

ITEM RATIONALE

2022 SCHOOL HEALTH PROFILES

SCHOOL PRINCIPAL QUESTIONNAIRE

QUESTION:

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

(a) Physical education and physical activity... (b) Nutrition... (c) Tobacco-use prevention... (d) Alcohol- and other drug-use prevention... (e) Chronic health conditions (e.g., asthma, food allergies)... (f) Unintentional injury and violence prevention (safety)... (g) Sexual health, including HIV, other STD, and pregnancy prevention

RATIONALE:

This question assesses whether the school has conducted an assessment or diagnosis as a critical first step in improving implementation of policies, programs, or environmental strategies to effect change or improvement in school health.¹ Some states and districts require the use of the School Health Index, or specific modules of the School Health Index. Studies confirm that the School Health Index² can help bring health issues to the school's attention, strengthen school commitment, identify changes that do not require additional funding, encourage development of policy and action, raise awareness of federal policies, support partnership development, and set policies and standards that meet national health objectives.³⁻⁹

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QUESTION:

2. Each local education agency participating in the National School Lunch Program or the School Breakfast Program is required to develop and implement a local wellness policy.

During the past year, has anyone at your school done any of the following activities?

- (a) Reviewed your district's local wellness policy... (b) Helped revise your district's local wellness policy... (c) Communicated to school staff about your district's local wellness policy... (d) Communicated to parents and families about your district's local wellness policy... (e) Communicated to students about your district's local wellness policy... (f) Measured your school's compliance with your district's local wellness policy... (g) Developed an action plan that describes steps to meet requirements of your district's local wellness policy

RATIONALE:

A local school wellness policy is a written document that guides a local educational agency or school district's efforts to create supportive school nutrition and physical activity environments.¹ Each local education agency (school district) participating in the National School Lunch Program or the School Breakfast Program is required to develop and implement a local wellness policy.² School districts should develop wellness policies to meet the unique needs of each school under its jurisdiction, and meet the minimum requirements as defined by the United States Department of Agriculture.^{1,3} This question identifies some of the key implementation requirements.

REFERENCES:

1. CDC Healthy Schools. *Local School Wellness Policy*. Available at: <https://www.cdc.gov/healthyschools/npao/wellness.htm>.
 2. Healthy, Hunger-Free Kids Act of 2010. Public Law 111-296, 124 Stat 3183, Sec 203, 2010.
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QUESTION:

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

RATIONALE:

This question assesses whether the school has identified a person responsible for coordinating a school's health program. It is critical to have one person appointed to oversee the school health program.¹⁻³ This individual coordinates school health activities, leads a school health committee or team, and integrates community-based programs with school-based programs.^{4,5} Administration and management of school health programs requires devoted time, attention, training, and expertise.^{1,6,7}

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QUESTION:

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

RATIONALE:

This question assesses whether the school has a health committee or team. The school health committee or team should represent a coalition of representatives from within and outside of the school community interested in improving the health of youth in schools.¹⁻³ Participation on such committees or teams can empower others through increased awareness and knowledge of the school health program, increase the chance of ownership and commitment, activate channels of communication, and increase involvement in decision making.¹⁻⁶

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1. Cheung K, Lesesne C, Rasberry C, Kroupa E, Fisher D, Robin L, Barnes SP. Barriers and facilitators to sustaining school health teams in coordinated school health programs. *Health Promotion and Practice* 2016;8(3):418-427.
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QUESTION:

5. During the past year, has any school health council, committee, or team at your school done any of the following activities?
 - (a) Identified student health needs based on a review of relevant data...
 - (b) Recommended new or revised health and safety policies and activities to school administrators or the school improvement team...
 - (c) Sought funding or leveraged resources to support health and safety priorities for students and staff...
 - (d) Communicated the importance of health and safety policies and activities to district administrators, school administrators, parent-teacher groups, or community members...
 - (e) Reviewed health-related curricula or instructional materials

RATIONALE:

This question assesses the major responsibilities of a school health committee or team. A school health council, committee, or team should regularly assess progress of school health activities and assist school leaders with oversight, planning, evaluation, and periodic revision of school health efforts.¹⁻⁵ Such a team can address major health issues facing students, assess availability of opportunities and resources, coordinate activities and resources, coordinate funding, support school health staff, and seek active involvement of students, families and the community in designing and implementing strategies to improve school health.⁶

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QUESTION:

6. During the regular school day, does your school use each of the following types of security staff?

(a) Security guards (private or school employees/contractors)...(b) School resource officers (SROs)...(c) Police officers other than SROs (i.e., county or local law enforcement)

RATIONALE:

This question assesses the extent to which schools use police and other security officers on school grounds and provides a measure to evaluate the impact of school-based security personnel on school safety, school climate, and student outcomes. Although the use of police and other security officers is an increasingly common practice in U.S. public schools, the extent to which schools use such personnel is not well documented.^{1,2} Recent research indicates that expanded use of police in school settings may result in increased punitive and exclusionary disciplinary practices, which negatively impact educational and health outcomes of students, especially students with disabilities and students with racial/ethnic minority identities.³⁻⁸ Research also suggests that each type of security staff (i.e., security guards, school resource officers or SROs, police officers) may play different roles in the school environment; asking about the type of security staff in schools may clarify how schools use security staff with regard to disciplinary policies and practices.⁸⁻¹⁰ For example, SROs are reported to be more involved in classroom discipline, compared to general security guards who are reported to be more involved with protecting the school from outside intrusions.^{5, 8-10} As such, identifying what type of security schools use is important to evaluate how the use of security shapes the school environment and climate.^{1,3-5, 8-10}

REFERENCES:

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2. Montes AN, Mears DP, Collier NL, Pesta GB, Siennick, SE, Brown SJ. Blurred and confused: The paradox of police in schools. *Policing: A Journal of Policy and Practice* 2020.
 3. Finn JD, Servoss TJ. Misbehavior, suspensions, and security measures in high school: Racial/ethnic and gender differences. *Journal of Applied Research on Children: Informing Policy for Children at Risk* 2014;5(2):Article 11. Available at: <https://digitalcommons.library.tmc.edu/childrenatrisk/vol5/iss2/11>.
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 11. Curran FC, Fisher BW, Viano S Kupchik A. Why and when do school resource officers engage in school discipline? The role of context in shaping disciplinary involvement. *American Journal of Education* 2019;126(1):33-63.
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BEFORE- OR AFTER-SCHOOL PROGRAMS

