



Vermont School Health Profiles

2018 Report



Division of Health Surveillance

healthvermont.gov

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Executive Summary

The School Health Profiles is conducted every other year to help education and health agencies at various levels monitor and assess characteristics of and trends in school health education; physical education and physical activity; school health policies related to human immunodeficiency virus (HIV), tobacco-use prevention, and nutrition; school-based health services; family engagement; community involvement; and school health coordination. The Profiles includes two separate questionnaires, one for principals and one for the lead health educator (LHE) at each middle and high school.

The Principal Questionnaire focuses on policies and practices related to prevention, services provided, and family and community involvement, while the Lead Health Educator Questionnaire focuses on course requirements, content covered, and professional development.

School Health Coordination

- Almost all schools (87%) have at least one person who oversees or coordinates school health safety programs and activities. Nearly eight in ten have at least one group, such as a school health council or team, that offers guidance on the development and coordination of policies and health-related activities at the school (77%). More than half (53%) have at least one person who serves as a representative on a district-wide school health team that meets at least quarterly each year.
- During the past year, 89% of schools reviewed their district's local wellness policy. Two-thirds (67%) helped revise their local policy while half assessed their school's compliance in meeting the requirements set forth in the district's wellness policy.

Health Services

- Nearly eight in ten schools have a full-time registered nurse (78%) while nearly a third have a part-time nurse (35%) available to provide health services to students. Less than a quarter have a school-based health center (22%).
- More than 95% of schools identify and track students with chronic conditions such as asthma, diabetes, and food allergies that may require daily or emergency management. More than eight out of ten schools provide students with referrals to community-based health centers if they have been identified with these chronic conditions. However, fewer schools track or provide referrals for students with or who are at risk for activity, diet, and weight-related chronic conditions such as hypertension and obesity.
- While most schools have referral procedures for students who express concerns about or are in need of receiving mental health care (81%), just over half (51%) screen students for mental health issues.
- Just over half (56%) have a cooperative or formal agreement with an outside agency to provide services including assessments or treatment for students with suspected substance use issues.
- Few schools provide direct sexual health services on school property. These services are primarily provided through the provision of condoms (13%). However, about half of middle and high schools provide referrals for students to receive sexual health services such as HPV vaccinations, STD testing and treatment, contraceptives, and pregnancy testing.

Health and Physical Education

- Nearly three-quarters of lead health educators (73%) are certified, licensed, or endorsed by the state to teach health education. Four in ten lead health educators have 15 or more years of experience in teaching health education.
- All Vermont high schools and most middle schools (86%) require at least some health education instruction, either in a required health education course or in another academic setting. Most schools require students to receive this instruction in at least one formal required course with more than half (54%) requiring students to take two or more health education courses.
- Overall, schools are more likely to require students to complete a physical education course in each grade level compared to health education course. However, with both health and physical education, once students reach high school the percent of schools who require students to complete a required course decreases significantly after 9th grade with less than four in ten schools requiring students to complete a physical or health education course during their final year.
- Most schools have identified or are in the process of identifying Proficiency-Based Graduation Requirements (PBGR) related to Health Education (82%) and physical education (85%).

Policies and practices related to health and wellness

Tobacco, Alcohol, and Drug Use Policies

- Nearly all schools in Vermont have tobacco, alcohol, and drug use policies.
- Seven in ten schools (69%) have policies that mandate a “tobacco-free environment” in which tobacco use is prohibited by students, staff, and visitors in school buildings, at school functions, in school vehicles, on school grounds and at off-site school events at all times.
- However, schools are less likely to specify electronic vapor products in their policy compared to other tobacco products. Overall about three quarters of schools prohibited the use of electronic vapor products by students (76%), faculty (77%), or visitors (73%).
- Two-thirds of schools (67%) have procedures to provide referrals for students who are self-referred or suspected to have alcohol or drug-use problems. Just over half (56%) have a cooperative or formal agreement with an outside agency to provide services including assessments or treatment for students with suspected substance use issues.

Physical Activity and Nutrition Policies

- One in ten schools (12%) have a comprehensive school physical activity program (CSPAP).
- All schools provide at least some opportunities for physical activity before, during, and after the school day. Opportunities for physical activity most frequently occur after school through interscholastic (90%) or intramural sports (78%). Less than half (48%) provide opportunities for physical activity before school.
- Nearly seven in ten (67%) schools have joint use agreements for shared use of school or community facilities to use sport facilities and promote physical activity. Four in ten (41%) have agreements to share kitchen facilities and equipment.

- A supportive school nutrition environment includes multiple elements related to how schools provide students access to nutritious meals and snacks. Nearly all schools serve locally or regionally grown foods in the cafeteria (95%) and place fruits and vegetables where they are easy to access (92%). Most have a school garden (77%). Seven in ten schools prohibit advertisements for candy, fast food, and soft drinks (71%) or selling less healthy foods or beverages in fundraisers (72%).
- Few schools (12%) modify the cost of food and beverages making more healthy food and beverages available at a lower cost.
- Less than half of schools have vending machines, school stores, or snack bars available for students to purchase snack foods or beverages food (44%). Availability of vending machines varies by the type of school with 81% of high schools allowing students to purchase food and beverages outside the school meal program.

Safe and Inclusive Environments

- All schools have a designated staff member to whom students can confidentially report student bullying and sexual harassment.
- Most schools prohibit harassment based on a student’s perceived or actual sexual orientation or gender identity (99%) and have identified “safe spaces” (84%) where LGBTQ youth can receive support from administrators, teachers, or other school staff. Only a third of all schools (33%) implemented all six strategies identified to meet the needs of LGBTQ youth.
- Most schools have opportunities for students to learn about people different from them. Two-thirds of schools have clubs that provide students with opportunities to learn about people different from them, such as students with disabilities, homeless youth, or people from different cultures (65%); half (51%) provide clubs that create safe, welcoming, and accepting environments for all youth such as GSA’s (Gay Straight Alliances), 61% host special events at school.

Family and Community Engagement

- Seven in ten schools provide students opportunities to peer tutor other students (68%) and participate in service learning projects (69%); 44% have mentoring programs involving family or community members.
- Overall, 69% of schools implement in at least four strategies to increase parent and family engagement. Implementation of family engagement strategies range from communicating with families about health services and programs (93%) to providing students enrolled in health education courses assignments to complete with their family (59%) to involving families in the delivery of health education programs and services (28%).

Methodology and Background

The School Health Profiles (SHP) is a system of surveys designed to help education and health agencies at various levels monitor and assess characteristics of and trends in school health education; physical education and physical activity; school health policies related to human immunodeficiency virus (HIV), tobacco-use prevention, and nutrition; school-based health services; family engagement; community involvement; and school health coordination.*

The SHP is conducted biennially by education and health agencies among middle and high school principals and lead health education teachers across the United States. Lead Health Educators are typically appointed by the school's principal as the person most knowledgeable about health education at the school. This person could include the teacher most responsible for overseeing health education in the school. It could be a health educator in a school, an educator shared among several schools, a school nurse, or most experienced health educator.

In Vermont, SHP has been administered biennially since 2006. The Agency of Education was responsible for data collection between 2006 and 2012, the Department of Health since 2014. Since 2016, the Department of Health has implemented the survey using an online platform allowing principals and Lead Health Educators (LHE's) to complete the survey using a computer, tablet, or smartphone.

Topics Included on the School Health Profiles Questionnaires	
Principal Questionnaire	Lead Health Educator Questionnaire
Bullying and sexual harassment policies	Health education course requirements
Physical education and physical activity	Content of health education
Tobacco-use prevention policies	Materials provided
Nutrition-related policies and practices	Collaboration
Health services	Professional preparation
Family and community involvement	Professional development

* Centers for Disease Control and Prevention (CDC) *School Health Profiles*. <https://www.cdc.gov/healthyyouth/data/profiles/index.htm>

Methodology & Participants

In 2018, all Vermont public schools that serve students in two or more grades 6 through 12 were invited to participate. * During the late fall / early winter, principals were notified about the SHP and were asked to designate the school’s lead health education teacher or the person most knowledgeable about health education at their school. Beginning in February 2018, principals and LHEs were invited via email to complete the School Health Profiles. Each person received an individualized email with a link to access the Web-based questionnaire. Participation in the survey was confidential and voluntary; follow-up emails and telephone calls were used to encourage participation. Data collection was completed by the end of April 2018.

Of the 150 public schools, invited to participate, one or both questionnaires were received from 94% of schools. After data cleaning and editing, usable questionnaires were received from principals in 83% of schools and from lead health education teachers in 84% of schools.

Because the response rates for both the principal and lead health educator surveys were at least 70%, the results are weighted and are representative of all public schools in Vermont with any grades 6 through 12. Note, however, schools that end with grade 6 are ineligible for the School Health Profiles. Their responses are not reflected in this report.

PARTICIPATION AND RESPONSE RATE AMONG MIDDLE, JUNIOR / SENIOR HIGH, AND HIGH SCHOOLS, 2018

	Middle Schools ¹	Junior / Senior High Schools ²	High Schools ³	All Schools	Response Rate
Principals	76	28	21	125	83%
Lead Health Educators	72	32	22	126	84%

The following pages discuss survey results for traits about lead health educators, school health teams, health services, and required health and physical education. This is followed by a more in-depth look at specific the health-related aspects of school policies and programs, prevention, and education among all schools serving students in grades 6 through 12.

Differences between school types are shown in Appendix A.

* The CDC defines the type of school as:
¹ Middle schools with a high grade of 9 or lower;
² Junior/senior high schools with a low grade of 8 or lower and a high grade of 10 or higher; and
³ High schools with a low grade of 9 or higher and a high grade of 10 or higher;

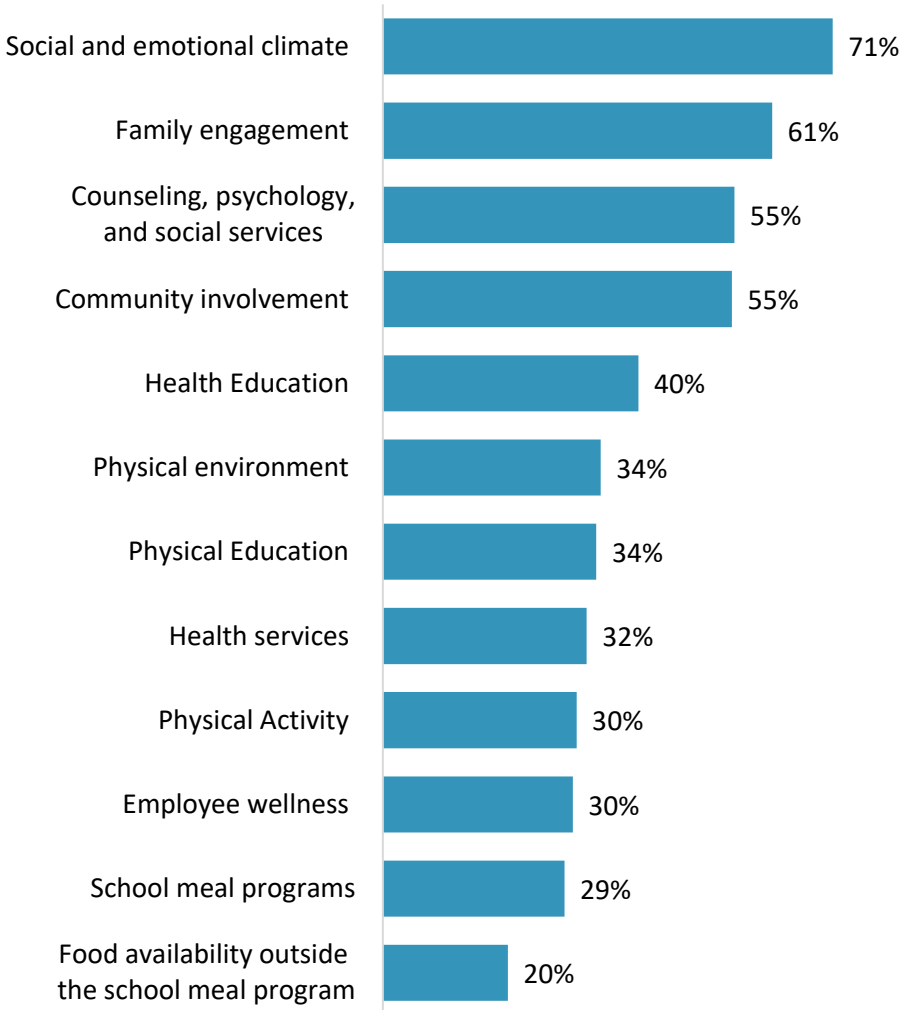
School Health Overview

School Improvement Plans and Wellness Policies

Objectives Included in School Improvement Plans

Two-thirds of all schools had a School Improvement Plan (SIP) that included at least one health-related objective. Of the 12 health-related objectives assessed, more than half of schools had a SIP that included social and emotional climate, family engagement, counseling, psychological or social services and community involvement. Health topics included in a SIP are shown below. Differences by school type are shown in Appendix A.

HEALTH-RELATED OBJECTIVES INCLUDED IN SCHOOL IMPROVEMENT PLANS



The number of objectives included have increased over time. Having objectives related to health education, physical education, physical activity, school meal programs, food and beverages available outside the school meal program, counseling, psychological and social services, and the physical environment have all significantly increased since first asked and since 2016 (data not shown).

School Improvement Planning Process

Most schools (82%) reviewed health and safety data such as the Youth Risk Behavior Survey as part of the school’s improvement planning process. Reviewing health and safety data has significantly decreased since 2012 (89%).

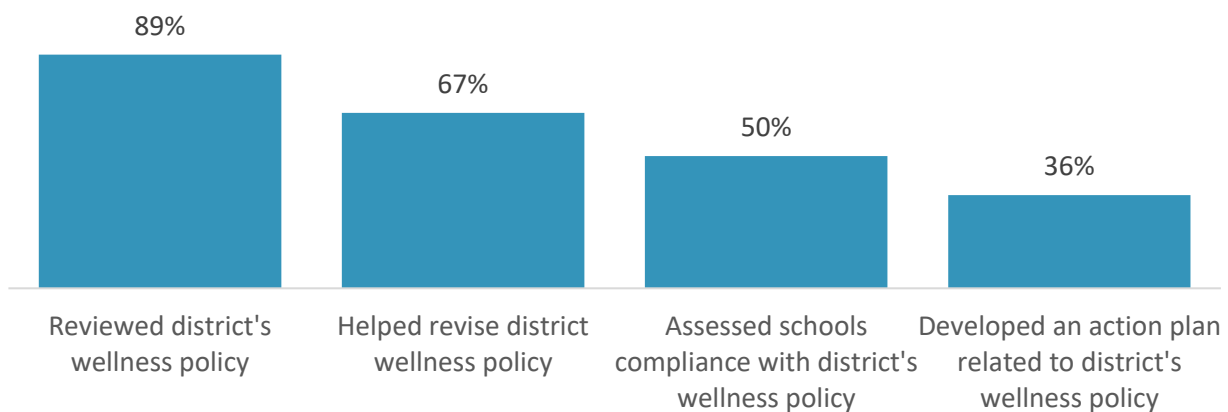
More than half of all schools used the School Health Index or other self-assessment to assess policies, activities, and programs related to physical education and activity (66%), tobacco-use prevention (65%), nutrition (62%), safety, unintentional injury and violence prevention (50%), HIV/STD and pregnancy prevention (53%). Slightly fewer assessed policies related to chronic health conditions such as asthma and food allergies (47%).

Activities Related to Local Wellness Policies

During the past year, 89% of schools reviewed their district’s local wellness policy. Two-thirds (67%) helped revise their local policy, half assessed their school’s compliance and a just over a third (36%) developed an action plan that described steps to meet the requirements set forth in the district’s wellness policy.

Overall, schools were significantly more likely to communicate information about their district’s wellness policy with school staff (72%) compared to students (46%) and parents or families (43%) (data not shown).

