

INTRODUCTION

In the United States, more than 55 million young people are enrolled in elementary and secondary schools.¹ Because young people attend school about six hours a day approximately 180 days per year, schools are in a unique position to help improve the health status of children and adolescents throughout the United States. The Centers for Disease Control and Prevention (CDC), in collaboration with state and local education and health agencies, developed the School Health Profiles (Profiles) to measure school health policies and practices. Profiles has been conducted biennially since 1996 and includes state, local, territorial, and tribal surveys of principals and lead health education teachers in middle and high schools. Profiles helps state, local, territorial, and tribal education and health agencies monitor and assess characteristics of and trends in school health education; physical education; school health policies related to human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) prevention, tobacco-use prevention, and competitive foods (i.e., foods and beverages sold outside of the United States Department of Agriculture [USDA] school meal programs); asthma management activities; and family and community involvement in school health programs.

The broad focus of Profiles is designed to provide information on 5 of the 8 components of coordinated school health:²⁻⁴

- **Health education** gives students opportunities to acquire the knowledge, attitudes, and skills they need to make health-promoting decisions, achieve health literacy, adopt health-enhancing behaviors, reduce health-related risk behaviors, and promote the health of others. Students are provided with a planned, sequential curriculum that addresses the physical, mental, emotional, and social dimensions of health. Health education allows students to demonstrate increasingly sophisticated health-related knowledge, attitudes, skills, and practices.
- **Physical education** provides students with a planned, sequential curriculum that provides cognitive content and learning experiences in various activity areas. Quality physical education should promote, through a variety of planned physical activities, each student's optimum physical, mental, emotional, and social development, and should promote activities and sports that all students enjoy and can pursue throughout their lives.
- **Health services** are provided for students to appraise, protect, and promote health. These services are designed to ensure access or referral to primary health care services or both, foster appropriate use of primary health care services, prevent and control communicable disease and other health problems, provide emergency care for illness or injury, promote and provide optimum sanitary conditions for a safe school facility and school environment, and provide educational and counseling opportunities for promoting and maintaining individual, family, and community health.
- **Healthy and safe school environment** refers to the physical and aesthetic surroundings and the psychosocial climate and culture of the school. A safe, positive physical and psychosocial environment helps to prevent school failure, substance use, and violence. Schools can create a safe and supportive

environment by implementing school health policies and activities that support the health and well-being of all students at the school.

- **Family and community involvement**

provides an integrated school, parent, and community approach for enhancing the health and well-being of students. School health advisory councils, coalitions, and broad based constituencies for school health can build support for school health program efforts. Schools can actively solicit parent involvement and engage community resources and services to respond more effectively to the health-related needs of students. Family involvement also can help family members become more knowledgeable about health issues, thereby enabling them to serve as positive role models and reinforce healthy behaviors at home.

In addition to providing information related to all of these areas, Profiles also provides data to measure School Level Impact Measures (SLIMs). SLIMs are measures of the percentage of secondary schools in a jurisdiction that are implementing policies and practices recommended by CDC to address critical health problems faced by children and adolescents. They are based on research findings and derived from CDC

scientific guidance documents. SLIMs are used as performance measures for the state, territorial, and local agencies and tribal governments funded by CDC to improve the health of young people through school policies and programs. See www.cdc.gov/dash/program_mgt/801_resources.htm for more information about SLIMs.

This report summarizes 2010 Profiles data. For each middle or high school that was sampled, the principal and the lead health education teacher (i.e., the person most knowledgeable about health education at the school) each completed a self-administered questionnaire. This report presents information from 47 states, 19 cities, 4 territories, and 2 tribal governments with weighted data from both principal and lead health education teacher surveys and 2 states (Colorado and New Mexico) and 1 territory (Marshall Islands) with weighted data from the principal survey only (Table 1). Principal and lead health education teacher data from Illinois and Puerto Rico were unweighted and are not included in this report. Palm Beach County obtained weighted data but did not grant CDC permission to include their data in this report. This report also examines both long-term (1996–2010) and short-term (2008–2010) trends in school health policies and practices among states and cities with weighted data for both years.

METHODS

SAMPLING

Profiles employs random, systematic, equal-probability sampling strategies to produce representative samples of schools that serve students in grades 6 through 12 in each jurisdiction. In most jurisdictions, the sampling frame consists of all regular secondary public schools with one or more of grades 6 through 12. In 2010, 13 states, 16 cities, all 5 territories, and both tribal governments modified this sampling procedure and invited all secondary schools, rather than just a sample, to participate (Table 1).

DATA COLLECTION

For the 2010 Profiles cycle, all 49 states, 19 cities, 5 territories, and 2 tribal governments included in this report collected data from each sampled school during the 2010 spring semester. Both the principal and lead health education teacher questionnaire booklets are mailed by the state, local, or territorial education or health agency or the tribal government to the principal, who then designates the school's lead health education teacher to complete the teacher questionnaire. Participation in the survey is confidential and voluntary; follow-up telephone calls, emails, and written reminders are used to encourage participation. The principal and teacher record their responses in the computer-scannable questionnaire booklets and return them directly to the state, local, or territorial education or health agency, or tribal government.

In 2010, eight states (Colorado, Delaware, Maryland, Pennsylvania, South Carolina, Washington, West Virginia, and Wisconsin) conducted Profiles using Web-based software

that contained the same questions as the computer-scannable questionnaire booklets. Respondents who had difficulty with the Web-based system or who did not want to use it were offered paper questionnaires. Responses to these paper questionnaires were then entered into the Web-based system. Data collected via Web-based systems were processed using the same procedures as those used for the computer-scannable booklets.

DATA ANALYSIS

Data from states and cities that had response rates of 70% or greater and appropriate documentation (separately for the principal and teacher surveys) were weighted. The data are weighted to reflect the likelihood of principals or teachers being selected and to adjust for differing patterns of nonresponse.

Across states, the sample sizes of the principal surveys ranged from 67 to 694, and response rates ranged from 70% to 90%; across cities, the sample sizes ranged from 25 to 277, and response rates ranged from 71% to 100%; and across territories, the sample sizes ranged from 8 to 68, and response rates ranged from 80% to 100% (Table 1). The sample sizes of the lead health education teacher surveys across states ranged from 65 to 677, and response rates ranged from 70% to 86%; across cities, the sample sizes ranged from 21 to 271, and the response rates ranged from 70% to 100%; and across territories, the sample sizes ranged from 8 to 26, and the response rates ranged from 90% to 100%. The sample descriptions for the two participating tribal governments can be found in Table 1.

SAS software was used to compute point estimates.⁵ Medians and ranges are presented separately for states, cities, and territories, and are available in the Results section and in Tables 2-48. Because only two tribal governments conducted surveys, medians and ranges are not presented among tribes. Data for all variables by site, including tribal governments, are available in Tables 2-48.

Analyses of long-term trends were conducted for 33 variables and included only the 23 states and 9 cities with weighted data available for 1996 and 2010 for the teacher questionnaire. Long-term trend analyses were not conducted for the principal questionnaire because no variables appeared on both the 1996 and 2010 versions of that questionnaire. Analyses of short-term trends were conducted for 147 variables from the principal questionnaire and 167 variables from the teacher questionnaire. These analyses included only the states and cities with weighted data available for both 2008 and 2010: 46 states and 17 cities for the principal questionnaire and 45 states and 17 cities for the teacher questionnaire. The Wilcoxon rank-sum test was used to test for differences between 1996 and 2010 data and between 2008 and 2010 data across states and cities. This is a nonparametric analogue to a two sample t-test⁶ and provides the greatest power under logistic distributions.⁷ This statistical procedure (1) rank ordered all

sites for both years separately for states and cities, (2) summed the ranks separately by year and for states and cities, and (3) compared the rank sums separately for states and cities to determine whether the distribution of a variable was the same for 1996 and 2010, or for 2008 and 2010. Assuming the percentages have an underlying continuous distribution, the distribution of ranks is approximately normal; however, because of the small sample sizes, 2-tailed p values were obtained from the t distribution rather than from the normal distribution. Because multiple comparisons were made, the distributions were considered statistically significantly different if p was less than or equal to 0.01. Only statistically significant trend analyses are reported; the remaining variables examined did not show significant change over time.

To analyze long-term trends, some variables from the 1996 Profiles were recalculated so that the denominators used for each year of data were defined identically. In most cases, this denominator included all schools, rather than a subset of schools. As a result of this recalculation, percentages previously reported for the 1996 Profiles might differ from those reported here. In addition, because trend analyses were restricted to the states and cities with weighted data available for both years, median percentages reported in the trend results differ from those reported elsewhere.

BACKGROUND

HEALTH EDUCATION

Curricula

Comprehensive health education includes curricula for students in all grades in elementary, middle, and high school, and covers a variety of topics.²⁻⁴ Reviews conducted by CDC and others have shown that effective health education curricula emphasize teaching functional health information; shaping personal values that support healthy behaviors; shaping group norms that value a healthy lifestyle; and developing the essential health skills necessary to adopt, practice, and maintain healthy behaviors.⁸ Less effective curricula often overemphasize teaching scientific facts and increasing student knowledge.⁸ In addition, effective curricula incorporate learning strategies, teaching methods, and materials that are age-appropriate, developmentally appropriate, and culturally inclusive.⁸

Standards

The *National Health Education Standards* are written expectations for what students should know and be able to do by specified grade levels to promote personal, family, and community health.⁹ The standards provide a framework for curriculum development and selection, instruction, and student assessment in health education. The most recent version of the *National Health Education Standards* was released in 2007 and includes the following:

1. Students will comprehend concepts related to health promotion and disease prevention to enhance health.
2. Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.

3. Students will demonstrate the ability to access valid information and products and services to enhance health.
4. Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.
5. Students will demonstrate the ability to use decision-making skills to enhance health.
6. Students will demonstrate the ability to use goal-setting skills to enhance health.
7. Students will demonstrate the ability to practice health-enhancing behaviors to avoid or reduce health risks.
8. Students will demonstrate the ability to advocate for personal, family, and community health.

Support for comprehensive, standards-based school health education is found in the following U.S. Department of Health and Human Services' *Healthy People 2020*¹⁰ objectives, under Educational and Community-Based Programs (ECBP):

- **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 that address the

knowledge and skills articulated in the *National Health Education Standards*.

Requirements

Adequate instructional time is necessary for learning to take place and to support the adoption and maintenance of healthy behaviors.^{8,11} The *National Health Education Standards* recommends that students in pre-kindergarten through grade 2 receive 40 hours of instruction in health education per year and students in grades 3 through 12 receive 80 hours of instruction per academic year.⁹ The importance of adequate instructional time in health education is articulated in a *Healthy People 2020*¹⁰ sub-objective, under Early and Middle Childhood (EMC): to increase the proportion of schools that require cumulative instruction in health education that meet the U.S. *National Health Education Standards* for elementary, middle, and senior high schools (EMC 4.3), as determined by the number of minutes of health education instruction provided.

Professional Preparation and Professional Development

The quality of school health education is determined, in part, by teacher preparation.¹² Professional development for teachers through continuing education and training is critical for the implementation of effective school health education.¹³⁻¹⁵ Professional development for health education teachers should focus on strategies that actively engage students and help them master important health information and skills.¹⁶ Studies have shown that teachers who receive training tend to implement health education with more fidelity than do teachers who do not receive such training, resulting in increased knowledge gain among students.¹⁴ The need for adequate teacher preparation and ongoing professional development for health education teachers is

supported by two *Healthy People 2020*¹⁰ EMC sub-objectives:

- **EMC-4.1:** Increase the proportion of schools that require newly hired staff who teach required health education to have undergraduate or graduate training in health education.
- **EMC-4.2:** Increase the proportion of schools that require newly hired staff who teach required health instruction to be certified, licensed, or endorsed by the State in health education.

PHYSICAL EDUCATION

Young people should participate in at least 60 minutes of physical activity daily. As part of this 60 minutes of daily activity, youth should engage in vigorous physical activity, muscle strengthening, and bone strengthening activities at least 3 days per week.¹⁷ Regular participation in physical activity as a young person contributes to healthy bone and muscle development, reduces feelings of depression and anxiety, and promotes psychological well-being.¹⁸ Further, regular physical activity reduces the risk for youth becoming overweight. As of 2008, 19.6% of 6-year-olds to 11-year-olds and 18.1% of 12-year-olds to 19-year-olds were considered obese.¹⁹ Many youth become less active as they move from childhood into adolescence and adulthood.²⁰⁻²³ Regular physical activity can reduce risk for the development of chronic diseases among adults, including cardiovascular disease, cancer, and diabetes. Because participation in physical activity as a young person influences participation in physical activity as an adult, it can contribute to decreased risk for the development of such chronic diseases.

Schools can play an important role in providing opportunities for physical activity, as well as teaching students the necessary knowledge, skills, and behaviors to establish and maintain

a physically active lifestyle. CDC's *Guidelines for School and Community Programs to Promote Lifelong Physical Activity among Young People*²⁴ recommends that schools adopt a comprehensive approach to physical activity by requiring daily physical education, teaching skills and knowledge for maintaining and enjoying a physically active lifestyle, and providing extracurricular physical activity programs. In 2002, the Task Force on Community Preventive Services published recommendations that communities can implement to increase physical activity among young people. The task force strongly recommended enhancing school-based physical education because of its effectiveness in increasing physical activity and improving physical fitness among children and adolescents.²⁵ Another review by CDC found that increased time in physical education may help, and does not appear to adversely affect, academic achievement,²⁶ an important finding as schools face challenges to allocate time for physical education amidst competing demands. Specific strategies for improving the quality of physical education and increasing the amount of time students are moderately to vigorously active during physical education class include implementing a high-quality, well-designed curriculum based on national, state, or local physical education standards and providing teachers with appropriate training and supervision.²⁷

The importance of physical education and activity in promoting the health of young people is also supported by the following *Healthy People 2020*¹⁰ physical activity (PA) objectives:

- **PA-3:** Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity.
- **PA-4:** Increase the proportion of the Nation's public and private schools that require daily physical education for all students.
- **PA-5:** Increase the proportion of adolescents who participate in daily school physical education.
- **PA-10:** Increase the proportion of the Nation's public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours (that is, before and after the school day, on weekends, and during summer and other vacations).

HEALTHY AND SAFE SCHOOL ENVIRONMENT

Competitive Foods

Competitive foods are any foods or beverages sold or served at school separately from the USDA school meal programs.²⁸ While foods and beverages sold through the school meal programs must meet federal nutrition requirements, competitive foods are not subject to any federal nutrition standards unless they are sold inside the food service area during mealtimes.²⁸ Competitive foods are often relatively low in nutrient density and relatively high in fat, added sugars and calories.²⁸ There is a growing body of research showing that the school food environment is associated with youth dietary behaviors and obesity.²⁹⁻³²

Schools are in a unique position to provide students with healthy dietary choices and to help students learn about healthy food choices. The Child Nutrition and WIC Reauthorization Act of 2004 required school districts that participate in the USDA National School Lunch Program or School Breakfast Program to develop a local wellness policy that addresses, among other components, nutrition education and nutrition guidelines for all foods available on school campuses.³³ The passage of the Healthy, Hunger-Free Kids Act of 2010³⁴ updates these requirements, placing greater emphasis on evaluation and sharing

progress of local wellness policy implementation with the public. It also requires USDA to develop, by December 2011, federal nutrition standards for competitive foods sold on school campus during the school day that are consistent with the *Dietary Guidelines for Americans*. A 2007 Institute of Medicine report, *Nutrition Standards for Foods in Schools: Leading the Way Toward Healthier Youth*³⁵ provides specific recommendations for foods and beverages sold outside of the school meal programs that schools, districts, and states should consider when developing or strengthening policies related to nutrition in schools. The implementation of these recommendations, the local wellness policy requirement, and other initiatives, including the development of national standards for foods and beverages sold on school campus during the school day, helps support the achievement of *Healthy People 2020*¹⁰ objective Nutrition and Weight Status (NWS)-2: to increase the proportion of schools that offer nutritious foods and beverages outside of school meals. Specifically, this objective aims to increase the proportion of schools that do not sell or offer calorically sweetened beverages to students (NWS-2.1) and increase the proportion of school districts that require schools to make fruits or vegetables available whenever other food is offered or sold (NWS-2.2).

Tobacco-Use Prevention

Tobacco use, particularly cigarette smoking, remains the leading preventable cause of death in the United States.³⁶ Each year, 443,000 people die from smoking or exposure to secondhand smoke.³⁷ Approximately 82% of adults who ever smoked daily tried their first cigarette before age 18 years.³⁸ Each day in the United States, approximately 3,450 young people between the ages of 12 and 17 years initiate cigarette smoking, and an estimated 850 young people become daily cigarette smokers.³⁹ Thus, to be most effective,

school-based programs must target young people before they initiate tobacco use or drop out of school. CDC's *Best Practices for Comprehensive Tobacco Control Programs—2007* provides evidence-based guidance to assist in planning and establishing comprehensive and effective tobacco control programs that include efforts to prevent youth initiation and reduce youth tobacco use.⁴⁰ Additionally, CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*⁴¹ recommends strategies to aid schools in preventing initiation and reducing tobacco use among youth. The following are key elements of those strategies:

- Develop and enforce a school policy on tobacco use that prohibits tobacco use by students, school staff, parents, and visitors on school property, in school buildings, in all school vehicles, and at school functions away from school property.
- Prohibit tobacco advertising in school buildings, on school property, and in school publications.
- Provide instruction about the negative consequences of short-term and long-term tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills.
- Provide tobacco-use prevention education for students in kindergarten through grade 12.
- Provide program-specific training for teachers.
- Support cessation efforts among students and staff who use tobacco.

To be comprehensive, a tobacco-use prevention policy should prohibit all tobacco use by students, faculty, staff, and visitors during school and non-school hours, in school buildings, on school grounds, in school buses or other vehicles used to transport students, and at off-campus, school-

sponsored events.⁴¹ Instituting such a policy can assist schools in achieving *Healthy People 2020*¹⁰ objective Tobacco Use-15: to increase tobacco-free environments in schools, including all school facilities, property, vehicles, and school events.

HIV Infection and AIDS Prevention

Within the 37 states with confidential name-based HIV infection reporting, an estimated 6,872 persons aged 13 to 19 years were living with HIV/AIDS in 2007 and an additional 1,901 had received a diagnosis of HIV infection in 2008.⁴²

School health policies can help protect the rights of HIV-infected students and school staff members and reduce the likelihood of transmitting HIV infection to others. To address these issues, the National Association of State Boards of Education provides policy recommendations to guide educators,⁴³ including:

- The right to school attendance for students with HIV infection or AIDS.
- Nondiscrimination for employees with HIV infection or AIDS.
- The right to privacy regarding HIV infection status.
- Adherence to infection-control guidelines.
- Accommodations for students living with HIV infection or AIDS to facilitate their participation in school-sponsored physical activities.
- An HIV infection prevention education program.
- Confidential counseling for students.
- A planned HIV education program for staff.
- Provisions for school administrators to notify students, parents, and school personnel about current policies concerning HIV infection and AIDS.

Delaying the initiation of sexual intercourse, consistent condom use among sexually active students, and HIV testing are important strategies for preventing the transmission of HIV. However, 46.0% of students in grades 9 through 12 have had sexual intercourse, and among students who were currently sexually active, 38.9% did not use a condom during last sexual intercourse. In addition, only 12.7% of students have been tested for HIV infection.⁴⁴ School policies should protect HIV-positive students and staff and help all students decrease their risk for HIV infection, as well as other STDs and pregnancy.

Safe and Supportive Environments for All Students

School activities and policies should create a safe and supportive environment for all students, including lesbian, gay, bisexual, transgender, or 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.⁴⁵ In addition, sexual minority youth who are victimized at school have an increased risk of attempting suicide than those who are not.⁴⁵ Sexual minority youth who attend schools with an anti-bullying policy, however, have a lower risk of suicidality than those who do not attend schools with such policies.⁴⁵ The importance of improving the health and safety of LGBTQ youth is underscored by the addition of a new objective for *Healthy People 2020*,¹⁰ Adolescent Health-9: to increase the proportion of middle and high schools that prohibit harassment based on a student's sexual orientation or gender identity.