QUESTION:

7. During the past year, has your school taken any of the following actions related to before- or after-school programs?

(a) Included before- or after-school settings as part of the School Improvement Plan...
(b) Encouraged before- or after-school program staff or leaders to participate in school health council, committee, or team meetings...
(c) Partnered with community-based organizations (e.g., Boys & Girls Clubs, YMCA, 4H Clubs) to provide students with before- or after-school programming

RATIONALE:

More than 10 million children in the United States head to after-school programs when the school day ends.¹ These programs, also called out-of-school time programs, provide youth with safety and supervision.² Research shows that some out-of-school time programs can support student academic achievement²⁻⁴ and may play a role in reducing health disparities.^{3,4} Additionally, programs that follow evidence-based practices aimed at improving personal and social skills are linked with positive social behaviors.^{5,6} These questions ask about different actions that secondary schools may be taking to promote communication about and coordination with after-school programs.

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Learning for Student Success (pp. 194-198). Washington, DC: Collaborative Communication Group; 2013.

6. Durlak JA, Weissberg RP, Pachan M. A meta-analysis of after-school programs that seek to promote personal and social skills in children and adolescents. *American Journal of Community Psychology*. 2010;45(3-4):294-309.
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SEXUAL AND GENDER MINORITY STUDENTS

QUESTIONS:

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

(a) Identify “safe spaces” (e.g., a counselor’s office, designated classroom, student organization) where LGBTQ youth can receive support from administrators, teachers, or other school staff... (b) Prohibit harassment based on a student’s perceived or actual sexual orientation or gender identity... (c) Encourage staff to attend professional development on safe and supportive school environments for all students, regardless of sexual orientation or gender identity... (d) Facilitate access to providers not on school property who have experience in providing health services, including HIV/STD testing and counseling, to LGBTQ youth... (e) Facilitate access to providers not on school property who have experience in providing social and psychological services to LGBTQ youth

RATIONALE:

These questions assess whether the school has policies or implements activities designed to create a safe and supportive school environment for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. Research shows that LGB youth are more likely than their heterosexual peers to be electronically bullied, bullied at school, threatened or injured with a weapon on school property, and to skip school because they felt unsafe.^{1,2} Research also indicates that transgender youth experience elevated rates of harassment and violence victimization in schools compared to their cisgender (not transgender) peers.^{3,4} In 2017, 70% of LGBTQ students reported that they were verbally harassed at school during the past year because of their sexual orientation, while 29% were physically harassed at school, and 12% were physically assaulted at school.⁵ LGB youth who experience victimization at school are at a

greater risk of attempting suicide than those who do not,¹ and transgender youth who report being bullied are at greater risk for substance use than those who are not.³

Gay/straight alliances (GSA) or similar clubs are associated with greater safety for LGBTQ youth. LGBTQ youth who attend schools with a GSA are less likely than those at schools without such clubs to report violence victimization and have reduced rates of absenteeism.^{1,6} In addition, LGB youth who attend schools with gay/straight alliances or similar clubs, those who attend schools with an anti-bullying policy, and those who feel that there is a school staff member who could be approached about a problem have a lower risk of suicidality than those who attend schools without these respective supports available,^{1,7} and transgender youth in schools that prohibit harassment, have a gay/straight alliance or similar club on campus, and access to a supportive teacher report increased feelings of safety at school and reduced absenteeism.^{6,8}

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS18-1807: Promoting Adolescent Health Through School-Based HIV Prevention.

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BULLYING AND SEXUAL HARASSMENT

QUESTIONS:

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

RATIONALE:

These questions address actions schools can take to help prevent bullying and sexual harassment, including electronic aggression. The 2019 National Youth Risk Behavior Survey found that 20% of high school students reported being bullied on school property in the prior 12 months, and 16% of high school students reported that they were bullied electronically.¹ Another nationally representative survey of middle and high school students found that nearly half (48%) experienced some form of sexual harassment during the 2010–11 academic year.² Adverse academic, psychological, and health consequences of bullying and sexual harassment have been documented, including absenteeism, depression and anxiety, and increased risk of violence involvement, substance use, and risky sexual behaviors.³⁻⁵

Evidence suggests that school-based strategies, including a combination of whole-school programs with classroom curricula and small group or individual-level programs, can be used to prevent bullying.⁶⁻⁸ Additional promising practices have been identified, such as having a school-wide anti-bullying policy, enforcing it consistently, and promoting cooperation among school teachers, administrators, and parents.⁹ Moreover, under Title IX of the Education Amendments of 1972, federally funded schools are required to distribute to students, parents, and employees a formal policy for addressing sexual harassment.¹⁰ In addition to having policies in place, studies have also demonstrated the need for professional development to help school staff respond

appropriately to bullying and sexual harassment.¹¹ Responding quickly and consistently to bullying and sexual harassment can help stop this behavior over time.¹²

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2. Hill C, Kears H. *Crossing the Line: Sexual Harassment at School*. Washington, DC: American Association of University Women Educational Foundation; 2011.
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SUICIDE PREVENTION

QUESTION:

13. Does your school have written protocols for each of the following suicide prevention practices?
- (a) Assessing student suicide risk...(b) Notifying parents when a student is at risk for suicide...(c) Referring students at risk for suicide to mental health services...(d) Responding to a suicide attempt at school...(e) Supporting students returning to school after a suicide attempt...(f) Responding to the death of a student or staff member from suicide

RATIONALE:

This question assesses the extent to which schools have written policies to prevent and safely respond to student suicide risk and behaviors. Suicide is often not caused by a single event or factor.^{1,2} As such, prevention approaches that address suicide risk at the individual, relationship, and school level and across the prevention spectrum from early intervention to response after a suicide death are important and most likely to be effective.¹⁻⁵ Research indicates that schools play a critical role in youth suicide prevention. By identifying youth who are at risk for suicide and connecting them with mental health services, schools may prevent youth suicide attempts and death.^{6,7} Schools may also reduce the impact of a suicide attempt or death on the broader school community through intentional postvention approaches such as offering counseling and support groups for surviving friends, family members, school staff, and other close contacts⁸ and by adhering to safe messaging guidelines that avoid sensationalizing events and instead focus on suicide prevention messages, stories of hope and resilience, and providing and links to helping resources (e.g., National Suicide Prevention Lifeline).⁹

REFERENCES:

1. US Office of the Surgeon General, National Action Alliance for Suicide Prevention. *2012 National strategy for suicide prevention: goals and objectives for action*. Washington, DC: US Department of Health and Human Services; 2012.
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REQUIRED PHYSICAL EDUCATION

QUESTION:

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

RATIONALE:

This question measures the extent to which physical education is required for students in grades 6 through 12. Physical education provides students with the knowledge, attitudes, skills, behaviors, enjoyment, and confidence to adopt and maintain physically active lifestyles.¹⁻⁵ The importance of physical education in promoting the health of young people is supported by

Healthy People 2030 Physical Activity baseline objective (ECBP-01): increase the proportion of adolescents who participate in daily school physical education.⁶

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP18-1801: Improving Student Health and Academic Achievement through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools.

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PHYSICAL EDUCATION AND PHYSICAL ACTIVITY

QUESTION:

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

RATIONALE:

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

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP18-1801: Improving Student Health and Academic Achievement through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools.

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QUESTION:

16. Does your school engage in the following physical education practices?

(a) Provide physical education teachers with a written physical education curriculum that aligns with national standards for physical education...(b) Require physical education teachers to follow a written physical education curriculum...(c) Allow the use of waivers, exemptions, or substitutions for physical education requirements for one grading period or longer...(d) Allow teachers to exclude students from physical education to punish them for inappropriate behavior or failure to complete class work in another class...(e) Require physical education teachers to be certified, licensed, or endorsed by the state in physical education...(f) Limit physical education class sizes so that they are the same size as other subject areas...(g) Have a dedicated budget for physical education materials and equipment...(h) Provide adapted physical education (i.e., special courses separate from regular PE courses) for students with disabilities as appropriate...(i) Include students with disabilities in regular physical education courses as appropriate

RATIONALE:

This question examines the extent to which schools are implementing key physical education policies and curricular approaches identified in *The Essential Components of Physical Education*. This document identifies four essential components to help schools create a strong foundation for physical education programs: 1) policy and environment; 2) curriculum; 3) appropriate instruction; and 4) student assessment.^{1,2} Specifically, the policy and environment component raises awareness of the critical policies that need to be in place to ensure physical education is part of a well-rounded education for all students.^{3,4} Strongly worded and well-monitored physical education policies have the potential to improve physical education programs and increase physical activity levels among students. The curriculum component underscores the need for a physical education curriculum that aligns with national standards for physical education.⁵ The appropriate instruction and student assessment components are also important aspects of the curriculum. Appropriate instruction aligns the student objectives and outcomes with the learning activities that are identified in the curriculum.^{1,2} Student assessments provide evidence of whether students have achieved grade-level outcomes and national and state standards.^{1,2,5}

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP18-1801: Improving Student Health and Academic Achievement through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools.

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QUESTIONS:

17. Outside of physical education, do students participate in physical activity in classrooms during the school day?
18. Not including physical education and classroom physical activity, does your school offer opportunities for all students to be physically active during the school day, such as recess, lunchtime intramural activities, or physical activity clubs?

RATIONALE:

These questions examine the extent to which schools are providing physical activity opportunities outside of physical education. Schools play a critical role in helping students participate in the recommended 60 minutes of physical activity every day.^{1,2} In order to achieve this recommendation, it is important to provide physical activity opportunities, such as classroom physical activity, recess, lunchtime intramurals, and physical activity clubs, in addition to physical education.³⁻⁶ Students can accumulate physical activity through these opportunities and such participation can also enhance time on task, attentiveness, concentration in the classroom, and academic performance.^{7,8}

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP18-1801: Improving Student Health and Academic Achievement through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools.

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QUESTIONS:

19. Does your school offer interscholastic sports to students?

20. Does your school offer opportunities for students to participate in physical activity through organized physical activities or access to facilities or equipment for physical activity during the following times?

(a) Before the school day...(b) After the school day

RATIONALE:

These questions measure the extent to which students are provided the opportunity to participate in physical activities before and after the school day, through intramural activities, physical activity clubs, and interscholastic sports. Offering a variety of opportunities can increase students' physical activity and help them attain their 60 minutes of daily activity.^{1,2} According to SHAPE America, intramural activities, physical activity clubs, and recreation clubs contribute to young people's physical and social development. Additionally, intramural activities or physical activity clubs offer students the opportunity to be involved in planning and implementing such programs and offer safe and structured opportunities to be physically active.³⁻⁶

School or community-based sports programs provide structured time for students to accumulate minutes of physical activity, establish cooperative and competitive skills, and learn sport-specific and performance-based skills. Evidence indicates that participation in sports is related to higher levels of participation in overall physical activity.⁷ Additionally, participation in sports programs has been associated with improved mental health and fewer risky health behaviors.^{7,8}

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP18-1801: Improving Student Health and Academic Achievement through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools.