LOCAL WELLNESS POLICY ACTIVITIES



Collaboration to Implement Health Education Activities

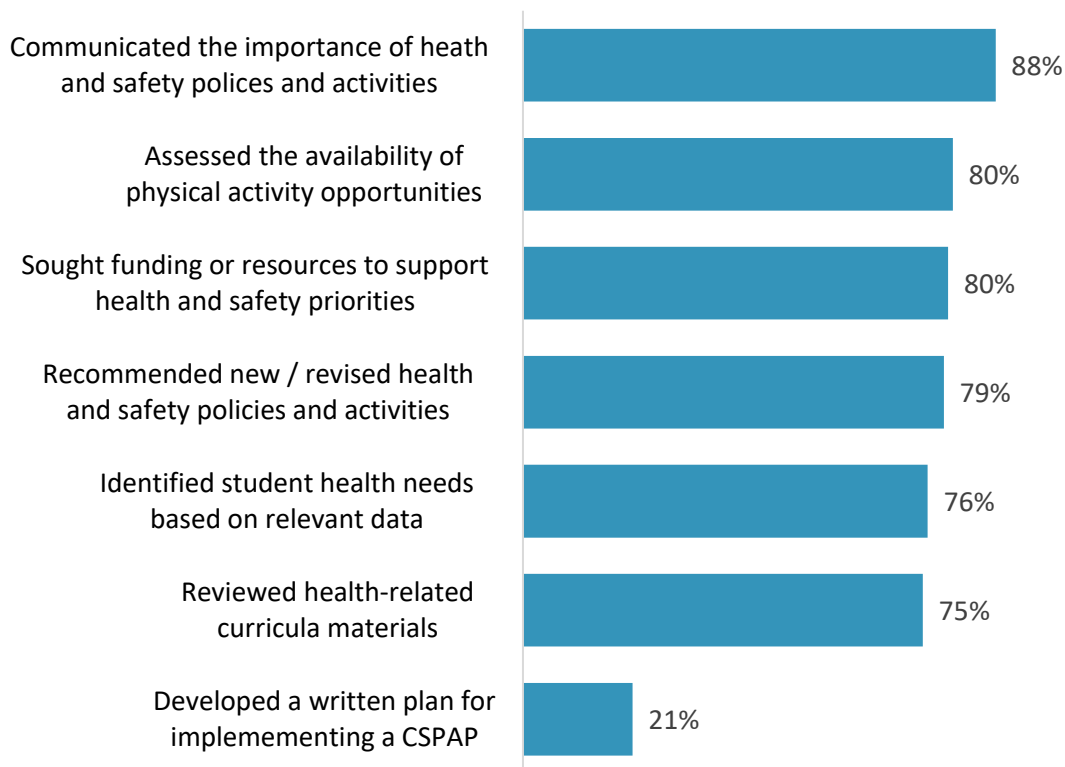
During the current school year, health education staff worked with physical education staff (88%), mental health or social services staff (80%), health services (77%), school health council or wellness team (62%), and nutrition staff (35%). Middle school teachers were significantly more likely to interact with other groups compared to high school teachers (See Appendix A).

School Health Teams

Nearly nine out of ten schools (87%) have at least one person who oversees or coordinates school health safety programs and activities, most (77%) have a group such as a school health council or team that offers guidance on the development and coordination of policies and health-related activities.

During the past year 21% of schools developed a written Comprehensive School Physical Activity Program (CSPAP). Specific activities performed by a school health team are shown below.*

ACTIVITIES PERFORMED BY SCHOOL HEALTH TEAMS

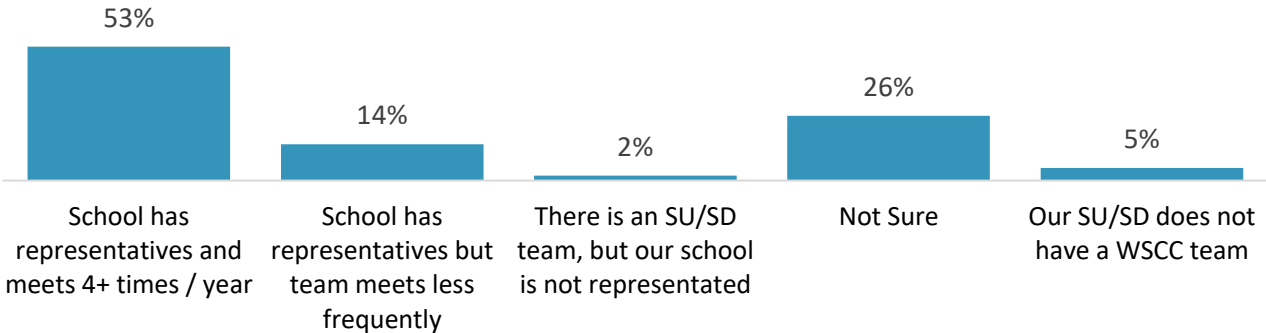


Since 2012, significantly more school health teams have communicated the importance of these policies and activities (80% vs 88%), recommended new or revised health and safety policies and activities (73% vs 79%), and reviewed health related curricula or instructional materials (70% vs 75%). Significantly more school health teams have assessed the availability of physical activity opportunities for students (75% in 2014 vs 80%) and help develop or implement a written CSPAP plan (12% in 2016 vs 21% in 2018).

* Among schools that have a school health council or team.

District-Wide School Health Teams. In addition to having a school health council or team, seven in ten school districts or supervisory unions (69%) have a Whole School, Whole Child, Whole Community (WSCC) team. However, frequency of participation varied among schools, with about half of all schools having and participating on a district school health team that meets at least quarterly. In addition, a quarter (26%) of schools were not sure if their district has a WSCC team.

**SCHOOL DISTRICT / SUPERVISORY UNION
WHOLE SCHOOL, WHOLE CHILD, WHOLE COMMUNITY TEAM
PARTICIPATION**



School Health Services

Registered Nurses on Staff

Overall, 78% of schools have a full-time registered nurse available to provide health services to students; about a third (36%) have a part time registered nurse.

Having a full-time nurse has not significantly changed over the past ten years. Compared to high schools, middle schools are significantly less likely to have a full-time school nurse (100% vs 66%) although are more likely to have part-time nurses (24% vs 42%). Differences by school type are shown in Appendix A.

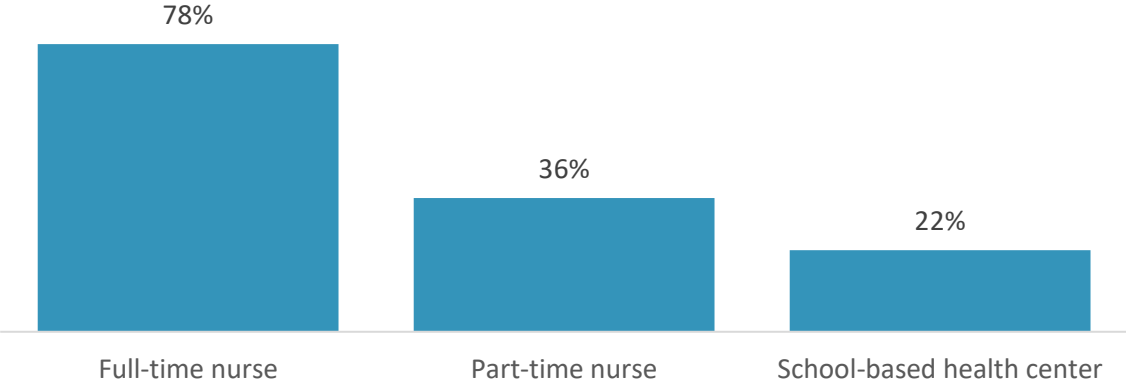
School-Based Health Centers

About two in ten Vermont schools (22%) have a school-based health center that offers health services to students, significantly less than in 2016 (26%). A quarter of schools (25%) provide direct services to students for dental care such as those through an on-site dental chair or mobile dental van.

Access to Insurance

Seven in ten (72%) schools have protocols to ensure eligible students with chronic conditions are enrolled in state or federally funded insurance programs.

SCHOOL HEALTH CENTERS AND STAFF

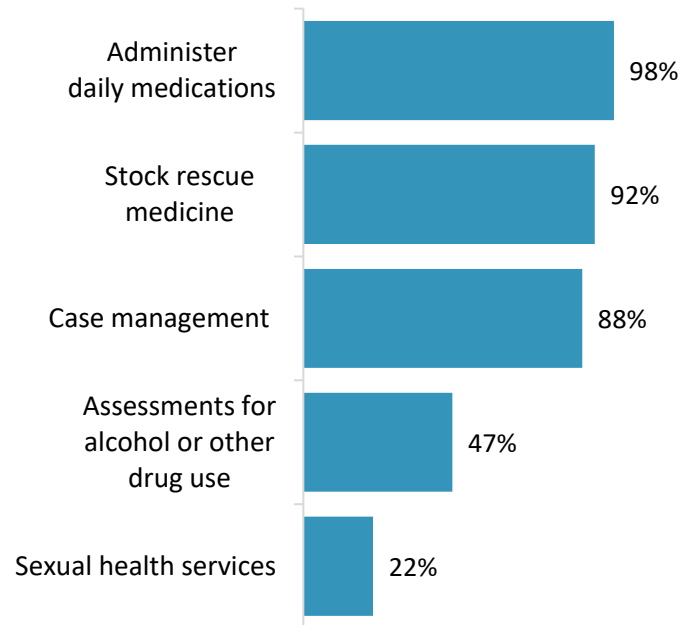


Health Services Provided

The majority of schools provide daily medication administration for students with chronic health conditions such as asthma and diabetes (98%), stock rescue or “as needed” medication for students experiencing a health emergency such as a severe allergic reaction (92%) and provide case management for students with chronic health conditions (88%).

Fewer schools (47%) provide assessments for alcohol or other drug use, abuse, or dependency. Less than a quarter provide sexual health services on school property. More detailed information about specific sexual health services, referrals, and parental notification, as well as assessment and referrals for substance use is provided under specific school policies, procedures, and prevention practice sections.

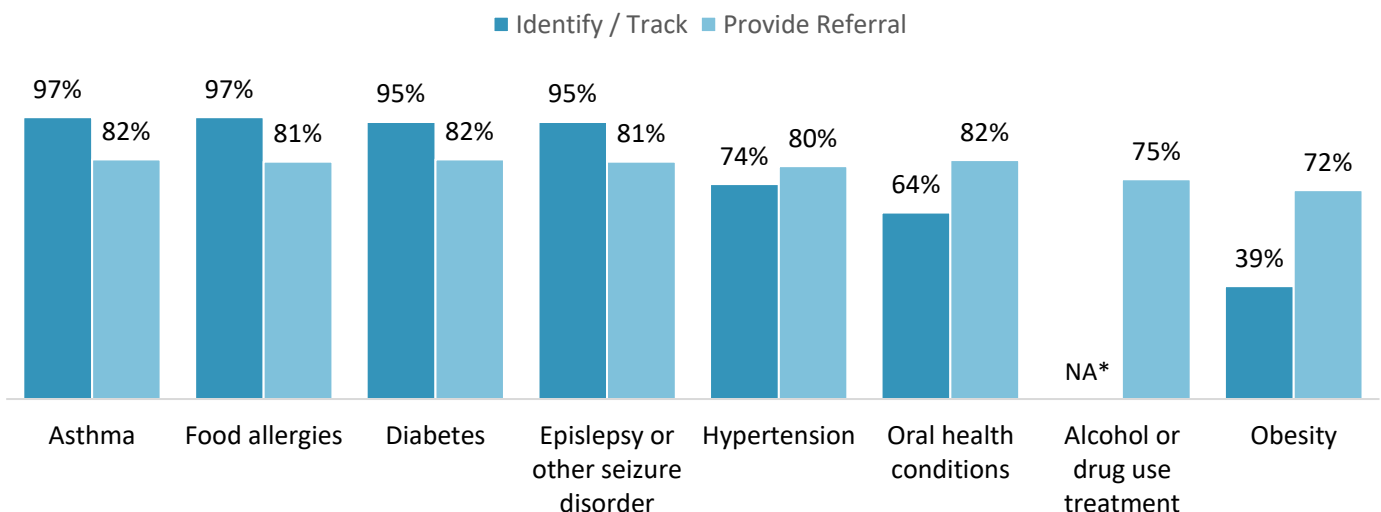
HEALTH SERVICES PROVIDED IN SCHOOLS



Tracking and Referrals Provided for Chronic Health Conditions. Most schools use school records to identify and track students with chronic conditions such as asthma (97%), food allergies (97%), diabetes (95%), and epilepsy or seizure disorders (95%) that may require daily or emergency management. More than eight in ten provide referrals to other health care providers or organizations for students diagnosed with or suspected to have these conditions. In addition, 75% of schools provide students with referrals for alcohol or other drug abuse treatment.

Fewer schools use school records to identify and track students with hypertension (74%), or obesity (39%); however, many provide referrals for students diagnosed with or suspected to have these conditions.

TRACKING AND REFERRALS FOR CHRONIC HEALTH CONDITIONS

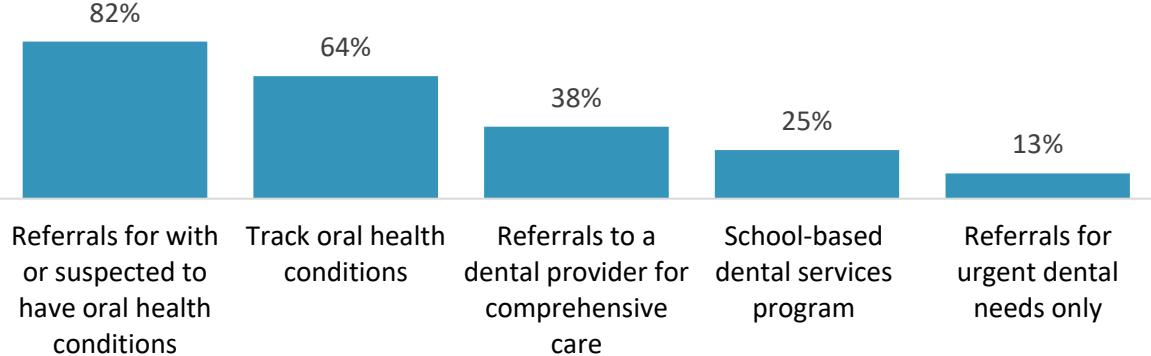


*NA= question not asked

Tracking, Screenings and Referrals Provided for Dental Health Care. Overall, a quarter of schools (25%) provide direct services to students for dental care such as those through an on-site dental chair or mobile dental van. Eight in ten (82%) provide referrals for students diagnosed with or suspected to have an oral health condition such as a tooth abscess or tooth decay.

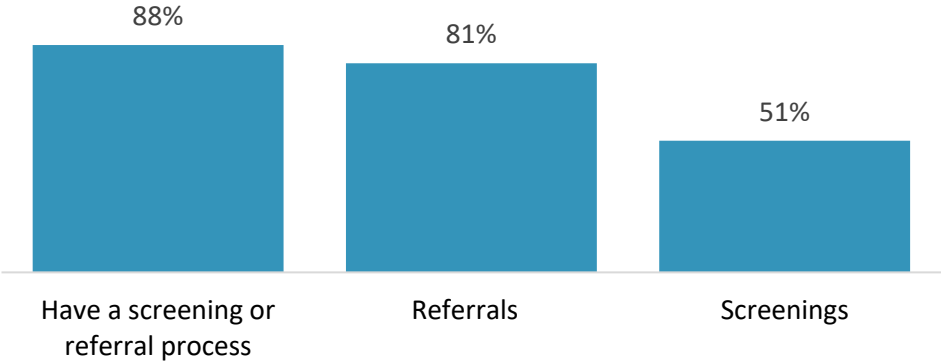
Less than two-thirds (64%) track oral health conditions; 38% provide referrals for students who have not visited a dentist in the past year to a dental provider for comprehensive care; 13% provide referrals only for students with urgent dental needs.

DENTAL AND ORAL HEALTH SERVICES



Screenings and Referrals Provided for Mental Health Issues. Most schools have screening and referral procedures for students who are suspected of or express concerns for having mental health issues (88%). Specifically, 81% of schools have referral procedures to assist a student in need of mental health services, just over half (51%) can screen students for mental health issues.

MENTAL HEALTH SCREENINGS AND REFERRALS



Trends in School Health Services

The percent of schools who ensure students with chronic conditions have insurance, identify, track, or provide referrals for students with chronic health has not significantly changed since 2014. However, in 2018 fewer schools reported using records to identify and track students diagnosed with obesity compared to 2014 (55% vs 39%) but they were more likely to refer students diagnosed or suspected to have obesity (67% vs 72%) and hypertension (75% vs 80%) to community based medical providers.