HEALTH SERVICES

School health services are designed to provide a continuum of care from home to school to community health care providers. According to the American Academy of Pediatrics (AAP), even though school systems offer a wide range of health services, at a minimum, schools should provide at least the following three types of services: 1) state-mandated services, including health screenings, verification of immunization status, and infectious disease reporting, 2) assessment of minor health complaints, medication administration, and care for students with special health care needs, and 3) capability to handle emergencies and other urgent situations.⁴⁶ More comprehensive services might include all of these services plus the administration of immunizations, case management and counseling, wellness promotion, and patient education, as well as services for students with chronic health conditions such as diabetes, seizures, or asthma.

School nurses are important gatekeepers and play many roles in the school setting, but their main purpose is to support student success by providing health care assessment, intervention, and follow-up for all children within the school setting.⁴⁷ School nurses keep students in school where they can learn. School nurses serve as an extension of the public health system by caring for school-aged children and adolescents during the school day.⁴⁸ The importance of having sufficient school nurses for all students is reflected in *Healthy People 2020*¹⁰ objective ECBP-5: to increase the proportion of the nation's elementary, middle, and high schools that have a nurse-to-student ratio of at least 1 to 750.

Asthma is a leading chronic illness among children and youth in the United States.⁴⁹ In 2009, more than 10 million U.S. children under 18 years of age (14%) had ever been diagnosed with asthma; approximately 7 million children (10%) still had asthma.⁴⁹ In 2007, children under 18 years of age made 7.5 million visits to doctors' offices and hospital outpatient departments for asthma. Additionally, there were approximately 640,000 emergency department visits and 157,000 asthma hospitalizations.⁵⁰

In 2008, children aged 5-17 years who reported at least one asthma attack in the past year missed a total of approximately 10.5 million school days.⁴⁹ Additionally, 5.5% of these children had an activity limitation due to asthma.⁴⁹

Although asthma cannot be cured, it can be controlled with proper diagnosis and appropriate care and management activities. Schools can help students manage their asthma by adopting policies and procedures to create safe and supportive learning environments for students with asthma. In *Strategies for Addressing Asthma Within a Coordinated School Health Program, with Updated Resources*,⁵¹ CDC recommends obtaining a written action plan for all students with asthma and ensuring that students have immediate access to medications, including allowing students to carry and self-administer quick relief medications. *Healthy People 2020*¹⁰ identifies the following Respiratory Diseases (RD) objectives:

- **RD-4.** Reduce activity limitations among persons with current asthma.
- **RD-5.** Reduce the proportion of persons with asthma who miss school or work days.

SCHOOL HEALTH COORDINATION

To ensure that the components of school health are coordinated, it is critical to have one person appointed to oversee the school health program.³ This individual coordinates school health activities; leads a school health council, committee, or team; and integrates community-based programs with school-based programs.^{52,53} Administration and management of school health programs requires devoted time, attention, training, and expertise.^{54,55} School health councils, committees, or teams also are integral parts of a coordinated school health program. 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.^{54,56} 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.^{52,54,56-60}

FAMILY AND COMMUNITY INVOLVEMENT

Partnerships between schools, families, and community members are key elements of effective school health programs.⁶¹ Schools that have a good relationship with families and community members are more likely to gain their cooperation with school health efforts. These relationships also increase the probability of successful school health programs and improved student health outcomes.^{43,62} Interventions aimed at preventing and treating childhood obesity,⁶³ school-based tobacco-use prevention programs,⁶⁴ and asthma interventions^{65,66} have all been found to be more effective when they involve parents and community organizations. Family and community involvement is especially important when addressing topics that can be emotionally charged, such as HIV infection, other STDs, and pregnancy prevention.⁶⁷ Without parental support of policies and programs to prevent HIV infection, other STDs, and pregnancy, they cannot be sustained.⁶⁷⁻⁶⁹

RESULTS

HEALTH EDUCATION

Required Health Education

Required health education is defined on the Profiles questionnaire as any classroom instruction on health topics, including instruction that occurs outside of health education courses that students must receive for graduation or promotion from school. The percentage of schools that required health education for students in any of grades 6 through 12 ranged from 39.2% to 98.7% across states (median: 89.6%), from 59.2% to 99.2% across cities (median: 82.5%), and from 87.5% to 100.0% across territories (median: 95.5%) (Table 2).

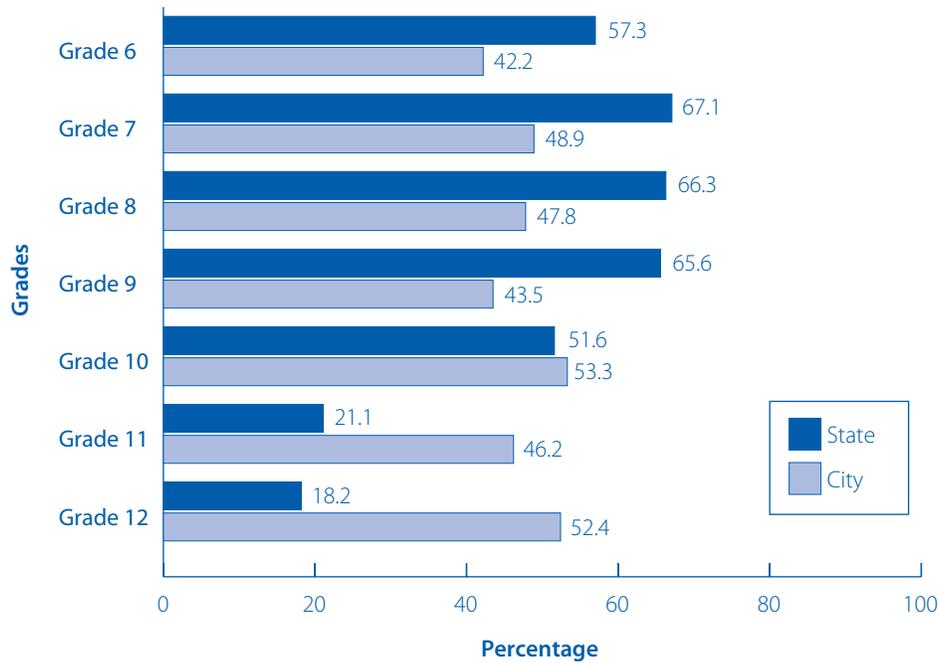
A required health education course is defined as one that students must take for graduation or promotion from school and includes instruction about health topics such as injuries and violence, alcohol and other drug use, tobacco use, nutrition, HIV infection, and physical activity. The percentage of schools that required students to take only one required health education course ranged from 7.0% to 72.3% across states (median: 36.9%), from 0.0% to 80.6% across cities (median: 44.9%), and from 15.4% to 100.0% across territories (median: 74.4%) (Table 2). The percentage of schools that required students to take two or more required health education courses ranged from 12.4% to 92.4% across states (median: 52.3%), from 0.0% to 66.4% across cities (median: 27.5%), and from 0.0% to 84.6% across territories (median: 25.6%) (Table 2).

Among schools that required a health education course for students in any of grades 6 through 12, the percentage that required students who fail such a course to repeat it ranged from 21.2% to

84.8% across states (median: 60.7%), from 35.3% to 80.4% across cities (median: 48.8%), and from 9.1% to 100.0% across territories (median: 62.3%) (Table 2).

Among schools with students in particular grades, the percentage of schools across states that taught a required health education course in that grade ranged from 14.0% to 94.0% (median: 57.3%) in grade 6, 17.0% to 94.6% (median: 67.1%) in grade 7, 22.7% to 94.6% (median: 66.3%) in grade 8, 12.3% to 95.6% (median: 65.6%) in grade 9, 12.1% to 92.0% (median: 51.6%) in grade 10, 2.9% to 96.0% (median: 21.1%) in grade 11, and from 2.9% to 99.0% (median: 18.2%) in grade 12 (Table 3, Figure 1). Among schools with students in particular grades, the percentage of schools across cities that taught a required health education course in that grade ranged from 0.0% to 92.7% (median: 42.2%) in grade 6, 0.0% to 100.0% (median: 48.9%) in grade 7, 0.0% to 92.7% (median: 47.8%) in grade 8, 0.0% to 100.0% (median: 43.5%) in grade 9, 0.0% to 100.0% (median: 53.3%) in grade 10, 0.0% to 100.0% (median: 46.2%) in grade 11, and from 0.0% to 100.0% (median: 52.4%) in grade 12 (Table 3, Figure 1). Among schools with students in particular grades, the percentage of schools across territories that taught a required health education course in that grade ranged from 37.5% to 100.0% (median: 100.0%) in grade 6, 75.0% to 100.0% (median: 100.0%) in grade 7, 12.5% to 100.0% (median: 83.4%) in grade 8, 75.0% to 100.0% (median: 92.9%) in grade 9, 66.7% to 100.0% (median: 87.5%) in grade 10, 25.0% to 100.0% (median: 66.7%) in grade 11, and from 25.0% to 100.0% (median: 66.7%) in grade 12 (Table 3).

FIGURE 1. Median percentages of schools that taught a required health education course in each grade,*
School Health Profiles, 2010



*Among schools with students in each grade.

Materials for Health Education Teachers

Schools can provide materials to health education teachers to help them teach. The percentage of schools that provided the following materials to those who teach health education ranged as follows (Table 4):

- Goals, objectives, and expected outcomes for health education:** from 68.7% to 97.8% across states (median: 86.7%), from 62.2% to 100.0% across cities (median: 87.4%), and from 84.6% to 100.0% across territories (median: 100.0%).
- A written health education curriculum:** from 53.6% to 94.4% across states (median: 77.3%), from 53.1% to 100.0% across cities (median: 82.6%), and from 69.2% to 100.0% across territories (median: 93.8%).
- All 4 types of materials:** from 33.0% to 69.8% across states (median: 52.4%), from 0.0% to 77.8% across cities (median: 58.6%), and from 38.5% to 92.3% across territories (median: 70.5%).
- Plans for how to assess student performance in health education:** from 47.9% to 86.2% across states (median: 65.1%), from 1.7% to 85.3% across cities (median: 71.8%), and from 46.2% to 92.3% across territories (median: 89.2%).

Content of Required Health Education

Required health education aims to increase student knowledge about a variety of health-related topics. The percentage of schools that tried to increase student knowledge on specific health-related topics in a required course during the 2009–2010 school year ranged as follows (Table 5a, b):

- **Alcohol- or other drug-use prevention:** from 75.9% to 99.1% across states (median: 95.7%), from 77.5% to 100.0% across cities (median: 90.8%), and from 84.6% to 100.0% across territories (median: 100.0%).
- **Asthma:** from 35.1% to 80.7% across states (median: 51.6%), from 10.0% to 76.6% across cities (median: 67.0%), and from 18.2% to 76.9% across territories (median: 68.3%).
- **Emotional and mental health:** from 60.4% to 97.2% across states (median: 90.5%), from 60.6% to 100.0% across cities (median: 79.9%), and from 76.9% to 100.0% across territories (median: 88.0%).
- **Foodborne illness prevention:** from 50.0% to 86.4% across states (median: 70.5%), from 13.4% to 80.9% across cities (median: 63.8%), and from 27.3% to 84.6% across territories (median: 55.8%).
- **HIV prevention:** from 52.8% to 97.2% across states (median: 89.9%), from 63.0% to 100.0% across cities (median: 88.6%), and from 91.7% to 100.0% across territories (median: 100.0%).
- **Human sexuality:** from 48.5% to 95.2% across states (median: 86.7%), from 62.4% to 100.0% across cities (median: 87.3%), and from 54.5% to 100.0% across territories (median: 77.3%).
- **Injury prevention and safety:** from 66.0% to 96.3% across states (median: 86.8%), from 54.1% to 96.5% across cities (median: 83.6%), and from 84.6% to 100.0% across territories (median: 93.8%).
- **Nutrition and dietary behavior:** from 79.1% to 100.0% across states (median: 96.5%), from 51.6% to 100.0% across cities (median: 92.7%), and from 91.7% to 100.0% across territories (median: 100.0%).
- **Physical activity and fitness:** from 84.0% to 100.0% across states (median: 98.4%), from 90.5% to 100.0% across cities (median: 98.0%), and was 100% in all territories.
- **Pregnancy prevention:** from 46.6% to 94.0% across states (median: 83.3%), from 57.1% to 100.0% across cities (median: 81.4%), and from 63.6% to 100.0% across territories (median: 83.7%).
- **STD prevention:** from 49.6% to 97.1% across states (median: 88.6%), from 59.6% to 100.0% across cities (median: 89.1%), and from 91.7% to 100.0% across territories (median: 100.0%).
- **Suicide prevention:** from 43.1% to 90.8% across states (median: 73.8%), from 20.7% to 87.4% across cities (median: 71.8%), and from 53.8% to 100.0% across territories (median: 89.9%).
- **Tobacco-use prevention:** from 75.1% to 99.4% across states (median: 95.7%), from 76.2% to 100.0% across cities (median: 89.7%), and from 84.6% to 100.0% across territories (median: 100.0%).
- **Violence prevention (e.g., bullying, fighting, or homicide):** from 73.3% to 97.8% across states (median: 89.8%), from 77.5% to 98.3% across cities (median: 90.3%), and from 84.6% to 100.0% across territories (median: 93.8%).

Health education curricula should address student skills that correspond to the *National Health Education Standards*.⁹ The percentage of schools with a health education curriculum that addressed specific skills ranged as follows (Table 6):

- **Comprehending concepts related to health promotion and disease prevention to enhance health:** from 68.6% to 99.1% across states (median: 94.2%), from 71.9% to 100.0% across cities (median: 90.6%), and from 84.6% to 100.0% across territories (median: 100.0%).
- **Analyzing the influence of family, peers, culture, media, technology, and other factors on health behaviors:** from 64.1% to 98.7% across states (median: 93.3%), from 67.2% to 100.0% across cities (median: 87.2%), and from 84.6% to 100.0% across territories (median: 91.6%).
- **Accessing valid information and products and services to enhance health:** from 59.3% to 97.7% across states (median: 86.4%), from 62.2% to 100.0% across cities (median: 84.3%), and from 69.2% to 90.9% across territories (median: 81.8%).
- **Using interpersonal communication skills to enhance health and avoid or reduce health risks:** from 62.3% to 98.7% across states (median: 92.3%), from 70.2% to 100.0% across cities (median: 89.9%), and from 81.8% to 100.0% across territories (median: 90.4%).
- **Using decision-making skills to enhance health:** from 68.4% to 99.1% across states (median: 94.7%), from 75.3% to 100.0% across cities (median: 92.6%), and from 84.6% to 100.0% across territories (median: 100.0%).
- **Using goal-setting skills to enhance health:** from 64.1% to 97.7% across states (median: 92.6%), from 71.2% to 100.0% across cities (median: 89.3%), and from 76.9% to 100.0% across territories (median: 93.8%).

- **Practicing health-enhancing behaviors to avoid or reduce health risks:** from 67.9% to 98.7% across states (median: 93.9%), from 70.2% to 100.0% across cities (median: 89.5%), and from 84.6% to 100.0% across territories (median: 98.1%).
- **Advocating for personal, family, and community health:** from 58.9% to 95.3% across states (median: 88.8%), from 69.7% to 98.3% across cities (median: 84.9%), and from 61.5% to 100.0% across territories (median: 91.6%).
- **All 8 skills:** from 37.2% to 83.0% across states (median: 66.6%), from 44.4% to 98.3% across cities (median: 67.8%), and from 53.8% to 88.5% across territories (median: 69.3%).

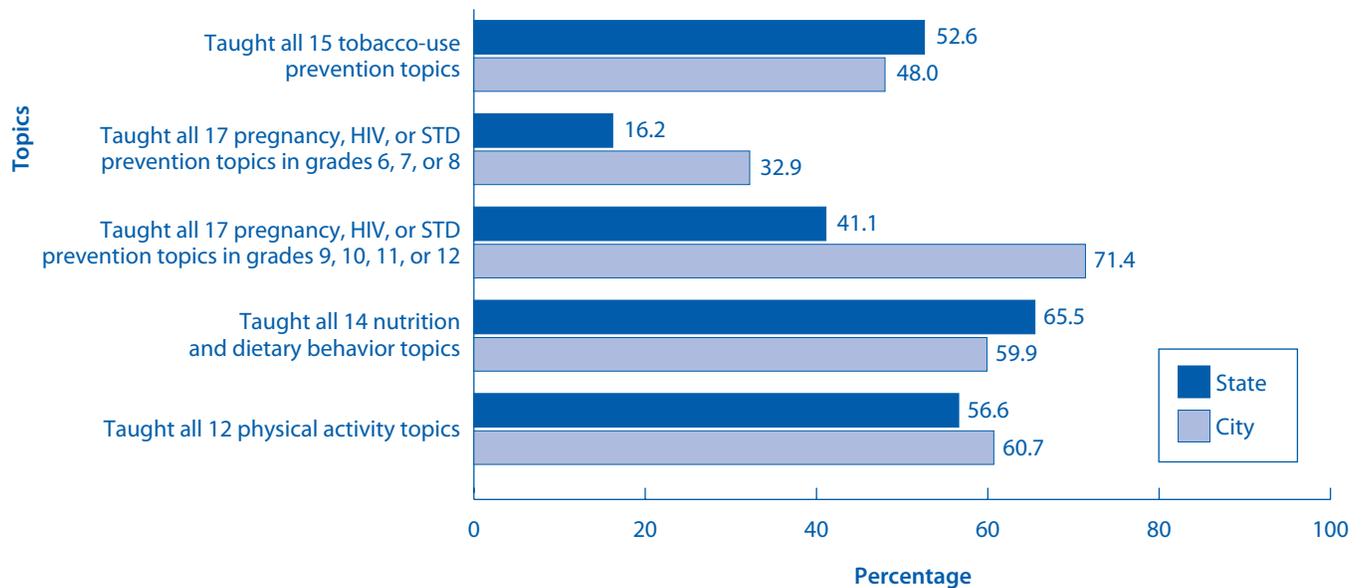
Tobacco-Use Prevention Topics

Tobacco-use prevention topics taught in a required course can include consequences of tobacco use, external influences on tobacco use, and skills to avoid and to stop using tobacco. The percentage of schools that taught specific tobacco-use prevention topics in a required course during the 2009–2010 school year ranged as follows (Table 7a, b, c):

- **Identifying tobacco products and the harmful substances they contain:** from 64.1% to 98.5% across states (median: 91.0%), from 55.0% to 100.0% across cities (median: 78.5%), and from 76.9% to 100.0% across territories (median: 97.9%).
- **Identifying short- and long-term health consequences of tobacco use:** from 65.7% to 99.4% across states (median: 91.4%), from 61.7% to 100.0% across cities (median: 79.8%), and from 76.9% to 100.0% across territories (median: 94.0%).

- **Identifying legal, social, economic, and cosmetic consequences of tobacco use:** from 58.6% to 97.1% across states (median: 86.6%), from 49.9% to 94.3% across cities (median: 70.2%), and from 69.2% to 100.0% across territories (median: 92.0%).
- **Understanding the addictive nature of nicotine:** from 64.9% to 99.4% across states (median: 90.7%), from 58.3% to 97.6% across cities (median: 78.5%), and from 69.2% to 100.0% across territories (median: 92.0%).
- **Effects of tobacco use on athletic performance:** from 60.9% to 95.2% across states (median: 83.6%), from 51.3% to 91.8% across cities (median: 74.6%), and from 76.9% to 100.0% across territories (median: 95.9%).
- **Effects of second-hand smoke and benefits of a smoke-free environment:** from 64.9% to 98.6% across states (median: 90.4%), from 62.3% to 100.0% across cities (median: 77.5%), and from 76.9% to 100.0% across territories (median: 91.3%).
- **Understanding the social influences on tobacco use, including media, family, peers, and culture:** from 59.2% to 96.5% across states (median: 88.6%), from 53.1% to 100.0% across cities (median: 74.3%), and from 69.2% to 100.0% across territories (median: 95.9%).
- **Identifying reasons why students do and do not use tobacco:** from 60.9% to 97.8% across states (median: 88.2%), from 51.5% to 98.4% across cities (median: 76.8%), and from 69.2% to 100.0% across territories (median: 89.6%).
- **Making accurate assessments of how many peers use tobacco:** from 48.8% to 85.4% across states (median: 70.0%), from 30.8% to 85.9% across cities (median: 59.2%), and from 61.5% to 100.0% across territories (median: 79.2%).
- **Using interpersonal communication skills to avoid tobacco use (e.g., refusal skills, assertiveness):** from 57.6% to 97.8% across states (median: 86.6%), from 52.9% to 100.0% across cities (median: 77.5%), and from 69.2% to 100.0% across territories (median: 84.3%).
- **Using goal-setting and decision-making skills related to not using tobacco:** from 57.9% to 96.5% across states (median: 83.0%), from 47.2% to 96.7% across cities (median: 70.9%), and from 69.2% to 95.8% across territories (median: 89.2%).
- **Finding valid information and services related to tobacco-use prevention and cessation:** from 51.6% to 92.3% across states (median: 74.9%), from 40.4% to 88.6% across cities (median: 67.6%), and from 61.5% to 100.0% across territories (median: 85.5%).
- **Supporting others who abstain from or want to quit using tobacco:** from 53.4% to 90.9% across states (median: 75.9%), from 43.0% to 92.8% across cities (median: 66.4%), and from 69.2% to 90.0% across territories (median: 79.2%).
- **Supporting school and community action to support a tobacco-free environment:** from 53.6% to 91.6% across states (median: 75.5%), from 42.1% to 89.5% across cities (median: 67.7%), and from 76.9% to 100.0% across territories (median: 89.6%).
- **Identifying harmful effects of tobacco use on fetal development:** from 50.5% to 92.7% across states (median: 80.3%), from 52.3% to 95.1% across cities (median: 69.9%), and from 69.2% to 100.0% across territories (median: 87.8%).

