.7	82.2	89.0	91.9	Increased
Smokeless tobacco use outside on school grounds	74.2	80.5	87.1	92.3	Increased
Smokeless tobacco use at off-campus school-sponsored events	72.6	78.3	84.6	90.3	Increased
Prohibits school visitors from					
Cigarette smoking outside on school grounds, including parking lots and playing fields	72.1	76.8	91.1	93.0	Increased

continued

Policy or practice	2000	2006	2012	2016	Trend
Cigarette smoking at off-campus, school-sponsored events	61.8	70.2	81.1	82.2	Increased
Smokeless tobacco use	79.4	82.6	90.3	90.8	Increased
Smokeless tobacco use in school buildings	78.7	81.7	89.5	90.0	Increased
Smokeless tobacco use outside on school grounds, including parking lots and playing fields	64.8	71.8	85.0	87.3	Increased
Smokeless tobacco use on school buses or other vehicles used to transport students	77.6	80.8	89.0	90.0	Increased
Smokeless tobacco use at off-campus, school-sponsored events	58.3	64.8	76.7	79.1	Increased
Has adopted a student drug-testing policy	NA	25.5	29.6	37.5	Increased
Injury prevention and safety					
Requires inspection or maintenance of smoke alarms	72.2	89.8	91.6	91.0	Increased
Requires students to wear appropriate protective gear when engaged in classes such as wood shop or metal shop	86.6	83.1	72.4	73.5	Decreased
Requires students to use hearing protection devices during classes or activities where they are exposed to potentially unsafe noise levels	NA	NA	47.5	61.3	Increased
Crisis prevention, response, and recovery					
Ever used any materials from the U.S. Department of Education to develop policies or plans related to crisis preparedness, response, and recovery	NA	85.9	73.8	71.8	Decreased
Worked with a local mental health or social services agency to develop their crisis preparedness, response, and recovery plan[6]	NA	57.5	46.1	43.6	Decreased
Evaluated or assessed district's crisis preparedness, response, and recovery plan[6,7]	NA	74.6	74.2	85.3	Increased
School health coordination					
Provided funding for professional development or offered professional development for school faculty and staff on how to implement school-wide policies and programs related to:					
Alcohol use prevention	NA	73.3	62.8	58.9	Decreased
Illegal drug use prevention	NA	76.7	64.9	63.8	Decreased
Tobacco use prevention	NA	70.0	58.8	56.7	Decreased
Had one or more district-level councils, committees, or teams that addressed[8]					
Alcohol or other drug use prevention	NA	86.1	84.6	69.6	Decreased
HIV prevention	NA	66.1	64.2	49.2	Decreased
Management of foodborne illnesses	NA	NA	64.6	52.4	Decreased
Management of infectious diseases (e.g., influenza)	NA	NA	78.1	64.3	Decreased
Tobacco use prevention	NA	84.2	82.5	70.6	Decreased
Had one or more school health councils that included representatives from[8]					
School maintenance staff	NA	NA	59.4	46.5	Decreased
School mental health or social services staff	NA	57.4	66.4	70.1	Increased
School transportation staff	NA	NA	48.3	35.6	Decreased
Students	NA	74.4	64.3	56.0	Decreased
Provided any funding or offered to help schools establish a school health council, committee, or team[9]	42.9	50.5	39.4	30.7	Decreased

NA = Data not available.

[1] Significant linear trends based on regression analyses with all years of available data. Trends are presented if $p < .01$ and the difference between the two endpoints (2000 and 2016, 2006 and 2016, or 2012 and 2016) was greater than 10 percentage points or a factor of 2.

[2] Inside or outside school building.

[3] Does not include the use of smart phones, tablets, or computers for educational purposes.

[4] Among districts that do not require school uniforms.

[5] Even if it does not occur on school property or at school-sponsored events.

[6] Among the 95.9% districts with either a district-level plan or a requirement for schools to have a plan.

[7] During the 12 months before the study.

[8] Among the districts with a district-level school health council, committee, or team.

[9] During the 2 years before the study.