Lead Health Educator

Professional Preparation and Experience

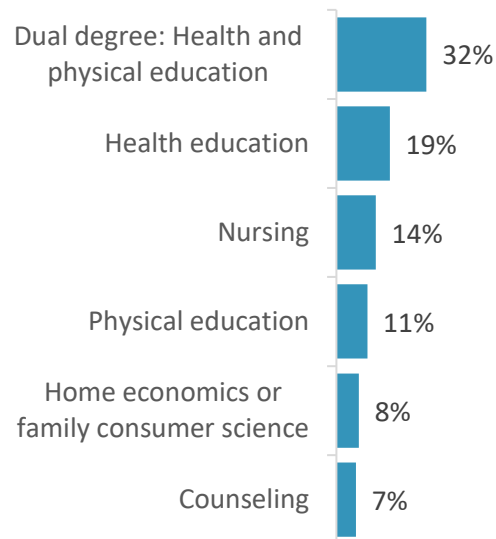
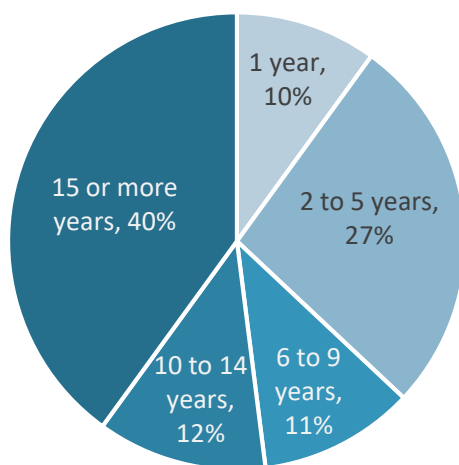
Experience, Licensure, Certification and Endorsement

Four in ten Vermont LHEs have 15 or more years of experience (40%), while one in ten have one year or less experience. In Vermont, nearly three-quarters of the LHEs (73%) are certified, licensed, or endorsed by the state to teach health education

Preparation

About half of LHEs have professional preparation in health education, with or without training in physical education. Other common professional backgrounds include degrees or training in nursing (14%), physical education (11%), home economics (8%), and counseling (7%). In addition, 2% or fewer teachers have backgrounds in biology or other science, nutrition, kinesiology or exercise science, public health, or another educational degree (data not shown).

YEARS OF EXPERIENCE AND PROFESSIONAL PREPARATION AMONG LEAD HEALTH EDUCATORS



Trends in LHE Professional Preparation and Experience

The percent of LHEs completing the School Health Profiles who are certified or licensed by the state to teach health education has significantly increased from 62% in 2008 to 73% in 2018. Likewise, more LHEs reported having 15 or more years of experience teaching health education in schools (31% vs 40%).

Since 2008, the percent of LHEs who were trained in health education or health and physical education combined has significantly increased from 34% to 51%.

Professional Development

In addition to formal professional training, LHEs receive professional development such as attending conferences or workshops on teaching health and sexual education. In the previous two years, almost all schools (97%) provided professional development opportunities for those teaching physical education. Professional development opportunities included receiving information on teaching pedagogy and assessment, working with special populations, teaching sexual health education, and information related to specific topics.

Pedagogical Techniques

Overall, LHEs were most likely to receive professional development related to teaching skills for behavioral change and classroom management techniques such as social skills training, environmental modification, conflict resolution and mediation, and behavioral management. Middle school LHEs were significantly more likely than high school LHEs to receive professional development related to classroom management techniques (57% vs 50%) and less likely to receive information about assessing or evaluating students in health education (34% vs 64%).

More than two-thirds of LHEs were interested in receiving more opportunities for professional development related to these areas of teaching and assessment. Most notably, middle school LHEs were significantly more likely to want additional training opportunities related to using interactive teaching methods (70% vs 50%) and classroom management techniques (71% vs 41%).

The following tables show the percent of LHEs who recently received professional development related to teaching and assessment in health education and the percent interested in more opportunities to learn about teaching pedagogy. Differences by type of school are shown in Appendix A.

Professional Development: Teaching and Assessment	% who received PD, past two years	% who would like more PD opportunities
Classroom management techniques	56	64
Teaching skills for behavior change	56	76
Using interactive teaching methods	51	69
Assessing students in health education	46	76
Encouraging community and family involvement	34	70

Working with Special Populations

Generally, fewer LHEs report recently receiving professional development related to teaching students of various backgrounds and special needs compared to that related to pedagogical techniques specific to health education. Middle school LHEs were significantly less likely to receive professional development opportunities related to working with special populations compared to high school LHEs. See Appendix A for differences in professional development opportunities by school type.

When asked about what areas they would like to receive additional training related to special populations, LHEs were most interested in having more opportunities to learn about teaching students of different sexual orientations or gender identities (71%) and teaching students with physical, medical, or cognitive disabilities (66%). Slightly fewer were interested in learning about teaching students of various cultural backgrounds (58%) or with limited English proficiency (43%).

High school LHEs were significantly more likely to desire professional development related to teaching students with limited English proficiency (55% vs 40%) whereas middle school LHEs were more likely to want more information related to teaching students of various cultural backgrounds (58% vs 50%) and different sexual orientations or gender identities (69% vs 62%). See Appendix A for additional results.

The following table show the percent of LHEs who recently received professional development related to working with special populations in health education and the percent interested in more opportunities to learn about teaching pedagogy.

Professional Development: Working with Special Populations	% who received PD, past two years	% who would like more PD opportunities
Teaching students of different sexual orientations or gender identities	58	71
Teaching students with physical, medical, or cognitive disabilities	44	66
Teaching students of various cultural backgrounds	32	58
Teaching students with limited English proficiency	15	43

Teaching Sexual Health Education

During the past two years, about a third (35%) of LHEs received professional development related to understanding their district’s policies or curriculum guidance related to sexual health; 44% received training on how to align sexual health lessons and materials with the district’s scope and sequence. Learning about district policies did not differ among middle school and high school LHEs, however, high school LHEs were significantly more likely than middle school LHEs to receive professional development on how to align their lessons and materials with the district recommendations (47% vs 37%).

About half of all LHEs received professional development related to creating a safe and comfortable learning environment for teaching sexual health education (50%) and using a variety of effective instructional strategies to deliver sexual health education (49%). Roughly four in ten teachers received professional development related to building student skills in HIV, other STD, and pregnancy prevention (38%) and assessing student knowledge and skills in sexual health education (42%). Fewer LHEs received professional development related to connecting students to on-site or community-based sexual health services (28%). High school LHEs were significantly more likely than middle school LHEs to receive professional development related to these topics.

See Appendix A for differences in professional development received by type of school.

While less than half of all LHEs received professional development during the past two years related to sexual health education, nearly two-thirds were interested in receiving professional development opportunities related to teaching this topic. Excluding connecting students to sexual health services and assessing student knowledge and skills in sexual health, middle school LHEs were significantly more likely than high school LHEs to want additional professional development opportunities.

Professional Development: Sexual Health Education	% who received PD past two years	% who would like more PD opportunities
Creating a comfortable and safe learning environment in sexual health education	50	59
Using a variety of effective instructional strategies to deliver sexual health education	49	70
Aligning lessons and materials with the district scope and sequence for sexual health education	44	66
Assessing student knowledge and skills in sexual health education	42	72
Building student skills in HIV, STD, and pregnancy prevention	38	65
Understanding district policies or curriculum guidance regarding sexual health education	35	60
Connecting students to on-site or community-based sexual health services	28	63

Areas of Focus

In addition to pedagogical based professional development LHEs received opportunities to participate in topic focused trainings. More than half received training focused on alcohol and drug use prevention (51%), emotional and mental health (72%), human sexuality (56%), physical activity and fitness (52%), and violence prevention (55%).

The five most commonly report topics health education teachers reported wanting additional training in are: emotional and mental health (82%), human sexuality (72%), suicide prevention (70%), violence prevention (66%), and alcohol and other drug-use prevention (65%). The following table shows specific health topics covered during recent professional development opportunities.

Professional Development: Areas of Focus	% who received PD, past two years	% who would like more PD opportunities
Alcohol / drug use prevention	51	65
Asthma	16	27
Chronic disease prevention	24	46
Emotional and mental health	72	82
Epilepsy	14	31
Food allergies	21	32
Foodborne illness prevention	11	26
HIV prevention	40	45
Human sexuality	56	72
Infectious disease prevention	31	38
Injury prevention and safety	41	46
Nutrition and dietary behavior	36	60
Physical activity and fitness	52	50
Pregnancy prevention	37	50
STD prevention	39	54
Suicide prevention	43	70
Tobacco use prevention	37	47
Violence prevention	55	66

Trends in Professional Development Received During the Previous Two Years

The percent of LHEs who received professional development significantly decreased between 2008 and 2018 for the following areas: asthma (27% vs 16%), foodborne illness prevention (19% vs 11%), HIV prevention (52% vs 40%), STD prevention (47% vs 39%), using interactive teaching methods (54% vs 51%) significantly decreased. During that same time period, the percent of LHE who received professional development significantly increased for: emotional and mental health (54% vs 72%), human sexuality (48% vs 56%), injury prevention and safety (39% vs 41%), suicide prevention (30% vs 43%), teaching students of various cultural backgrounds (19% vs 32%), encouraging family or community involvement (30% vs 34%).

Notably, while only asked since 2010, professional development opportunities related to teaching students of different sexual orientations or gender identities more than tripled, increasing from 16% to 58%.

Specific training related to teaching sexual health were only asked about in 2016 and 2018. In 2018 significantly more LHEs reported receiving professional development related to creating a safe and comfortable learning environment (41% vs 50%), using a variety of effective instructional strategies (37% vs 49%), assessing student knowledge and skills (35% vs 42%), and understanding current district policies or curriculum guidance regarding sexual health education (26% vs 35%). The percent of LHEs receiving professional development opportunities related to aligning lessons and materials with the district scope of sexual education, building students skills in HIV, other STD, and pregnancy prevention, and connecting students with on-site or community based sexual health services did not change between 2016 and 2018.

Health and Physical Education in Schools

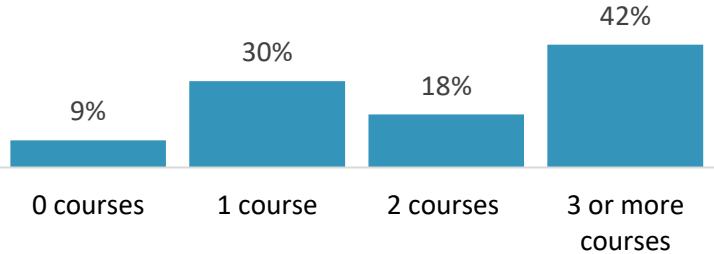
Number and Frequency of Required Courses

Health education or instruction is not required to occur in a stand-alone health course taught to students. All Vermont high schools and most middle schools (86%) require at least some health education instruction, either in a required health education course or another academic setting.

Required *health education courses* are specific courses that students must take for graduation or promotion from school and include instruction about health topics such as injuries and violence, alcohol and other drug use, tobacco use, nutrition, HIV infection, and physical activity.

Nearly all schools (91%) require students to take at least one health education course. Most require students to take at least three courses (42%). Three in ten require students to complete one courses (30%). The number of courses required varied by middle and high schools (see Appendix A).

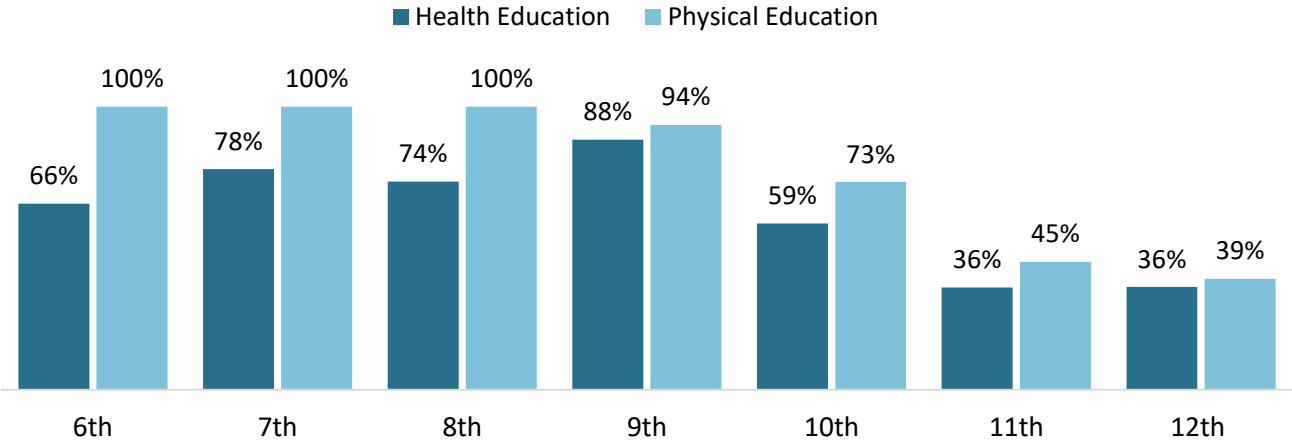
NUMBER OF REQUIRED HEALTH EDUCATION COURSES



About half of schools (52%) require students who fail a required health course repeat it.

Overall, schools are more likely to require physical education courses compared to health education. All students are required to complete physical education courses every year in grades six through eight. Similarly, the percent of schools who require physical and health education decreases with each grade level beginning in ninth grade.

SCHOOLS WITH REQUIRED HEALTH AND PHYSICAL EDUCATION COURSES, BY GRADE LEVEL



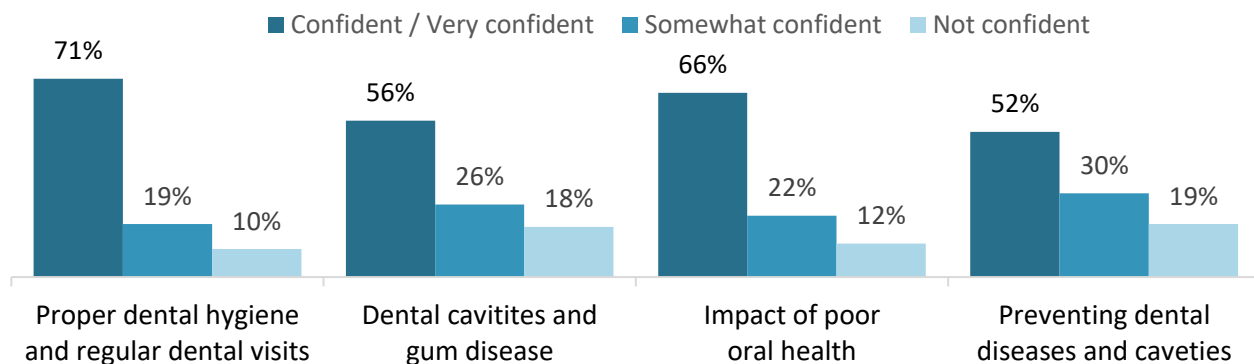
Content Covered in Health Education Courses

Health Education Standards focus on developing skills necessary to adopt, practice, and maintain health-enhancing behaviors as well as increasing knowledge on specific topics.¹ Health education curriculum covers a variety of topics ranging from alcohol and other drug use prevention to bullying and violence prevention. Excluding epilepsy or seizure disorders and foodborne illness prevention, high schools are significantly more likely than middle schools to teach health-related topics. These differences are shown in Appendix A.

Content Areas Covered in a Required Health Education Course			
Alcohol and other drug use	94	Infectious disease prevention	74
Asthma	32	Injury prevention and safety	76
Chronic disease prevention	79	Nutrition and dietary behavior	93
CPR/AED use	48	Oral health	40
Emotional and mental health	92	Physical activity and fitness	98
Environmental health	43	Practices to maintain health	91
Epilepsy or seizure disorder	20	Pregnancy prevention	79
Food allergies	55	STD prevention	84
Foodborne illness prevention	59	Suicide prevention	82
HIV prevention	79	Tobacco-use prevention	93
Human sexuality	89	Violence prevention	93

While most LHEs do not cover oral health in a required health course, most are at least somewhat confident in their ability to teach topics related to oral health.