FIGURE 2. Median percentage of schools that taught all 15 tobacco-use prevention topics; all 17 pregnancy, HIV,* or STD† prevention topics; all 14 nutrition and dietary behavior topics; or all 12 physical activity topics in a required course during the 2009-2010 school year, School Health Profiles, 2010



*Human immunodeficiency virus.
 †Sexually transmitted disease.

- **All 15 tobacco-use prevention topics:** from 34.3% to 77.6% across states (median: 52.6%), from 12.9% to 71.0% across cities (median: 48.0%), and from 50.0% to 72.0% across territories (median: 61.9%) (Table 7c, Figure 2).

HIV, STD, or Pregnancy Prevention Topics

HIV, STD, or pregnancy prevention topics taught in a required course can include how HIV and STDs are transmitted, diagnosed, and treated and how to reduce the risk of HIV, STDs, and pregnancy, including the benefits of being sexually abstinent, negotiation and decision-making skills, and condom use. The HIV, STD, and pregnancy prevention topics taught in a required course may vary by grade level. The percentage of schools that taught specific HIV, STD, or pregnancy prevention topics in a required course for students in any of grades 6, 7, or 8 during the 2009–2010 school year ranged as follows (Table 8a, b, c):

- **The differences between HIV and AIDS:** from 32.1% to 93.6% across states (median: 77.1%), from 50.9% to 100.0% across cities (median: 87.7%), and from 87.5% to 100.0% across territories (median: 100.0%).
- **How HIV and other STDs are transmitted:** from 33.7% to 95.5% across states (median: 78.8%), from 51.1% to 100.0% across cities (median: 86.1%), and from 87.5% to 100.0% across territories (median: 100.0%).
- **How HIV and other STDs are diagnosed and treated:** from 24.6% to 88.4% across states (median: 69.6%), from 47.1% to 100.0% across cities (median: 80.9%), and from 75.0% to 100.0% across territories (median: 90.0%).
- **Health consequences of HIV, other STDs, and pregnancy:** from 31.1% to 95.5% across states (median: 76.6%), from 42.4% to 100.0% across cities (median: 82.4%), and from 75.0% to 100.0% across territories (median: 90.0%).

- **The relationship among HIV, other STDs, and pregnancy:** from 28.5% to 92.3% across states (median: 70.9%), from 39.1% to 100.0% across cities (median: 80.5%), and from 75.0% to 100.0% across territories (median: 87.5%).
- **The relationship between alcohol and other drug use and risk for HIV, other STDs, and pregnancy:** from 30.0% to 90.8% across states (median: 74.1%), from 39.6% to 100.0% across cities (median: 77.8%), and from 75.0% to 100.0% across territories (median: 87.5%).
- **The benefits of being sexually abstinent:** from 31.7% to 93.8% across states (median: 78.9%), from 50.6% to 100.0% across cities (median: 81.6%), and from 87.5% to 100.0% across territories (median: 100.0%).
- **How to prevent HIV, other STDs, and pregnancy:** from 32.3% to 95.5% across states (median: 77.3%), from 47.0% to 100.0% across cities (median: 84.2%), and from 75.0% to 100.0% across territories (median: 100.0%).
- **How to access valid and reliable health information, products, and services related to HIV, other STDs, and pregnancy:** from 25.8% to 82.3% across states (median: 64.0%), from 40.9% to 100.0% across cities (median: 76.0%), and from 62.5% to 95.0% across territories (median: 72.5%).
- **The influences of media, family, and social and cultural norms on sexual behavior:** from 28.6% to 86.5% across states (median: 71.4%), from 40.2% to 100.0% across cities (median: 77.4%), and from 40.0% to 100.0% across territories (median: 82.5%).
- **Communication and negotiation skills related to eliminating or reducing risk for HIV, other STDs, and pregnancy:** from 29.2% to 88.9% across states (median: 67.6%), from 36.2% to 100.0% across cities (median: 77.1%), and from 30.0% to 100.0% across territories (median: 76.3%).
- **Goal-setting and decision-making skills related to eliminating or reducing risk for HIV, other STDs, and pregnancy:** from 26.5% to 92.6% across states (median: 70.3%), from 42.2% to 100.0% across cities (median: 77.4%), and from 75.0% to 100.0% across territories (median: 90.0%).
- **Compassion for persons living with HIV or AIDS:** from 19.8% to 80.2% across states (median: 58.0%), from 39.8% to 100.0% across cities (median: 69.7%), and from 45.0% to 100.0% across territories (median: 62.5%).
- **Efficacy of condoms, that is, how well condoms work and do not work:** from 19.5% to 84.5% across states (median: 50.7%), from 29.8% to 100.0% across cities (median: 66.2%), and from 12.5% to 100.0% across territories (median: 50.0%).
- **The importance of using condoms consistently and correctly:** from 8.1% to 72.3% across states (median: 38.1%), from 23.0% to 100.0% across cities (median: 63.1%), and from 16.7% to 75.0% across territories (median: 40.0%).
- **How to obtain condoms:** from 1.9% to 64.6% across states (median: 26.0%), from 18.2% to 100.0% across cities (median: 45.0%), and from 16.7% to 100.0% across territories (median: 33.8%).
- **How to correctly use a condom:** from 0.0% to 63.1% across states (median: 20.2%), from 0.0% to 100.0% across cities (median: 38.9%), and from 11.8% to 50.0% across territories (median: 27.5%).
- **All 4 condom use topics:** from 0.0% to 57.3% across states (median: 18.4%), from

0.0% to 100.0% across cities (median: 37.2%), and from 11.8% to 50.0% across territories (median: 27.5%).

The percentage of schools that taught all 17 HIV, STD, and pregnancy prevention topics, including all 4 condom use topics, in a required course for students in any of grades 6, 7, and 8 during the 2009–2010 school year ranged from 0.0% to 47.6% across states (median: 16.2%), from 0.0% to 100.0% across cities (median: 32.9%), and from 11.8% to 50.0% across territories (median: 22.5%) (Table 8c, Figure 2).

The percentage of schools that taught specific HIV, STD, or pregnancy prevention topics in a required course for students in any of grades 9, 10, 11, and 12 during the 2009–2010 school year ranged as follows (Table 9a, b, c):

- **The differences between HIV and AIDS:** from 62.0% to 100.0% across states (median: 94.4%), from 86.5% to 100.0% across cities (median: 96.0%), and was 100% in all territories.
- **How HIV and other STDs are transmitted:** from 65.8% to 100.0% across states (median: 95.2%), from 86.5% to 100.0% across cities (median: 98.4%), and was 100% in all territories.
- **How HIV and other STDs are diagnosed and treated:** from 59.2% to 100.0% across states (median: 92.6%), from 86.5% to 100.0% across cities (median: 96.7%), and was 100% in all territories.
- **Health consequences of HIV, other STDs, and pregnancy:** from 65.2% to 100.0% across states (median: 93.4%), from 86.1% to 100.0% across cities (median: 97.7%), and was 100% in all territories.
- **The relationship among HIV, other STDs, and pregnancy:** from 56.6% to 100.0% across states (median: 91.3%), from 86.1% to 100.0% across cities (median: 96.2%), and was 100% in all territories.
- **The relationship between alcohol and other drug use and risk for HIV, other STDs, and pregnancy:** from 62.0% to 100.0% across states (median: 93.2%), from 86.1% to 100.0% across cities (median: 96.4%), and was 100% in all territories.
- **The benefits of being sexually abstinent:** from 65.1% to 100.0% across states (median: 95.1%), from 86.5% to 100.0% across cities (median: 100.0%), and was 100% in all territories.
- **How to prevent HIV, other STDs, and pregnancy:** from 65.9% to 100.0% across states (median: 94.2%), from 86.1% to 100.0% across cities (median: 98.1%), and was 100% in all territories.
- **How to access valid and reliable health information, products, and services related to HIV, other STDs, and pregnancy:** from 61.3% to 99.0% across states (median: 90.0%), from 79.1% to 100.0% across cities (median: 95.4%), and from 80.0% to 100.0% across territories (median: 100.0%).
- **The influences of media, family, and social and cultural norms on sexual behavior:** from 56.7% to 98.1% across states (median: 90.4%), from 83.3% to 100.0% across cities (median: 92.5%), and was 100% in all territories.
- **Communication and negotiation skills related to eliminating or reducing risk for HIV, other STDs, and pregnancy:** from 58.2% to 100.0% across states (median: 89.4%), from 85.7% to 100.0% across cities (median: 92.5%), and was 100% in all territories.
- **Goal-setting and decision-making skills related to eliminating or reducing risk for HIV, other STDs, and pregnancy:** from 56.9%

to 98.9% across states (median: 87.7%), from 85.7% to 100.0% across cities (median: 95.0%), and was 100% in all territories.

- **Compassion for persons living with HIV or AIDS:** from 44.8% to 95.7% across states (median: 76.6%), from 70.1% to 100.0% across cities (median: 87.5%), and from 83.3% to 100.0% across territories (median: 100.0%).
- **Efficacy of condoms, that is, how well condoms work and do not work:** from 37.4% to 98.1% across states (median: 80.5%), from 58.9% to 100.0% across cities (median: 92.9%), and from 66.7% to 100.0% across territories (median: 100.0%).
- **The importance of using condoms consistently and correctly:** from 26.8% to 96.6% across states (median: 69.5%), from 47.9% to 100.0% across cities (median: 92.9%), and from 66.7% to 100.0% across territories (median: 87.5%).
- **How to obtain condoms:** from 12.4% to 94.4% across states (median: 57.1%), from 39.4% to 100.0% across cities (median: 85.7%), and from 66.7% to 100.0% across territories (median: 100.0%).
- **How to correctly use a condom:** from 10.1% to 89.9% across states (median: 49.2%), from 26.1% to 100.0% across cities (median: 86.7%), and from 50.0% to 100.0% across territories (median: 87.5%).
- **All 4 condom use topics:** from 9.0% to 88.4% across states (median: 44.7%), from 22.4% to 100.0% across cities (median: 81.0%), and from 50.0% to 100.0% across territories (median: 87.5%).

The percentage of schools that taught all 17 HIV, STD, and pregnancy prevention topics, including all 4 condom use topics, in a required course for students in any of grades 9, 10, 11, and 12 during

the 2009–2010 school year ranged from 8.9% to 83.2% across states (median: 41.1%), from 23.3% to 100.0% across cities (median: 71.4%), and from 50.0% to 100.0% across territories (median: 77.5%) (Table 9c, Figure 2).

Nutrition and Dietary Behavior Topics

Nutrition and dietary behavior topics taught in a required course can include choosing healthful foods, food safety, and behaviors that contribute to maintaining a healthy weight. The percentage of schools that taught specific nutrition and dietary behavior topics in a required course during the 2009–2010 school year ranged as follows (Table 10a, b):

- **Benefits of healthy eating:** from 68.8% to 100.0% across states (median: 94.5%), from 33.7% to 100.0% across cities (median: 90.5%), and from 83.3% to 100.0% across territories (median: 93.8%).
- **Food guidance using MyPyramid:** from 60.7% to 98.1% across states (median: 89.2%), from 30.1% to 99.2% across cities (median: 84.4%), and from 83.3% to 100.0% across territories (median: 93.8%).
- **Using food labels:** from 54.7% to 98.5% across states (median: 88.7%), from 27.8% to 100.0% across cities (median: 78.9%), and from 72.7% to 100.0% across territories (median: 81.3%).
- **Balancing food intake and physical activity:** from 64.8% to 100.0% across states (median: 92.1%), from 29.0% to 99.2% across cities (median: 86.4%), and from 83.3% to 100.0% across territories (median: 91.8%).
- **Eating more fruits, vegetables, and whole grain products:** from 64.8% to 100.0% across states (median: 92.5%), from 31.3% to 100.0% across cities (median: 87.8%), and from 83.3% to 100.0% across territories (median: 91.8%).

- **Choosing foods that are low in fat, saturated fat, and cholesterol:** from 59.4% to 99.3% across states (median: 91.0%), from 29.9% to 99.2% across cities (median: 83.2%), and from 81.8% to 92.0% across territories (median: 85.4%).
- **Using sugars in moderation:** from 59.4% to 99.4% across states (median: 88.9%), from 25.1% to 98.3% across cities (median: 80.4%), and from 63.6% to 87.5% across territories (median: 83.7%).
- **Using salt and sodium in moderation:** from 57.5% to 99.4% across states (median: 87.6%), from 21.0% to 97.5% across cities (median: 79.4%), and from 63.6% to 87.5% across territories (median: 77.1%).
- **Eating more calcium-rich foods:** from 55.5% to 97.3% across states (median: 84.1%), from 19.9% to 97.6% across cities (median: 76.4%), and from 83.3% to 100.0% across territories (median: 89.6%).
- **Food safety:** from 54.6% to 94.4% across states (median: 78.1%), from 13.8% to 89.3% across cities (median: 73.8%), and from 75.0% to 96.0% across territories (median: 83.0%).
- **Preparing healthy meals and snacks:** from 57.9% to 95.9% across states (median: 85.0%), from 19.5% to 97.5% across cities (median: 79.5%), and from 66.7% to 88.0% across territories (median: 84.7%).
- **Risks of unhealthy weight control practices:** from 60.2% to 97.4% across states (median: 89.3%), from 27.5% to 98.3% across cities (median: 81.5%), and from 81.8% to 100.0% across territories (median: 87.7%).
- **Accepting body size differences:** from 57.9% to 95.1% across states (median: 85.9%), from 22.9% to 94.3% across cities (median: 79.3%),

and from 72.7% to 100.0% across territories (median: 79.5%).

- **Signs, symptoms, and treatment for eating disorders:** from 53.3% to 94.6% across states (median: 82.7%), from 20.1% to 95.0% across cities (median: 70.0%), and from 62.5% to 80.0% across territories (median: 73.9%).
- **All 14 nutrition and dietary behavior topics:** from 40.5% to 88.4% across states (median: 65.5%), from 13.0% to 84.2% across cities (median: 59.9%), and from 45.5% to 64.0% across territories (median: 54.2%) (Table 10b, Figure 2).

Physical Activity Topics

Physical activity topics taught in a required course can include the benefits of physical activity, guidance for engaging in physical activity, and the challenges to engaging in physical activity. The percentage of schools that taught specific physical activity topics in a required course during the 2009–2010 school year ranged as follows (Table 11a, b):

- **Physical, psychological, or social benefits of physical activity:** from 69.5% to 99.7% across states (median: 96.2%), from 85.0% to 100.0% across cities (median: 92.5%), and from 91.7% to 100.0% across territories (median: 96.0%).
- **Health-related fitness (i.e., cardiorespiratory endurance, muscular endurance, muscular strength, flexibility, and body composition):** from 66.4% to 98.9% across states (median: 95.1%), from 79.9% to 100.0% across cities (median: 94.2%), and from 88.5% to 100.0% across territories (median: 100.0%).
- **Phases of a workout (i.e., warm-up, workout, and cool down):** from 66.1% to 97.6% across states (median: 92.2%), from 81.1% to 98.8% across cities (median: 90.0%), and was 100.0% in all territories.

- **How much physical activity is enough (i.e., determining frequency, intensity, time, and type of physical activity):** from 60.7% to 96.0% across states (median: 90.6%), from 77.8% to 100.0% across cities (median: 88.5%), and from 84.6% to 100.0% across territories (median: 95.5%).
- **Developing an individualized physical activity plan:** from 49.7% to 87.1% across states (median: 77.1%), from 48.2% to 100.0% across cities (median: 77.2%), and from 81.8% to 100.0% across territories (median: 83.2%).
- **Monitoring progress toward reaching goals in an individualized physical activity plan:** from 51.1% to 86.4% across states (median: 76.2%), from 60.2% to 100.0% across cities (median: 81.2%), and from 72.7% to 100.0% across territories (median: 89.7%).
- **Overcoming barriers to physical activity:** from 54.4% to 92.1% across states (median: 80.9%), from 60.9% to 98.3% across cities (median: 81.8%), and from 75.0% to 100.0% across territories (median: 85.2%).
- **Decreasing sedentary activities (e.g., television viewing):** from 62.5% to 99.3% across states (median: 89.6%), from 77.3% to 100.0% across cities (median: 89.0%), and from 83.3% to 100.0% across territories (median: 87.8%).
- **Opportunities for physical activity in the community:** from 57.1% to 93.4% across states (median: 83.9%), from 68.1% to 100.0% across cities (median: 85.7%), and from 90.9% to 100.0% across territories (median: 98.0%).
- **Preventing injury during physical activity:** from 67.0% to 97.4% across states (median: 90.0%), from 76.3% to 98.3% across cities (median: 89.0%), and from 96.0% to 100.0% across territories (median: 100.0%).
- **Weather-related safety (e.g., avoiding heat stroke, hypothermia, and sunburn while physically active):** from 58.2% to 94.8% across states (median: 80.1%), from 59.1% to 98.3% across cities (median: 78.1%), and from 81.8% to 90.9% across territories (median: 86.1%).
- **Dangers of using performance-enhancing drugs (e.g., steroids):** from 58.5% to 95.8% across states (median: 84.9%), from 62.1% to 98.3% across cities (median: 80.1%), and from 75.0% to 100.0% across territories (median: 77.9%).
- **All 12 physical activity topics:** from 39.0% to 75.2% across states (median: 56.6%), from 24.6% to 98.3% across cities (median: 60.7%), and from 54.5% to 66.7% across territories (median: 60.1%) (Table 11b, Figure 2).

Collaboration

During the 2009–2010 school year, health education staff worked on health education activities with other school staff. The percentage of schools in which health education staff worked on health education activities with others ranged as follows (Table 12):

- **Physical education staff:** from 52.0% to 95.6% across states (median: 83.5%), from 26.5% to 93.1% across cities (median: 76.6%), and from 69.2% to 100.0% across territories (median: 91.9%).
- **School health services staff (e.g., nurses):** from 41.7% to 90.5% across states (median: 73.6%), from 43.1% to 87.6% across cities (median: 67.2%), and from 61.5% to 100.0% across territories (median: 62.0%).
- **School mental health or social services staff (e.g., psychologists, counselors, and social workers):** from 40.2% to 81.0% across states (median: 62.8%), from 36.2% to 94.7% across

cities (median: 65.6%), and from 46.2% to 81.8% across territories (median: 65.9%).

- **Nutrition or food service staff:** from 24.8% to 62.7% across states (median: 40.5%), from 9.7% to 59.2% across cities (median: 38.2%), and from 23.1% to 81.8% across territories (median: 71.7%).
- **School health council, committee, or team:** from 27.2% to 73.9% across states (median: 42.9%), from 9.7% to 92.0% across cities (median: 45.7%), and from 30.8% to 100.0% across territories (median: 69.7%).