Physical Environment

Table 7.6. Significant trends over time[1] in the percentage of districts with specific physical school environment policies and practices, SHPPS 2000, 2006, 2012, and 2016

Policy or practice	2000	2006	2012	2016	Trend
Has an indoor air quality management program	NA	35.4	47.7	48.9	Increased
Provided funding for training or offered training to custodial or maintenance staff on how to reduce the use of hazardous materials[2]	NA	NA	74.8	63.3	Decreased
Includes green design when building new school buildings or renovating existing buildings	NA	13.4	30.0	28.0	Increased
Provided funding for professional development or offered professional development for school faculty and staff on how to implement school-wide policies and programs related to integrated pest management[2]	NA	27.4	41.4	43.9	Increased

NA = Data not available.
[1] Significant linear trends based on regression analyses with all years of available data. Trends are presented if $p < .01$ and the difference between the two endpoints (2000 and 2016, 2006 and 2016, or 2012 and 2016) was greater than 10 percentage points or a factor of 2.
[2] During the 2 years before the study.

Healthy People 2020 Objectives

Table 8.1. National health objectives from Healthy People 2020 measured by SHPPS

Healthy People 2020 Objective	2020 Target (%)	Baseline data (%)	Data from SHPPS 2016 (%)
NWS-2.2: Increase the proportion of school districts that require schools to make fruits or vegetables available whenever other food is offered or sold	18.6	6.6[1]	16.3
PA-6.2: Increase the proportion of school districts that require regularly scheduled elementary school recess	62.8	57.1[1]	64.8
PA-7: Increase the proportion of school districts that require or recommend elementary school recess for an appropriate period of time	67.7	61.5[1]	64.5
PREP-5: Increase the percentage of school districts that require schools to include specific topics in their crisis preparedness, response, and recovery plans			
PREP-5.1: Increase the percentage of school districts that required schools to include family reunification plans	74.6	67.8[2]	74.4
PREP-5.2: Increase the percentage of school districts that required schools to include procedures for responding to pandemic flu or other infectious disease outbreaks	75.9	69.0[2]	65.3
PREP-5.3: Increase the percentage of school districts that required schools to include specific provisions for students and staff with special needs	87.9	79.9[2]	79.9
PREP-5-4: Increase the percentage of school districts that required schools to include specific provisions for mental health services for students, faculty, and staff after a crisis has occurred	76.2	69.3[2]	77.6

[1] 2006 data.
[2] 2012 data.

Discussion

The SHPPS 2016 results presented in this report provide detailed information about school health policies and practices in districts nationwide. Below, results from several of the WSCC model's components are highlighted, noting areas of strength as well as those in need of improvement.

Health Education

Nationwide, 81.7% of districts required schools to follow any national, state, or district health education standards which is a significant increase from the 68.8% of districts that had this policy in 2000. However, less than two thirds specifically required schools to follow standards based on the National Health Education Standards and less than half specifically required schools to follow standards based on the National Sexuality Education Standards. Among districts that follow any standards for health education, 38.5% require elementary schools, 44.6% require middle schools, and 54.6% require high schools to assess student achievement of the health education standards used by the district. Districts can help improve the quality of health education by providing additional support to schools for following well established standards such as the National Health Education Standards (19) and the National Sexuality Education Standards.

Requiring schools to teach specific health topics is an appropriate role for districts and one that can demonstrate commitment to a comprehensive, developmentally appropriate curriculum. Unfortunately, districts are most likely to have adopted a policy stating that high schools rather than elementary schools or middle schools will teach specific health topics. Elementary schools and middle schools were required by more than 80% of districts to teach about just one (violence prevention) and two (tobacco use prevention and violence prevention), topics, respectively. However, high schools were required by more than 80% of districts to teach about seven topics (alcohol or other drug use prevention, emotional and mental health, HIV prevention, nutrition and dietary behavior, other sexually transmitted disease prevention, tobacco use prevention, and violence prevention). Interestingly, violence prevention was the only specific health topic that more than 80% of districts in 2016 required schools at the elementary, middle, and high school levels to teach and the only topic for which an increase was observed since 2000 at all three levels in the percentage of districts that required schools to teach it. The percentage of districts requiring suicide prevention to be taught by middle schools is the only other specific health topic for which an increase was observed since 2000. In contrast, declines since 2000 were observed in the percentage of districts requiring elementary schools to teach alcohol or drug use prevention, HIV prevention, infectious disease prevention, STD prevention, and tobacco use prevention and middle schools to teach HIV prevention. Reversing these trends is critical to ensure that elementary schools and middle schools are teaching topics closely linked to priority public health issues.

Among districts requiring that pregnancy prevention, HIV prevention, other STD prevention, or human sexuality be taught, more than three fourths required elementary and middle schools and two thirds required high schools to notify parents or guardians before students receive instruction and more than half required schools at all three levels to require parental permission before instruction. Three fourths or more of districts required schools at all three levels to allow parents or guardians to exclude their children from receiving instruction on these topics.