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QUESTION:

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

(a) Physical activity facility...(b) Kitchen facilities and equipment...(c) Gardens (e.g., herb or vegetable plots)

RATIONALE:

This question measures the extent to which schools and communities have an agreement to share physical activity and kitchen facilities. School spaces and facilities should be available to young people for physical activity before, during, and after the school day, on weekends, and during summer and other vacations.^{1,2} Access to these facilities increases visibility of schools, provides youth, their families, and community members a safe place for physical activity, and might increase partnerships with community-based physical activity programs.^{1,2} Community resources can expand existing school programs by providing program staff as well as intramural and club activities on school grounds. For example, community agencies and organizations can use school facilities for after-school physical fitness programs for children and adolescents, weight management programs for overweight or obese young people, and sports and recreation programs for young people with disabilities or chronic health conditions.²⁻⁶ The American Heart

Association recommends the shared use of school spaces to increase opportunities for physical activity in communities.⁷

Access to school kitchen facilities and equipment outside of school hours, as school-community kitchens, is an emerging topic of interest. Such shared use agreements can support culinary and nutrition education for students, school employees, parents, and community members. Kitchen facilities and equipment also can be a resource for school events, start-up food businesses, emergency preparedness, and other school and community initiatives.⁸⁻¹⁰ Limited access to a kitchen or refrigerator can be a barrier for out-of-school time programs to provide healthy foods to participants.¹¹ Shared use of kitchen facilities may therefore help support healthy eating in such programs.¹⁰⁻¹²

The Community Preventive Services Task Force (CPSTF) recommends school-based gardening interventions in combination with nutrition education to increase children's vegetable consumption.¹³ Shared use agreements can expand garden-based learning opportunities to community organizations, including after-school programs and SNAP-ED, and can promote school garden sustainability. Community-based organizations can help maintain gardens during highly productive periods when school is out of session (e.g., summer recess).

Question 21a provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP18-1801: Improving Student Health and Academic Achievement through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools.

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QUESTIONS:

22. Does your school have a written plan for providing opportunities for students to be physically active before, during, and after school? This also may be referred to as a Comprehensive School Physical Activity Program plan.
23. During the past year, has your school assessed opportunities available to students to be physically active before, during, or after school?

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding CDC-RFA-DP18-1801: Improving Student Health and Academic Achievement through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools.

RATIONALE:

These questions examine whether schools are developing and evaluating a Comprehensive School Physical Activity Program (CSPAP). CSPAP is a framework for planning and organizing activities for school physical education and physical activity.¹⁻³ The goal of a CSPAP is to increase physical activity opportunities before, during, and after school and to increase students' overall physical activity and health.^{1,2} Healthy and physically active students tend to have better grades, school attendance, cognitive performance (e.g., memory), and classroom behaviors (e.g., on-task behavior).⁴ The Centers for Disease Control and Prevention's Comprehensive School Physical Activity Programs: A Guide for Schools outlines a step-by-step process to develop, implement, and evaluate a CSPAP.² This process helps schools develop a yearly plan for physical education and physical activity that they can implement and evaluate. The plan can be for CSPAP exclusively or incorporated into school improvement or other school health plans.

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TOBACCO-USE PREVENTION POLICIES

QUESTIONS:

24. Has your school adopted a policy prohibiting tobacco use?
25. Does the tobacco-use prevention policy specifically prohibit use of each type of tobacco for each of the following groups during any school-related activity?
 - (a) Cigarettes...
 - (b) Smokeless tobacco (e.g., chewing tobacco, snuff, dip, snus, dissolvable tobacco)...
 - (c) Cigars...
 - (d) Pipes...
 - (e) Electronic vapor products (e.g., e-cigarettes, vapes, vape pens, e-hookahs, mods, or brands such as JUUL)
26. Does the tobacco-use prevention policy specifically prohibit tobacco use during each of the following times for each of the following groups?
 - (a) During school hours...
 - (b) During non-school hours
27. Does the tobacco-use prevention policy specifically prohibit tobacco use in each of the following locations for each of the following groups?
 - (a) In school buildings...
 - (b) Outside on school grounds, including parking lots and playing fields...
 - (c) On school buses or other vehicles used to transport students...
 - (d) At off-campus, school-sponsored events

RATIONALE:

These questions measure the extent to which schools develop, implement, and enforce a policy that creates a totally tobacco-free environment within the school experience for both young people and adults, as outlined in the *CDC Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*.¹

Because tobacco use is the most preventable contributor to mortality in the United States, it is important to restrict use of or exposure to tobacco products at an early age.² Newer products like e-cigarettes have quickly become the most widely used tobacco product by youth and because of the discreet design use of e-cigarettes in school is common. The existence and enforcement of a school policy creates a tobacco-free environment that models acceptable behavior and sends a clear message to students, teachers, staff, parents, and visitors that the use of all types of tobacco products is socially unacceptable.³ Environmental interventions aimed at reducing use of tobacco in homes, public places, and worksites lead to reduction of tobacco use.⁴ Likewise, tobacco-free school policies are associated with lower rates of student smoking.^{3,5-7} However, school policies alone are not enough to curb smoking prevalence but policies that are strongly enforced and include accompanying education and prevention efforts are associated with decreased smoking.^{8,9} These conclusions are in line with the Surgeon General Report recommendations

from 2012, which stated “research has shown that, to be effective, tobacco-related policy needs to be enforced and should foster a proactive approach by schools to prevention.”¹⁰

Prohibiting any use of any tobacco product at all times, whether or not school is in session, and regardless of whether students are present, protects students and staff from the harmful effects of secondhand smoke (a mixture of smoke from the burning end of tobacco products and the smoke exhaled by smokers). The 2006 U.S. Surgeon General’s report, *The Harmful Effects of Involuntary Exposure to Tobacco Smoke*, outlines a large body of research findings which demonstrate that breathing secondhand smoke is harmful to health.¹¹ Evidence shows that there is no safe level of secondhand smoke exposure, and even the most advanced ventilation systems cannot eliminate secondhand smoke or its harmful effects.¹¹ Further, e-cigarette aerosol is not harmless and can contain harmful and potentially harmful constituents, including nicotine. Nicotine exposure during adolescence can cause addiction and can harm the developing adolescent brain.¹ A complete ban of indoor tobacco product use at all times in a facility (such as a school building) is the only effective approach to controlling involuntary inhalation of secondhand tobacco product emissions.^{11,12}

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QUESTION:

28. When students are caught using electronic vapor products, how often are each of the following actions taken?

- (a) Issue a warning to the student... (b) Confiscate product... (c) Notify parents or guardians... (d) Develop a behavior contract with the student... (e) Refer to a school counselor... (f) Refer to a school administrator... (g) Refer to an assistance, education, or cessation program... (h) Refer to legal authorities (e.g., school resource officer)... (i) Issue an in-school suspension (half day or full day)... (j) Issue an after-school or weekend detention... (k) Issue an out-of-school suspension... (l) Expel from school