Health Information to Increase Parent and Family Knowledge

During the 2009–2010 school year, schools provided parents and families with health information designed to increase parent and family knowledge. The percentage of schools that provided this information on specific health topics ranged as follows (Table 13):

- **HIV prevention, STD prevention, or pregnancy prevention:** from 11.0% to 93.3% across states (median: 28.1%), from 18.6% to 94.8% across cities (median: 39.8%), and from 23.1% to 100.0% across territories (median: 46.2%).
- **Asthma:** from 6.6% to 37.3% across states (median: 20.0%), from 23.4% to 63.2% across cities (median: 43.6%), and from 0.0% to 38.5% across territories (median: 22.6%).
- **Tobacco-use prevention:** from 23.5% to 52.8% across states (median: 33.8%), from 24.9% to 68.7% across cities (median: 39.4%), and from 46.2% to 63.6% across territories (median: 62.0%).

- **Physical activity:** from 31.5% to 60.6% across states (median: 44.5%), from 31.0% to 65.5% across cities (median: 56.8%), and from 30.8% to 69.2% across territories (median: 52.3%).
- **Nutrition and healthy eating:** from 31.6% to 58.9% across states (median: 44.0%), from 34.7% to 68.3% across cities (median: 57.2%), and from 38.5% to 100.0% across territories (median: 59.0%).

The percentage of schools that provided parents and families with health information on tobacco-use prevention, physical activity, and nutrition and healthy eating ranged from 16.3% to 46.3% across states (median: 27.6%), from 18.7% to 55.4% across cities (median: 33.5%), and from 30.8% to 57.7% across territories (median: 52.3%) (Table 13).

Professional Preparation and Professional Development

Lead health education teachers reported professional preparation in many disciplines. The percentage of schools in which the major emphasis of the lead health education teacher's professional preparation was in each specific discipline ranged as follows (Table 14):

- **Health and physical education combined:** from 15.3% to 87.6% across states (median: 48.8%), from 0.0% to 79.3% across cities (median: 34.6%), and from 0.0% to 73.1% across territories (median: 32.2%).
- **Health education only:** from 0.0% to 31.2% across states (median: 7.4%), from 0.0% to 53.5% across cities (median: 5.1%), and from 0.0% to 9.1% across territories (median: 6.1%).
- **Physical education only:** from 2.9% to 37.9% across states (median: 12.8%), from 0.0% to 30.0% across cities (median: 14.2%), and from 0.0% to 16.7% across territories (median: 6.5%).

- **Other education degree:** from 1.1% to 31.4% across states (median: 5.5%), from 1.4% to 31.8% across cities (median: 5.8%), and from 0.0% to 81.8% across territories (median: 18.2%).
- **Kinesiology, exercise science, or exercise physiology; home economics or family and consumer science; or biology or other science:** from 0.0% to 31.8% across states (median: 7.3%), from 0.0% to 82.7% across cities (median: 11.2%), and from 0.0% to 28.6% across territories (median: 6.1%).
- **Nursing or counseling:** from 0.0% to 22.3% across states (median: 3.3%), from 0.0% to 13.0% across cities (median: 4.3%), and from 0.0% to 16.7% across territories (median: 7.2%).
- **Public health, nutrition, or another discipline:** from 0.0% to 20.8% across states (median: 3.0%), from 0.0% to 25.5% across cities (median: 5.3%), and from 0.0% to 14.3% across territories (median: 3.9%).

The percentage of schools in which all staff who teach health topics were certified, licensed, or endorsed by the state in health education ranged from 25.6% to 98.8% across states (median: 85.7%), from 0.0% to 100.0% across cities (median: 71.4%), and from 0.0% to 92.3% across territories (median: 21.1%) (Table 15).

The percentage of schools in which the lead health education teacher was certified, licensed, or endorsed by their state to teach health education in middle school or high school ranged from 29.2% to 98.7% across states (median: 82.2%), from 41.7% to 96.9% across cities (median: 64.0%), and from 9.1% to 84.6% across territories (median: 31.6%) (Table 15).

The percentage of schools in which the lead health education teacher had experience teaching health education courses or topics for a specific number of years ranged as follows (Table 15):

- **1 year:** from 1.7% to 21.0% across states (median: 5.9%), from 0.0% to 27.5% across cities (median: 9.9%), and from 0.0% to 42.9% across territories (median: 16.8%).
- **2 to 5 years:** from 10.4% to 35.5% across states (median: 24.1%), from 12.0% to 47.1% across cities (median: 23.6%), and from 18.2% to 28.6% across territories (median: 23.1%).
- **6 to 9 years:** from 5.5% to 25.8% across states (median: 17.0%), from 9.6% to 31.9% across cities (median: 16.3%), and from 23.1% to 38.5% across territories (median: 32.5%).
- **10 to 14 years:** from 9.4% to 25.6% across states (median: 16.2%), from 6.8% to 25.6% across cities (median: 13.7%), and from 0.0% to 18.2% across territories (median: 11.6%).
- **15 years or more:** from 14.9% to 56.7% across states (median: 36.1%), from 5.1% to 48.7% across cities (median: 32.9%), and from 0.0% to 30.8% across territories (median: 16.1%).

Lead health education teachers received professional development during the 2 years before the survey on many topics. The percentage of schools in which the lead health education teacher received professional development on specific topics ranged as follows (Table 16a, b):

- **Alcohol- or other drug-use prevention:** from 21.4% to 60.7% across states (median: 42.4%), from 26.0% to 92.3% across cities (median: 47.6%), and from 30.8% to 100.0% across territories (median: 75.6%).

- **Asthma:** from 8.5% to 42.7% across states (median: 19.2%), from 11.6% to 63.0% across cities (median: 36.7%), and from 0.0% to 57.7% across territories (median: 22.6%).
- **Emotional and mental health:** from 20.4% to 67.5% across states (median: 35.5%), from 18.3% to 81.4% across cities (median: 40.7%), and from 23.1% to 100.0% across territories (median: 65.9%).
- **Foodborne illness prevention:** from 9.9% to 44.4% across states (median: 20.3%), from 7.7% to 40.4% across cities (median: 28.0%), and from 23.1% to 76.9% across territories (median: 32.4%).
- **HIV prevention:** from 15.3% to 66.5% across states (median: 37.7%), from 43.7% to 88.2% across cities (median: 69.5%), and from 46.2% to 100.0% across territories (median: 96.2%).
- **Human sexuality:** from 9.9% to 64.4% across states (median: 30.7%), from 32.1% to 79.5% across cities (median: 52.7%), and from 38.5% to 88.5% across territories (median: 69.3%).
- **Injury prevention and safety:** from 26.6% to 70.4% across states (median: 41.9%), from 32.0% to 81.1% across cities (median: 47.2%), and from 15.4% to 100.0% across territories (median: 89.9%).
- **Nutrition and dietary behavior:** from 21.0% to 59.0% across states (median: 40.5%), from 18.3% to 76.5% across cities (median: 52.2%), and from 23.1% to 100.0% across territories (median: 89.9%).
- **Physical activity and fitness:** from 29.6% to 75.9% across states (median: 54.8%), from 23.7% to 91.2% across cities (median: 66.9%), and from 23.1% to 100.0% across territories (median: 93.8%).
- **Pregnancy prevention:** from 10.2% to 58.8% across states (median: 27.6%), from 27.4% to 70.2% across cities (median: 47.9%), and from 15.4% to 92.3% across territories (median: 63.1%).
- **STD prevention:** from 13.2% to 62.7% across states (median: 31.5%), from 39.0% to 76.9% across cities (median: 61.9%), and from 38.5% to 100.0% across territories (median: 89.9%).
- **Suicide prevention:** from 12.8% to 73.1% across states (median: 30.4%), from 22.7% to 71.4% across cities (median: 37.0%), and from 30.8% to 88.0% across territories (median: 73.9%).
- **Tobacco-use prevention:** from 17.3% to 51.3% across states (median: 33.2%), from 13.0% to 81.3% across cities (median: 40.6%), and from 38.5% to 100.0% across territories (median: 73.9%).
- **Violence prevention (e.g., bullying, fighting, or homicide):** from 36.5% to 80.4% across states (median: 54.7%), from 47.0% to 89.4% across cities (median: 62.2%), and from 23.1% to 84.6% across territories (median: 73.9%).

The percentage of schools in which the lead health education teacher wanted to receive professional development on specific topics ranged as follows (Table 17a, b):

- **Alcohol- or other drug-use prevention:** from 59.9% to 86.3% across states (median: 74.7%), from 53.1% to 93.9% across cities (median: 76.1%), and from 27.3% to 100.0% across territories (median: 76.0%).
- **Asthma:** from 37.7% to 74.6% across states (median: 56.9%), from 44.2% to 90.2% across cities (median: 71.3%), and from 75.0% to 100.0% across territories (median: 90.9%).

- **Emotional and mental health:** from 58.3% to 87.3% across states (median: 71.6%), from 58.3% to 90.1% across cities (median: 78.1%), and from 36.4% to 100.0% across territories (median: 79.8%).
- **Foodborne illness prevention:** from 35.3% to 71.9% across states (median: 51.5%), from 36.9% to 86.3% across cities (median: 65.6%), and from 63.6% to 100.0% across territories (median: 83.7%).
- **HIV prevention:** from 48.4% to 79.3% across states (median: 66.3%), from 40.1% to 91.4% across cities (median: 69.3%), and from 63.6% to 100.0% across territories (median: 76.0%).
- **Human sexuality:** from 47.2% to 81.7% across states (median: 65.8%), from 38.2% to 91.5% across cities (median: 72.8%), and from 72.7% to 100.0% across territories (median: 79.8%).
- **Injury prevention and safety:** from 44.2% to 78.6% across states (median: 62.8%), from 44.5% to 88.9% across cities (median: 69.4%), and from 27.3% to 100.0% across territories (median: 76.0%).
- **Nutrition and dietary behavior:** from 58.8% to 85.1% across states (median: 73.1%), from 54.8% to 87.5% across cities (median: 76.3%), and from 27.3% to 100.0% across territories (median: 72.1%).
- **Physical activity and fitness:** from 46.7% to 84.3% across states (median: 68.6%), from 37.8% to 88.9% across cities (median: 72.8%), and from 18.2% to 100.0% across territories (median: 76.0%).
- **Pregnancy prevention:** from 49.6% to 77.4% across states (median: 64.2%), from 42.1% to 93.8% across cities (median: 68.7%), and from 72.7% to 100.0% across territories (median: 79.8%).
- **STD prevention:** from 53.3% to 79.4% across states (median: 67.0%), from 42.0% to 92.6% across cities (median: 71.2%), and from 63.6% to 100.0% across territories (median: 76.0%).
- **Suicide prevention:** from 65.7% to 84.8% across states (median: 74.0%), from 61.7% to 95.0% across cities (median: 79.1%), and from 27.3% to 100.0% across territories (median: 79.8%).
- **Tobacco-use prevention:** from 47.6% to 77.3% across states (median: 66.1%), from 51.5% to 91.4% across cities (median: 68.9%), and from 18.2% to 100.0% across territories (median: 72.1%).
- **Violence prevention (e.g., bullying, fighting, or homicide):** from 60.8% to 90.3% across states (median: 76.3%), from 59.8% to 90.5% across cities (median: 84.2%), and from 54.5% to 100.0% across territories (median: 77.4%).

Lead health education teachers also received professional development during the 2 years before the survey on critical topics related to HIV and STD prevention. The percentage of schools in which the lead health education teacher received professional development on these topics ranged as follows (Table 18):

- **Describing how widespread HIV and other STD infections are and the consequences of these infections:** from 9.7% to 64.7% across states (median: 32.9%), from 42.5% to 94.9% across cities (median: 64.1%), and from 38.5% to 100.0% across territories (median: 95.5%).
- **Understanding the modes of transmission and effective prevention strategies for HIV and other STDs:** from 9.3% to 65.1% across states (median: 33.7%), from 42.5% to 94.9% across cities (median: 66.0%), and from 38.5% to 100.0% across territories (median: 95.5%).

- **Identifying populations of youth who are at high risk of being infected with HIV and other STDs:** from 9.5% to 60.0% across states (median: 30.0%), from 34.3% to 94.9% across cities (median: 58.7%), and from 38.5% to 100.0% across territories (median: 91.6%).
- **Implementing health education strategies using prevention messages that are likely to be effective in reaching youth:** from 13.9% to 59.0% across states (median: 34.3%), from 43.1% to 94.9% across cities (median: 56.6%), and from 38.5% to 92.3% across territories (median: 84.7%).
- **All 4 of these topics:** from 7.0% to 48.4% across states (median: 22.1%), from 28.0% to 94.9% across cities (median: 49.9%), and from 30.8% to 87.5% across territories (median: 78.7%).

Lead health education teachers also received professional development during the 2 years before the survey on other specific topics related to HIV prevention. The percentage of schools in which the lead health education teacher received professional development on these topics ranged as follows (Table 19a, b):

- **Teaching HIV prevention education to students with physical, mental, or cognitive disabilities:** from 5.9% to 41.4% across states (median: 17.2%), from 16.9% to 94.9% across cities (median: 40.7%), and from 23.1% to 75.0% across territories (median: 60.0%).
- **Teaching HIV prevention education to students of various cultural backgrounds:** from 5.1% to 46.0% across states (median: 18.8%), from 31.2% to 94.9% across cities (median: 54.9%), and from 38.5% to 90.9% across territories (median: 82.2%).

- **Using interactive teaching methods for HIV prevention education (e.g., role plays or cooperative group activities):** from 6.2% to 53.8% across states (median: 24.1%), from 32.0% to 94.9% across cities (median: 54.9%), and from 30.8% to 100.0% across territories (median: 87.8%).
- **Teaching essential skills for health behavior change related to HIV prevention and guiding student practice of these skills:** from 8.3% to 52.7% across states (median: 25.7%), from 33.1% to 94.9% across cities (median: 60.4%), and from 30.8% to 90.9% across territories (median: 84.2%).
- **Teaching about health-promoting social norms and beliefs related to HIV prevention:** from 8.7% to 50.0% across states (median: 25.2%), from 33.5% to 94.9% across cities (median: 55.5%), and from 30.8% to 100.0% across territories (median: 85.9%).
- **Strategies for involving parents, families, and others in student learning of HIV prevention education:** from 5.1% to 35.7% across states (median: 16.7%), from 13.0% to 93.2% across cities (median: 44.5%), and from 30.8% to 76.9% across territories (median: 69.3%).
- **Assessing students' performance in HIV prevention education:** from 6.1% to 49.3% across states (median: 20.4%), from 1.6% to 68.7% across cities (median: 47.3%), and from 23.1% to 75.0% across territories (median: 72.9%).
- **Implementing standards-based HIV prevention education curricula and student assessment:** from 5.1% to 56.3% across states (median: 20.7%), from 26.2% to 94.9% across cities (median: 51.1%), and from 23.1% to 87.5% across territories (median: 66.4%).

- **Using technology to improve HIV prevention education instruction:** from 6.3% to 46.6% across states (median: 20.3%), from 1.7% to 67.3% across cities (median: 41.9%), and from 30.8% to 87.5% across territories (median: 58.9%).
 - **Teaching HIV prevention education to students with limited English proficiency:** from 3.5% to 36.2% across states (median: 11.7%), from 0.0% to 53.5% across cities (median: 35.8%), and from 23.1% to 81.8% across territories (median: 74.1%).
 - **Addressing community concerns and challenges related to HIV prevention education:** from 5.2% to 36.8% across states (median: 13.3%), from 7.7% to 94.9% across cities (median: 40.7%), and from 30.8% to 75.0% across territories (median: 69.1%).
 - **At least 6 of these 11 topics:** from 5.1% to 49.4% across states (median: 18.7%), from 26.0% to 94.9% across cities (median: 50.1%), and from 23.1% to 88.5% across territories (median: 84.7%).
- Lead health education teachers also received professional development during the 2 years before the survey on other topics. The percentage of schools in which the lead health education teacher received professional development on these topics ranged as follows (Table 20):
- **Teaching students with physical, medical, or cognitive disabilities:** from 21.8% to 61.3% across states (median: 40.7%), from 24.1% to 68.8% across cities (median: 44.3%), and from 36.4% to 69.2% across territories (median: 50.5%).
 - **Teaching students of various cultural backgrounds:** from 14.0% to 56.6% across states (median: 36.1%), from 27.1% to 78.7% across cities (median: 51.3%), and from 50.0% to 81.8% across territories (median: 72.1%).
 - **Teaching students with limited English proficiency:** from 7.7% to 68.1% across states (median: 24.6%), from 12.0% to 81.5% across cities (median: 40.7%), and from 61.5% to 96.2% across territories (median: 72.2%).
 - **Teaching students of different sexual orientations or gender identities:** from 3.4% to 25.6% across states (median: 11.8%), from 18.2% to 59.2% across cities (median: 26.0%), and from 30.8% to 88.5% across territories (median: 41.5%).
 - **Using interactive teaching methods (e.g., role plays or cooperative group activities):** from 33.6% to 70.5% across states (median: 56.1%), from 49.7% to 84.2% across cities (median: 65.5%), and from 61.5% to 90.9% across territories (median: 88.0%).
 - **Encouraging family or community involvement:** from 23.9% to 71.4% across states (median: 34.6%), from 34.3% to 60.2% across cities (median: 40.8%), and from 38.5% to 90.9% across territories (median: 81.8%).
 - **Teaching skills for behavior change:** from 28.1% to 60.6% across states (median: 44.9%), from 25.8% to 68.3% across cities (median: 50.0%), and from 41.7% to 92.3% across territories (median: 83.0%).
 - **Classroom management techniques (e.g., social skills training, environmental modification, conflict resolution and mediation, and behavior management):** from 38.9% to 83.9% across states (median: 58.3%), from 34.3% to 81.5% across cities (median: 62.9%), and from 30.8% to 92.3% across territories (median: 83.0%).
 - **Assessing or evaluating students in health education:** from 14.7% to 54.4% across states (median: 36.3%), from 17.0% to 62.6% across cities (median: 41.5%), and from 23.1% to 96.2% across territories (median: 67.6%).

The percentage of schools in which the lead health education teacher wanted to receive professional development on these topics ranged as follows (Table 21):

- **Teaching students with physical, medical, or cognitive disabilities:** from 48.0% to 82.1% across states (median: 62.6%), from 37.8% to 90.8% across cities (median: 73.9%), and from 69.2% to 96.2% across territories (median: 81.2%).
- **Teaching students of various cultural backgrounds:** from 34.7% to 75.0% across states (median: 56.9%), from 40.2% to 85.1% across cities (median: 70.2%), and from 63.6% to 96.2% across territories (median: 70.3%).
- **Teaching students with limited English proficiency:** from 25.9% to 77.0% across states (median: 48.8%), from 37.2% to 84.0% across cities (median: 67.5%), and from 69.2% to 100.0% across territories (median: 79.2%).
- **Teaching students of different sexual orientations or gender identities:** from 34.5% to 75.0% across states (median: 53.4%), from 37.2% to 85.5% across cities (median: 71.9%), and from 45.5% to 100.0% across territories (median: 81.3%).
- **Using interactive teaching methods (e.g., role plays or cooperative group activities):** from 49.1% to 82.6% across states (median: 65.4%), from 45.2% to 87.5% across cities (median: 73.4%), and from 72.7% to 100.0% across territories (median: 85.2%).
- **Encouraging family or community involvement:** from 54.2% to 81.1% across states (median: 70.3%), from 42.9% to 91.5% across cities (median: 78.5%), and from 81.8% to 100.0% across territories (median: 85.2%).

- **Teaching skills for behavior change:** from 62.9% to 87.8% across states (median: 74.2%), from 60.3% to 92.5% across cities (median: 85.5%), and from 63.6% to 100.0% across territories (median: 81.9%).
- **Classroom management techniques (e.g., social skills training, environmental modification, conflict resolution and mediation, and behavior management):** from 53.7% to 79.6% across states (median: 63.6%), from 35.6% to 88.9% across cities (median: 76.6%), and from 69.2% to 100.0% across territories (median: 88.3%).
- **Assessing or evaluating students in health education:** from 58.3% to 82.3% across states (median: 70.4%), from 34.2% to 88.8% across cities (median: 76.8%), and from 76.8% to 100.0% across territories (median: 88.3%).

