

ITEM RATIONALE
2016 SCHOOL HEALTH PROFILES
SCHOOL PRINCIPAL QUESTIONNAIRE

QUESTION:

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

RATIONALE:

This question assesses whether the school has conducted an assessment or diagnosis as a critical first step in improving implementation of policies, programs, or environmental strategies to effect change or improvement in school health.¹ Studies confirm that the School Health Index² helps bring health issues to the school's attention, builds school commitment, identifies changes that do not require resources, encourages development of policy and action, raises awareness of federal policies, and helps schools set policies and standards that meet national health objectives.³⁻⁷

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

2. The Elementary and Secondary Education Act requires certain schools to have a written School Improvement Plan (SIP). Many states and school districts also require schools to have a written SIP. Does your school's written SIP include health-related objectives on any of the following topics?
3. During the past year, did your school review health and safety data such as Youth Risk Behavior Survey data or fitness data as part of your school's improvement planning process?

RATIONALE:

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

REFERENCES:

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2. Grossman M, Kaestner R. Effects of education on health. In: Behrman JR, Stacey N, eds. *The Social Benefits of Education*. Ann Arbor, MI: University of Michigan Press, 1997.
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4. Vernez G, Krop RA, Rydell CP. The public benefits of education. In: *Closing the Education Gap: Benefits and Costs*. Santa Monica, CA: RAND Corporation, 1999, pp. 13–32.
5. Association for Supervision and Curriculum Development, Centers for Disease Control and Prevention. *Whole School, Whole Child, Whole Community: A Collaborative Approach to Learning and Health*. Alexandria, VA: Association for Supervision and Curriculum Development, 2014. Available at:

QUESTION:

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

RATIONALE:

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

REFERENCES:

1. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.
 2. Lohrmann DK. A complementary ecological model of the coordinated school health program. *Journal of School Health* 2010; 80(1):1-9.
 3. Fetro JV. Implementing coordinated school health programs in local schools. In: Marx E, Wooley S, eds. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York, NY: Teachers College Press, 1998.
 4. American Cancer Society. *School Health Program Elements of Excellence: Helping Children to Grow Up Healthy and Able to Learn*. Atlanta, GA: American Cancer Society, 2000.
 5. National Association of State Boards of Education. *Fit, Healthy, and Ready to Learn: A School Health Policy Guide*. Washington, DC: National Association of State Boards of Education, 2000.
 6. American Cancer Society. *Improving School Health: A Guide to the Role of School Health Coordinator*. Atlanta, GA: American Cancer Society, 1999.
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QUESTION:

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

RATIONALE:

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

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

REFERENCES:

1. National Association of State Boards of Education. *Fit, Healthy, and Ready to Learn: A School Health Policy Guide*. National Association of State Boards of Education. Washington, DC: NASBE, 2000.
2. Shirer K. *Promoting Healthy Youth, Schools and Communities: A Guide to Community-School Health Councils*. Atlanta, GA: American Cancer Society, 2003.
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4. Fetro JV. Implementing coordinated school health programs in local schools. In: Marx E, Wooley S, eds. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York, NY: Teachers College Press, 1998, pp. 15-42.
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QUESTION:

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

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

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

RATIONALE:

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

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

REFERENCES:

1. National Association of State Boards of Education. *Fit, Healthy, and Ready to Learn: A School Health Policy Guide*. Washington, DC: National Association of State Boards of Education, 2012.
2. Shirer, K. *Promoting Healthy Youth, Schools, and Communities: A Guide to Community-School Health Councils*. Atlanta, GA: American Cancer Society, 2003.
3. Fetro JV. Implementing coordinated school health programs in local schools. In: Marx E, Wooley S, eds. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York, NY: Teachers College Press, 1998, pp. 15-43.

4. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.
 5. North Carolina Department of Public Instruction. *Effective School Health Advisory Councils: Moving from Policy to Action*. Raleigh, NC: North Carolina Department of Public Instruction, 2003.
 6. Lee S, Burgeson C, Fulton J, Spain C. Physical education and physical activity: Results from the School Health Policies and Programs Study 2006. *Journal of School Health* 2007; 77(8):435–463.
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 8. Centers for Disease Control and Prevention. *A Guide for Developing Comprehensive School Physical Activity Programs*. Atlanta, GA: U.S. Department of Health and Human Services; 2013.
 9. Centers for Disease Control and Prevention. *School Health Index: A Self-Assessment and Planning Guide. Elementary school version*. Atlanta, GA: Centers for Disease Control and Prevention, 2014.
 10. Centers for Disease Control and Prevention. *School Health Index: A Self-Assessment and Planning Guide. Middle school/high school version*. Atlanta, GA: Centers for Disease Control and Prevention, 2014.
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QUESTIONS:

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

RATIONALE:

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

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

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

REFERENCES:

1. Battistich V, Schaps E, Watson MS, Solomon D. Prevention effects of the Child Development Project: early findings from an ongoing multisite demonstration trial. *Journal of Adolescent Research* 1996; 11(1):12–35.
 2. Centers for Disease Control and Prevention. *School Connectedness: Strategies for Increasing Protective Factors among Youth*. Atlanta, GA: U.S. Department of Health and Human Services, 2009.
 3. Ryan AM, Patrick H. The classroom social environment and changes in adolescents' motivation and engagement during middle school. *American Educational Research Journal* 2001; 38(2):437–460.
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SEXUAL ORIENTATION

QUESTION:

9. Does your school have a student-led club that aims to create a safe, welcoming, and accepting school environment for all youth, regardless of sexual orientation or gender identity? These clubs are sometimes called gay/straight alliances.
10. Does your school engage in each of the following practices related to lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth?

RATIONALE:

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

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

REFERENCES:

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

2. Kann L, Olsen E, McManus T, et al. Centers for Disease Control and Prevention. Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9–12 — Youth Risk Behavior Surveillance, Selected Sites, United States, 2001–2009. *MMWR Early Release* 2011; 60:1-133.
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 4. U.S. Department of Health and Human Services. *Healthy People 2020*. Washington, DC: U.S. Department of Health and Human Services, 2010. Available at: www.healthypeople.gov/2020/topicobjectives2020/overview.aspx?topicid=25. Accessed June 15, 2015.
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BULLYING AND SEXUAL HARASSMENT

QUESTIONS:

11. During the past year, did all staff at your school receive professional development on preventing, identifying, and responding to student bullying and sexual harassment, including electronic aggression?
12. Does your school have a designated staff member to whom students can confidentially report student bullying and sexual harassment, including electronic aggression?
13. Does your school use electronic (e.g., e-mails, school website), paper (e.g., flyers, postcards), or oral (e.g., phone calls, parent seminars) communication to publicize and disseminate policies, rules, or regulations on bullying and sexual harassment, including electronic aggression?

RATIONALE:

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

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

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

REFERENCES:

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

2. Hill C, Kearl H. *Crossing the Line: Sexual Harassment at School*. Washington, DC: American Association of University Women Educational Foundation, 2011.
 3. Vreeman RC, Carroll AE. A systematic review of school-based interventions to prevent bullying. *Archives of Pediatrics & Adolescent Medicine* 2007; 161(1):78-88.
 4. Smokowski P, Kopasz, KH. Bullying in school: an overview of types, effects, family characteristics, and intervention strategies. *Children & Schools* 2005; 27(2):101-110.
 5. Farrington DP, Ttofi MM. School-based programs to reduce bullying and victimization. *Campbell Systematic Reviews* 2009; 6.
 6. Office for Civil Rights, U.S. Department of Education. Revised Sexual Harassment Guidance: Harassment of Students by School Employees, Other Students, and Third Parties. 2001. Available at: <http://www.ed.gov/about/offices/list/ocr/docs/shguide.pdf>. Accessed June 15, 2015.
 7. Charmaraman L, Jones AE, Stein N, Espelage DL. Is it bullying or sexual harassment? Knowledge, attitudes, and professional development experiences of middle school staff. *Journal of School Health* 2013; 83(6):438-44.
 8. U.S. Department of Health and Human Services in partnership with the Department of Education and the Department of Justice. Respond to bullying. Available at: <http://www.stopbullying.gov/respond/index.html>. Accessed June 15, 2015.
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REQUIRED PHYSICAL EDUCATION

QUESTION:

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

RATIONALE:

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

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

REFERENCES:

1. SHAPE America. *National Standards & Grade-level Outcomes for K-12 Physical Education*. Champaign, IL: Human Kinetics, 2014.
2. SHAPE America. *The Essential Components of Physical Education*. Reston, VA: SHAPE America, 2015.
3. Lee SM, Burgeson CR, Fulton JE, Spain CG. Physical education and activity: results from the School Health Policies and Programs Study 2006. *Journal of School Health* 2007; 77(8):435-463.
4. Centers for Disease Control and Prevention. School health guidelines to promote healthy eating and physical activity. *MMWR* 2011; 60(No. RR-5).
5. Institute of Medicine. *Educating the Student Body: Taking Physical Activity and Physical Education to School*. Harold W. Kohl III and Heather D. Cook, eds; Committee on Physical Activity and Physical Education in the School Environment; Food and Nutrition Board; Institute of Medicine. Washington DC: The National Academies Press, 2013. Available at: http://www.nap.edu/catalog.php?record_id=18314. Accessed June 15, 2015.
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www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=33. Accessed June 15, 2015.