CONFIDENCE IN TEACHING STUDENTS ABOUT ORAL HEALTH



Skills Addressed in Health Education Curriculum

More than nine in ten schools have health education curriculum that includes comprehending concepts, using skills, practicing behaviors, accessing information, analyzing the influence of others, and being an advocate for personal, family, and community health. High school health education curriculum is significantly more likely to include these components in their health education curriculum, compared with middle schools (see Appendix A).

Components Included in Health Education Curriculum		%
Using interpersonal communication skills to enhance health and avoid or reduce health risks		96
Using decision making skills to enhance health		95
Using goal-setting skills to enhance health		94
Comprehending concepts related to health promotion and disease prevention		93
Analyzing the influence of peers, family, culture, media, technology, and other factors on health behaviors		93
Practicing health-enhancing behaviors to avoid or reduce risks		93
Accessing valid information and products and services to enhance health		90
Advocating for personal, family, and community health		89

Trends in Required Health and Physical Education and Content Covered

Since 2008, the percent of schools requiring students complete two or more health education courses has significantly increased from 51% to 61% in 2018. Advocating for personal, family and community health (94%), accessing valid information, products and services (90%), and using goal setting skills to enhance health (94%) have all increased over the past decade from 86%, 81%, and 82%, respectively.

Notably, the percent of schools who teach about suicide prevention has also significantly increased from 68% in 2008 to 82% in 2018.

Materials and Curriculum Provided in Health and Physical Education

Schools provide teachers with materials such as written curriculums, goals and objectives, sequence of instruction, and methods for assessment related to health, including sexual health, and physical education courses. *

Materials Provided to Those Who Teach Health, Sexual, and Physical Education		%
A written curriculum	Health education	61
	Sexual health education	62
	Physical education	73
Goals, objectives, and expected outcomes	Health education	86
	Sexual health education	77
	Physical education	95
Plans for how to assess student performance or methods to assess student knowledge and skills	Health education	66
	Sexual health education	69
	Physical education	87
A chart describing the annual scope and sequence of instruction	Health education	62
	Sexual health education	52
	Physical education	75
Strategies in sexual health education are age-appropriate, relevant, and actively engage students in learning		69
Curricula or supplementary materials that include HIV, STD, or pregnancy prevention information that is relevant to LGBTQ youth		65
Resources for fitness testing		97
Physical activity monitoring devices such as pedometers or heart rate monitors		82

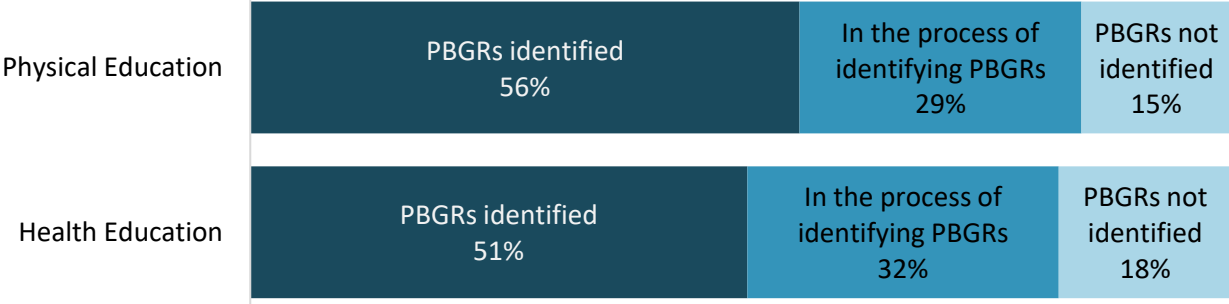
Since 2010, the percent of schools that provide curricula or supplementary materials that include HIV, STD, or pregnancy information that is relevant to LGBTQ youth has significantly increased from 43% to 65%.

* Providing key materials to those who teach health and sexual health education was asked on the LHE questionnaire. Providing materials to those who teach physical education was asked among principals only.

Proficiency-Based Standards in Health and Physical Education

Most schools have identified or are in the process of identifying Proficiency-Based Graduation Requirements (PBGR) related to Health Education (82%) and physical education (85%).

PROFICIENCY-BASED GRADUATION REQUIREMENTS





Policies, Programs, and Prevention

In addition to increasing knowledge and skills related to health education topics, an ecological approach to health education includes an alignment of health education across the school and community. It involves coordinating policies, processes, and practices within the school and community to improve the health and learning of young people.

The following section addresses what schools are doing in terms of teaching specific content, policies, processes, and practices related to tobacco use prevention, alcohol and other drug prevention, nutrition, sexual health, creating safe, inclusive environments and family and community involvement. These topics are presented in the context of what we know about youth behaviors in Vermont based on the results of the 2017 Vermont Youth Risk Behavior Survey (YRBS).

The YRBS can detect changes in risk behaviors over time and identify differences among ages, grades, and genders. With these data, we can focus prevention efforts and determine whether school policies and community programs are having the intended effect on student behaviors.

More information on the [Vermont YRBS](#) is available on the [Vermont Department of Health](#) website including general information about the YRBS, sample questionnaires, the Vermont YRBS reports, data briefs, local level results and reports from previous years.²

Tobacco, Alcohol, and Other Substance-Use Prevention

Among youth, alcohol is the most frequently abused substance, followed by marijuana and tobacco.³ Substance use among youth has both immediate and long-term impacts. These impacts may depend on the substance, age of first use, frequency of use, and amount used.⁴

While all youth are at risk for using tobacco, alcohol and other drugs, the likelihood youth will use can be modified through prevention programs, connections with caring adults, school engagement, and developing good coping skills. Preventing substance use requires a comprehensive approach and coordinated efforts. Prevention through effective policies, education, early intervention, and community engagement can impact the degree to which risk factors impact behaviors, reduce risk-taking and problem behaviors associated with alcohol, tobacco, and other drug use while promoting factors that support health lifestyles, communities and fosters resiliency.^{3, 5, 6}

To Reduce Substance Use Among Youth Protective Factors Should Outweigh Risk Behaviors

Risk Behaviors

- Use at an early age or frequent use and high-risk use (i.e. binge drinking)
- Peer pressure and peer substance use
- Poor coping skills and impulse control
- Perceived social norms including media portrayal of use and perceptions that substance use is acceptable by family and peers

- Low connection to school or community (i.e. not feeling accepted, valued, welcome)
- Family problems, conflict, unclear expectations
- Low perceptions of harm and easy access

- Resiliency
- Early intervention
- Academic competence
- Self-confidence not to use and to resist peer pressure
- Recognition for and motivation to engage in positive behaviors

- Positive adult role models
- Involvement in school, spiritual, or community activities
- Feeling accepted and supported in one's school and community
- Family, school, and community norms that provide clear and consistent messages about not misusing substances

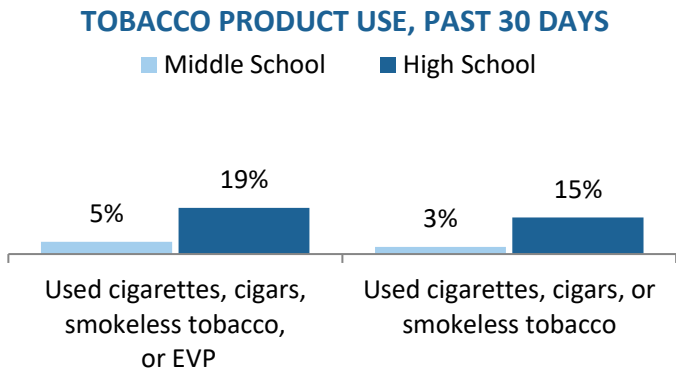
Protective Factors


It has been shown that evidence-based school prevention programs can save Vermont \$18 for every \$1 invested.⁴ The Vermont Department of Health (VDH) and Agency of Education (AOE) have invested in school- and community-based prevention grants and programs. For example, the Partnerships for Success, Regional Prevention Partnership, School-based Substance Abuse Services, and Comprehensive School-Based Tobacco Use Prevention grants have provided support for schools to reduce substance use and provide mental health services. Additionally, VDH provides funding for Student Assistance Professionals (SAP) to work with schools by providing screening, crisis services, and education related to alcohol, tobacco, and marijuana use.

WHAT WE KNOW: TOBACCO USE

Current Tobacco Product Use

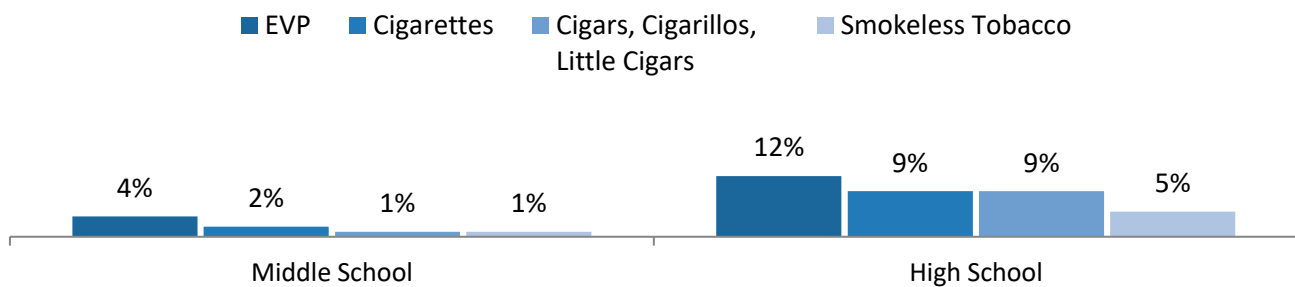
In 2017, nearly two in ten (19%) high school students and 5% of middle school students used cigarettes, cigars, smokeless tobacco, or electronic vapor products on at least one day during the previous 30 days. Excluding electronic vapor products* (EVP), 15% of high school students and 3% of middle school students used either cigarettes, cigars, or smokeless tobacco products during the past 30 days.





Among high school students, current cigarette use has decreased by 50% during the past decade. In 2017, 9% of high school students reported smoking a cigarette during the past 30 days dropping below the Healthy Vermonters 2020 goal of 10%.

COMPARED TO ALL OTHER TOBACCO PRODUCTS STUDENTS WERE SIGNIFICANTLY MORE LIKELY TO USE EVP DURING THE PAST 30 DAYS



* Electronic vapor products (EVP) include products such as e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens.

WHAT WE ARE DOING: TOBACCO USE POLICIES

Tobacco Use Policies

Nearly all schools (99%) in Vermont have policies prohibiting tobacco use. These policies vary as to the types of tobacco products, who the policies apply to, and at what times or where the policy applies. Seven in ten schools (69%) have policies that mandate a “tobacco-free environment” in which tobacco use is prohibited by students, staff, and visitors in school buildings, at school functions, in school vehicles, on school grounds and at off-site school events at all times. Eight in ten schools (80%) post “tobacco-free zone” signs.

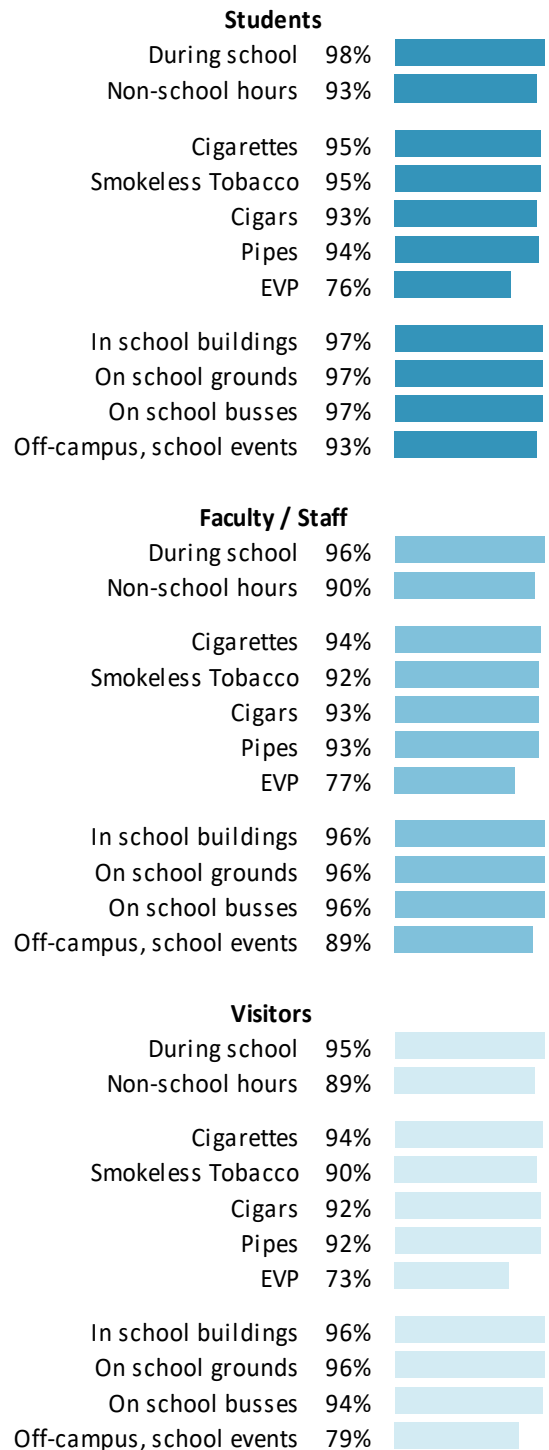
Products prohibited. Overall, most (>90%) schools have policies prohibiting the use of cigarettes, smokeless tobacco products, cigars, and pipes among students, faculty and staff, and visitors. However, about three-quarters include the use of electronic vapor products (EVP) in their policy. Middle schools are significantly less likely than high schools to prohibit the use of these products by students, faculty and staff, and visitors (see Appendix A).

Areas and time covered. More than 95% of school policies apply to everyone during school hours with about nine in ten policies addressing use after school hours. Overall, schools are less likely to include off-campus, school sponsored events in their tobacco-use policy compared to use in school buildings, on school grounds, and in school busses or other vehicles used to transport students. Middle schools are significantly less likely than high schools to prohibit tobacco use for students and for visitors during non-school hours and were less likely to address specific locations in their policy.

Trends in Tobacco Use Policies

Since 2008, the percent of schools that prohibit tobacco use by students, faculty, staff, and visitors in all locations and at all school functions, everyday regardless if school is in session or not, has significantly increased from 63% to 69%. The percent of schools who post signs indicating tobacco-free school zones has also increased from 70% to 80% during the past decade.

TOBACCO USE POLICIES



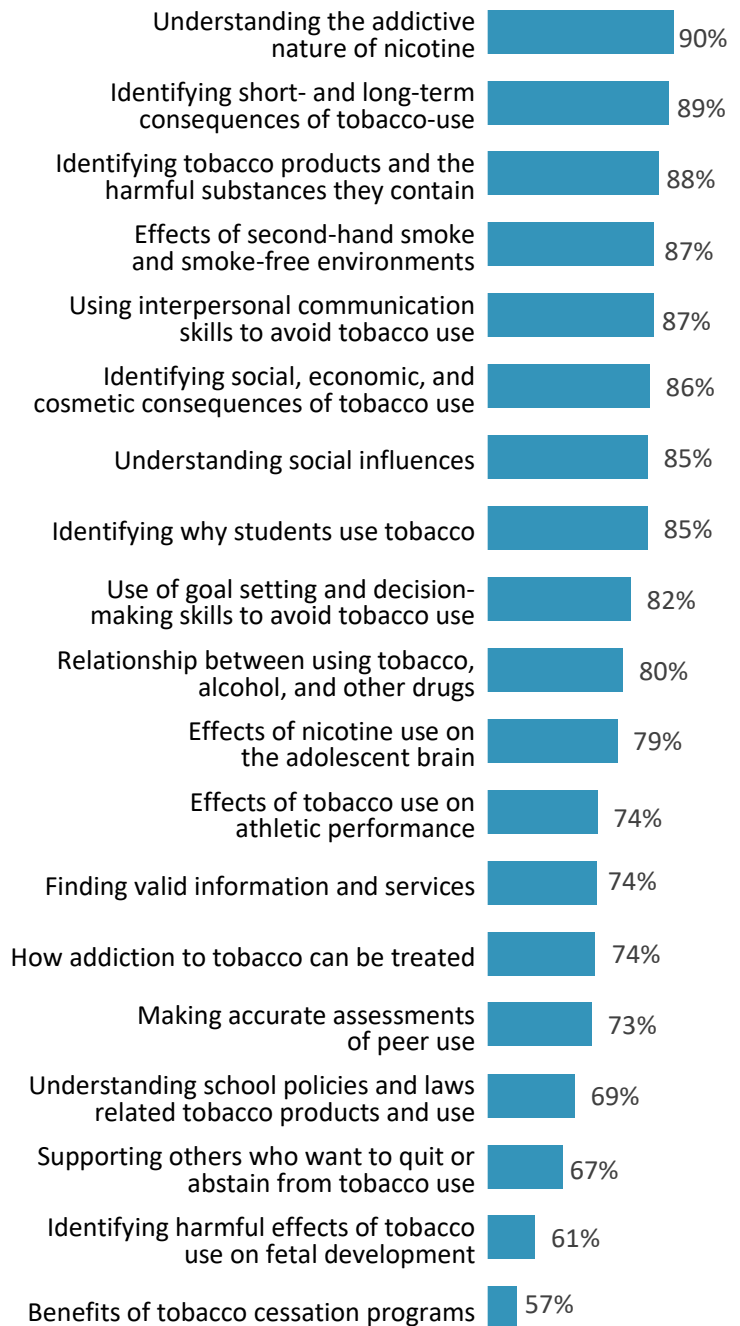
WHAT WE ARE DOING: HEALTH EDUCATION: TOBACCO USE PREVENTION

Overall, 93% of schools taught about tobacco-use prevention in a required health education course. Of the 19-specific tobacco use prevention topics included on the SHP, nearly four in ten (36%) LHEs covered all 19-specific tobacco-use prevention topics.