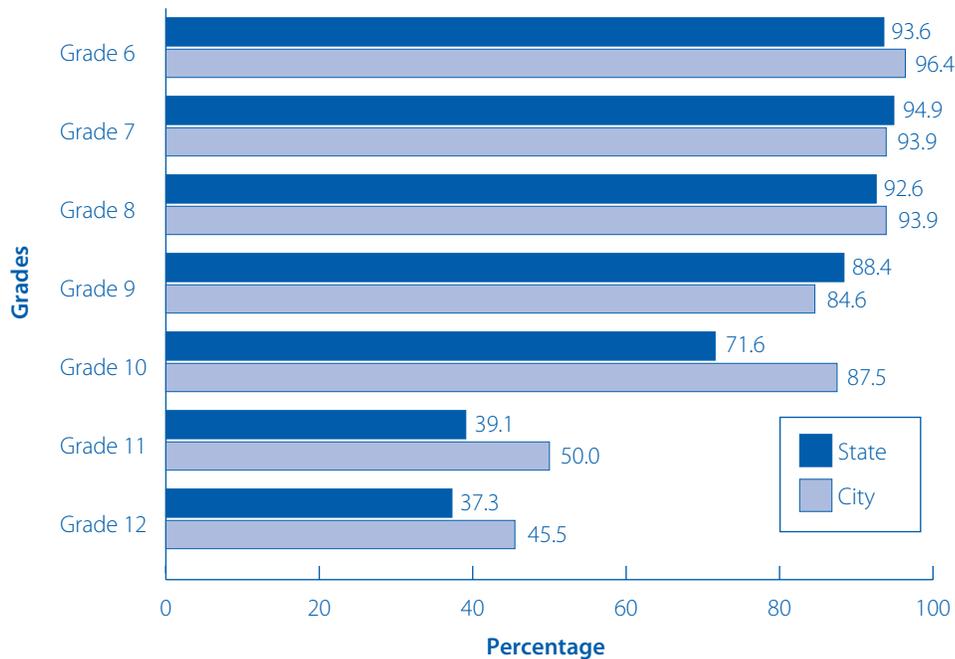
PHYSICAL EDUCATION AND PHYSICAL ACTIVITY

Required Physical Education

Physical education is defined on the Profiles questionnaire as instruction that helps students develop the knowledge, attitudes, skills, and confidence needed to adopt and maintain a physically active lifestyle that students must receive for graduation or promotion from school. The percentage of schools that required physical education for students in any of grades 6 through 12 ranged from 61.1% to 100.0% across states (median: 97.0%), from 79.7% to 100.0% across cities (median: 95.9%), and from 85.7% to 100.0% across territories (median: 98.5%) (Table 22).

Among schools with students in particular grades, the percentage of schools across states that taught a required physical education course in that grade

FIGURE 3. Median percentage of schools that taught a required physical education course in each grade,*
School Health Profiles, 2010



*Among schools with students in each grade.

ranged from 66.0% to 100.0% (median: 93.6%) in grade 6, 47.5% to 100.0% (median: 94.9%) in grade 7, 44.5% to 100.0% (median: 92.6%) in grade 8, 15.4% to 99.0% (median: 88.4%) in grade 9, 13.0% to 100.0% (median: 71.6%) in grade 10, 7.5% to 100.0% (median: 39.1%) in grade 11, and from 6.1% to 100.0% (median: 37.3%) in grade 12 (Table 23, Figure 3). Among schools with students in particular grades, the percentage of schools across cities that taught a required physical education course in that grade ranged from 63.9% to 100.0% (median: 96.4%) in grade 6, 48.2% to 100.0% (median: 93.9%) in grade 7, 20.3% to 100.0% (median: 93.9%) in grade 8, 48.5% to 100.0% (median: 84.6%) in grade 9,

15.4% to 100.0% (median: 87.5%) in grade 10, 0.0% to 100.0% (median: 50.0%) in grade 11, and from 0.0% to 100.0% (median: 45.5%) in grade 12 (Table 23, Figure 3). Among schools with students in particular grades, the percentage of schools across territories that taught a required physical education course in that grade ranged from 95.0% to 100.0% (median: 100.0%) in grade 6, 93.2% to 100.0% (median: 100.0%) in grade 7, 37.5% to 100.0% (median: 95.0%) in grade 8, 55.3% to 100.0% (median: 80.0%) in grade 9, 50.0% to 100.0% (median: 100.0%) in grade 10, 25.0% to 100.0% (median: 80.0%) in grade 11, and from 25.0% to 100.0% (median: 75.0%) in grade 12 (Table 23).

Among schools that required physical education for students in any of grades 6 through 12, the percentage of schools that allowed students to be exempted from required physical education for specific reasons ranged as follows (Table 24):

- **Religious reasons:** from 19.0% to 65.2% across states (median: 42.0%), from 7.5% to 67.2% across cities (median: 51.2%), and from 0.0% to 29.7% across territories (median: 0.0%).
- **Long-term physical or medical disability:** from 50.3% to 93.7% across states (median: 81.9%), from 39.5% to 100.0% across cities (median: 80.8%), and from 12.0% to 100.0% across territories (median: 66.7%).
- **Cognitive disability:** from 13.9% to 56.8% across states (median: 34.3%), from 12.8% to 61.2% across cities (median: 34.2%), and from 8.0% to 100.0% across territories (median: 33.3%).
- **Enrollment in other courses (e.g., math or science):** from 2.9% to 57.8% across states (median: 19.8%), from 0.0% to 67.9% across cities (median: 12.9%), and from 0.0% to 34.9% across territories (median: 16.7%).
- **Participation in school sports:** from 0.9% to 72.9% across states (median: 9.7%), from 1.6% to 57.8% across cities (median: 10.5%), and from 0.0% to 42.2% across territories (median: 0.0%).
- **Participation in other school activities (e.g., ROTC, band, or chorus):** from 1.2% to 70.6% across states (median: 12.2%), from 2.2% to 67.8% across cities (median: 23.0%), and from 0.0% to 34.4% across territories (median: 16.7%).
- **Participation in community sports activities:** from 0.0% to 36.0% across states (median: 3.3%), from 0.0% to 41.0% across cities (median: 4.7%), and from 0.0% to 40.6% across territories (median: 0.0%).

- **High physical fitness competency test**

- score:** from 0.0% to 13.8% across states (median: 1.7%), from 0.0% to 9.7% across cities (median: 5.2%), and from 0.0% to 34.9% across territories (median: 0.0%).

- **Participation in vocational training:** from 0.5% to 23.7% across states (median: 4.1%), from 0.0% to 26.9% across cities (median: 4.6%), and from 0.0% to 26.1% across territories (median: 0.0%).

- **Participation in community service**

- activities:** from 0.0% to 16.4% across states (median: 2.1%), from 0.0% to 12.0% across cities (median: 3.9%), and from 0.0% to 41.0% across territories (median: 0.0%).

The percentage of schools that did not allow students in any of grades 6 through 12 to be exempted from required physical education for enrollment in other courses, participation in school sports, participation in other school activities, participation in community sports activities, high physical fitness competency test scores, participation in vocational training, or participation in community service activities ranged from 14.9% to 89.3% across states (median: 65.4%), from 15.0% to 86.3% across cities (median: 64.4%), and from 34.6% to 100.0% across territories (median: 66.7%) (Table 24).

Professional Development

Professional development for physical education teachers is an important component of a quality physical education program. The percentage of schools in which at least one physical education teacher or specialist at the school received professional development on physical education during the 2 years before the study ranged from 37.5% to 98.3% across states (median: 87.5%), from 86.8% to 100.0% across cities (median: 95.6%), and

from 65.7% to 100.0% across territories (median: 75.0%) (Table 22).

Materials for Physical Education Teachers

Schools can provide materials to physical education teachers to help them teach. The percentage of schools that provided the following materials to those who teach physical education ranged as follows (Table 25):

- **Goals, objectives, and expected outcomes for physical education:** from 67.8% to 100.0% across states (median: 95.3%), from 91.2% to 100.0% across cities (median: 97.6%), and from 85.3% to 100.0% across territories (median: 100.0%).
- **A chart describing the annual scope and sequence of instruction for physical education:** from 49.3% to 96.1% (median: 78.9%) across states, from 76.8% to 100.0% across cities (median: 90.9%), and from 69.2% to 100.0% across territories (median: 87.5%).
- **Plans for how to assess student performance in physical education:** from 52.2% to 95.7% across states (median: 84.3%), from 78.6% to 100.0% across cities (median: 92.7%), and from 79.6% to 100.0% across territories (median: 100.0%).
- **A written physical education curriculum:** from 59.1% to 98.3% across states (median: 89.2%), from 71.7% to 100.0% across cities (median: 90.8%), and from 85.4% to 100.0% across territories (median: 100.0%).
- **All 4 types of materials:** from 39.1% to 93.9% across states (median: 71.6%), from 62.9% to 98.5% across cities (median: 83.8%), and from 64.9% to 100.0% across territories (median: 87.5%).

Physical Activity

To promote physical activity, schools may offer students the opportunity to participate in intramural sports or physical activity clubs or allow the use of school facilities outside of school hours for community-sponsored classes or lessons. Intramural activities or physical activity clubs were defined on the questionnaire as any physical activity programs that are voluntary for students, in which students are given an equal opportunity to participate regardless of physical ability. The percentage of schools that offered opportunities for students to participate in intramural activities or physical activity clubs ranged from 40.6% to 87.1% across states (median: 62.8%), from 47.5% to 100.0% across cities (median: 81.3%), and from 74.5% to 100.0% across territories (median: 92.3%) (Table 22).

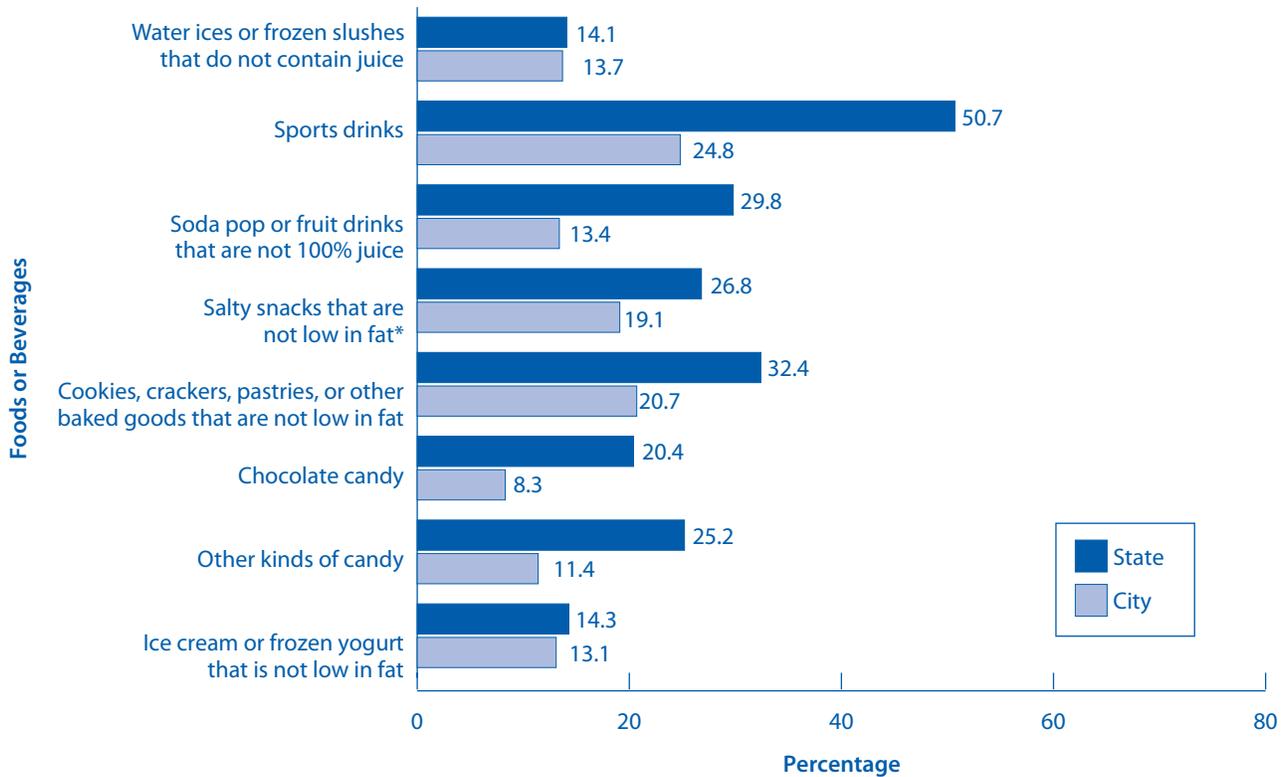
The percentage of schools in which children or adolescents use any of the school's indoor physical activity or athletic facilities for community-sponsored physical activity classes or lessons outside of school hours or when school is not in session ranged from 54.8% to 96.8% across states (median: 81.3%), from 48.2% to 91.8% across cities (median: 70.6%), and from 9.1% to 100.0% across territories (median: 73.2%) (Table 22).

HEALTHY AND SAFE SCHOOL ENVIRONMENT

Nutrition-Related Policies and Practices

The school nutrition environment includes not only the federal school meal programs, but also foods and beverages sold at school separately from these programs. The percentage of schools that allowed students to purchase snack foods or beverages from one or more vending machines

FIGURE 4. Median percentage of schools that allowed students to purchase less nutritious snack foods or beverages, School Health Profiles, 2010



*Such as regular potato chips.

at the school or at a school store, canteen, or snack bar ranged from 37.0% to 92.8% across states (median: 70.5%), from 21.5% to 89.4% across cities (median: 62.7%), and from 0.0% to 76.9% across territories (median: 50.0%) (Table 26). The percentage of schools that limited the package or serving size of any individual food or beverage items sold in vending machines or at the school store, canteen, or snack bar ranged from 17.8% to 83.5% across states (median: 45.5%), from 15.1% to 66.1% across cities (median: 35.5%), and from 0.0% to 38.5% across territories (median: 20.0%) (Table 26). The percentage of schools that allowed students to purchase less nutritious snack

foods and beverages from vending machines or at the school store, canteen, or snack bar ranged as follows (Table 27, Figure 4):

- 2% or whole milk (plain or flavored):** from 6.3% to 53.1% across states (median: 34.8%), from 11.7% to 59.5% across cities (median: 24.0%), and from 0.0% to 45.5% across territories (median: 37.5%).
- Foods or beverages containing caffeine:** from 1.0% to 49.1% across states (median: 27.6%), from 2.6% to 51.0% across cities (median: 8.3%), and from 0.0% to 63.6% across territories (median: 0.0%).

- **Ice cream or frozen yogurt that is not low in fat:** from 0.6% to 41.4% across states (median: 14.3%), from 0.0% to 51.4% across cities (median: 13.1%), and from 0.0% to 54.5% across territories (median: 12.5%).
- **Water ices or frozen slushes that do not contain juice:** from 2.3% to 32.5% across states (median: 14.1%), from 2.9% to 48.7% across cities (median: 13.7%), and from 0.0% to 45.5% across territories (median: 25.0%).
- **Cookies, crackers, cakes, pastries, or other baked goods that are not low in fat:** from 6.0% to 69.7% across states (median: 32.4%), from 1.8% to 71.5% across cities (median: 20.7%), and from 0.0% to 63.6% across territories (median: 25.0%).
- **Salty snacks that are not low in fat (e.g., regular potato chips):** from 8.3% to 68.5% across states (median: 26.8%), from 5.8% to 67.9% across cities (median: 19.1%), and from 0.0% to 63.6% across territories (median: 12.5%).
- **Chocolate candy:** from 0.0% to 75.2% across states (median: 20.4%), from 0.0% to 58.0% across cities (median: 8.3%), and from 0.0% to 63.6% across territories (median: 12.5%).
- **Other kinds of candy:** from 2.0% to 74.0% across states (median: 25.2%), from 0.0% to 65.8% across cities (median: 11.4%), and from 0.0% to 63.6% across territories (median: 0.0%).
- **Soda pop or fruit drinks that are not 100% juice:** from 2.9% to 54.3% across states (median: 29.8%), from 3.2% to 73.8% across cities (median: 13.4%), and from 0.0% to 54.5% across territories (median: 7.7%).

- **Sports drinks (e.g., Gatorade):** from 8.4% to 73.0% across states (median: 50.7%), from 9.2% to 83.9% across cities (median: 24.8%), and from 0.0% to 63.6% across territories (median: 50.0%).

The percentage of schools that did not sell baked goods that are not low in fat, salty snacks that are not low in fat, candy, soda pop or fruit drinks that are not 100% juice, or sports drinks in vending machines or at the school store, canteen, or snack bar ranged from 8.3% to 81.6% across states (median: 38.4%), from 12.1% to 81.5% across cities (median: 62.8%), and from 36.4% to 100.0% across territories (median: 50.0%) (Table 27).

The percentage of schools that allowed students to purchase fruits (not fruit juice) from vending machines or at the school store, canteen, or snack bar ranged from 2.8% to 50.2% across states (median: 28.3%), from 8.0% to 46.7% across cities (median: 29.2%), and from 0.0% to 63.6% across territories (median: 23.1%), and the percentage of schools that allowed students to purchase non-fried vegetables (not vegetable juice) from these venues ranged from 2.3% to 36.3% across states (median: 20.2%), from 5.1% to 40.1% across cities (median: 20.5%), and from 0.0% to 54.5% across territories (median: 15.4%) (Table 26). The percentage of schools that always or almost always offered fruits or non-fried vegetables when foods and beverages are offered at school celebrations ranged from 12.2% to 52.4% across states (median: 32.4%), from 18.6% to 91.1% across cities (median: 41.5%), and from 24.2% to 76.9% across territories (median: 63.6%) (Table 26). The percentage of schools that made fruits and vegetables available in vending machines or at the school store, canteen, or snack bar and at school celebrations

ranged from 1.4% to 23.4% across states (median: 9.9%), from 3.9% to 24.9% across cities (median: 13.3%), and from 0.0% to 63.6% across territories (median: 12.5%) (Table 26).

The percentage of schools that implemented strategies to promote healthy eating during the 2009-2010 school year ranged as follows (Table 28):

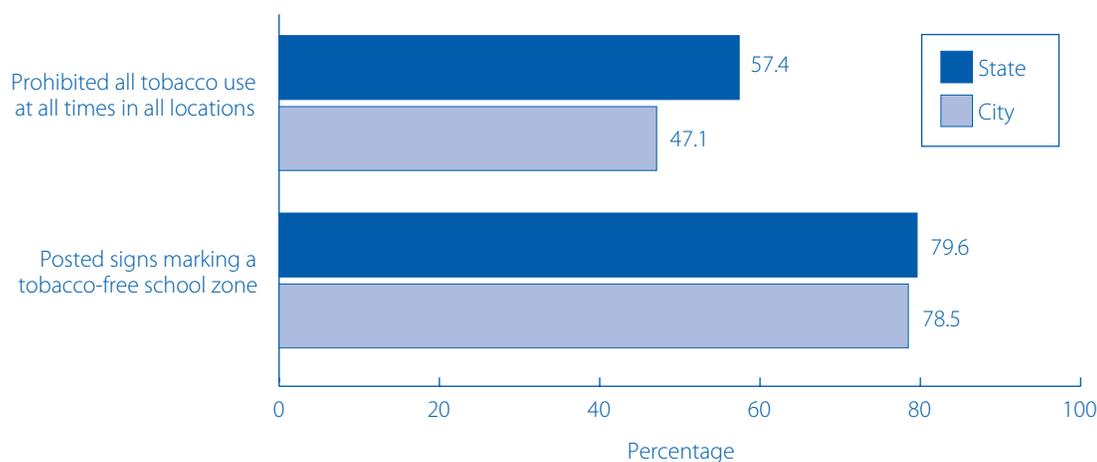
- **Priced nutritious foods and beverages at a lower cost while increasing the price of less nutritious foods and beverages:** from 0.6% to 20.0% across states (median: 10.3%), from 3.8% to 20.0% across cities (median: 9.5%), and from 0.0% to 38.5% across territories (median: 9.1%).
- **Collected suggestions from students, families, and school staff on nutritious food preferences and strategies to promote healthy eating:** from 30.2% to 70.8% across states (median: 45.7%), from 30.4% to 80.5% across cities (median: 45.1%), and from 15.4% to 71.4% across territories (median: 63.3%).
- **Provided information to students or families on the nutrition and caloric content of foods available:** from 30.1% to 68.8% across states (median: 45.8%), from 37.9% to 67.5% across cities (median: 50.1%), and from 38.5% to 85.7% across territories (median: 63.6%).
- **Conducted taste tests to determine food preferences for nutritious items:** from 7.1% to 54.3% across states (median: 20.6%), from 9.8% to 58.2% across cities (median: 24.2%), and from 23.1% to 45.5% across territories (median: 38.5%).
- **Provided opportunities for students to visit the cafeteria to learn about food safety, food preparation, and other nutrition-related topics:** from 13.0% to 43.5% across states (median: 18.7%), from 10.7% to 38.1% across cities (median: 24.2%), and from 16.7% to 64.0% across territories (median: 54.5%).