RATIONALE:

This question measures the degree to which electronic vapor product policies are enforced in schools. It is important to ask about *enforcement* of policies in addition to the *presence* of school policies, as just having a policy is not enough to curb tobacco use prevalence. Rather, policies that are strongly enforced and include accompanying education and prevention efforts are associated with decreased smoking and electronic vapor product use.¹⁻⁴ These conclusions are in line with the Surgeon General Report recommendations from 2012, which stated “research has shown that, to be effective, tobacco-related policy needs to be enforced and should foster a proactive approach by schools to prevention.”⁵ Measurement of enforcement is also enhanced when comprehensiveness of enforcement is measured, including asking about the frequency of a broad range of possible enforcement actions (e.g., punitive actions like expulsions and suspensions, and non-punitive actions like referral to education or cessation programs). Given the highly addictive nature of tobacco and intentional targeting of youth by tobacco companies, quitting tobacco use is difficult, and best approached from a prevention and treatment of addiction angle rather than through punitive and criminal justice means.⁶ Punitive actions may not align with prevention and treatment principles and can affect students’ success later in school and life.⁶ CDC suggests that non-punitive actions like counseling and education may be more beneficial in helping youth quit tobacco.⁷

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NUTRITION-RELATED POLICIES AND PRACTICES

QUESTIONS:

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

(a) Foods or beverages are not offered at school celebrations... (b) Never... (c) Rarely... (d) Sometimes... (e) Always or almost always
30. Can students purchase snack foods or beverages from one or more vending machines at the school or at a school store, canteen, or snack bar?
31. Can students purchase each of the following snack foods or beverages from vending machines or at the school store, canteen, or snack bar?

(a) Chocolate candy... (b) Other kinds of candy... (c) Salty snacks that are not low in fat (e.g., regular potato chips)... (d) Low sodium or “no added salt” pretzels, crackers, or chips... (e) Cookies, crackers, cakes, pastries, or other baked goods that are not low in fat (f) Ice cream or frozen yogurt that is not low in fat... (g) 2% or whole milk (plain or

flavored) (h) Nonfat or 1% (low-fat) milk (plain)...(i) Water ices or frozen slushes that do not contain juice...(j) Soda pop or fruit drinks that are not 100% juice...(k) Sports drinks (e.g., Gatorade)...(l) Energy drinks (e.g., Red Bull, Monster)...(m) Plain water, with or without carbonation (e.g., Dasani, Aquafina, Smart Water)...(n) Calorie-free, flavored water, with or without carbonation (e.g., Dasani Flavors, Aquafina FlavorSplash)...(o) 100% fruit or vegetable juice (p) Foods or beverages containing caffeine...(q) Fruits (not fruit juice)...(r) Non-fried vegetables (not vegetable juice)

RATIONALE:

These questions address the extent to which schools are making more nutritious foods available to students and not offering less nutritious foods and beverages. Many schools sell foods and beverages in vending machines, school stores, snack bars, and canteens.^{1,2} These foods and beverages, called competitive foods because they compete with school meals as a source of nutrition for students, historically have been relatively low in nutrient density and relatively high in fat, added sugars, and calories.³⁻⁵ However, in 2014, the United States Department of Agriculture required the Smart Snacks in Schools nutrition standards for competitive foods sold during the school day to help ensure that foods and beverages sold outside of the school meal programs are consistent with national dietary recommendations.⁶ Additionally, all local school wellness policies must include nutrition standards for foods and beverages that are made available to students during the schools day (e.g., in classroom parties, school celebrations, other foods given as incentives).⁷ Schools can provide an environment that is conducive to healthful eating behaviors by ensuring that that all foods sold during the schools day, including those in school stores, snack bars, and vending machines, meet the Smart Snack Standards, and that healthful foods (e.g., fruits and vegetables) are available when foods and beverages are offered during school celebrations.⁸⁻¹¹

Questions 30 and 31 provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP18-1801: Improving Student Health and Academic Achievement Through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools (DP18-1801 Healthy Schools).

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QUESTION:

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

Planted a school food or vegetable garden...(g) Placed fruits and vegetables near the cafeteria cashier, where they are easy to access...(h) Used attractive displays for fruits and vegetables in the cafeteria...(i) Offered a self-serve salad bar to students...(j) Provided students with at least 20 minutes to eat lunch after they receive their meal...(k) Encouraged students to drink plain water...(l) Prohibited school staff from giving students food or food coupons as a reward for good behavior or good academic performance...(m) Prohibited less nutritious foods and beverages (e.g., candy, baked goods) from being sold for fundraising purposes

RATIONALE:

This question addresses the variety of methods schools can use to promote healthy eating. Students' food choices are influenced by the total food environment. The simple availability of fruits and vegetables may not be sufficient to prompt the choice of these items when items high in fat and/or added sugar are also available.^{1,2} Schools should employ effective or promising strategies to promote healthy eating, such as pricing strategies,^{3,4} obtaining input from students and parents,⁵ providing nutrition information,⁶ conducting taste tests,⁶ using the cafeteria as a learning laboratory,⁶ implementing school gardens,⁷ and serving locally or regionally grown foods in the cafeteria or classrooms.⁸ Additional promising strategies include placing fruit and vegetables near the cafeteria cashier, where they are easy to access,⁹ using attractive displays for fruits and vegetables in the cafeteria,⁹ offering a self-serve salad bar to students,^{10,11} ensuring students have at least 20 minutes to eat their lunch,^{12,13} and encouraging students to drink plain water.¹⁴⁻¹⁷ Additionally, schools can implement practices that limit access to less healthful foods and beverages including prohibiting school staff from giving students food or food coupons as a reward for good behavior or good academic performance^{16,17} and prohibiting less nutritious foods and beverages (e.g., candy, baked goods) from being sold for fundraising purposes.^{16,18}