Staffing in support of health education could be improved at both the district and school levels. About two-thirds (69.0%) of districts have someone who oversees or coordinates health education and less than half (42.2%) of districts require each school to have someone to oversee or coordinate health education at the school. Only 4 of 10 districts require those who teach health education to earn continuing education credits on health education topics or instructional strategies. At the middle school level, newly hired staff who teach health education must have undergraduate or graduate training in health education in 58.7% of districts; must be certified, licensed, or endorsed by the state to teach health education in 67.8% of districts; and must be Certified Health Education Specialists (CHES) in 16.9% of districts. Expectations for newly hired staff are not much better at the high school level. Newly hired staff who teach health education must have undergraduate or graduate training in health education in 68.6% of districts; must be certified, licensed, or endorsed by the state to teach health education in 78.4% of districts; and must be CHES in 19.3% of districts.

Professional development for those who teach health education can improve the effectiveness of health education. While 54.6% of districts required those who teach health education to receive professional development on violence prevention, less than half of districts had adopted a policy requiring those who teach health education to receive professional development on 17 other specific health topics. However, even though few districts required professional development on specific health topics, more than half provided funding for or offered professional development during the two years before the study on alcohol or other drug use prevention, emotional and mental health, human

sexuality, injury prevention and safety, nutrition and dietary behavior, physical activity and fitness, suicide prevention, tobacco use prevention, and violence prevention. Since 2000, the percentage of districts that provided funding for professional development or offered professional development to those who teach health education on the following topics increased: emotional and mental health, injury prevention and safety, nutrition and dietary behavior, physical activity and fitness, suicide prevention, and violence prevention. Additional district requirements for those who teach health education to receive professional development on specific health topics are needed.

Besides professional development on specific health topics, it is also important for those who teach health education to receive professional development on specific instructional strategies. Districts can make sure that this kind of professional development is made available. More than 60% of districts provided funding for or offered professional development during the two years before the study to those who teach health education on the following specific instructional strategy topics: aligning health education standards to curriculum, instruction, or student assessment; assessing or evaluating students in health education; creating safe and supportive learning environments for all students; teaching skills for behavior change; teaching students of various cultural backgrounds; teaching students with limited English proficiency; teaching students with long-term physical medical, or cognitive disabilities; using classroom management techniques; using interactive teaching methods; and using technology to enhance instruction or improve student learning. Since 2000, the percentage of districts that provided funding for professional development or offered professional development to those who teach health education on the following instructional strategy topics increased: assessing or evaluating students in health education; teaching students of various cultural backgrounds; teaching students with limited English proficiency; teaching students with long-term physical, medical, or cognitive disabilities; and using interactive teaching methods.

Physical Education and Physical Activity

In the recent 2016 National Physical Activity Report Card, the U.S. received the grade of D-, which indicates that most U.S. children and adolescents are not getting the nationally recommended 60 minutes of physical activity daily (44). Districts can provide leadership to help schools enhance policies and practices for physical education and physical activity through a CSPAP that will assist students in attaining the national recommendation and improving their health and education outcomes (24). SHPPS 2016 found that only 15% of districts require each school to have someone to oversee or coordinate a CSPAP at the school and even fewer districts (13%) require each school to have a written plan for a CSPAP. One possible way to increase these practices in schools is to incorporate them into a district policy such as the local wellness policy.

Physical education is the cornerstone for CSPAP and can be adequately addressed by four essential components of physical education: policy and environment; curriculum; student assessment; and appropriate instruction (26). SHPPS 2016 revealed that there is policy and environmental support for physical education at the district level. For all school levels, more than 89% of districts require schools to teach physical education, and this requirement increased significantly for elementary schools since 2000. In addition, for all school levels, the majority of districts follow national standards for physical education; have time requirements for physical education; and have staffing policies that require staff who teach physical education to be certified, licensed, or endorsed by the state to teach physical education. However, for all school levels, less than 20% of districts prohibit the use of waivers, exemptions, or substitutions for physical education requirements for students. It is essential that physical education be taught to students so they may gain the knowledge, skills, and confidence to be physically active for a lifetime. Allowing waivers, exemptions, and substitutions reduces the opportunity for all students to experience physical education.