- **Implemented at least 3 of these 5 strategies during the 2009-2010 school year:** from 8.6% to 50.2% across states (median: 21.0%), from 10.0% to 36.8% across cities (median: 29.8%), and from 15.4% to 71.4% across territories (median: 46.2%).

Another important aspect of the school nutrition environment is advertisements for and promotion of candy, fast-food restaurants, and soft drinks. The percentage of schools that promoted candy, meals from fast-food restaurants, or soft drinks through the distribution of products such as t-shirts, hats, and book covers to students ranged from 0.0% to 9.2% across states (median: 2.3%), from 0.0% to 11.6% across cities (median: 2.2%), and from 0.0% to 57.7% across territories (median: 7.7%) (Table 29). The percentage of schools that prohibited advertisements for candy, fast-food restaurants, or soft drinks in specific locations ranged as follows (Table 29):

- **In the school building:** from 43.1% to 89.7% across states (median: 67.9%), from 61.2% to 100.0% across cities (median: 77.0%), and from 0.0% to 84.6% across territories (median: 54.3%).
- **On school grounds, including on the outside of the school building, on playing fields, or other area of the campus:** from 40.3% to 79.9% across states (median: 57.1%), from 58.7% to 100.0% across cities (median: 72.4%), and from 0.0% to 84.6% across territories (median: 49.2%).
- **On school buses or other vehicles used to transport students:** from 49.3% to 87.4% across states (median: 74.1%), from 57.4% to 100.0% across cities (median: 75.3%), and from 0.0% to 84.6% across territories (median: 40.2%).
- **In school publications (e.g., newsletters, newspapers, Web sites, or other school publications):** from 45.2% to 82.6% across states (median: 61.4%), from 57.4% to 100.0% across

FIGURE 5. Median percentage of schools that prohibited all tobacco use at all times in all locations* and posted signs marking a tobacco-free school zone,[†] School Health Profiles, 2010



*Prohibited the use of all tobacco, including cigarettes, smokeless tobacco, cigars, and pipes, by students, faculty, school staff, and visitors, in school buildings, outside on school grounds, on school buses or other vehicles used to transport students, and at off-campus, school-sponsored events, during school hours and non-school hours.
[†]A specified distance from school grounds where tobacco use is not allowed.

cities (median: 73.5%), and from 9.1% to 84.6% across territories (median: 38.5%).

The percentage of schools that prohibited advertisements for candy, fast-food restaurants, or soft drinks in all locations and did not promote candy, meals from fast-food restaurants, or soft drinks through the distribution of products to students ranged from 32.1% to 73.0% across states (median: 49.1%), from 45.5% to 100.0% across cities (median: 61.2%), and from 0.0% to 76.9% across territories (median: 31.7%) (Table 29).

Tobacco-Use Prevention

Policies prohibiting tobacco use at school can help prevent tobacco use among students. The percentage of schools that had a policy prohibiting tobacco use ranged from 90.2% to 100.0% across states (median: 97.9%), from 72.9% to 100.0% across cities (median: 95.5%), and from 95.2% to 100.0% across territories (median: 100.0%) (Table 30). The percentage of schools that prohibited the use of all tobacco, including cigarettes, smokeless tobacco (i.e., chewing tobacco, snuff, or dip), cigars, and pipes by students, faculty, school staff,

and visitors, in school buildings, outside on school grounds (including parking lots and playing fields), on school buses or other vehicles used to transport students, and at off-campus, school-sponsored events, during school hours and non-school hours ranged from 23.5% to 79.3% across states (median: 57.4%), from 29.3% to 95.5% across cities (median: 47.1%), and from 0.0% to 60.0% across territories (median: 14.9%) (Table 30, Figure 5).

Schools may take specific actions when students are caught smoking cigarettes. The percentage of schools that sometimes, almost always, or always took specific actions when students are caught smoking cigarettes ranged as follows (Table 31a, b):

- **Notified parents or guardians:** from 95.5% to 100.0% across states (median: 99.5%), from 95.1% to 100.0% across cities (median: 99.3%), and from 97.1% to 100.0% across territories (median: 100.0%).
- **Referred students to a school counselor:** from 64.3% to 94.0% across states (median:

77.9%), from 71.4% to 100.0% across cities (median: 87.4%), and from 84.6% to 100.0% across territories (median: 89.7%).

- **Referred students to a school administrator:** from 95.2% to 100.0% across states (median: 99.3%), from 84.8% to 100.0% across cities (median: 97.7%), and from 95.5% to 100.0% across territories (median: 100.0%).
- **Encouraged, but not required, students to participate in an assistance, education, or cessation program:** from 38.7% to 85.1% across states (median: 66.6%), from 45.5% to 89.4% across cities (median: 65.2%), and from 9.1% to 84.6% across territories (median: 71.6%).
- **Required students to participate in an assistance, education, or cessation program:** from 17.0% to 85.8% across states (median: 42.0%), from 27.5% to 84.5% across cities (median: 39.6%), and from 9.1% to 76.9% across territories (median: 65.2%).
- **Referred students to legal authorities:** from 12.7% to 97.2% across states (median: 59.9%), from 13.0% to 87.3% across cities (median: 36.7%), and from 18.2% to 50.0% across territories (median: 36.5%).
- **Placed students in detention:** from 50.9% to 89.8% across states (median: 64.2%), from 46.2% to 91.8% across cities (median: 74.4%), and from 50.0% to 90.9% across territories (median: 87.5%).
- **Did not allow students to participate in extra-curricular activities or interscholastic sports:** from 48.9% to 96.5% across states (median: 75.8%), from 48.5% to 82.6% across cities (median: 61.4%), and from 60.7% to 100.0% across territories (median: 96.2%).

- **Gave students in-school suspension:** from 53.2% to 90.6% across states (median: 72.4%), from 41.3% to 89.9% across cities (median: 75.9%), and from 30.8% to 100.0% across territories (median: 85.7%).

- **Suspended students from school:** from 54.2% to 92.4% across states (median: 76.9%), from 41.1% to 94.9% across cities (median: 77.3%), and from 39.8% to 100.0% across territories (median: 90.9%).

- **Expelled students from school:** from 1.4% to 62.9% across states (median: 9.6%), from 0.0% to 35.8% across cities (median: 9.1%), and from 0.0% to 81.8% across territories (median: 23.1%).

- **Reassigned students to an alternative school:** from 0.6% to 64.8% across states (median: 12.5%), from 0.0% to 58.4% across cities (median: 11.0%), and from 15.4% to 72.7% across territories (median: 25.0%).

Among schools with a policy prohibiting tobacco use, the percentage of these schools that had procedures to inform specific groups about the tobacco-use prevention policy that prohibited their use of tobacco ranged from 96.5% to 100.0% across states (median: 99.1%), from 92.3% to 100.0% across cities (median: 98.5%), and was 100.0% in all territories for students; from 90.9% to 99.4% across states (median: 96.6%), from 82.2% to 100.0% across cities (median: 96.0%), and from 60.0% to 100.0% across territories (median: 92.3%) for faculty and staff; and from 73.4% to 98.4% across states (median: 89.1%), from 72.9% to 100.0% across cities (median: 88.4%), and from 40.0% to 100.0% across territories (median: 91.8%) for visitors (Table 32).

In addition to informing students, faculty, staff, and visitors about the policy that prohibits their use of tobacco, schools can take specific actions to support such a policy. The percentage of schools that took these specific actions ranged as follows (Table 32):

- **Included guidelines in the policy on what actions the school should take when students are caught smoking cigarettes:** from 92.5% to 99.5% across states (median: 96.8%), from 93.1% to 100.0% across cities (median: 97.7%), and from 96.5% to 100.0% across territories (median: 100.0%).
- **Always or almost always notified parents or guardians when students are caught smoking cigarettes:** from 88.1% to 99.5% across states (median: 96.9%), from 85.0% to 100.0% across cities (median: 96.7%), and from 88.3% to 100.0% across territories (median: 100.0%).
- **Used the effect or severity of the violation or repeat offender status to determine actions to take when students are caught smoking cigarettes:** from 71.3% to 94.6% across states (median: 84.3%), from 70.2% to 96.2% across cities (median: 82.7%), and from 83.0% to 100.0% across territories (median: 100.0%).
- **Used remedial rather than punitive sanctions when students are caught smoking cigarettes (i.e., always or almost always took at least one of the following actions: referred to a school counselor; encouraged to participate in an assistance, education, or cessation program; or required to participate in an assistance, education, or cessation program):** from 25.7% to 85.2% across states (median: 49.0%), from 45.1% to 97.0% across cities (median: 63.2%), and from 53.8% to 100.0% across territories (median: 85.7%).
- **Had an individual responsible for enforcing the policy:** from 42.0% to 70.5% across states (median: 55.2%), from 30.3% to 62.8% across cities (median: 45.8%), and from 50.0% to 97.7% across territories (median: 63.6%).
- **Posted signs marking a tobacco-free school zone, that is, a specified distance from school grounds where tobacco use is not allowed:** from 40.9% to 95.4% across states (median: 79.6%), from 46.5% to 98.5% across cities (median: 78.5%), and from 18.2% to 100.0% across territories (median: 57.1%) (Figure 5).
- **Met all 7 of these criteria:** from 5.0% to 34.0% across states (median: 14.4%), from 7.0% to 32.3% across cities (median: 13.4%), and from 0.0% to 39.3% across territories (median: 16.7%).

Tobacco cessation efforts are an important component of creating a tobacco-free environment at school. The percentage of schools that provided tobacco cessation services for faculty and staff ranged from 5.6% to 33.1% across states (median: 16.1%), from 6.9% to 32.8% across cities (median: 19.4%), and from 9.1% to 61.5% across territories (median: 42.9%), and the percentage of schools that provided tobacco cessation services for students ranged from 11.5% to 71.6% across states (median: 27.3%), from 8.9% to 72.1% across cities (median: 30.7%), and from 9.1% to 88.5% across territories (median: 62.5%) (Table 33). The percentage of schools with arrangements with any organizations or health care professionals not on school property to provide tobacco cessation services for faculty and staff ranged from 12.9% to 46.5% across states (median: 27.0%), from 12.7% to 50.5% across cities (median: 24.3%), and from 38.5% to 88.5% across territories (median: 57.5%), and the percentage with such arrangements for students ranged from 17.4% to 61.5% across states (median: 36.6%), from 18.2% to 72.7% across cities (median:

32.4%), and from 50.0% to 92.3% across territories (median: 69.2%) (Table 33). The percentage of schools that provided tobacco cessation services at school or had arrangements with organizations or health care professionals not on school property to provide these services for faculty and staff and students ranged from 13.8% to 43.1% across states (median: 26.1%), from 13.3% to 43.0% across cities (median: 24.2%), and from 38.5% to 92.3% across territories (median: 59.7%) (Table 33).

To enhance tobacco-use prevention efforts, schools should coordinate their messages and programs with community mass-media efforts. The percentage of schools that gathered and shared information with students and families about mass-media messages or community-based tobacco-use prevention efforts during the two years before the survey ranged from 33.3% to 74.4% across states (median: 47.7%), from 29.9% to 81.6% across cities (median: 43.6%), and from 33.3% to 100.0% across territories (median: 64.2%) (Table 34). The percentage of schools that worked with local agencies or organizations to plan and implement events or programs intended to reduce tobacco use during the 2 years before the survey ranged from 33.9% to 82.9% across states (median: 52.0%), from 22.6% to 69.2% across cities (median: 39.7%), and from 59.6% to 100.0% across territories (median: 71.4%) (Table 34). The percentage of schools that conducted both of these activities during the 2 years before the survey ranged from 19.2% to 68.4% across states (median: 36.5%), from 16.3% to 66.3% across cities (median: 29.1%), and from 16.7% to 100.0% across territories (median: 57.1%) (Table 34).

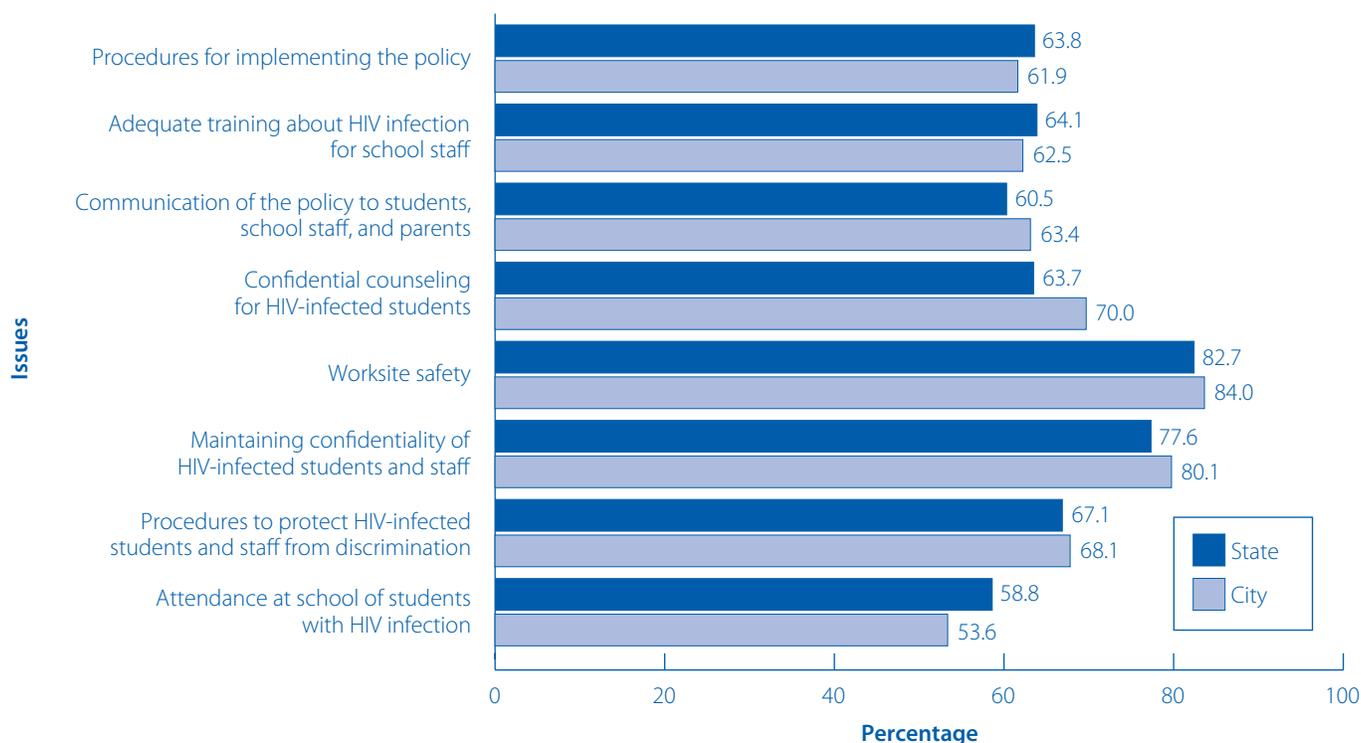
HIV Infection and AIDS Prevention

School policies can provide critical support for HIV-infected students and staff. The percentage of schools with a policy that addresses specific issues

for students or staff with HIV infection or AIDS ranged as follows (Table 35, Figure 6):

- **Worksite safety (i.e., universal precautions for all school staff):** from 58.4% to 94.3% across states (median: 82.7%), from 62.3% to 100.0% across cities (median: 84.0%), and from 38.5% to 100.0% across territories (median: 83.9%).
- **Confidential counseling for HIV-infected students:** from 40.0% to 75.0% across states (median: 63.7%), from 42.1% to 98.5% across cities (median: 70.0%), and from 23.1% to 100.0% across territories (median: 85.7%).
- **Communication of the policy to students, school staff, and parents:** from 36.8% to 83.5% across states (median: 60.5%), from 42.9% to 98.5% across cities (median: 63.4%), and from 16.7% to 100.0% across territories (median: 87.5%).
- **Adequate training about HIV infection for school staff:** from 30.9% to 90.6% across states (median: 64.1%), from 36.5% to 100.0% across cities (median: 62.5%), and from 15.4% to 100.0% across territories (median: 62.5%).
- **Procedures for implementing the policy:** from 34.9% to 80.4% across states (median: 63.8%), from 37.2% to 98.5% across cities (median: 61.9%), and from 15.4% to 100.0% across territories (median: 84.0%).
- **Attendance of students with HIV infection:** from 26.1% to 85.1% across states (median: 58.8%), from 32.9% to 98.5% across cities (median: 53.6%), and from 23.1% to 100.0% across territories (median: 79.5%).
- **Procedures to protect HIV-infected students and staff from discrimination:** from 38.5% to 89.4% across states (median: 67.1%), from

FIGURE 6. Median percentage of schools with a policy that addressed specific issues for students or staff with HIV* infections or AIDS,† School Health Profiles, 2010



*Human immunodeficiency virus.

†Acquired immunodeficiency syndrome.

42.3% to 100.0% across cities (median: 68.1%), and from 15.4% to 100.0% across territories (median: 88.5%).

- **Maintaining confidentiality of HIV-infected students and staff:** from 54.1% to 93.5% across states (median: 77.6%), from 59.4% to 100.0% across cities (median: 80.1%), and from 30.8% to 100.0% across territories (median: 80.8%).
- **Attendance of students with HIV infection, procedures to protect HIV-infected students and staff from discrimination, and maintaining confidentiality of HIV-infected students and staff:** from 25.4% to 85.1% across states (median: 56.3%), from 31.4% to 98.5% across cities (median: 53.1%), and from 15.4% to 100.0% across territories (median: 76.9%).

HIV, STD, or Pregnancy Prevention Programs for Youth at High Risk

Some schools gear HIV prevention efforts toward specific high-risk groups. The percentage of schools that required professional development for school staff on HIV, STD, or pregnancy prevention for youth who participate in drop-out prevention, alternative education, or GED programs ranged from 10.6% to 51.6% across states (median: 27.3%), from 0.0% to 63.7% across cities (median: 42.8%), and from 23.1% to 81.8% across territories (median: 46.2%) (Table 36). The percentage of schools that required any school staff to receive professional development on HIV, STD, or pregnancy prevention issues and resources for ethnic/racial minority youth at high risk (e.g., black, Hispanic, or American Indian youth) ranged from 2.7% to

50.6% across states (median: 24.5%), from 20.3% to 100.0% across cities (median: 58.6%), and from 23.1% to 72.7% across territories (median: 50.0%) (Table 36).

During the 2009-2010 school year, some schools provided HIV, STD, or pregnancy prevention programs for ethnic/racial minority youth at high risk, including after-school or supplemental programs. The percentage of schools that implemented specific activities for ethnic/racial minority youth at high risk ranged as follows (Table 37):

- **Provided curricula or supplementary materials that include pictures, information, and learning experiences that reflect the life experiences of these youth in their communities:** from 9.4% to 52.7% across states (median: 26.0%), from 32.2% to 100.0% across cities (median: 50.2%), and from 30.8% to 100.0% across territories (median: 70.2%).
- **Provided curricula or supplementary materials in the primary languages of the youth and families:** from 5.1% to 40.5% across states (median: 21.6%), from 26.0% to 98.3% across cities (median: 46.9%), and from 0.0% to 90.9% across territories (median: 44.3%).
- **Facilitated access to direct health services or arrangements with providers not on school property who have experience in serving these youth in the community:** from 8.9% to 46.7% across states (median: 25.9%), from 29.9% to 100.0% across cities (median: 48.6%), and from 30.8% to 81.8% across territories (median: 58.2%).
- **Facilitated access to direct social and psychological services or arrangements with providers not on school property who have experience in serving these youth in**

the community: from 9.9% to 46.7% across states (median: 25.8%), from 31.4% to 100.0% across cities (median: 49.2%), and from 30.8% to 90.9% across territories (median: 52.4%).