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QUESTION:

33. Does your school prohibit advertisements for candy, fast food restaurants, or soft drinks in each of the following locations?
 - (a) In school buildings...
 - (b) On school grounds including on the outside of the school building, on playing fields, or other areas of the campus...
 - (c) On school buses or other vehicles used to transport students...
 - (d) In school publications (e.g., newsletters, newspapers, web sites, other school publications)...
 - (e) In curricula or other educational materials (including assignment books, school supplies, book covers, and electronic media)

RATIONALE:

This question addresses prohibiting marketing of less nutritious foods to students while at school or at school-sponsored events. Marketing and promotion of foods and beverages in schools occur in many forms including posters, coupons, commercials during educational programming (e.g., Channel One television), and the sale of branded foods and beverages.¹ In 2014, 36.9% of schools held fundraiser nights at fast food restaurants where a portion of the sales made on a particular night benefit the school, 22.2% allowed soft drink companies to advertise soft drinks on vending machines, and 5.8% allowed advertisements for junk food or fast food restaurants on school property.² Exposure to advertisements may have adverse effects on children's eating habits.³ Food advertisements have been found to trigger food purchase by parents, have effects on children's product and brand preferences, and have an effect on consumption behavior.⁴ Further, younger children do not generally understand the difference between information and advertising,⁵ such that children may interpret school-based advertising to mean that teachers or other adults endorse the use of the advertised product. More than \$149 million is spent on marketing of foods and beverages in schools annually, with carbonated beverages and noncarbonated beverages making up the majority of in-school marketing expenditures.¹ Given that schools provide a captive audience of students, the Institute of Medicine report on food

marketing to children and youth recommends that schools should promote healthful diets for children and youth in all aspects of the school environment (e.g., commercial sponsorships, meals and snacks, curriculum).⁶ School districts are now required to include language in the local school wellness policy that allows marketing and advertising of only those foods and beverages that meet the Smart Snacks in School nutrition standards.^{7,8}

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QUESTIONS:

34. Are students permitted to have a drinking water bottle with them during the school day?
35. Does your school offer a free source of drinking water in the following locations?
 - (a) Cafeteria during breakfast...
 - (b) Cafeteria during lunch...
 - (c) Gymnasium or other indoor physical activity facilities...
 - (d) Outdoor physical activity facilities or sports fields...
 - (e) Hallways throughout the school

RATIONALE:

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

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

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HEALTH SERVICES

QUESTIONS:

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

RATIONALE:

These questions examine the degree to which schools are being staffed by school nurses. A school nurse, whether part- or full-time, is an essential component of a healthy school. School nurses can link students and schools to physician and community resources in addition to providing services to students in schools. *Healthy People 2030* has listed increasing the proportion of secondary schools with a full-time registered nurse as a research objective in promoting health, safety, and learning in school settings.¹

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1. U.S. Department of Health and Human Services. *Healthy People 2030*. Office of Disease Prevention and Health Promotion. Available at: <https://health.gov/healthypeople>.
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QUESTION:

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

RATIONALE:

This question assesses if schools have a school-based health center (SBHC). SBHCs provide a range of age-appropriate health services to students including screening, early intervention, risk reduction, counseling, and treatment for both mental and physical conditions, although the specific services offered vary by community needs and resources.¹ Schools typically partner with community health organizations to provide these services.¹ SBHCs are well suited to provide care for youth without some of the associated barriers of the traditional health care model.² There is evidence that SBHC usage may not only improve the health of children and adolescents, but also may reduce health care costs and improve school outcomes.²

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QUESTIONS:

39. Does your school provide the following services to students? (Mark yes or no for each service.)
- (a) HIV testing... (b) HIV treatment (ongoing medical care for persons living with HIV)... (c) STD testing... (d) STD treatment... (e) Pregnancy testing... (f) Provision of condoms... (g) Provision of condom-compatible lubricants (i.e., water- or silicone-based)... (h) Provision of contraceptives other than condoms (e.g., birth control pill, birth control shot, intrauterine device [IUD])... (i) Prenatal care... (j) Human papillomavirus (HPV) vaccine administration... (k) Assessment for alcohol or other drug use, abuse, or dependency... (l) Tobacco-use cessation (e.g., individual or group counseling)... (m) Daily medication administration for students with chronic health conditions (e.g., asthma, diabetes)... (n) Stock rescue or “as needed” medication for any student experiencing a health emergency (e.g., asthma episode, severe allergic reaction) ... (o) Case management for students with chronic health conditions (e.g., asthma, diabetes)
40. Does your school provide students with referrals to any organizations or health care professionals not on school property for the following services?
- (a) HIV testing... (b) HIV treatment (ongoing medical care for persons living with HIV)... (c) nPEP (non-occupational post-exposure prophylaxis for HIV-- a short course of medication given within 72 hours of exposure to infectious bodily fluids from a person known to be HIV positive)... (d) PrEP (pre-exposure prophylaxis for HIV—medication taken daily to prevent HIV infection for those at substantial risk for HIV)... (e) STD testing... (f) STD treatment... (g) Pregnancy testing... (h) Provision of condoms... (i) Provision of condom-compatible lubricants (i.e., water- or silicone-based)... (j) Provision of contraceptives other than condoms (e.g., birth control pill, birth control shot, intrauterine device [IUD])... (k) Prenatal care... (l) Human papillomavirus (HPV) vaccine administration... (m) Alcohol or other drug abuse treatment... (n) Tobacco-use cessation (e.g., individual or group counseling)

RATIONALE:

These questions address students' access to sexual health services either provided on-site or through referrals to health care professionals not on school property. Many adolescents engage in sexual behaviors that can result in unintended health outcomes. In 2019, among U.S. high school students, 38.4% reported ever having had sex.¹ Of those sexually active in the previous 3 months, only 54.3% used a condom at last sexual intercourse.² In 2018, young people aged 13–24 accounted for 21% of all new HIV diagnoses in the United States and dependent areas.³ In 2019, more than half (55.4%) of reported cases of STDs were among young people aged 15-24 years.⁴ Several official and national guidelines for adolescent preventive care specifically include recommendations for the provision of sexual health services for adolescents.⁵⁻⁹ Schools in the United States have a critical role to play in facilitating delivery of such needed preventive services for adolescents. Many U.S. schools already have health care service infrastructure in place and can play an important role in providing adolescents with access to sexual health services.