Districts provide leadership and direction for physical education curriculum, and having a comprehensive written curriculum provides the framework for what and how physical education should be taught to ensure equitable education for all students. SHPPS 2016 found districts could be doing more to support improvements in physical education curriculum. For example, for all school levels, less than 15% of districts ever used a curriculum analysis tool to assess one or more physical education curricula. In addition, for all school levels, less than 50% of districts provide a chart describing the annual scope and sequence of instruction for physical education.

Trend analyses showed a significant increase since 2000 in the percentage of districts that require or recommend that schools at each level use Fitnessgram®, a fitness assessment. While this is a positive finding, physical education teachers can collect information other than fitness assessment results to measure student learning and improvement. SHPPS 2016 found that for all school levels only about 60% of districts provide plans for how to assess student performance in physical education. This finding indicates a need for improvement in the area of student assessment. Suggestions and additional resources for how to assess students in physical education are explained in SHAPE America's Essential Components of Physical Education (26).

An important aspect of appropriate instruction is ensuring the inclusion of all students and making the necessary adaptations for students with special needs or disabilities. SHPPS 2016 revealed that the percentage of districts that require schools to meet the physical education needs of students with disabilities by mainstreaming into regular physical education as appropriate, providing adapted physical education as appropriate, using modified equipment or facilities in regular physical education, and using teaching assistants in regular education increased significantly since 2000.

SHPPS also found that only 46% of districts require those who teach physical education to earn continuing education credits on physical education topics and instructional strategies. However, the percentage of districts that provided funding for professional development or offered professional development to those who teach physical education on several topics (e.g., teaching movement skills and concepts, assessing or evaluating student performance in physical education, and teaching team or group activities or sports) increased significantly since 2000. Providing physical education teachers with professional development is necessary for improving physical education instruction and programs.

In addition to physical education, other opportunities exist for students to engage in physical activity that allow them to apply the knowledge and skills they learn from physical education. SHPPS 2016 found that 65% of districts require that elementary schools provide students with regularly scheduled recess. SHPPS 2016 also found that the percentage of districts requiring schools to provide regular classroom physical activity breaks during the school day varied by school level—only 11% of elementary schools, 8% of middle schools, and 2% of high schools. Very few districts require that schools provide before and after school physical activity. However, more districts recommend these type of activities, especially opportunities after the school day.

SHPPS 2016 results show that districts can be playing a larger role in helping schools provide physical activity opportunities before, during, and after school. The CDC and some national organizations have developed key resources to assist districts in supporting schools to develop, implement, and evaluate a CSPAP. In addition, many resources are available to help implement the individual components of CSPAP. This information can be found in CDC's National Framework for School Physical Education and Physical Activity at www.cdc.gov/healthyschools/PEandPA.

Concussions among student athletes are a potential negative outcome of physical activity, so it is important to prevent, recognize, and respond to them. While increases have occurred since 2012 in the percentage of districts that require head coaches of interscholastic sports to have training on concussions, as well as in the percentage of districts that provide educational materials and sessions to student athletes or their parents, room for improvement still exists. To help guide districts and schools in these efforts, CDC has developed Heads Up (www.cdc.gov/headsup/index.html), a series of resources for recognizing, responding to, and minimizing the risk of concussion or other serious brain injury.

Nutrition Environment and Services

Many school districts are using a variety of policies and practices to improve the school nutrition environment. Almost all districts participate in the NSLP and SBP, which provide students with access to balanced meals during the school day. However, only one third of districts participate in the After-School Snack Program, and fewer than 10% of districts participate in the After-School Supper Program. Additionally, only one third of districts sponsor the United States Department of Agriculture (USDA) Summer Food Service Program in any schools within the district. Participation in these programs can help combat food insecurity by ensuring that students have access to nutritious snacks and meals outside of the typical school day and during summer break.

It is recommended that students receive at least 10 minutes to eat breakfast and at least 20 minutes to eat lunch once they receive their meal (25) and research indicates that students consume more of their meal and have better intake of key nutrients when they have more than 20 minutes to eat their lunch (45-47). Among the districts that require or recommend that a minimum amount of time be given to students for meals, most require or recommend that students receive at least 10 minutes to consume breakfast, while only 65% of districts require or recommend that students receive at least 20 minutes to consume lunch.

Among the 80% of school districts that have the primary responsibility for preparing foods for schools, there has been a significant increase since 2000 in the percentage that are using a range of healthy food preparation techniques including reducing the amount of salt called for in recipes or using low-sodium recipes, reducing the amount of sugar called for in recipes or using low-sugar recipes, using low-sodium canned vegetables instead of regular canned vegetables, using other seasonings instead salt, and using part-skim or low-fat cheese instead of regular cheese. As districts continue to implement federal requirements for school meals, food preparation strategies to reduce the sodium and saturated fat content of meals will continue to be important.