Trends in Tobacco-Use Prevention

The percent of schools teaching tobacco-use prevention topics has remained relatively stable over the past ten years. However, during this time period, the percent of schools teaching students how to find valid information and services has increased from 68% in 2008 to 74% in 2018. Since first asked in 2014, the percent of schools teaching students about the relationship between tobacco and alcohol or other drugs decreased from 87% to 80% in 2018. Fewer also taught students about understanding school policies and community laws related to the sale and use of tobacco products (78% vs 69%) and the benefits of tobacco cessation programs (62% vs 57%).

TOBACCO-USE PREVENTION TOPICS TAUGHT IN HEALTH EDUCATION



WHAT WE KNOW: ALCOHOL AND OTHER SUBSTANCE USE

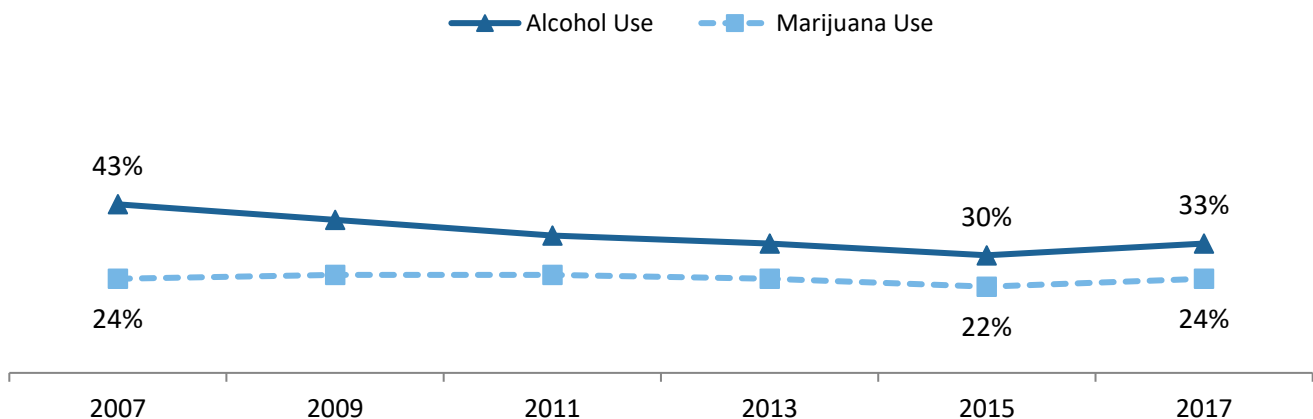
Current Alcohol Use

During the past 30 days a third of high school students (33%) drank alcohol. While current alcohol use among high school students significantly decreased between 2005 and 2015, it increased 2017. Nearly two in ten high school students (17%) binge drank during the past month.* Overall, 7% of middle school students drank at least one time during the past month. Alcohol use significantly increases with each grade level, doubling each year in middle school and more than doubling between 9th and 12th grades.

Current Marijuana Use

Nearly a quarter of high school students (24%) and 4% of middle school students used marijuana during the past 30 days. Marijuana use has remained stable over the past 10 years, however, similar to current alcohol use, marijuana use significantly increased between 2015 and 2017 among high school students. Current marijuana use has remained stable among middle school students.

CURRENT ALCOHOL AND MARIJUANA USE AMONG HIGH SCHOOL STUDENTS



Prescription Drug and Other Illicit Substance Use

Few middle school students have ever misused a prescription pain medicine (2%) or stimulant (2%). Less than ten percent of high school students have ever misused a prescription pain medicine (8%), or stimulant (6%). Five percent of high school students misused a prescription drug such as OxyContin, Percocet, Vicodin, codeine, Adderall, and Ritalin during the past 30 days.

During their lifetime, less than one in twenty high school students have ever tried heroin (2%), methamphetamines (2%), cocaine (4%), and inhalants (6%). Four percent of middle school students have used an inhalant.

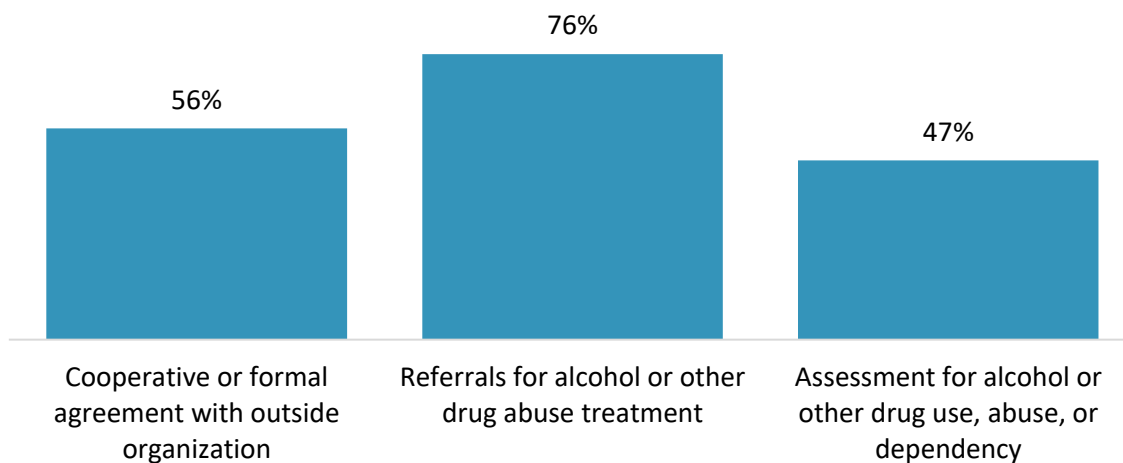
* Binge drinking was redefined in 2017 as occurring when males consume five or more drinks in a row and when females consume four or more drinks in a row in one sitting.

WHAT WE ARE DOING: SUBSTANCE USE POLICIES AND SERVICES

In addition, just over half (56%) of schools have a cooperative or formal agreement with an outside agency to provide services including assessments or treatment for students with suspected substance use issues. Cooperative

Three-quarters of schools (76%) provide referrals to outside organizations or health care professionals for students needing alcohol or other drug abuse treatment. About half (47%) of schools provide assessments for alcohol or other drug use, abuse, or dependency.

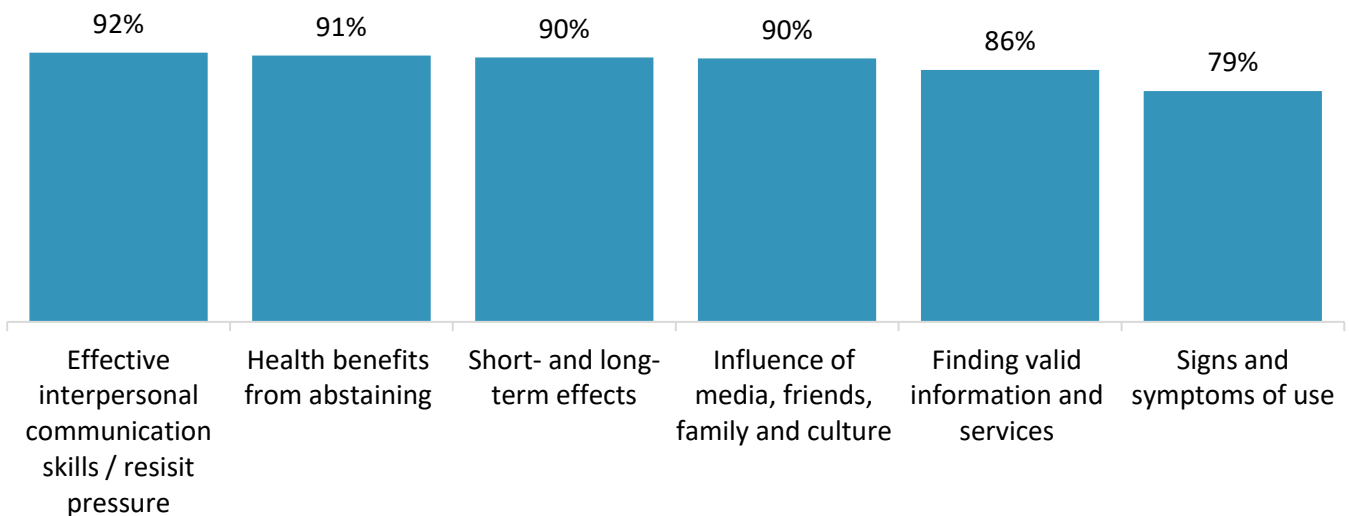
ALCOHOL AND OTHER DRUG-USE RELATED SERVICES



WHAT WE ARE DOING: HEALTH EDUCATION: SUBSTANCE USE PREVENTION

Nearly all schools (94%) address alcohol and other drug-use prevention in a required health course. At least nine in ten LHEs covered most substance use topics shown below. Slightly fewer taught students how to find valid information and services related to alcohol, tobacco, and other drugs (86%) and the signs and symptoms of alcohol and other drug use including the progression from non-use to addiction (79%).

TOPICS RELATED TO ALCOHOL, TOBACCO, AND OTHER DRUG USE TAUGHT IN A REQUIRED HEALTH EDUCATION COURSE



Physical Education and Physical Activity

Physical activity has numerous benefits for children and adults. Regular physical activity during childhood and adolescence increases the chance one will have a healthier adulthood.⁵ It decreases risk factors for chronic diseases, reduces symptoms of anxiety and depression, helps maintain favorable body composition, and increases bone-density which peaks during puberty.⁵ School-based physical activity is shown to have strong associations with cognitive development and academic performance. Physical activity in schools includes immediate and long-term benefits. It increases the rate at which students learn and increases attention and memory while decreasing disruptive behavior.⁶

Physical Activity Guidelines for Americans recommend that youth have 60 minutes or more of physical activity each day.^{7, 8} Most should be performed at either moderate or vigorous intensity level, such as riding a bike, playing sports, dancing, or active games like tag. Other activities should include muscle- and bone-strengthening activities such as gymnastics, playing on a jungle gym, locomotor activities for younger students and weight-lifting for older students.

Physical activity can be accumulated throughout the day in a variety of settings. Schools provide an ideal setting for students to be active and learn the skills necessary to enjoy physical activity and to participate in lifetime physical activity.⁹

In schools, physical activity goes beyond required physical education courses. It can be formal or informal, integrated into before and after-school programs such as physical activity clubs, intramural and interscholastic sports, as well as breaks during school including recess and breaks built into classroom lessons. Regardless of skill level, all students should have opportunities to participate.

In order for schools to expand opportunities for physical activity and knowledge for sustaining physical activity, the CDC and SHAPE America collaborated to help schools develop a comprehensive plan for physical activity.¹⁰ A Comprehensive School Physical Activity Program (CSPAP) is a multi-component approach for schools to provide opportunities for students to meet the nationally-recommended 60 minutes of daily physical activity and to become physically educated and well-equipped for a lifetime of physical activity. It builds upon providing quality physical education to offering physical activity before, during, and after school, staff involvement, and family and community engagement.

“Each school shall offer options for students in grades K-12 to participate in at least 30 minutes of physical activity within or outside of the school day. Physical activity may include recess and movement built into the curriculum that does not replace physical education classes.”

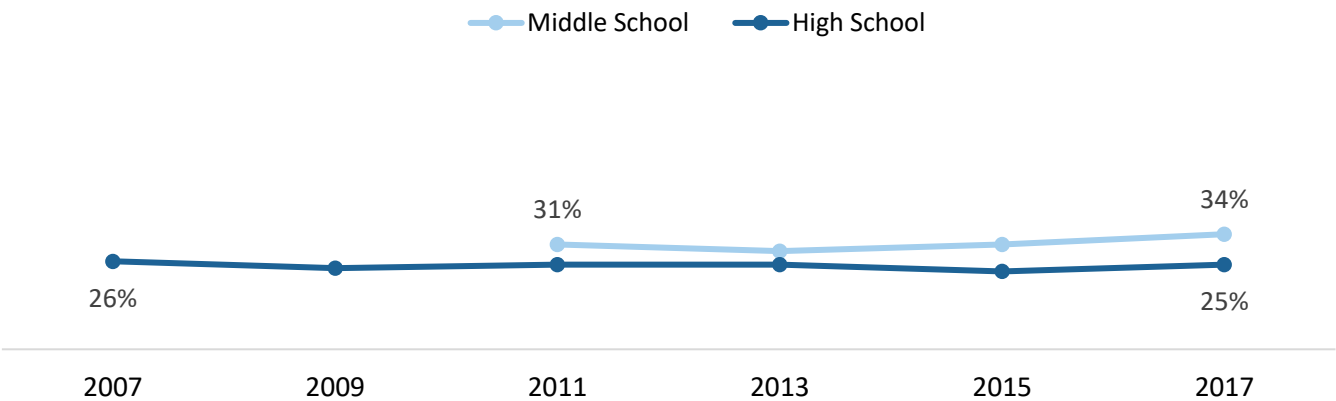
Vermont Agency of Education
Education Quality Standards, August 2014

WHAT WE KNOW: PHYSICAL ACTIVITY

The percent of high school students engaging in daily physical activity, no physical activity, and physical activity on most days has not significantly changed over the past decade. In 2017, a quarter of high school students met physical activity guidelines, participating in at least 60 minutes of physical activity every day during the previous week. About half (49%) participated in 60 minutes of physical activity on five or more days; 13% did not participate in at least 60 minutes of physical activity on any day.

During the previous week, about a third of all middle school students engaged in activities that increased their heart rate and sometimes made them breathe hard for at least 60 minutes every day, while fewer than one in ten students did not participate in any physical activity. Among middle school students, engaging in physical activity every day or on at least five or more days during the previous week significantly increased since 2011. There has been no significant change in the percent of middle school students not engaging in 60 minutes of physical activity on any day during the previous week.

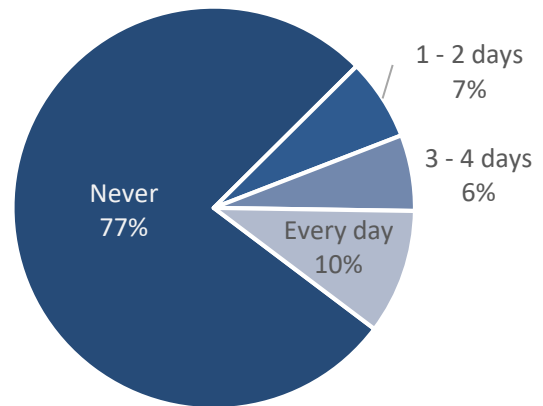
PARTICIPATED IN AT LEAST 60 MINUTES OF PHYSICAL ACTIVITY PER DAY DURING THE PREVIOUS WEEK



In 2017, when weather permitted, most middle school students (77%) did not walk or ride a bike to school during an average week. One in ten walked or rode a bike every day.