Chronic health conditions such as seizure disorders, diabetes, asthma, high blood pressure/hypertension, food allergies, or poor oral health conditions may affect students' physical and emotional well-being, school attendance, academic performance, and social participation. Given the clustering of chronic health conditions, many students face the added burden of living with two conditions. The opportunity for academic success is increased when communities, schools, families, and students work together to meet the needs of students with chronic health conditions and provide safe and supportive learning environments.¹⁰

These questions provide information on how students with chronic health conditions are being managed during the school day, including medication administration and availability of stock medications for students who have NOT been identified as having a condition (e.g., asthma or allergies), or for students with a known condition who do not have or are unable to administer their own medication. Case management, and more broadly care coordination, refers to the oversight and alignment of multiple evidence-based components and interventions that support the health and well-being of students with chronic health conditions. This team-based model requires consistent engagement and communication among the student, parents/caregivers, community-based providers, and others who interact directly with the student with a goal to manage the chronic health conditions so students can remain present at school and ready to learn.¹¹

Questions 39a,c,e,f,g,h,j and 40a,c,e,f,g,h,j provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS18-1807: Promoting Adolescent Health Through School-Based HIV Prevention.

Question 39n provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-DP18-1801: Improving Student Health and Academic Achievement Through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools (DP18-1801 Healthy Schools).

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QUESTIONS:

41. Does your school have a protocol that ensures students with a chronic condition that may require daily or emergency management (e.g., asthma, diabetes, food allergies) are enrolled in private, state, or federally funded insurance programs if eligible?
42. Does your school routinely use school records to identify and track students with a current diagnosis of the following chronic health conditions? School records might include student emergency cards, medication records, health room visit information, emergency care and daily management plans, physical exam forms, or parent notes.
 - (a) Asthma...
 - (b) Food allergies...
 - (c) Diabetes...
 - (d) Epilepsy or seizure disorder...
 - (e) Obesity...
 - (f) Hypertension/high blood pressure...
 - (g) Oral health condition (e.g., abscess, tooth decay)

RATIONALE:

These questions address how schools can help support students with chronic health conditions. The first question acknowledges the role schools can play in ensuring that students with chronic health conditions have access to appropriate clinical care and disease management through a primary care provider and medical home. The medical home is increasingly accepted as the standard for provision of high-quality comprehensive health care. Insurance provides an important tool for reducing disparities by increasing access to medical homes. School health personnel can establish systematic protocols and processes for determining the health insurance status of students with chronic conditions and if necessary, assist parents and families in enrolling eligible students into private, state, or federally funded insurance programs.^{1,2}

The second question examines the type of information schools use to identify and track students with a known chronic health condition, such as asthma, food allergies, diabetes, obesity, high blood pressure/hypertension, seizure disorders, or poor oral health. Collecting this information for students with chronic conditions can also help assess the potential need for additional case management of these students. Assessment of successful school-based chronic disease management programs, such as school-based asthma management programs, reveal that this type of tracking and case management can contribute to improved medical management, such as symptom management, of students with chronic conditions.²

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QUESTION:

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

(a) Asthma...(b) Food allergies...(c) Diabetes...(d) Epilepsy or seizure disorder...(e) Obesity...(f) Hypertension/high blood pressure...(g) Oral health condition (e.g., abscess, tooth decay)

RATIONALE:

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

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QUESTION:

44. During the past two years, did any staff in your school receive professional development on each of the following topics?
 - (a) Basic sexual health overview including community-specific information about STD, HIV, and unplanned pregnancy rates and prevention strategies...
 - (b) Sexual health services that adolescents should receive...
 - (c) Laws and policies related to adolescent sexual health services, such as minor consent for sexual health services...
 - (d) Importance of maintaining student confidentiality for sexual health services...
 - (e) How to create or use a student referral guide for sexual health services...
 - (f) How to make successful referrals of students to sexual health services...
 - (g) Best practices for adolescent sexual health services provision, such as making services youth-friendly...
 - (h) Ensuring sexual health services are inclusive of lesbian, gay, bisexual, and transgender students

RATIONALE:

Professional development (PD) provides an excellent opportunity to ensure that teachers and school staff continually expand their knowledge and skills to implement school health services activities and are up to date on laws, policies and best practices to do this. Evaluation findings from previous CDC programs concluded that school staff may benefit from training to increase their self-efficacy and make them more comfortable with referring students to available sexual health services.¹ PD trainings are also typically a staple component of effective quality improvement programs and interventions for health clinic and school health staff.³

This item provides data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS18-1807: Promoting Adolescent Health Through School-Based HIV Prevention.

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MENTAL HEALTH SERVICES

QUESTION:

45. Does your school provide each of the following mental health programs or services to students?

(a) Universal mental health promotion programs (e.g., Positive Behavioral Interventions and Supports, Social-Emotional Learning programs or supports)...(b) Confidential mental health screening to identify students in need of services (e.g., students at risk of mental health disorders, students experiencing trauma) ... (c) School-wide trauma-informed practices (i.e., efforts to ensure that all students, including those affected by trauma, are experiencing social, emotional, and educational success)...(d) Cognitive behavioral therapy groups (e.g., for students with depression, anxiety, or other mental health disorders)...(e) Pro-social skills training (e.g., school counseling groups)... (f) Small groups for specific issues (e.g., depression, parental divorce)

RATIONALE:

This question addresses the extent to which mental health services are provided to students in or through schools. *Healthy People 2030* objective EMC-D06 calls for an increase in the proportion of children and adolescents who receive evidence-based preventive mental health interventions in school and early childhood care and education programs.¹ School-based mental health services are efficacious and can help reduce barriers to accessing mental health services,^{2,3} enable providers to see students in their natural environment (school) and help them generalize skills to that setting, facilitate engagement of teachers and teachers in the treatment process, provide opportunities for screening and early identification of mental health concerns, and offer access to the full continuum of mental health activities (i.e., universal, selected, and indicated interventions).^{4,5}