SHPPS 2016 results demonstrate significant improvements in competitive food policies and practices. Between 2006 and 2016, there has been a significant decrease in the percentage of districts that receive a specified percentage of soft drink sales as well as incentives from soft drink sales (e.g., cash awards or donations of equipment) once receipts total a specified amount. Additionally, the percentage of districts prohibited from selling soft drinks produced by more than one company (e.g., exclusive contracts) has decreased significantly. The target for the Healthy People 2020 objective NWS-2.2 (increase the proportion of school districts that require schools to make fruits or vegetables available whenever other food is offered or sold) (3) is 18.6% and SHPPS 2016 found that 16.3% of districts require schools to make fruits and vegetables available whenever other food is offered or sold, up from 6.6% in 2006. While these trends are encouraging, it is important for districts to continue to ensure that competitive foods meet or exceed Smart Snacks in School nutrition standards.

SHPPS 2016 revealed that fewer than half of districts prohibit schools from marketing fast food restaurants and unhealthy foods and beverages on school grounds, on school buses or other vehicles used to transport students, in school publications, in curricula or other educational materials, and through distribution of products to students. Additionally, only 33.2% of districts prohibit schools from selling foods and beverages that do not meet Smart Snacks in School nutrition standards for fundraisers, and fewer than 6% prohibit fundraiser nights at fast food restaurants. Marketing unhealthy foods and beverages in schools sends inconsistent messages to students about good nutrition and healthy eating. School districts are now required to address food marketing in the local school wellness policy by establishing nutrition standards that allow marketing and advertising of only those foods and beverages that meet the Smart Snacks in School nutrition standards (31).

Providing students with access to clean, free drinking water during the school day can help improve students' overall water consumption and maintain adequate hydration (48) which affects their cognitive function (49-52). While more than half of districts have a policy that allows students to have a drinking water bottle with them during the school day, more than one third of districts do not require schools to provide drinking water to students in the cafeteria during breakfast, and in the cafeteria during lunch, which is required by USDA under the Healthy, Hunger-Free Kids Act of 2010 (30). Additionally, more than one-third of districts do not require schools to provide free drinking water to students in other locations including the gymnasium and hallways throughout the school. School districts can help support water access and encourage water consumption by ensuring that schools regularly clean and maintain water fountains; by periodically testing water and sharing results with students, parents, and school staff; by helping schools implement water promotion campaigns; and by including language about water access in a local school wellness policy.

Results from SHPPS 2016 provide insight about districts' implementation of local school wellness policy requirements. Engaging stakeholders and communicating broadly about the wellness policy is important so that students, parents, school and district staff, as well as community members are aware of the policy and the role they play in helping to implement the policy. While more than 60% of districts engaged representatives of the school food authority and school administrators in the process of reviewing and revising the local wellness policy (LWP), students, community members, or other classroom teachers were involved in this process in fewer than half of districts. Nearly one third of districts have not identified anyone as responsible for ensuring compliance with the LWP, which is required by the 2017-18 school year (31). Almost all districts posted the LWP on the district website, but fewer than half of districts used other strategies to communicate about the LWP including posting it in schools, sharing it during meetings where parents are in attendance, and sharing it through social media. Finally, most districts have evaluated or assessed the implementation of their LWP, but only two thirds of those have made the results of that evaluation or assessment available to the public. While there has been some progress in wellness policy strength and comprehensiveness (i.e., addressing required components) since the wellness policy mandate first went into effect during the 2006-2007 school year, wellness policies remain weak overall (53). Districts can continue to strengthen wellness policy language, and focus on ensuring that wellness policy requirements are implemented at schools within the district.

Health Services and Counseling, Psychological, and Social Services (includes Employee Wellness)

Despite recent a policy statement from the American Academy of Pediatrics recommending a full-time nurse in every school (33), SHPPS 2016 revealed that only about one third of districts nationwide require each school to have a full-time school nurse. Further, few districts offer health services or counseling, psychological, or social services through school-based health centers, and less than half have arrangements to provide these services to students in the district at other sites not on school property. Indeed, trend analyses showed that the percentage of districts with arrangements to provide several specific services at other sites not on school property has

decreased significantly since 2000. Taken together, these district policies and practices create a missed opportunity to help students obtain access to health services.