During a typical week, three-quarters (75%) of middle school students have at least one physical activity break at school such as recess, time before or after classes, and short breaks during class, nearly half (46%) have opportunities for physical activity at school outside of physical education every day.

WALK OR RIDE A BIKE TO SCHOOL WHEN WEATHER PERMITS



WHAT WE ARE DOING: COMPREHENSIVE SCHOOL PHYSICAL ACTIVITY PROGRAMS

Comprehensive school physical activity programs (CSPAP) aim to provide a variety of school-based physical activities to enable all students to participate in at least 60 minutes of moderate-to-vigorous physical activity each day so all students will be fully physically educated and well-equipped for a lifetime of physical activity.⁸

Schools who implement a CSPAP provide opportunities for students to participate in physical activity before, during, and after the school day and require students to take physical education courses every year. In addition, schools with a CSPAP assess opportunities and policies related to health and physical activity and work with others in their community to increase physical activity through shared use of facilities.

For this report, a school is defined as establishing and implementing a CSPAP if it meets all of the following criteria:

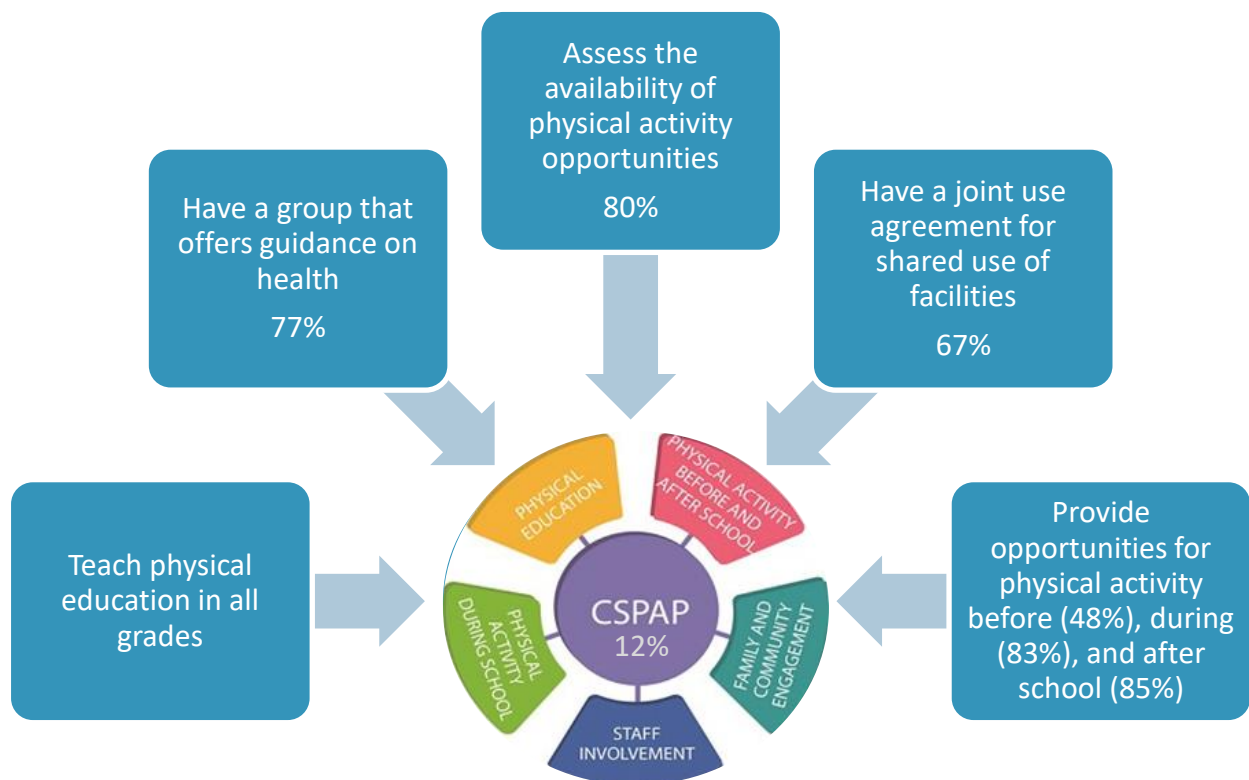
- Students participate in physical activity breaks in classrooms during the school day;
- Offer opportunities for students to participate in physical activity before the school day through organized physical activities or access to facilities or equipment for physical activity;
- Offer intramural sports programs or physical activity clubs;*
- Offer interscholastic sports;
- Have a school health council that assessed the availability of physical activity opportunities for students;
- Have a joint use agreement for shared use of school or community physical activity and sport facilities; and
- Require physical education courses for students in all grades.

* Any physical activity programs that are voluntary for students, in which students are given an equal opportunity to participate regardless of physical ability

Comprehensive School Physical Activity Programs

While 21% of schools have developed a written plan for implementing a Comprehensive School Physical Activity Program (CSPAP) only 12% of schools have established or implemented a CSPAP* and provides opportunities for physical activity before, during, and after school, has a group that offers guidance on health and assesses the availability of physical activity opportunities, has a joint use agreements for shared facility use, and teaches teaching physical education for all students in all grades.

Details about the specific opportunities for students to engage in physical activity and physical education curriculum are discussed on the following pages. Both having a written plan for and implementing a CSPAP differ significantly by school type. Middle schools are more than three times as likely as high schools to have a CSPAP. Specific differences by type of school are shown in Appendix A.



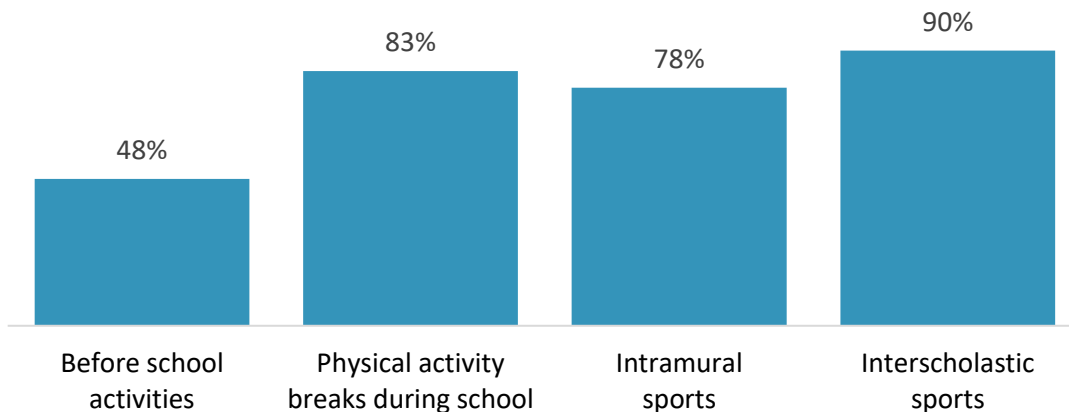
* Implementing a CSPAP was calculated based on schools that have one or more than one group that offers guidance on the development of policies or coordinates activities on health topics including the availability of physical activity opportunities; provide opportunities for physical activity are available for students through (a) physical activity breaks in the classroom, (b) intramural sports programs or clubs, (c) interscholastic sports, and (d) activities offered before the school day or access to facilities before school; have a joint use agreement for shared use of physical activity or sports facilities; and requires physical education in all grades taught at that school.

Opportunities for Physical Activity

While all schools provide at least some opportunities for physical activity before, during, and after the school day, schools are nearly two times as likely to offer students opportunities for physical activity after school (85%) than before school (48%). In addition, nearly seven in ten (67%) of schools also have joint use agreements for shared use of school or community facilities.

Opportunities for physical activity vary among middle and high schools (see Appendix A). While high schools are more likely than middle schools to offer interscholastic sports (95% vs 85%), middle schools are twice as likely to have opportunities for students to participate in physical activity breaks in classroom (96% vs 47%) and significantly more likely to offer intramural sports or physical activity clubs (87% vs 62%).

OPPORTUNITIES FOR PHYSICAL ACTIVITY OUTSIDE PHYSICAL EDUCATION



Trends in Policies and Opportunities Related to Physical Activity

The percent of schools who have established a CSPAP has nearly doubled since first asked in 2014 (7% vs 12%). Schools and communities with agreements to share physical activity facilities increased from 50% in 2012 to 67% in 2018.

Significantly more schools currently provide opportunities for students to participate in physical activity breaks in classrooms and through interscholastic sports compared to 2012 (67% vs 83% and 86% vs 90%, respectively), however, the percent of schools offering intramural sport programs or physical activity clubs where all students can participate regardless of ability decreased since 2014 (84% vs 78%).

WHAT WE ARE DOING: HEALTH EDUCATION: PHYSICAL ACTIVITY

Nearly all (98%) schools teach physical activity and fitness in a required health course. Six in ten LHE covered all 13 physical activity topics shown to the right.

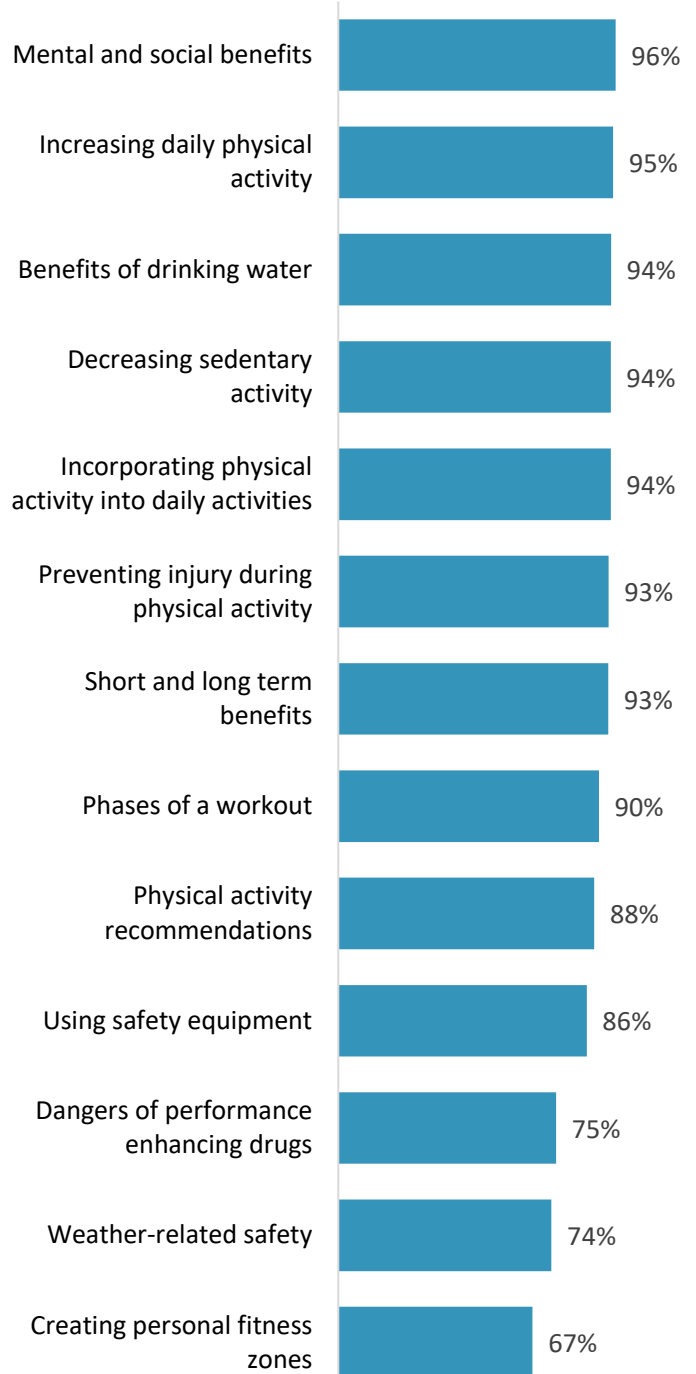
Most topics addressed on the SHP are taught by at least nine in ten schools. Schools are less likely to teach about the dangers of using safety equipment (86%), performance enhancing drugs (75%), weather-related safety (74%), and using personal fitness zones to track, assess, and evaluate personal fitness levels using FitnessGram (67%).

While most teachers are at least confident (73%) or somewhat confident (15%) in their ability to help students develop individualized plans for increasing or maintaining physical activity, they were less confident in their ability to administer or use fitness tests such as the FitnessGram to assess and track student's physical activity (55% confident / very confident; 7% somewhat confident; 37% not confident)

Trends in Teaching Physical Activity and Fitness in Health Education

Overall the percent of schools teaching physical activity and fitness including teaching all 13 specific topics has remained stable over the past decade.

PHYSICAL ACTIVITY TOPICS TAUGHT IN HEALTH EDUCATION



Nutrition Environment and Services

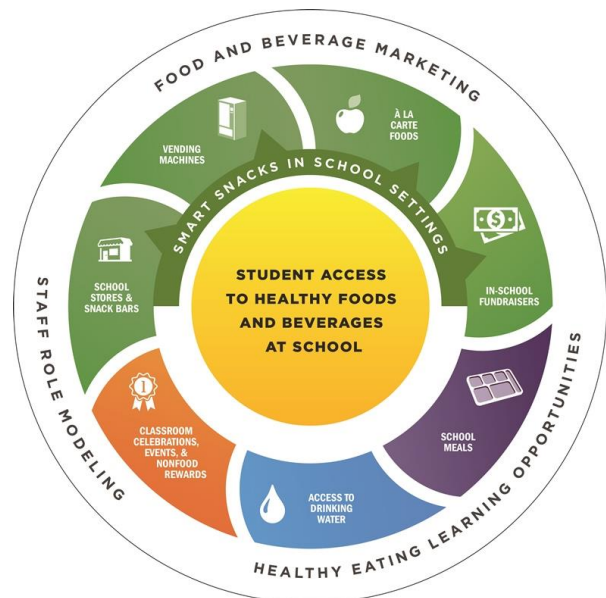
The 2015–2020 Dietary Guidelines for Americans recommend that children and adolescents follow a healthy eating pattern that includes a variety of fruits and vegetables, whole grains, fat-free and low-fat dairy products, and a variety of protein sources.¹¹ In addition, youth should increase water consumption, reduce sodium intake and limit calories from solid fats and added sugars. However, most youth do not follow the current dietary guidelines with 40% of their diet coming from empty calories such as those found in soda, sugar-sweetened beverages, dairy and other processed dessert, pizza, and whole milk.¹²

Most U.S. children attend school for 6 hours a day and consume as much as half of their daily calories at school.^{13, 14} The CDC recommends that schools implement policies and practices to create a nutrition environment that supports students in making healthy choices. A healthy school nutrition environment helps students develop lifelong healthy eating behavior by providing students with nutritious and appealing foods and beverages, consistent and accurate messages about good nutrition, and ways to learn about and practice healthy eating.

The school nutrition environment includes multiple components within the school grounds. These include food and beverages available during school meals, “Smart Snacks”, access to water, and other areas where students may access food and beverages such as in the classroom and at school events.¹⁶ In addition the school nutrition environment addresses opportunities to learn about healthy eating information, positive role modeling, and the messages students encounter about food, beverages, and nutrition throughout all schools.

The Vermont Agency of Education administers federal programs that support nutritious high-quality meals and snacks in schools.¹⁵ Federal programs include: National School Lunch Program, School Breakfast Program, After School Snack Program, Community Eligibility Provision, Seamless Summer Option and Summer Food Service Programs, and the Fresh Fruit and Vegetable Program.

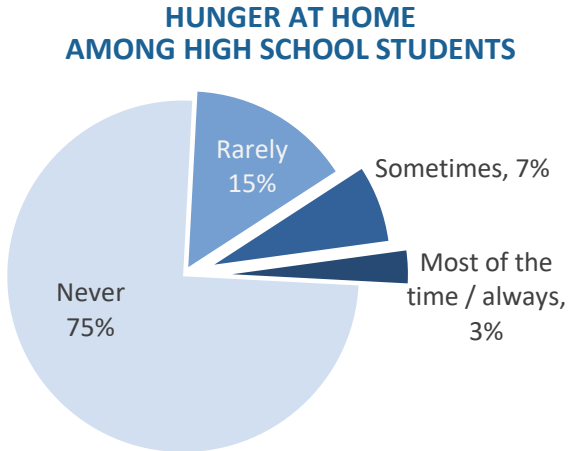
In addition, many Vermont schools work with local farmers and community organizations to provide education and access to whole, fresh, and local foods.