The percentage of schools that required professional development for school staff on issues and resources for ethnic/racial minority youth and implemented all 4 activities related to ethnic/racial minority youth at high risk ranged from 0.0% to 15.3% across states (median: 4.7%), from 0.0% to 98.3% across cities (median: 21.1%), and from 0.0% to 63.6% across territories (median: 7.4%) (Table 37).

Safe and Supportive School Environments for All Students

Schools can implement multiple policies and practices that help create a safe and supportive environment for all students, including lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth. The percentage of schools that provide curricula or supplementary materials that include HIV, STD, or pregnancy prevention information that is relevant to LGBTQ youth (e.g., curricula or materials that use inclusive language or terminology) ranged from 6.1% to 50.8% across states (median: 21.4%), from 15.7% to 100.0% across cities (median: 37.3%), and from 18.2% to 54.2% across territories (median: 47.2%) (Table 38). The percentage of schools that engage in practices related to LGBTQ youth ranged as follows (Table 38):

- **Identify “safe spaces” (e.g., a counselor’s office, designated classroom, or student organization) where LGBTQ youth can receive support from school administrators, teachers, or other school staff:** from 28.4% to 71.5% across states (median: 51.6%), from 31.5% to 100.0% across cities (median: 68.0%), and from 18.2% to 75.0% across territories (median: 61.5%).

- **Prohibit harassment based on a student's perceived or actual sexual orientation or gender identity:** from 71.9% to 98.9% across states (median: 88.3%), from 47.7% to 100.0% across cities (median: 88.0%), and from 9.1% to 87.5% across territories (median: 76.9%).
- **Encourage staff to attend professional development on safe and supportive school environments for all students, regardless of sexual orientation or gender identity:** from 38.4% to 80.2% across states (median: 54.1%), from 35.4% to 100.0% across cities (median: 73.3%), and from 18.2% to 87.5% across territories (median: 47.0%).
- **Facilitate access to providers not on school property who have experience in providing health services, including HIV/STD testing and counseling to LGBTQ youth:** from 28.4% to 65.3% across states (median: 43.8%), from 29.0% to 100.0% across cities (median: 55.4%), and from 9.1% to 75.0% across territories (median: 30.8%).
- **Facilitate access to providers not on school property who have experience in providing social and psychological services to LGBTQ youth:** from 30.0% to 65.6% across states (median: 44.5%), from 28.9% to 100.0% across cities (median: 54.9%), and from 9.1% to 61.5% across territories (median: 30.8%).

The percentage of schools that provide curricula or supplementary materials and engage in all 5 practices related to LGBTQ youth ranged from 0.7% to 21.4% across states (median: 5.7%), from 3.5% to 81.6% across cities (median: 14.2%), and from 0.0% to 28.0% across territories (median: 7.7%) (Table 38).

The percentage of schools with a student-led club that aims to create a safe, welcoming, and accepting school environment for all youth,

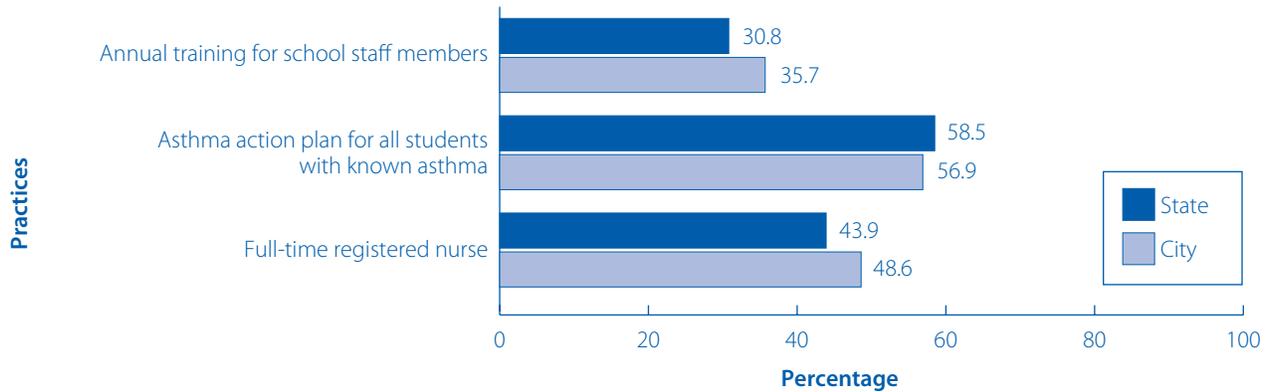
regardless of sexual orientation or gender identity (sometimes called gay/straight alliances) ranged from 9.3% to 50.1% across states (median: 25.5%), from 16.4% to 90.8% across cities (median: 33.9%), and from 26.7% to 81.8% across territories (median: 46.2%) (Table 38).

Injury and Violence Prevention Programs

To create a safe, positive physical and psychosocial environment, some schools participate in injury and violence prevention programs or youth development programs. The percentage of schools that participated in each of the following programs ranged as follows (Table 39):

- **A student mentoring program:** from 41.4% to 85.4% across states (median: 67.1%), from 59.7% to 95.5% across cities (median: 81.3%), and from 57.7% to 100.0% across territories (median: 69.2%).
- **A safe passages to school program:** from 12.7% to 64.2% across states (median: 21.4%), from 15.6% to 68.0% across cities (median: 40.7%), and from 19.2% to 70.1% across territories (median: 45.5%).
- **A program to prevent bullying:** from 69.0% to 95.9% across states (median: 81.9%), from 54.1% to 98.3% across cities (median: 86.1%), and from 71.2% to 100.0% across territories (median: 90.9%).
- **A program to prevent dating violence:** from 20.2% to 77.5% across states (median: 32.2%), from 23.5% to 88.1% across cities (median: 39.7%), and from 53.0% to 73.1% across territories (median: 54.5%).
- **A youth development program:** from 32.1% to 76.7% across states (median: 49.8%), from 42.8% to 86.6% across cities (median: 66.7%), and from 46.2% to 100.0% across territories (median: 84.6%).

FIGURE 7. Median percentage of schools with specific asthma management practices, School Health Profiles, 2010



HEALTH SERVICES

Schools can support student success by providing health services to students. School nurses play a critical role in providing these services. A full-time nurse was defined on the questionnaire as one who is at the school during all school hours, 5 days per week. The percentage of schools that had a full-time registered nurse who provided health services to students ranged from 4.9% to 99.4% across states (median: 43.9%), from 14.7% to 100.0% across cities (median: 48.6%), and from 0.0% to 91.7% across territories (median: 12.5%) (Table 40, Figure 7).

Students with known asthma are those identified by the school to have a current diagnosis of asthma as reported on student emergency cards, medication records, health room visit records, emergency care plans, physical exam forms, parent notes, and other forms of healthcare clinician notification. The percentage of schools that had an asthma action plan on file for all students with known asthma ranged from 31.0% to 87.6% across states (median: 58.5%), from 31.3% to 87.0% across cities (median: 56.9%), and from 0.0% to 30.8% across territories (median: 4.9%) (Table 40, Figure 7). The percentage of schools in which school staff members were required to receive training at least once per year on recognizing and responding to severe asthma symptoms ranged from 11.6% to

65.8% across states (median: 30.8%), from 0.0% to 94.3% across cities (median: 35.7%), and from 0.0% to 50.0% across territories (median: 30.4%) (Table 40, Figure 7).

The percentage of schools that used specific types of information to identify students with poorly controlled asthma ranged as follows (Table 41):

- Frequent absences from school:** from 18.1% to 59.4% across states (median: 39.0%), from 27.6% to 77.6% across cities (median: 52.6%), and from 0.0% to 80.8% across territories (median: 15.4%).
- Frequent visits to the school health office due to asthma:** from 17.9% to 84.8% across states (median: 65.6%), from 32.9% to 92.2% across cities (median: 73.8%), and from 0.0% to 76.9% across territories (median: 37.5%).
- Frequent asthma symptoms at school:** from 30.4% to 75.9% across states (median: 58.5%), from 47.2% to 86.7% across cities (median: 57.8%), and from 0.0% to 61.5% across territories (median: 37.5%).
- Frequent non-participation in physical education class due to asthma:** from 22.7% to 60.2% across states (median: 44.9%), from 16.7% to 70.1% across cities (median: 40.5%), and from 0.0% to 53.8% across territories (median: 37.5%).

- **Students sent home early due to asthma:** from 14.3% to 59.0% across states (median: 42.5%), from 19.5% to 81.7% across cities (median: 47.9%), and from 5.0% to 80.0% across territories (median: 25.0%).
- **Calls from school to 911, or other local emergency numbers, due to asthma:** from 7.2% to 44.0% across states (median: 25.8%), from 17.3% to 55.6% across cities (median: 41.0%), and from 0.0% to 46.2% across territories (median: 1.5%).
- **At least 3 of these 6 types of information:** from 40.7% to 75.9% across states (median: 63.9%), from 44.8% to 91.7% across cities (median: 64.5%), and from 0.0% to 91.7% across territories (median: 60.0%).

The percentage of schools that provided specific services for students with poorly controlled asthma ranged as follows (Table 42a, b):

- **Provided referrals to primary healthcare clinicians or child health insurance programs:** from 33.8% to 95.2% across states (median: 63.0%), from 49.9% to 96.2% across cities (median: 73.2%), and from 29.8% to 100.0% across territories (median: 69.2%).
- **Ensured an appropriate written asthma action plan is obtained:** from 47.7% to 95.4% across states (median: 83.3%), from 63.0% to 100.0% across cities (median: 86.8%), and from 0.0% to 80.8% across territories (median: 37.5%).
- **Ensured access to and appropriate use of asthma medications, spacers, and peak flow meters at school:** from 52.9% to 98.3% across states (median: 86.4%), from 66.4% to 97.5% across cities (median: 90.5%), and from 0.0% to 75.0% across territories (median: 42.3%).
- **Offered asthma education for students with asthma:** from 21.9% to 82.4% across states (median: 55.7%), from 38.9% to 97.4% across cities (median: 67.4%), and from 0.0% to 73.1% across territories (median: 25.0%).
- **Minimized asthma triggers in the school environment:** from 52.4% to 93.7% across states (median: 72.7%), from 40.5% to 90.8% across cities (median: 72.2%), and from 0.0% to 76.9% across territories (median: 50.0%).
- **Addressed social and emotional issues related to asthma:** from 30.9% to 81.6% across states (median: 52.0%), from 29.3% to 86.9% across cities (median: 64.3%), and from 0.0% to 61.5% across territories (median: 37.5%).
- **Provided additional psychosocial counseling or support services as needed:** from 30.2% to 79.7% across states (median: 52.0%), from 39.0% to 84.6% across cities (median: 66.7%), and from 0.0% to 61.5% across territories (median: 50.0%).
- **Ensured access to safe, enjoyable physical education and activity opportunities:** from 67.1% to 98.4% across states (median: 90.3%), from 80.2% to 100.0% across cities (median: 90.8%), and from 0.0% to 80.8% across territories (median: 75.0%).
- **Ensured access to preventive medications before physical activity:** from 62.4% to 98.4% across states (median: 86.8%), from 70.0% to 100.0% across cities (median: 83.2%), and from 0.0% to 76.9% across territories (median: 73.1%).
- **All 9 of these services:** from 9.8% to 50.6% across states (median: 25.7%), from 16.8% to 70.5% across cities (median: 30.9%), and from 0.0% to 26.9% across territories (median: 12.5%).

The percentage of schools that had adopted a policy stating that students are permitted to carry and self-administer asthma medications ranged from 39.9% to 86.7% across states (median: 73.9%), from 36.7% to 100.0% across cities (median:

63.6%), and from 0.0% to 76.9% across territories (median: 37.5%) (Table 43). Among these schools, the percentage that had procedures to inform students about the school's policy ranged from 80.4% to 98.2% across states (median: 92.5%), from 81.2% to 98.5% across cities (median: 90.7%), and from 61.9% to 100.0% across territories (median: 97.5%), and the percentage that had procedures to inform parents and families about the school's policy ranged from 80.5% to 98.2% across states (median: 92.3%), from 83.2% to 100.0% across cities (median: 91.4%), and from 67.1% to 100.0% across territories (median: 90.0%) (Table 43). Among schools with a policy, the percentage that had an individual responsible for implementing the policy ranged from 63.8% to 95.3% across states (median: 80.9%), from 55.2% to 94.5% across cities (median: 83.3%), and from 35.0% to 100.0% across territories (median: 87.5%) (Table 43). The percentage of schools that had adopted a policy, had procedures to inform students as well as parents and families about the policy, and had an individual responsible for implementing the policy ranged from 21.9% to 69.6% across states (median: 52.5%), from 23.8% to 81.8% across cities (median: 37.8%), and from 0.0% to 28.6% across territories (median: 23.1%) (Table 43).

SCHOOL HEALTH COORDINATION

To help with coordination of school health, schools might have an individual who oversees school health and safety programs and activities. Schools might also have a school health council, committee, or team. The percentage of schools in which someone at the school oversees or coordinates school health and safety programs and activities ranged from 71.0% to 92.8% across states (median: 85.0%), from 57.1% to 100.0% across cities (median: 90.5%), and from 58.3% to 100.0% across territories (median: 100.0%) (Table 44). The percentage of schools with one or more than one group at the school that offers guidance on the

development of policies or coordinates activities on health topics (e.g., a school health council, committee, or team) ranged from 33.1% to 80.4% across states (median: 57.6%), from 35.8% to 90.5% across cities (median: 57.4%), and from 45.9% to 100.0% across territories (median: 75.0%) (Table 47a). Among schools with school health councils, the percentage in which specific groups were represented on any council, committee, or team ranged as follows (Table 47a,b):

- **School administrators:** from 84.8% to 98.5% across states (median: 94.3%), from 77.0% to 100.0% across cities (median: 90.1%), and from 80.0% to 100.0% across territories (median: 100.0%).
- **Health education teachers:** from 66.0% to 98.6% across states (median: 89.6%), from 62.5% to 100.0% across cities (median: 80.6%), and from 90.0% to 100.0% across territories (median: 100.0%).
- **Physical education teachers:** from 72.6% to 98.2% across states (median: 90.3%), from 56.9% to 100.0% across cities (median: 89.9%), and from 89.9% to 100.0% across territories (median: 100.0%).
- **Mental health or social services staff:** from 28.5% to 87.8% across states (median: 55.3%), from 54.7% to 100.0% across cities (median: 79.5%), and from 14.3% to 73.1% across territories (median: 44.8%).
- **Nutrition or food service staff:** from 33.6% to 86.5% across states (median: 66.8%), from 32.8% to 78.1% across cities (median: 60.4%), and from 20.0% to 85.7% across territories (median: 76.9%).
- **Health services staff (e.g., school nurse):** from 32.8% to 95.8% across states (median: 79.8%), from 52.6% to 96.8% across cities (median: 76.7%), and from 28.6% to 80.0% across territories (median: 42.8%).

- **Maintenance and transportation staff:** from 10.9% to 39.2% across states (median: 20.5%), from 3.0% to 52.3% across cities (median: 19.7%), and from 0.0% to 60.0% across territories (median: 29.4%).
 - **Technology staff:** from 11.0% to 35.2% across states (median: 24.1%), from 8.6% to 61.2% across cities (median: 33.3%), and from 0.0% to 85.7% across territories (median: 57.7%).
 - **Library/media center staff:** from 11.5% to 42.0% across states (median: 21.2%), from 13.4% to 52.4% across cities (median: 32.3%), and from 10.0% to 73.1% across territories (median: 45.1%).
 - **Student body:** from 35.5% to 87.7% across states (median: 53.4%), from 29.6% to 87.8% across cities (median: 62.5%), and from 40.0% to 100.0% across territories (median: 84.6%).
 - **Parents or families of students:** from 50.0% to 90.1% across states (median: 66.7%), from 19.5% to 83.9% across cities (median: 66.7%), and from 20.0% to 100.0% across territories (median: 92.3%).
 - **Community members:** from 38.8% to 80.3% across states (median: 58.5%), from 13.7% to 81.8% across cities (median: 50.7%), and from 20.0% to 100.0% across territories (median: 86.3%).
 - **Local health departments, agencies, or organizations:** from 17.9% to 63.7% across states (median: 43.9%), from 12.1% to 79.1% across cities (median: 44.9%), and from 40.0% to 88.5% across territories (median: 80.0%).
 - **Faith-based organizations:** from 1.9% to 46.9% across states (median: 11.2%), from 0.0% to 56.2% across cities (median: 13.9%), and from 0.0% to 100.0% across territories (median: 73.1%).
 - **Businesses:** from 8.4% to 53.0% across states (median: 21.5%), from 0.0% to 58.8% across cities (median: 20.8%), and from 20.0% to 64.5% across territories (median: 57.1%).
 - **Local government agencies:** from 6.4% to 38.1% across states (median: 23.9%), from 0.0% to 53.0% across cities (median: 22.7%), and from 20.0% to 85.9% across territories (median: 80.0%).
 - **10 or more of these groups:** from 6.4% to 43.6% across states (median: 17.7%), from 4.5% to 41.9% across cities (median: 21.0%), and from 7.7% to 84.6% across territories (median: 42.9%).
- Schools can use the *School Health Index* or other self-assessment tools to assess their health and safety policies around each of the components of coordinated school health and plan for improvement. Schools that are required to have a School Improvement Plan (SIP) may incorporate health and safety goals into their written plan for improvement. The percentage of schools that ever used the *School Health Index* or other self-assessment tool to assess their school's policies, activities, and programs in specific areas ranged as follows (Table 44):
- **Asthma:** from 11.8% to 59.3% across states (median: 23.4%), from 11.9% to 56.0% across cities (median: 34.3%), and from 0.0% to 69.2% across territories (median: 29.2%).
 - **Injury and violence:** from 23.0% to 70.0% across states (median: 36.6%), from 20.5% to 74.8% across cities (median: 41.8%), and from 0.0% to 92.3% across territories (median: 62.5%).
 - **Physical activity:** from 25.8% to 82.4% across states (median: 45.3%), from 25.4% to 77.5% across cities (median: 48.3%), and from 0.0% to 96.2% across territories (median: 62.5%).

- **Nutrition:** from 24.9% to 79.5% across states (median: 43.8%), from 16.4% to 73.6% across cities (median: 47.6%), and from 0.0% to 96.2% across territories (median: 62.5%).
- **Tobacco-use prevention:** from 25.4% to 75.0% across states (median: 43.4%), from 17.5% to 65.0% across cities (median: 40.7%), and from 0.0% to 96.2% across territories (median: 66.7%).
- **Physical activity, nutrition, and tobacco-use prevention:** from 17.7% to 71.9% across states (median: 34.2%), from 14.6% to 58.4% across cities (median: 32.6%), and from 0.0% to 96.2% across territories (median: 62.5%).

The Elementary and Secondary Education Act requires certain schools to have a written SIP. Many states and school districts also require schools to have a written SIP. Among schools with a SIP, the percentage of schools that included health-related goals and objectives in their SIP on the following topics ranged as follows (Table 45):

- **Health education:** from 10.1% to 80.1% across states (median: 34.9%), from 9.0% to 63.4% across cities (median: 42.2%), and from 15.4% to 100.0% across territories (median: 90.7%).
- **Physical education:** from 12.7% to 80.1% across states (median: 35.6%), from 9.0% to 63.0% across cities (median: 46.9%), and from 15.4% to 100.0% across territories (median: 89.3%).
- **Nutrition services and foods and beverages available at school:** from 5.7% to 72.4% across states (median: 29.5%), from 6.0% to 56.5% across cities (median: 31.9%), and from 15.4% to 96.2% across territories (median: 75.0%).