SHPPS 2016 also found that the percentage of districts requiring schools to offer specific services varied widely by type of service. For example, while more than 90% of districts had adopted a policy that schools will provide basic services such as administration of medications and first aid, fewer than 2% had policies requiring schools to provide sexual health services such as testing for HIV, STDs, and pregnancy. More districts, however, require schools to provide referrals for these types of services, although such policies are far from prevalent. Room for improvement clearly exists in the support school districts offer to help students obtain sexual health services.

In contrast, the majority of districts require schools to provide services to students with chronic health conditions, such as case management for students with chronic health conditions and tracking of students with chronic health conditions. In addition, the percentage of districts requiring schools to provide identification or school-based management of chronic health conditions and instruction on self-management of chronic health conditions has increased significantly since 2000 and 2006, respectively. Strategies to further support districts' efforts in meeting the needs of students with chronic health conditions can be found in a series of briefs recently released by CDC (54-56).

Specific to counseling, psychological, and social services, SHPPS 2016 found significant improvements since 2000 in collaboration among district-level staff working on activities in this area. Further, since 2000, the percentage of districts that had someone to oversee and coordinate counseling, psychological, or social services in the district also increased. These improvements in infrastructure can help better meet the counseling, psychological, and social services needs of students.

Regarding employee wellness, SHPPS 2016 revealed a significant increase since 2006 in the percentage of districts that require each school to have someone to oversee or coordinate employee wellness programs, as well as in the percentage that provided funding for health risk appraisals or offered health risk appraisals for employees. Despite these positive changes, however, the prevalence of this requirement and this practice remain low, which indicates areas for further improvement in supporting wellness programs for school employees.

Healthy and Safe School Environment (includes Social and Emotional Climate)

Districts use a variety of policies and practices to ensure students and staff are safe from unintentional injuries. SHPPS 2016 found that most districts have policies related to the inspection and maintenance of school safety systems or supplies (e.g., fire extinguishers, smoke alarms, sprinkler systems), the school building (e.g., lighting, classrooms, halls), and physical activity facilities and equipment. Since 2012, the percentage of districts that required students to use hearing protection devices during classes or activities where they are exposed to potentially unsafe noise levels increased significantly to 61.3%.

The *Surgeon General's Call to Action to Prevent Skin Cancer* (57) promotes policies that encourage sun safety in schools, because not only do such policies offer protection to students during the school day, but they also can support broader community efforts to reduce skin cancer risk. However, fewer than half of districts recommended and almost no districts required a variety of policies and practices related to sun safety such as allowing or encouraging students to apply sunscreen while at school and encouraging students to wear hats or visors, protective clothing, or sunglasses when in the sun during the school day.

Other district policies and practices address school violence and security. Policies requiring faculty and staff and visitors to wear identification badges at all school levels (elementary, middle, and high school) increased significantly since 2006, and policies requiring high school students to wear identification badges increased significantly since 2000. Likewise, policies requiring schools at all three levels to use security or surveillance cameras increased significantly since 2006. District policies requiring high school students to wear school uniforms, requiring high schools to enforce student dress codes, and requiring schools at all levels to prohibit gang activity (e.g., recruiting or wearing gang colors, symbols, or other gang attire) all significantly increased since 2000. However, policies requiring elementary and middle schools to assign staff or adult volunteers to monitor school halls during classes and requiring middle and high schools to assign staff or adult volunteers to monitor school restrooms have decreased significantly since 2006. Policies requiring students in middle and high schools to refrain from using personal communication devices (e.g., cell phones) during the school day decreased significantly since 2012. Except in relatively rare instances, schools remain safe places for students and staff. The Task Force on Community Preventive Services concluded that universal school-based violence prevention programs—that is, programs administered to all students in classrooms and not to only those

students who have already exhibited violent or aggressive behavior or have risk factors for these behaviors—can be effective in addressing school violence (58).

Nearly every district prohibits bullying and sexual harassment on school property, at any location on the way to and from school (e.g., school bus stops), and at off-campus, school-sponsored events; 71.9% of districts have a policy prohibiting bullying that lists (or enumerates) groups with specific traits or characteristics. The percentage of districts that prohibited electronic aggression or cyber-bullying that interferes with the educational environment (even if it does not occur on school property or at school-sponsored events) increased significantly since 2012 such that nearly all districts (93.2%) had such a policy. This increase follows increased attention throughout the 2000s and into the 2010s to bullying in general, but especially to electronic aggression as schools began to struggle to balance off-campus cyber-bullying behavior and school discipline (59, 60).