WHAT WE KNOW: NUTRITION

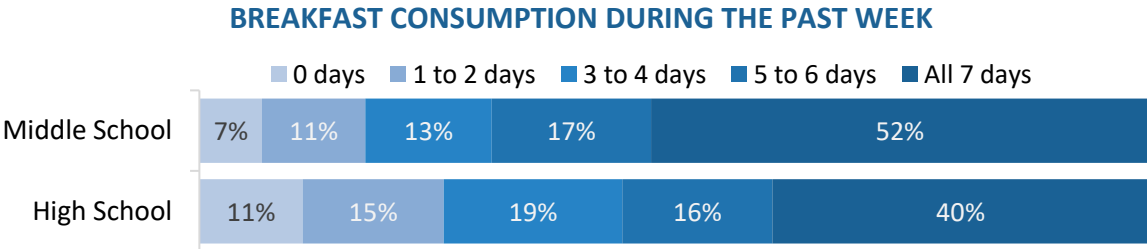
Food Insecurity

During the past 30 days, three-quarters of middle school students (77%) never went hungry because there was not enough food at home; one in seven rarely went hungry (14%) and nearly one in ten (10%) went hungry at least sometimes. A similar amount of high school students also reported going hungry during the past 30 days.



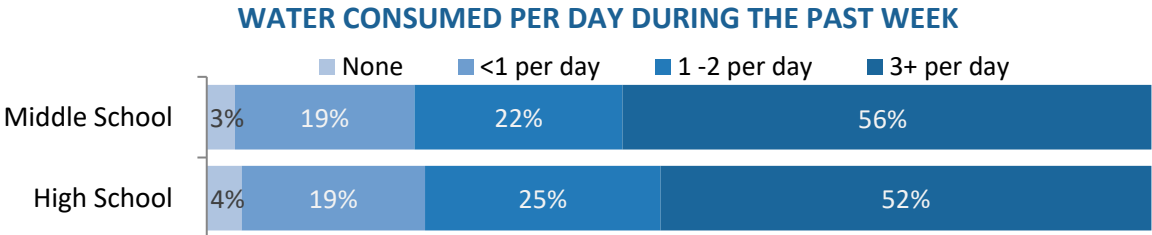
Breakfast Consumption

Most students eat breakfast at least five times per week. More than half of all middle school students (52%) and four in ten high school students (40%) ate breakfast every day in the past week. About one in ten middle (7%) and high (11%) school students reported never eating breakfast.



Water Consumption

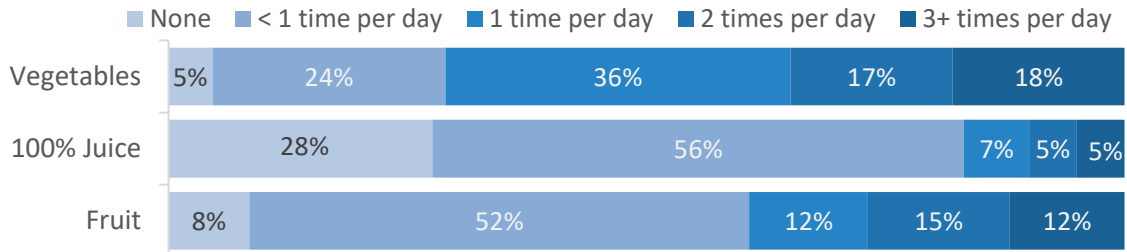
The majority of middle school students drank three or more bottles or glasses of plain water per day during the previous week. Among high school students, one out of every five students drank less than one glass or bottle per day during the previous week; 4% did not have any water.



Fruit and Vegetable Consumption⁶

In 2017, a third of high school students (33%) ate two or more fruits per day during the past week; 18% ate three or more vegetables.

FRUIT, 100% FRUIT JUICE, AND VEGETABLES CONSUMED PER DAY DURING THE PAST WEEK, AMONG HIGH SCHOOL STUDENTS

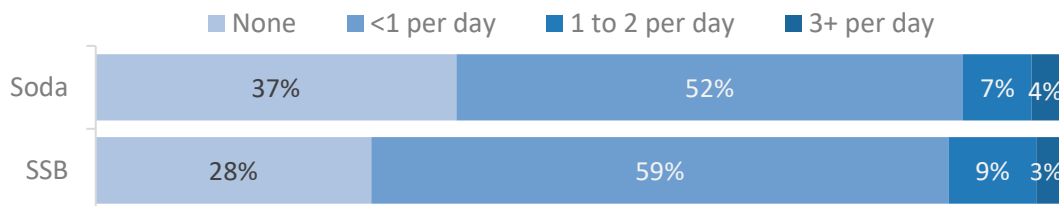


Soda and Sugar-Sweetened Beverage Consumption

During the previous week, a third of students did not drink any soda or pop (37%) and nearly three in ten (28%) did not have any sugar-sweetened beverage (SSB) such as sport drinks, energy drinks, lemonade, sweetened tea or coffee drinks, flavored milk, Snapple or Sunny Delight.

Less than one in five (11%) high school students drink at least one can, bottle, or glass of soda or pop daily; 12% drank at least one SSB every day during the previous week.

SODA AND SUGAR-SWEETENED BEVERAGES CONSUMED PER DAY DURING THE PAST WEEK, AMONG HIGH SCHOOL STUDENTS



⁶ Questions about fruit, vegetable, soda and sugar-sweetened beverage consumption were only asked on the VT High School YRBS

WHAT WE ARE DOING: SCHOOL NUTRITION ENVIRONMENT

Key Components of a Supportive School Nutrition Environment

The supportive school nutrition environment includes multiple elements related to how schools provide students access to nutritious meals and snacks.^{17, 16} These include increasing access to fruits and vegetables during meal times, at school celebrations and from vending machines or school stores; pricing nutritious foods and beverages at a lower cost; providing nutritional information to students or families; and not allowing advertisements for or selling less healthy foods or beverages in fundraisers.

The CDC identifies eight key components that help schools create a supportive school nutrition environment. The percent of schools engaging in each of these are shown below. Specific components and additional methods used to create a supportive school nutrition environment are discussed in more detail on the following pages.

KEY COMPONENTS OF A SUPPORTIVE SCHOOL NUTRITION ENVIRONMENT: ACCESSING HEALTHY FOODS AND BEVERAGES AT SCHOOL



Access to Water

Providing easy access to drinking water helps to increase students' overall water consumption and can provide students a healthy alternative to sugar-sweetened beverages. To help students increase their water intake schools should:

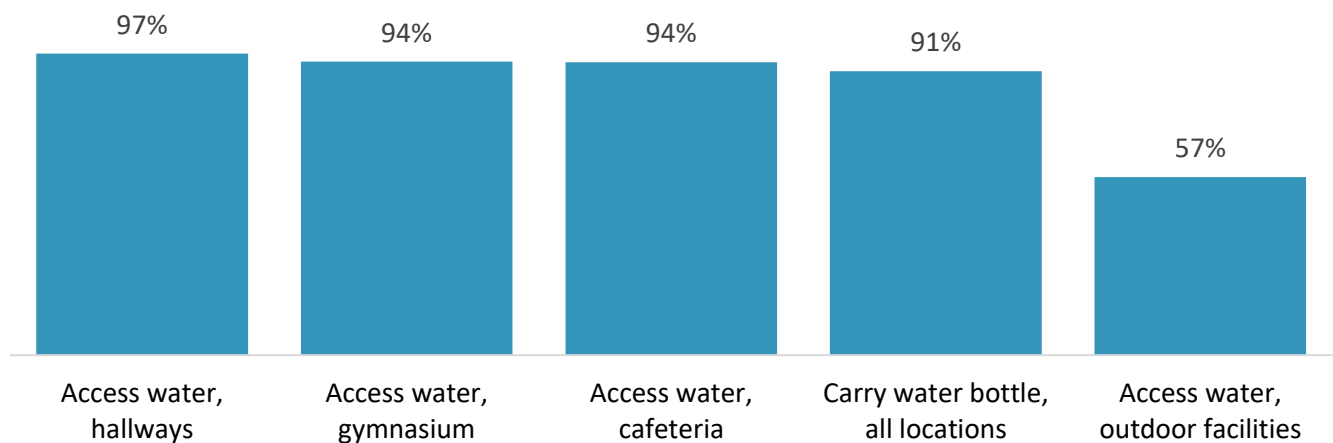
- Provide access to water fountains, dispensers, and hydration stations throughout the school,
- Ensure that water fountains are clean and properly maintained, and
- Allow students to have water bottles in class or to go to the water fountain if they need to drink water.*

Most schools (89%) encourage students to drink water throughout the day. All Vermont middle and high schools allow students to have a water bottle with them during the school day, however, nearly one in ten prohibit water bottles in at least some locations. Four in ten schools allow students to purchase water in a vending machine or at a school store.

Access to a free source of water is provided by schools in most locations including hallways (97%), during breakfast (93%), lunch (95%), or gymnasium (94%). However, fewer schools (57%) provide students access to water when they are at an outdoor physical activity facility or sport field.

Notably, among schools with outdoor physical activity facilities and sport fields, three quarters of high schools (75%) provide students access to water in outdoor facilities compared to less than half of middle schools (46%). Middle schools are significantly more likely than high schools to have free water available in school gymnasiums. The percent of middle and high schools who allow students to purchase water from vending machines or at the school store significantly differs (15% vs 75%, respectively). See Appendix A for additional differences by type of school.

ACCESS TO WATER



* <https://www.cdc.gov/healthyschools/npao/wateraccess.htm>

Food and Beverage Marketing

Marketing and advertisements. Marketing for foods and beverages can be seen in schools on posters, the fronts of vending machines, textbook covers, and scoreboards.*

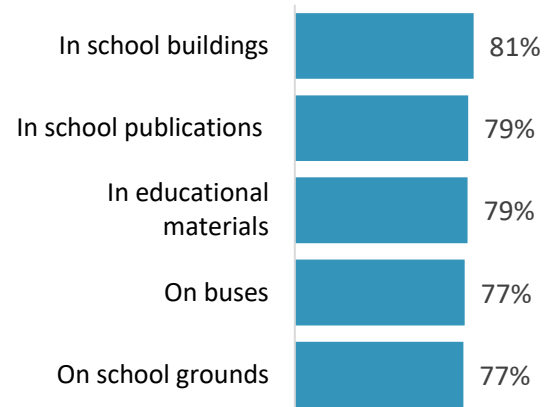
Nearly eight out of ten schools prohibit advertisements for candy, fast food restaurants and soft drinks throughout the school and on school grounds. High schools are significantly more likely than middle schools to ban such advertisements.

Strategies used. In addition, schools can promote healthful foods and beverages through “low-cost” strategies such as:

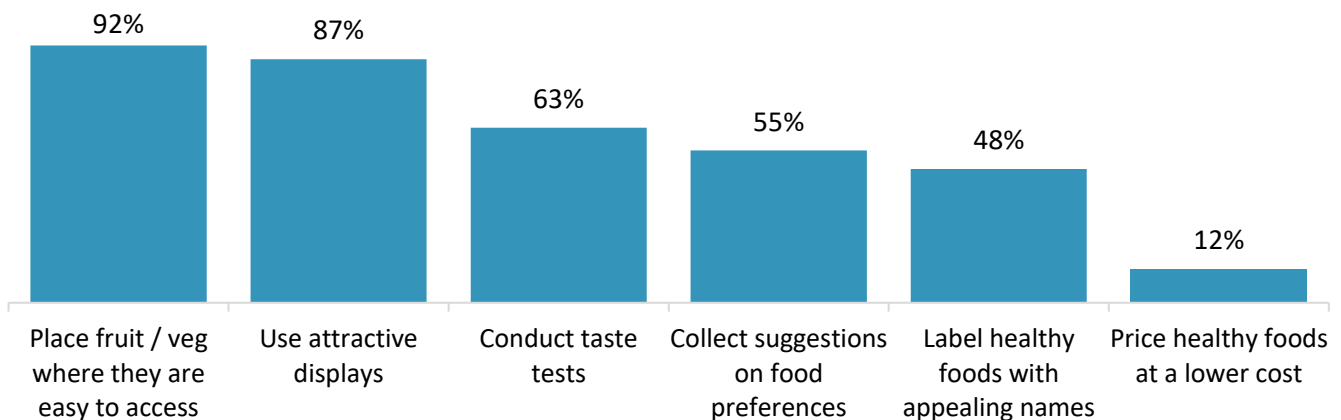
- Collecting suggestions from students and families for meals and snack items that might be offered
- Conducting taste tests of new menu items and asking students to provide feedback
- Placing nutritious items where they are easy for students to select
- Pricing nutritious foods and beverages at a lower cost while increasing the cost of less healthy items
- Using attractive displays for fruits and vegetables, and
- Using signs or verbal prompts to encourage students to try healthy foods.*

Overall, most schools place fruits and vegetables near the cashier where they are easy to access (92%) and use attractive displays (87%). About half collect suggestions on food preferences and strategies to promote healthy eating (55%) and label healthy foods with appealing names like “crunchy carrots” (48%), relatively few modify the prices of food and beverages making healthy foods cost less while increasing the cost of less healthy foods and beverages (12%).

LOCATIONS WHERE CANDY, FAST FOOD, AND SODA ADVERTISEMENTS ARE PROHIBITED



ADDITIONAL STRATEGIES USED TO PROMOTE HEALTHFUL EATING



* https://www.cdc.gov/healthyschools/npao/food_beverage_marketing.htm

School Meal Program and Smart Snacks

Meals served through a school meal program must meet [specific nutrition requirements](#) that include more fruits, vegetables, and whole grains, and fewer foods with sodium and trans-fat.* In addition, all food sold at school during the school day, including snacks and items sold as fundraisers, are required to meet nutritional standards which include limits on fat, sugar, sodium, and calorie content. These [Smart Snacks in School Standards](#) apply to all food sold a la carte and in school stores, snack bars, or vending machines.†

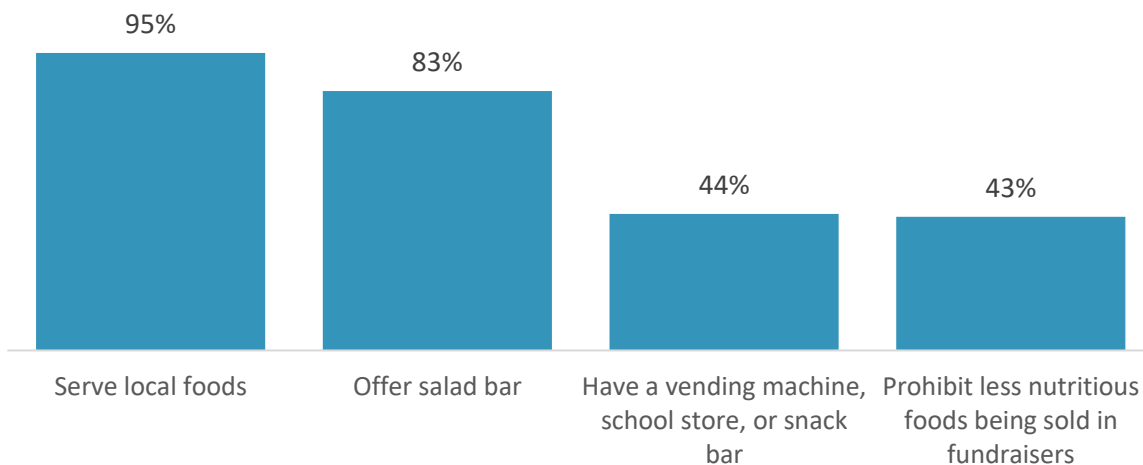
School Meals. Nearly all schools serve locally or regionally grown foods in the cafeteria (95%). Eight in ten offer a self-serve salad bar to students (83%). High schools are significantly more likely than middle schools to have self-serve salad bars in the cafeteria (See Appendix A).