- **Health services:** from 8.1% to 74.9% across states (median: 28.4%), from 13.6% to 65.4% across cities (median: 40.9%), and from 7.7% to 100.0% across territories (median: 61.6%).
- **Mental health and social services:** from 9.6% to 66.7% across states (median: 29.0%), from 13.4% to 68.0% across cities (median: 50.9%), and from 7.7% to 92.0% across territories (median: 37.5%).
- **Healthy and safe school environment:** from 25.8% to 85.2% across states (median: 60.7%), from 28.4% to 86.2% across cities (median: 70.3%), and from 46.2% to 96.2% across territories (median: 86.6%).
- **Family and community involvement:** from 23.7% to 92.2% across states (median: 60.8%), from 35.8% to 93.2% across cities (median: 77.7%), and from 53.8% to 100.0% across territories (median: 81.8%).
- **Faculty and staff health promotion:** from 9.6% to 59.6% across states (median: 27.5%), from 6.0% to 52.4% across cities (median: 28.8%), and from 15.4% to 100.0% across territories (median: 62.5%).
- **Any health-related goals and objectives:** from 28.7% to 94.3% across states (median: 72.0%), from 37.3% to 94.5% across cities (median: 83.2%), and from 61.5% to 100.0% across territories (median: 97.0%).

Wellness policies also play a role in coordinating school health. Local wellness policies must include: goals for nutrition education, physical activity, and other school-based activities designed to promote student wellness; nutrition guidelines

for all foods available on campus; and a plan for measuring the implementation of the local wellness policy. The percentage of schools that were required to report to their district each of the following types of information regarding the implementation of the local wellness policy ranged as follows (Table 46):

- **Number of minutes of physical education required in each grade:** from 50.1% to 93.6% across states (median: 74.2%), from 48.5% to 97.8% across cities (median: 78.7%), and from 69.2% to 100.0% across territories (median: 100.0%).
- **Rates of student participation in school meal programs:** from 72.5% to 98.2% across states (median: 88.6%), from 87.1% to 100.0% across cities (median: 92.3%), and from 52.1% to 100.0% across territories (median: 100.0%).
- **Revenue from sale of foods and beverages from school-sponsored fundraisers, vending machines, school stores, or a la carte lines in the school cafeteria:** from 38.2% to 83.6% across states (median: 66.6%), from 54.3% to 93.5% across cities (median: 79.2%), and from 18.2% to 100.0% across territories (median: 57.7%).
- **Number of minutes of physical activity outside of physical education (e.g., classroom physical activity breaks, free time physical activity, or recess):** from 22.2% to 85.0% across states (median: 37.4%), from 21.2% to 65.5% across cities (median: 49.2%), and from 38.5% to 100.0% across territories (median: 81.8%).

FAMILY AND COMMUNITY INVOLVEMENT

Partnerships between schools, families, and community members are important elements of coordinated school health. The percentage of schools in which students' families helped develop or implement policies and programs during the 2 years before the survey related to specific topics ranged as follows (Table 48a, b):

- **HIV, STD, or teen pregnancy prevention:** from 7.0% to 40.9% across states (median: 13.2%), from 0.0% to 31.6% across cities (median: 21.8%), and from 7.7% to 100.0% across territories (median: 37.5%).
- **Asthma:** from 4.8% to 29.3% across states (median: 12.4%), from 0.0% to 39.5% across cities (median: 21.7%), and from 0.0% to 37.5% across territories (median: 7.7%).
- **Tobacco-use prevention:** from 12.5% to 44.5% across states (median: 22.8%), from 0.0% to 35.6% across cities (median: 22.4%), and from 7.7% to 100.0% across territories (median: 62.5%).
- **Physical activity:** from 16.9% to 51.0% across states (median: 29.4%), from 0.0% to 44.4% across cities (median: 30.8%), and from 7.7% to 100.0% across territories (median: 62.5%).
- **Nutrition and healthy eating:** from 22.4% to 60.6% across states (median: 39.2%), from 0.0% to 59.2% across cities (median: 37.9%), and from 0.0% to 100.0% across territories (median: 75.0%).

The percentage of schools in which community members helped develop or implement policies and programs during the 2 years before the survey on specific topics ranged as follows (Table 48a, b):

- **HIV, STD, or teen pregnancy prevention:** from 11.7% to 45.2% across states (median: 22.3%), from 11.7% to 100.0% across cities (median: 33.6%), and from 61.5% to 100.0% across territories (median: 75.8%).
- **Asthma:** from 7.2% to 29.3% across states (median: 15.1%), from 11.0% to 98.5% across cities (median: 25.8%), and from 11.1% to 88.5% across territories (median: 25.0%).
- **Tobacco-use prevention:** from 18.8% to 49.2% across states (median: 31.6%), from 16.2% to 100.0% across cities (median: 30.9%), and from 69.2% to 100.0% across territories (median: 86.7%).
- **Physical activity:** from 19.2% to 49.0% across states (median: 32.4%), from 16.2% to 100.0% across cities (median: 40.7%), and from 61.5% to 100.0% across territories (median: 85.2%).
- **Nutrition and healthy eating:** from 22.9% to 59.8% across states (median: 43.8%), from 26.9% to 100.0% across cities (median: 45.2%), and from 61.5% to 100.0% across territories (median: 87.5%).

The percentage of schools in which students' families and community members helped develop or implement policies and programs during the 2

years before the survey on specific topics ranged as follows (Table 48a, b):

- **HIV, STD, or teen pregnancy prevention:** from 4.8% to 37.1% across states (median: 11.2%), from 0.0% to 28.5% across cities (median: 17.6%), and from 7.7% to 100.0% across territories (median: 37.5%).
- **Asthma:** from 2.5% to 24.8% across states (median: 9.6%), from 0.0% to 33.8% across cities (median: 16.2%), and from 0.0% to 25.0% across territories (median: 7.7%).
- **Tobacco-use prevention:** from 21.5% to 53.3% across states (median: 35.1%), from 24.3% to 100.0% across cities (median: 35.2%), and from 69.2% to 100.0% across territories (median: 88.4%).
- **Physical activity:** from 25.6% to 55.1% across states (median: 37.1%), from 29.5% to 100.0% across cities (median: 44.2%), and from 61.5% to 100.0% across territories (median: 89.9%).
- **Nutrition and healthy eating:** from 31.0% to 64.9% across states (median: 48.6%), from 31.3% to 100.0% across cities (median: 51.9%), and from 61.5% to 100.0% across territories (median: 87.5%).
- **Tobacco-use prevention, physical activity, or nutrition and healthy eating:** from 4.4% to 30.5% across states (median: 13.2%), from 0.0% to 23.5% across cities (median: 12.6%), and from 0.0% to 100.0% across territories (median: 50.0%).

TRENDS

The Profiles were first conducted in 1996 and are repeated biennially. Although the questionnaires are modified each year, some questions remain constant, which allows for the analysis of changes over time. **Long-term trends** compare median percentages calculated across the 23 states and 9 cities with weighted data for both the **1996**⁷⁰ and **2010** Profiles. **Short-term trends** compare median percentages across the 46 states and 17 cities with weighted principal data, and the 45 states and 17 cities with weighted teacher data for both the **2008**⁷¹ and **2010** Profiles. Because territories have not participated consistently in previous Profiles cycles, they are not included in these trend analyses.

LONG-TERM TRENDS

Significant improvements in school health practices were detected between 1996 and 2010 in the following areas:

- Across **states**, the median percentage of schools in which health education staff worked on health education activities with physical education staff, school health services staff, school mental health and social services staff, and nutrition or food service staff increased from 67.4% to 83.5%, from 51.4% to 74.1%, from 56.1% to 66.8%, and from 18.7% to 43.5%, respectively.
- Across **states**, increases were found in the median percentage of schools in which the lead health education teacher received professional development during the 2 years before the survey on emotional and mental health (from 21.2% to 36.5%), injury prevention and safety (from 23.5% to 41.9%), nutrition and dietary behavior (from 28.5% to 40.4%), physical activity and fitness (from 32.8% to 53.4%), pregnancy prevention (from 20.7% to 26.2%), suicide prevention (from 15.2% to 30.4%), and violence prevention (from 40.0% to 53.3%).
- Across **states**, increases were found in the median percentage of schools in which the lead health education teacher wanted to receive professional development on alcohol- or other drug-use prevention (from 52.4% to 74.8%), emotional and mental health (from 51.8% to 73.1%), HIV prevention (from 52.3% to 64.7%), human sexuality (from 50.8% to 65.5%), injury prevention and safety (from 33.7% to 62.4%), nutrition and dietary behavior (from 47.2% to 72.6%), physical activity and fitness (from 38.6% to 68.4%), pregnancy prevention (from 47.2% to 63.1%), STD prevention (from 54.6% to 65.7%), suicide prevention (from 66.6% to 75.8%), tobacco-use prevention (from 45.0% to 65.6%), and violence prevention (62.2% to 75.9%).
- Across **cities**, increases were found in the median percentage of schools in which the lead health education teacher wanted to receive professional development on injury prevention and safety (from 43.2% to 75.1%), nutrition and dietary behavior (from 54.9% to 76.6%), physical activity and fitness (from 44.3% to 76.9%), and tobacco-use prevention (from 44.2% to 72.0%).

Significant deteriorations in school health practices were detected between 1996 and 2010 in the following areas:

- Across **states**, the median percentage of schools in which the lead health education received professional development on HIV prevention during the two years before the survey decreased from 51.5% to 37.4%.
- Across **states** and **cities**, the median percentage of schools in which the lead health education teacher had experience teaching health education classes or topics for 15 years or more decreased from 52.9% to 36.9% and from 66.7% to 36.4%, respectively.

SHORT-TERM TRENDS

Significant improvements in school health practices and policies were detected between 2008 and 2010 in the following areas:

- Across **states**, the median percentage of schools in which teachers tried to increase student knowledge on asthma increased from 47.0% to 53.5%.
- Across **states**, the median percentage of schools that allowed students to purchase snack foods or beverages from vending machines or at a school store, canteen, or snack bar decreased from 78.3% to 70.5%.
- Across **states**, the median percentage of schools that allowed students to purchase sports drinks from vending machines or at the school store, canteen, or snack bar decreased from 59.2% to 49.6%.
- Across **states**, the median percentage of schools that had an asthma action plan on file for all students with known asthma increased from 46.1% to 57.7%.

- Across **states**, the median percentage of schools that provided additional psychosocial counseling or support services as needed to students with poorly controlled asthma increased from 46.3% to 52.0%.
- Across **states**, among schools that had one or more than one group (e.g., a school health council, committee, or team) that offered guidance on the development of policies or coordinated activities on health topics, the median percentage with representatives from local government agencies on any of these groups increased from 15.4% to 23.8%.
- Across **states**, increases were found in the median percentage of schools that have adopted a policy that addresses maintaining confidentiality of HIV-infected students (from 72.1% to 77.7%) and confidential counseling for HIV-infected students (from 57.1% to 62.9%).

Significant deteriorations in school health practices and policies were detected between 2008 and 2010 in the following areas:

- Across **states**, the median percentage of schools in which someone oversees or coordinates school health and safety programs and activities decreased from 90.5% to 84.8%.
- Across **states** and **cities**, the median percentage of schools in which staff members are required to receive annual training on recognizing and responding to severe asthma symptoms decreased from 37.5% to 29.4% and from 50.9% to 31.8%, respectively.
- Across **states**, the median percentage of schools in which community members helped develop or implement policies and programs related to nutrition during the 2 years before the survey decreased from 49.0% to 44.4%.

DISCUSSION

School health programs can help improve the health status of children and adolescents in the United States. Specifically, school health education helps students develop and improve health-related knowledge, attitudes, and skills. Health education and other components of coordinated school health can help improve health behaviors, health outcomes, educational outcomes, and social outcomes among adolescents and young adults.⁷² School Health Profiles provides information to help assess some aspects of 5 of the 8 components of coordinated school health. Point-in-time data from each Profiles cycle, along with long-term and short-term trends in Profiles data, illustrate not only how health policies and practices have improved over time to meet the needs of students, but also identify areas for improvement.

By providing school-level data that are representative of each participating state, city, territory, and tribal government, Profiles allows comparisons of school health policies and practices across these jurisdictions. Differences in the prevalence of these policies and practices reflect differences in how resources are allocated in each jurisdiction, which in turn reflects varying priorities in implementation of these policies and practices. Profiles also complements the School Health Policies and Practices Study (SHPPS), which provides nationally representative data on school health policies and practices related to all 8 components of school health.⁷³ SHPPS was conducted most recently in 2006, and will be conducted again in 2012.

School health education can be guided by the *National Health Education Standards*, which provide expectations for specific student skills related to health.⁹ Across states, a median of

more than 85 percent of middle schools and high schools had a health education curriculum that addressed each of these skills individually, but the median percentage of schools addressing all 8 skills was lower. Schools should strive to address all of these critical skills as part of their health education curricula.

Profiles also provides data related to other *Healthy People 2020* objectives¹⁰ in the area of school health education. Across states, cities, and territories, the median percentage of middle and high schools that tried to increase student knowledge about how to prevent unintentional injury, violence, suicide, tobacco use, alcohol and other drug use, unintended pregnancy, HIV/AIDS, STD infection, unhealthy dietary patterns, and inadequate physical activity exceeded 80 percent for all topics except suicide. Still, not all schools taught about all of these topics, indicating room for improvement in the comprehensiveness of school health education. Teacher certification is another important aspect of quality health education that is supported by a *Healthy People 2020* objective.¹⁰ The percentage of schools in which all staff who teach health education topics are certified, licensed, or endorsed by the state in health education and the percentage of schools in which the lead health education teacher is certified to teach health education varied widely across states, cities, and territories. Jurisdictions with few certified health education teachers should work toward improving access to and requirements for certification.

Coordination of health education activities with other components of the school health program helps ensure that health issues are addressed and reinforced at school. Since 1996, the median

percentage of middle and high schools in which health education staff worked on health education activities with physical education staff, school health services staff, school mental health and social services staff, and nutrition or food service staff has increased. Since 2008, however, the median percentage of middle and high schools with a school health coordinator has decreased. This decrease is of concern, because administration and management of school health programs requires time and expertise.⁷⁴

In the area of physical education, CDC guidelines²⁴ and *Healthy People 2020* objectives¹⁰ recommend that schools require daily physical education to promote active, productive, and healthy lifestyles among youth. Across states, cities, and territories, the median percentage of schools that required physical education for students in any of grades 6 through 12 exceeded 95 percent, but schools also allowed exemptions from required physical education for enrollment in other courses, participation in school sports, participation in other school activities, participation in community sports activities, high physical competency test scores, participation in vocational training, and participation in community service activities. In addition, across states, cities, and territories, the median percentage of schools that taught a required physical education course in a particular grade decreased as grade level increased. This finding is problematic because as students' grade increases, the amount of physical activity they engage in tends to decrease.⁴⁴ Schools should do more to increase physical activity among students during the school day.

In addition to increasing physical activity among students, schools also can help stem the obesity epidemic by making improvements in the school nutrition environment. The Institute of Medicine report, *Nutrition Standards for Foods in Schools: Leading the Way Toward Healthier Youth*³⁵

provides specific recommendations for foods and beverages sold outside of the school meal programs. With the exception of sports drinks, across states, cities, and territories, the median percentage of schools selling each less nutritious food and beverage was below 40 percent. It is encouraging, however, that across states, the percentage of schools that allowed students to purchase sports drinks from vending machines or at a school store, canteen, or snack bar decreased between 2008 and 2010. In addition, the median percentage of schools that allowed students to purchase any foods and beverages from these venues decreased between 2008 and 2010. This finding is encouraging because these venues often sell less nutritious foods and beverages. On the other hand, these venues also provide an opportunity to make fruits or non-fried vegetables available to students, and the median percentage of schools doing so is still low, as is the median percentage of schools making fruits and vegetables available at school celebrations. Increased efforts are needed to encourage greater daily consumption of fruits and vegetables whenever students have the opportunity to eat and drink at school.

According to CDC guidelines, a tobacco-use prevention policy should prohibit all tobacco use at all times by students, faculty, staff, and visitors on school property, in all school vehicles, and at off-campus, school sponsored events.⁴¹ Although the median percentage of schools across states, cities, and territories that had a policy prohibiting tobacco use exceeded 95 percent, the median percentage of schools that prohibited all tobacco use in all locations was far lower. More schools should adopt and enforce components of a tobacco-use prevention policy to meet the *Healthy People 2020* objective of 100 percent tobacco-free environments.¹⁰

Profiles revealed that school policies and programs related to HIV prevention could be improved. Although the median percentage of schools across states with policies addressing 2 specific issues for students or staff with HIV infection or AIDS increased between 2008 and 2010, the overall medians for most other issues remain below 80 percent. In addition, across states, the median percentage of schools in which the lead health education teacher received professional development on HIV prevention during the 2 years before the survey decreased from 51.5 percent in 1996 to 34.7 percent in 2010. This finding is especially notable given the significant increases during the same time period in professional development on emotional and mental health, injury prevention, nutrition, and physical activity. The HIV epidemic continues to grow in many communities and will continue to do so without increased prevention efforts by schools.

Ensuring a safe and supportive environment for all students, including LGBTQ students, is important not only for HIV prevention, but also for preventing suicide-related behaviors.⁴⁵ In 2010, Profiles collected data to assess school health practices in this area for the first time. Results showed that while states, cities, and territories varied widely in the percentage of schools with such practices in place, overall medians were strikingly low, and demonstrate an area that is ripe for improvement. To assist in these efforts, CDC funded the American Psychological Association Healthy Lesbian, Gay, and Bisexual Students Project to help schools and youth-serving organizations improve health and mental health outcomes for sexual minority youth. This project conducted workshops for school staff on how to effectively reach sexual minority students with messages regarding HIV prevention and other health information.

Health services can help support student success. School nurses play a central role in the provision of these services, and Profiles revealed wide variability in the percentage of schools with a full-time registered nurse. Regarding asthma specifically, Profiles showed improvements between 2008 and 2010 in the median percentage of schools across states that had an asthma action plan on file for all students with known asthma, as well as in the median percentage that provided additional counseling and support services for students with poorly controlled asthma. In addition, the median percentage of schools across states in which teachers tried to increase student knowledge about asthma increased between 2008 and 2010. Significant decreases, however, were seen during this same time period in the median percentage of schools across both states and cities requiring annual training for school staff on recognizing and responding to severe asthma symptoms. Schools should continue to work toward improving the health and school attendance of students with asthma. Resources for improving asthma management practices are available, including *Strategies for Addressing Asthma Within a Coordinated School Health Program*⁵¹ and a toolkit, *Initiating Change: Creating an Asthma-Friendly School*.⁷⁵

Several limitations of Profiles should be noted. First, the data presented in this report apply only to public middle schools and high schools; policies and practices among non-public schools were not assessed. Second, because the data were combined across middle schools and high schools, differences in policies and practices between the two school levels may be masked. Third, the data are self-reported by school principals and lead health education teachers and may be subject to bias. Finally, the Profiles data do not provide an in-depth assessment of all elements of coordinated school health.

State and local education and health agencies use Profiles data to describe school health policies and practices, identify professional development needs, plan and monitor programs, support health-related policies and legislation, seek funding, and garner support for future surveys.⁷⁶ For example, in Michigan, Profiles data were used to write a state Senate bill requiring health and physical education in each of grades K-8. In North Carolina, Profiles data were one of several data sources used to develop objectives and standards for the state's health improvement plan, Healthy NC 2020. The Delaware Department of Education used Profiles and other data sources to identify professional development needs related to sexual health curricula and to target professional development efforts to that area.

Profiles data help state, local, and territorial education and health agencies, as well as tribal governments, promote program strengths and advocate for resources to address weaknesses. Numerous resources exist to help states and districts address weaknesses identified through their Profiles data. For example, *Fit, Healthy, and Ready to Learn* is a guide to help schools develop policies to address physical activity, healthy eating, tobacco-use prevention, asthma, health services, and a healthy school environment.^{54,77}

The guide includes information on the policy development process, general school health policies, and examples of specific policies for all topic areas. In addition, *Someone at School Has AIDS: A Complete Guide to Education Policies Concerning HIV Infection* offers guidance on developing policies that address important issues related to HIV/AIDS in schools.⁴³ CDC also has developed several tools designed for use at the school level. The *School Health Index* helps schools identify strengths and weaknesses of their health and safety policies and practices through a self-assessment process, and helps them develop an action plan for improvement.⁷⁸ The *Health Education Curriculum Analysis Tool* helps schools analyze health education curricula based on alignment with national standards and characteristics of effective health education curricula.⁷⁹ Similarly, the *Physical Education Curriculum Analysis Tool* helps schools analyze written physical education curricula based on alignment with national standards, guidelines, and best practices for quality physical education programs.⁸⁰ Use of these and other resources can help schools improve their school health policies and practices, which in turn can help improve the health status of children and adolescents.

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