PHYSICAL EDUCATION AND PHYSICAL ACTIVITY

QUESTION:

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

RATIONALE:

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

REFERENCES:

1. SHAPE America. *National Standards & Grade-level Outcomes for K-12 Physical Education*. Champaign, IL: Human Kinetics, 2014.
2. SHAPE America. *The Essential Components of Physical Education*. Reston, VA: SHAPE America, 2015.
3. Centers for Disease Control and Prevention. School health guidelines to promote healthy eating and physical activity. *MMWR* 2011; 60(No. RR-5).
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5. McKenzie TL, Feldman H, Woods SE, et al. Children's activity levels and lesson context during third-grade physical education. *Research Quarterly for Exercise and Sport* 1996; 66(3):184-193.
6. Kelder S, Mitchell PD, McKenzie TL, et al. Long-term implementation of the CATCH physical education program. *Health Education and Behavior* 2003; 30(4):463-475.

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

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

RATIONALE:

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

REFERENCES:

1. Centers for Disease Control and Prevention. School health guidelines to promote healthy eating and physical activity. *MMWR* 2011; 60(No. RR-5).
 2. Institute of Medicine. *Educating the Student Body: Taking Physical Activity and Physical Education to School*. Harold W. Kohl III and Heather D. Cook, eds; Committee on Physical Activity and Physical Education in the School Environment; Food and Nutrition Board; Institute of Medicine. Washington DC: The National Academies Press, 2013. Available at: http://www.nap.edu/catalog.php?record_id=18314. Accessed June 15, 2015.
 3. SHAPE America. *National Standards & Grade-level Outcomes for K-12 Physical Education*. Champaign, IL: Human Kinetics, 2014.
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 5. Centers for Disease Control and Prevention. *Physical Education Curriculum Analysis Tool*. Atlanta, GA: U.S. Department of Health and Human Services, 2014. Available at <http://www.cdc.gov/healthyyouth/PECAT/>. Accessed June 11, 2015.
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QUESTION:

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

RATIONALE:

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

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

REFERENCES:

1. U.S. Department of Health and Human Services. *2008 Physical Activity Guidelines for Americans*. Washington, DC: U.S. Department of Health and Human Services, 2008.
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 3. Centers for Disease Control and Prevention. *A Guide for Developing Comprehensive School Physical Activity Programs*. Atlanta, GA: US Department of Health and Human Services, 2013.
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QUESTIONS:

18. Does your school offer opportunities for students to participate in intramural sports programs or physical activity clubs? (Intramural sports programs or physical activity clubs are any physical activity programs that are voluntary for students, in which students are given an equal opportunity to participate regardless of physical ability.)
19. Does your school offer interscholastic sports to students?
20. Does your school offer opportunities for students to participate in physical activity before the school day through organized physical activities or access to facilities or equipment for physical activity?

RATIONALE:

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

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

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

REFERENCES:

1. Physical Activity Guidelines for Americans Midcourse Report Subcommittee of the President's Council on Fitness, Sports & Nutrition. *Physical Activity Guidelines for Americans Midcourse Report: Strategies to Increase Physical Activity among Youth*. Washington, DC: U.S. Department of Health and Human Services, 2012.
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6. Pate RR, Saunders RP, Ward DS, Felton G, Trost SG, Dowda M. Evaluation of a community-based intervention to promote physical activity in youth: lessons from Active Winners. *American Journal of Health Promotion* 2003; 17(3):171-82.
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QUESTION:

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

RATIONALE:

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

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

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TOBACCO-USE PREVENTION POLICIES

QUESTIONS:

22. Has your school adopted a policy prohibiting tobacco use?
23. Does the tobacco-use prevention policy specifically prohibit use of each type of tobacco for each of the following groups during any school-related activity?
24. Does the tobacco-use prevention policy specifically prohibit tobacco use during each of the following times for each of the following groups?
25. Does the tobacco-use prevention policy specifically prohibit tobacco use in each of the following locations for each of the following groups?
26. Does your school post signs marking a tobacco-free school zone, that is, a specified distance from school grounds where tobacco use is not allowed?

RATIONALE:

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

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

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

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

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QUESTIONS:

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

RATIONALE:

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

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NUTRITION-RELATED POLICIES AND PRACTICES

QUESTIONS:

29. When foods or beverages are offered at school celebrations, how often are fruits or non-fried vegetables offered?
30. Can students purchase snack foods or beverages from one or more vending machines at the school or at a school store, canteen, or snack bar?
31. Can students purchase each of the following snack foods or beverages from vending machines or at the school store, canteen, or snack bar?