Another way to keep schools safe is to have a crisis preparedness, response, and recovery plan. These plans help schools respond quickly and efficiently in a crisis (61, 62). Nearly all districts (94.6%) had a comprehensive district-level plan to address crisis preparedness, response, and recovery in the event of a natural disaster or other emergency or crisis situation, and since 2006, there has been a significant increase in the percentage of districts that evaluated or assessed the district's crisis preparedness, response, and recovery plan during the 12 months before the study.

The percentage of districts that had adopted a student drug-testing policy increased significantly from 2006 to 2012 such that more than one third (37.5%) have such a program. Although the effectiveness of such programs is controversial (63), it is generally agreed that if testing is used, it should not be a stand-alone drug use prevention strategy (64). During 2000 to 2012, many tobacco-related policies increased, such as prohibiting students from wearing tobacco brand-name apparel or carrying merchandise with tobacco company names, logos, or cartoon characters on it, as well as numerous policies related to tobacco use among faculty and staff and among school visitors. Further, most districts prohibited the use of electronic vapor products (e.g., e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens) among students (81.8%), among faculty and staff during any school-related activity (77.3%), and among visitors (75.7%).

In spite of these positive tobacco-related findings, however, during 2006 to 2012, the percentage of districts that provided funding for professional development or offered professional development for school faculty and staff on how to implement school-wide policies and programs related to alcohol use prevention, illegal drug use prevention, and tobacco use prevention decreased, and the percentage of districts with a district-level council, committee, or team that addressed alcohol or other drug use prevention, HIV prevention, and tobacco use prevention decreased. In 2012, 61.0% of districts had a district-level school health council, committee, or team, but since 2000, the percentage of districts that during the two years before the study had provided any funding for or offered to help schools establish a school health council, committee, or team decreased significantly. Through school health councils, schools can work with community partners to identify and find solutions to health problems and concerns, not just for substance use, but for any school health topic the school and community determines to be a priority (65).

The 2015 *Step it up! The Surgeon General's Call to Action to Promote Walking and Walkable Communities* recognizes the benefits of active school transport and encourages walking to school through community-wide approaches that address safety concerns (66). The percentage of students who walk or bike to school is influenced by the distance students live from school and school programs and policies that support walking or biking to school (65). Despite a significant increase since 2006 in the percentage of districts that support or promote walking or biking to and from school, in 2016 only 32.9% of districts did this. Recognizing the health benefits of physical activity and the need for more active school transport, the National Center for Safe Routes to School provides resources related to building a safe routes to school program that involves school and community partners (http://www.saferoutesinfo.org).

Physical Environment

EPA developed their School Siting Guidelines (42) for school districts considering new school construction. The document recommends a variety of environmental and public health factors to be considered such as community involvement, environmental evaluation of candidate sites and nearby environments, environmental justice, possibilities for renovation, transportation alternatives (e.g., walking, biking, and public transit), community uses of the school, and costs and benefits of various design and construction decisions (42). In line with these guidelines, SHPPS examined factors that are influential in deciding whether to build a new school facility rather than renovating an existing facility, where to build a new school facility, formal consultation policies related to new school construction, and green building policies.

Among districts that had initiated the construction of a school facility on a new school site during the five years before the study, only three factors were deemed "very

influential" among 50% or more districts in deciding to build a new school rather than renovate an existing school: the need to support current or future educational programs, the need to accommodate population growth, and the cost of repairing the existing facility. In deciding where to build the new school facility, the only factor deemed "very influential" by more than half of districts was that the site was already owned. Among all districts, the public was the most common group with which districts required formal consultation or input on new school construction (67.5%) and where to build a new school (55.8%). Finally, although the percentage of districts that had a policy to include green design when building new school buildings or renovating existing buildings more than doubled since 2006, only 28.0% of districts had such a policy. Even so, more than half of districts had adopted specific green building policies, even if not part of a more general green building design policy. These specific policies included the use of energy efficient lighting and electrical systems, the implementation of recycling programs, and the use of procedures or systems to protect indoor air quality. Eventually all school districts will find themselves faced with a decision about renovating existing schools and building new schools. The U.S. EPA's voluntary School Siting Guidelines (42) and Smart School Siting Tool (67) can assist schools faced with the decision about where to build a new school and offer insights into improving the extent to which the environment and public health are influencing factors in school siting and building decisions.