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FAMILY AND COMMUNITY INVOLVEMENT

QUESTION:

46. During this school year, has your school done any of the following activities?
- (a) Provided parents and families with information to support parent-adolescent communication about sex... (b) Provided parents with information to support parent-adolescent communication about topics other than sex... (c) Provided parents with information about how to monitor their teen (e.g., setting parental expectations, keeping track of their teen, responding when their teen breaks the rules)... (d) Provided parents with information to support one-on-one time between adolescents and their health care providers... (e) Provided parents with information about physical education and physical activity programs... (f) Involved parents as school volunteers in the delivery of health education activities and services... (g) Involved parents as school volunteers in physical education or physical activity programs... (h) Linked parents and families to health services and programs in the community... (i) Provided disease-specific education for parents and families of students with chronic health conditions (e.g., asthma,

diabetes)...(j) Provided parents with information about before- or after-school programs available in the community?

RATIONALE:

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

- 1) *Provide parenting support:* School staff can use seminars, workshops, and digital and print resources to build parents' skills to support the development of positive health attitudes and behaviors among students. Information should be provided on the following two parenting practices: parental monitoring and communication. Research shows that adolescents whose parents use effective monitoring practices are less likely to engage in risk behaviors, such as having sex at an early age, smoking cigarettes, drinking alcohol, being physically aggressive, or skipping school.³⁻⁵ Clear communication about sex and parental expectations is also important. Research shows that parent communication with their adolescents is associated with reductions in adolescent sexual risk behavior.⁶ Parenting programs, including those that are school-based, can increase parent-adolescent communication.^{7,8}
- 2) *Provide a variety of volunteer opportunities:* Involving parent members as school volunteers can enrich health and physical education classes, improve the delivery of health services, and help create safe and healthy environments for students.^{1,7}
- 3) *Collaborate with the community:* Schools that work with community groups and organizations can help parents obtain useful information and resources from these groups and organizations and give parents access to community programs, services, and resources.⁸
- 4) *Communicate with parents:* Research shows that two-way communication (school-to-home and home-to-school) can help ensure parents receive educational materials about different health topics, learn how they can be involved in school health activities, receive feedback and recommendations about health activities, and stay in constant communication with teachers, administrators, counselors, and other staff about their adolescent's health.¹

Questions 46a, 46b, 46c, and 46d provide data for a school health specific performance measure. This measure is required for grantees receiving funding under CDC-RFA-PS18-1807: Promoting Adolescent Health Through School-Based HIV Prevention.

Questions 46e and 46g provide data for a school health specific performance measure. This measure is required for grantees receiving funding under CDC-RFA-DP18-1801: Improving Student Health and Academic Achievement Through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools (DP18-1801 Healthy Schools).

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QUESTIONS:

47. Currently, does your school implement any of the following school-based positive youth development programs? (A school-based program is one that is led by the school or school district.)
 - (a) Service-learning programs, that is, community service designed to meet specific learning objectives...
 - (b) Mentoring programs, that is, programs in which family or community members serve as role models to students or mentor students

48. Currently, does your school connect students to any of the following community-based positive youth development programs? (A community-based program is one that is led by a community organization, but to which your school refers students. Include only community-based programs that are collaborations between your school and the program.)

(a) Service-learning programs, that is, community service designed to meet specific learning objectives...(b) Mentoring programs, that is, programs in which family or community members serve as role models to students or mentor students

RATIONALE:

Positive youth development (PYD) programs strengthen young people's sense of identity; belief in future; self-regulation; self-efficacy; and social, emotional, cognitive, and behavioral competence. These programs also provide youth with networks of supportive adults.¹ Unlike many prevention programs that focus solely on risk behaviors, PYD programs aim to develop and enhance the protective factors available to youth, whether that be their individual assets (i.e., positive characteristics that enable youth to avoid risk) or the resources available to them in their relationships, communities, and schools.² By increasing protective factors rather than focusing on risk behaviors related to a single adverse outcome, PYD programs benefit a wide range of health and academic outcomes. Most salient to DASH, these programs appear to be effective in reducing sexual risk behaviors, HIV, other STDs, and unintended pregnancy.^{1,3} PYD programs also have the potential to prevent substance use and violence behaviors that contribute to HIV and other STD risk.^{4,5} Finally, PYD programs are associated with improvements in academic performance, which strengthens the rationale for school-based implementation.⁶

Two types of PYD programs of interest to DASH are service-learning and mentoring programs. Service learning programs deliver "a teaching and learning strategy that connects academic curricula to community problem-solving."⁷ Service learning is distinct from volunteer work and community service in that it is linked to school curricula.⁸ The National Youth Leadership Council outlines standards for effective service learning programs, such as service that meaningfully engages youth, links to curriculum, encourages reflection and critical thinking, promotes diversity, elevates youth voices, and promotes community partnerships.⁹ Mentoring programs are those that promote a formal relationship between a mentor and a mentee, wherein the mentor can both model positive behaviors and provide "guidance, support, and skills through regular meetings to overcome health, social, and economic challenges."¹⁰ Mentoring programs can be group-based or one-on-one, although group-based mentoring programs have shown more effectiveness in reducing sexual risk.¹⁰

These items provide data for a school health specific performance measure. These measures are required for grantees receiving funding under CDC-RFA-PS18-1807: Promoting Adolescent Health Through School-Based HIV Prevention.

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QUESTION:

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

RATIONALE:

This question assesses whether schools have included parents as participants in school decisions, school activities, and/or advocacy activities through the Parent Teacher Association (PTA) or Parent Teacher Organization (PTO), school health council, school action teams to plan special health related events, and/or other school groups and organizations. Studies show that parent engagement in schools, which includes encouraging parents to be part of decision making, is linked to better health and education outcomes, both in adolescence and young adulthood.¹⁻⁵ This specific strategy for involving parents is supported by CDC's *Parent Engagement: Strategies for Involving Parents in School Health*.⁶

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