RATIONALE:

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

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

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QUESTION:

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

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

RATIONALE:

This question addresses the variety of methods schools can use to promote healthy eating. Students' food choices are influenced by the total food environment. The simple availability of fruits and vegetables may not be sufficient to prompt the choice of these items when items high in fat and/or added sugar are also available.¹ Even when healthful foods (e.g. fruits and vegetables) are available, they compete in the context of a vast array of other food items, mostly high in fat and sugar, that are competitively priced.² Schools should employ effective or promising strategies in the school setting to promote healthy eating, such as pricing strategies,^{3,4} input from stakeholders,⁵ provision of nutrition information,⁶ taste tests, using the cafeteria as a learning laboratory,⁷ school gardens⁸ and serving locally or regionally grown foods in the cafeteria or classrooms.⁹ Additional promising strategies include placing fruit and vegetables near the cafeteria cashier, where they are easy to access,¹⁰ using attractive displays for fruits and vegetables in the cafeteria,¹⁰ labeling healthful foods with appealing names,¹⁰ offering a self-serve salad bar to students,^{11,12} and encouraging students to drink plain water.¹³⁻¹⁵ Additionally schools can implement practices that limit access to less healthful foods and beverages including prohibiting school staff from giving students food or food coupons as a reward for good behavior or good academic performance,^{15,16} and prohibiting less nutritious foods and beverages (e.g., candy, baked goods) from being sold for fundraising purposes^{15,16}

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

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QUESTION:

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

RATIONALE:

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

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

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

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QUESTIONS:

34. Are students permitted to have a drinking water bottle with them during the school day?
35. Does your school offer a free source of drinking water in the following locations?

RATIONALE:

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

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

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

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HEALTH SERVICES

QUESTION:

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

RATIONALE:

These questions examine the degree to which schools are being staffed by school nurses. Because a school nurse is an essential component of a healthy school, *Healthy People 2020* Educational and Community-Based Program objective-5 calls to increase the proportion of the Nation's elementary, middle, and senior high schools that have a full-time registered school nurse-to-student ratio of at least 1:750.¹ School nurses, whether part- or full-time can link students and schools to physician and community resources in addition to providing services to students in schools.

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QUESTION:

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

RATIONALE:

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

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

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QUESTIONS:

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

RATIONALE:

These questions address students' access to sexual health services either provided on-site or through referrals to health care professionals not on school property. Many adolescents engage in sexual risk behaviors that can result in unintended health outcomes. In 2013, among U.S. high school students, almost half reported ever having had sex. Of those sexually active in the previous 3 months, about a third did not use a condom.¹ In 2010, young people aged 13-24 accounted for 26% of all new HIV infections in the United States.² Of the 19.7 million incident sexually transmitted infections in 2008, nearly 50% (9.8 million) were acquired by young women and men aged 15 to 24 years.³ Several official and national guidelines for adolescent preventive care specifically include recommendations for the provision of sexual health services for adolescents.⁴⁻⁷ Schools in the United States have a critical role to play in facilitating delivery of such needed preventive services for adolescents; schools have direct daily contact with 31.7 million students ages 10-17.⁸ Many U.S. schools already have health care service infrastructure in place and can play an important role in providing adolescents access to sexual health services.

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

REFERENCES:

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

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QUESTIONS:

41. Does your school have a protocol that ensures students with a chronic condition that may require daily or emergency management (e.g., asthma, diabetes, food allergies) are enrolled in private, state, or federally funded insurance programs if eligible?
42. Does your school routinely use school records to identify and track students with a current diagnosis of the following chronic conditions? School records might include student emergency cards, medication records, health room visit information, emergency care and daily management plans, physical exam forms, or parent notes.

RATIONALE:

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

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

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

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

REFERENCES:

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

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

RATIONALE:

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

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

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QUESTION:

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

RATIONALE:

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

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

REFERENCES:

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FAMILY AND COMMUNITY INVOLVEMENT

QUESTIONS:

46. During this school year, has your school done any of the following activities?...
- (a) Provided parents and families with information about how to communicate with their child about sex...
 - (b) Provided parents with information about how to monitor their child (e.g., setting parental expectations, keeping track of their child, responding when their child breaks the rules)...
 - (c) Involved parents as school volunteers in the delivery of health education activities and services...
 - (d) Linked parents and families to health services and programs in the community
47. Does your school use electronic (e.g., e-mails, school web site), paper (e.g., flyers, postcards), or oral (e.g., phone calls, parent seminars) communication to inform parents about school health services and programs?

RATIONALE:

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

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

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

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QUESTION:

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

RATIONALE:

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

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

REFERENCES:

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QUESTIONS:

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

RATIONALE:

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

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

REFERENCES:

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

QUESTION:

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

RATIONALE:

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

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

REFERENCES:

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