Although the percentage of districts that had an indoor air quality management program decreased significantly since 2006, less than half (48.9%) of districts had such a program in 2016, suggesting that many districts could benefit from EPA's resources developed to help school districts and schools address indoor air quality (68). According to EPA, "good indoor air quality management includes control of airborne pollutants, introduction and distribution of adequate outdoor air, and maintenance of acceptable temperature and relative humidity" (68). SHPPS examined many policies related to indoor air quality and found wide variation in how common the policies were. For example, 77.0% of districts required schools to conduct periodic inspections of the heating, ventilation, and air conditioning system and 71.3% required schools to conduct periodic inspections of the building foundation, walls, and roof for cracks, leaks, or past water damage. However, only about one third required purchase of low-emitting products for use around the school and on school grounds and required schools to test for radon. Radon is a colorless, odorless radioactive gas determined by EPA to be one of the most serious environmental health problems facing people today (69). EPA recommends that all schools nationwide be tested for radon and provides resources to address radon measurement, mitigation, and prevention (69).

Engine idling reduction programs are another way schools can address indoor air quality. Such programs were implemented in 49.2% of districts for buses and in 16.5% of districts for cars. Idling reduction programs are meant to address exhaust from buses, cars, and trucks and are an important part of both outdoor air quality and indoor air quality because exhaust can infiltrate a school through windows, doors, and vents (70).

An integrated pest management (IPM) approach to pest management addresses pests' sources of food, water, and shelter so that pest infestation is minimized or prevented entirely, and the need for pesticides is limited (71). This study found 87.4% of districts used an IPM approach to pest management, though requirements for specific IPM strategies varied considerably. SHPPS 2016 found significant improvements since 2006 in the percentage of districts that provided funding for professional development or offered professional development for school faculty and staff during the two years before the study on how to implement school-wide policies and programs related to integrated pest management.

Part of a safe and healthy school environment includes access to safe drinking water because of both the health and academic consequences of exposure to lead or other contaminants that can be found in school drinking water (72). In particular, lead is of concern because even if water enters the school site lead free, lead can leach into school water once it comes in contact with the plumbing materials on the school site (72, 73). Unfortunately, only half (50.0%) of districts required schools to conduct periodic inspections that test drinking water outlets for lead. Less than one third of districts required schools to test drinking water at least once per year for bacteria, coliforms, or other contaminants. Running tap water or "flushing" can reduce lead levels in water by removing the water with the most lead from the drinking water system (73), but only 18.3% of districts required schools to flush drinking water outlets after periods of non-use (e.g., after weekends or school vacations).

For many communities, not only can schools offer a safe, accessible, and affordable place for community members to engage in physical activity outside of school hours (74), but they also can host a variety of student and community social services and amenities (75). SHPPS defined a formal joint use agreement as a formal written agreement between the school district and another public or private entity to jointly use or share either school facilities or community facilities to share costs and responsibilities. More than half (54.6%) of districts had such an agreement that allows community members or groups to use school facilities and 29.3% had such an

agreement allowing students to use community facilities such as a park or recreation center. Joint use agreements applied to a variety of uses with the three most common being indoor recreation, outdoor recreation, and emergency response (e.g., emergency food or shelter). ChangeLab Solutions provides strategies to address some common concerns schools have in implementing such agreements such as costs, liability, security, or maintenance (74).

Because such a diverse set of strategies is needed to keep the school environment healthy and safe, trained personnel are critical. SHPPS found that 57.6% of districts required a newly hired person who oversees custodial, maintenance, and environmental issues to have any formal training in issues related to the physical environment of buildings and health hazards likely to be encountered in schools. Since 2012, a significant decrease was found in the percentage of districts that provided funding for training or offered training to custodial or maintenance staff on how to reduce the use of hazardous materials. Relatedly, the percentage of districts that had one or more school health councils, committees, or teams that include representatives from school maintenance staff and school transportation staff decreased significantly between 2012 and 2016. These results indicate room for improvement in the training and utilization of school maintenance staff.

Conclusion

This discussion has highlighted some of the key results from SHPPS 2016, but the results presented in the tables of this report provide a much more detailed view of district-level school health policies and practices. Although these tables provide 95% confidence intervals, allowing for quick comparisons of differences between variables, more sophisticated analyses of these data also are possible. Those wanting to conduct secondary analyses can find all datasets and documentation at www.cdc.gov/shpps. Results in this report will be used by CDC and others working in the field of school health, including state education and health agencies, to help public school districts strengthen their school health policies and practices, which in turn can help improve health outcomes for the millions of young people attending public schools in the United States.

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