Fundraisers.‡ Roughly four in ten schools prohibit less nutritious foods and beverages such as candy and baked goods, from being sold for fundraising purposes. Middle schools are twice as likely as high schools to prohibit such items to be used in fundraisers (See Appendix A).

Vending machines, school stores, and snack bars. Overall, about four in ten schools (44%) allow students to purchase snack foods or beverages from one or more vending machines in the school or at a school store, canteen, or snack bar. While less than a quarter of middle schools (23%) have vending machines or food and beverages available in a school store, this increases to eight in ten high schools (81%) (See Appendix A).

Specific snack food and beverages students can purchase outside the school meal program are shown on the following page.

SCHOOL MEALS AND SMART SNACKS SOLD IN SCHOOLS



* <https://www.cdc.gov/healthyschools/npao/schoolmeals.htm>

† <https://www.cdc.gov/healthyschools/npao/smartsnacks.htm>

‡ While food sold in fundraisers is included as a competitive food and required to meet smart snack standards, schools may exempt an infrequent number of fundraisers from meeting these standards each year.

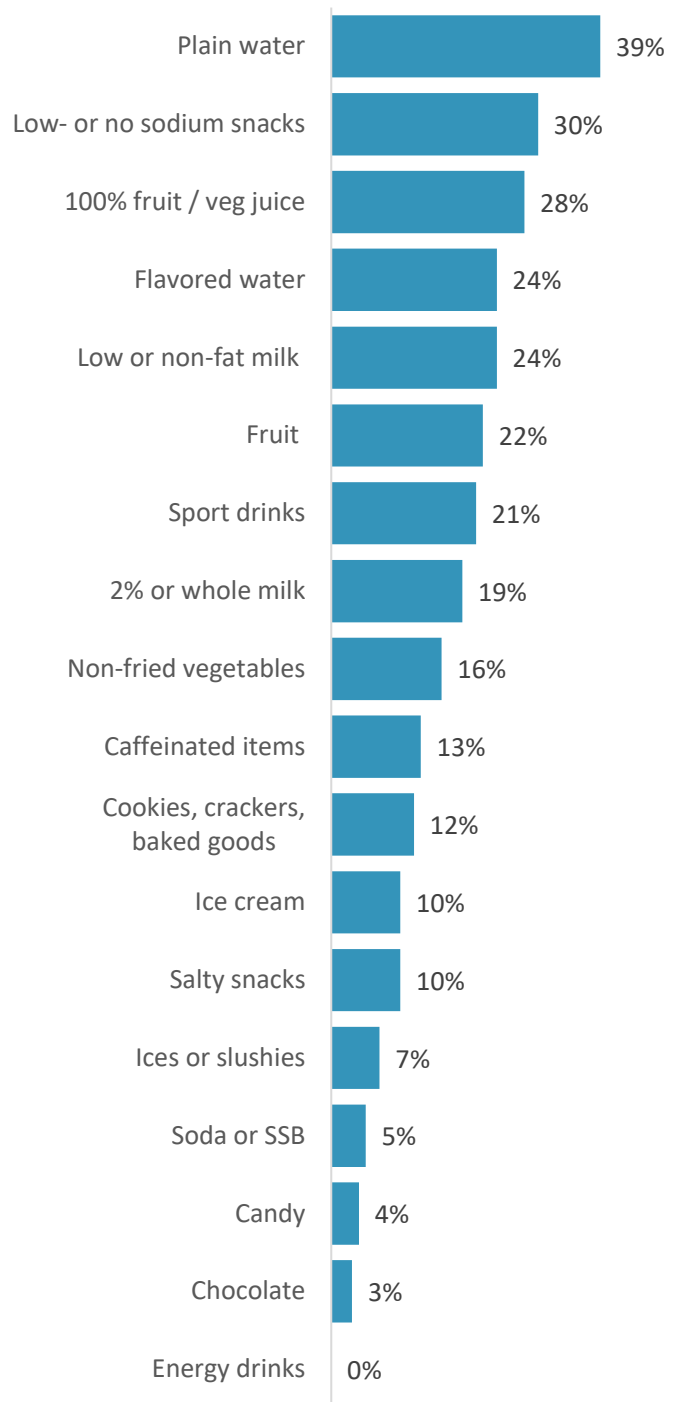
Vending machines, school stores, and snack bars cont.

Among all schools, less than four in ten students can purchase snack foods or beverages outside of the school meal program. These are typically available in vending machines, school stores, canteens, or snack bars.*

Overall, the most commonly available beverages and snacks are plain water (39%), low or no added sodium crackers/chips (30%), 100% fruit or vegetable juice (28%), non-fat or 1% milk (24%) and calorie-free flavored water (24%). No schools allow students to purchase energy drinks such as Red Bull or Monster, however, one in eight allow students to purchase other caffeinated items (13%). Five percent or fewer sell soda or sugar-sweetened beverages (5%), candy (4%), or chocolate (3%).

Excluding the sale of plain water (15%) and low- or no-sodium pretzels, crackers, or chips (13%), less than 10% of middle schools sell food or beverages outside the school meal program. High schools are significantly more likely to sell food and beverages ranging from one in ten high schools selling chocolate and other kinds of candy to 76% selling plain water and low- or no-sodium pretzels, crackers, or chips.

SNACK FOOD AND BEVERAGES SOLD OUTSIDE THE SCHOOL MEAL PLAN



* Includes schools with and without vending machines, school stores, and snack bars. Schools without vending machines, school stores, and snack bars are counted as not selling foods and beverages.

Using Food and Drinks as Rewards and in School Celebrations

All schools allow food and beverages to be offered during school celebrations. When food is available six in ten schools always or almost always include fruit or non-fried vegetable options. Middle schools are significantly more likely than high schools to rarely offer fruits and non-fried vegetables at school celebrations (4% vs 0%). See Appendix A for differences by school type.

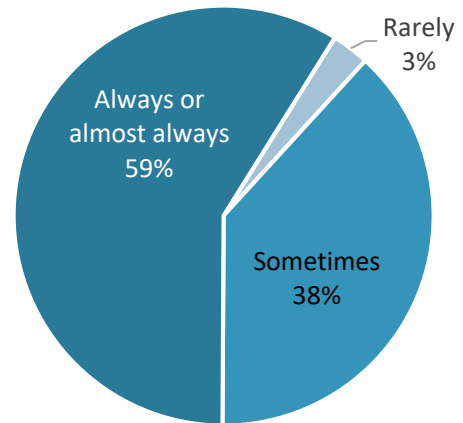
Less than a third of schools (31%) prohibit school staff from giving students food or food coupons as a reward for good behavior or academic performance.

Healthy Learning Opportunities

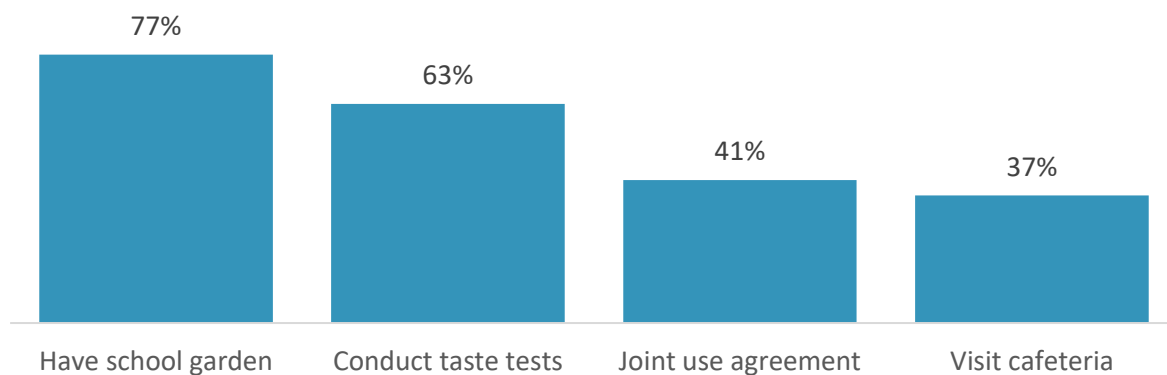
Healthy eating learning opportunities should be integrated throughout the school in the cafeteria, classroom, and school gardens in order to provide the knowledge and skills for students to help choose and consume healthy foods and beverages. In addition, shared use agreements to access kitchen equipment or facilities can extend learning opportunities.*

In Vermont, most schools have a school garden (77%) and nearly two-thirds (63%) conducted taste tests to determine food preferences. Fewer schools (37%) reported students had the opportunity to visit the cafeteria to learn about food safety, food preparation, or other nutrition related topics. Four in ten schools (41%) have a joint use agreement for shared kitchen facilities or equipment with their community.

AVAILABILITY OF FRUITS AND NON-FRIED VEGETABLES DURING SCHOOL CELEBRATIONS



HEALTHY LEARNING OPPORTUNITIES



* https://www.cdc.gov/healthyschools/npao/healthy_eating_learning_opportunities.htm

Trends in Supportive School Nutrition Environment

Since 2008, the percent of schools who do not sell less healthy foods and beverages such as soda, salty snacks, candy significantly increased from 39% to 72%. In addition, significantly more schools offered fruits and vegetables during school celebrations (37% vs 59%) and provided nutritional information to parents or students (46% to 57%).

During that same time period, the percent of schools where students can purchase foods or beverages from vending machines, school stores, or snack bars has decreased by nearly half from 80% to 44%.

In addition, since first asked in 2012, significantly more schools have gardens (65% vs 77%), self-serve salad bars (70% vs 83%), place fruits and vegetables where they are easy to access (84% vs 92%) and use attractive displays for fruits and vegetables (75% vs 87%). Likewise, since first asked in 2014, the percent of schools that prohibit advertisements and promotion of candy, fast food, and soda has significantly increased from 66% to 71%.

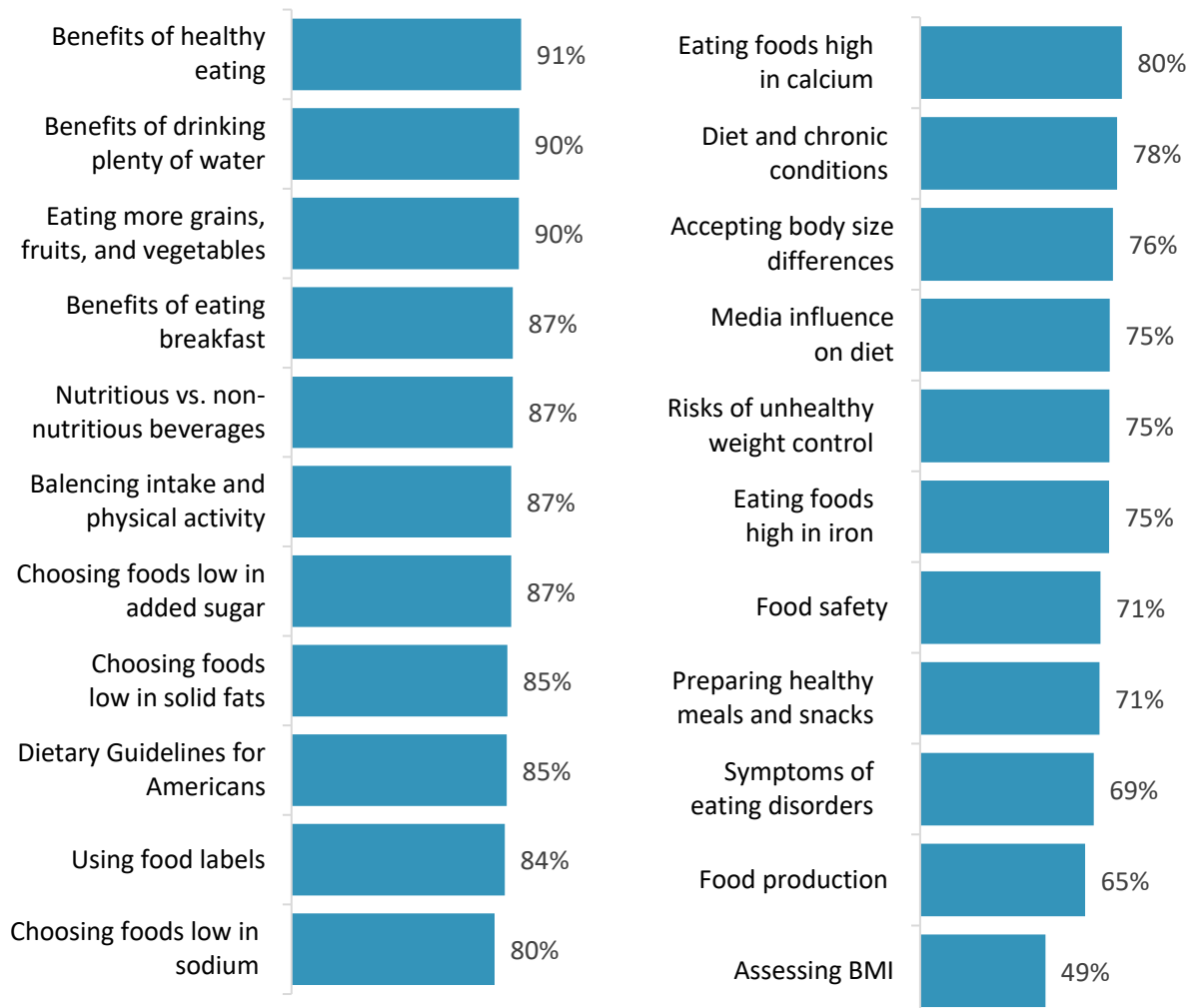
While significantly more schools lower the cost of healthy foods while increasing the price of less nutritious foods in 2018 compared to 2008, the percent of schools doing so has decreased since 2014 (9% in 2008 vs 18% in 2014 vs 12% in 2018).

THE WHAT WE ARE DOING: HEALTH EDUCATION & NUTRITION

In addition to providing opportunities for students to learn about nutrition and other dietary behaviors to help them develop the knowledge and skills necessary to choose and consume healthy foods, LHE's were also asked about nutrition and dietary behavior topics included in health education courses.

Overall, a third of schools taught about all 22 key nutrition and dietary behavior topics measured. High schools are significantly more likely to teach all nutrition and dietary behavior topics compared to middle schools (41% vs 28%). Individual topics included in health education curriculum are shown below, differences by school type are shown in Appendix A.

NUTRITION RELATED TOPICS TAUGHT IN HEALTH EDUCATION



Sexual Health

Exemplary Sexual Health Education

Many young people engage in sexual health behaviors that put them at risk for HIV infection, STDs, and unintended pregnancies.¹⁷ While sexual risk behaviors among young people have declined since the early 1990's, progress has stalled in recent years.¹⁸ Risky sexual health behaviors among youth in the United States remain substantially higher than other western industrialized nations.^{19, 24} Each year half of the 20 million new STDs reported occur among youth aged 15 to 24.²² Nearly 21% of new HIV diagnoses in the United States in 2017 were among young people between 13 and 24; in 2016 nearly 210,000 babies were born to teen girls aged 15 to 19 years.^{22, 20}

Sexual health is more than the absence of disease and dysfunction.²⁴ It includes the state of physical, emotional, mental and social well-being. Schools play a critical role in facilitating preventative services, providing youth with the knowledge and skills needed to take responsibility for their health.²¹ Sexual health education should be developmentally appropriate for students in grades K-12 including those who are and are not sexually active, as well youth of all sexual and gender identities.

Exemplary Sexual Health Education (ESHE) is a systematic, evidence-informed approach to sexual health education that includes the use of grade-specific, evidence-based interventions that provides adolescents the essential knowledge and critical skills needed to avoid HIV, other STDs, and unintended pregnancy.²² While abstinence is the only 100% effective way to prevent HIV, other STDs, and pregnancy,²⁶ there is no evidence that abstinence-only sexual education programs are effective or provide the tools necessary for young people to protect themselves from negative health outcomes.

Exemplary Sexual Health Education Programs	
Key Features	Supported Outcomes
<ul style="list-style-type: none">▪ Medically accurate▪ Based on scientific evidence▪ Developmentally appropriate▪ Inclusive of all youth regardless of gender or sexual orientation▪ Comprehensive classroom instruction that focuses on increasing student knowledge, developing critical skills, and practices and attitudes needed to avoid negative health outcomes▪ Expands beyond classroom instruction to include access to sexual health services, on and off school property	<ul style="list-style-type: none">▪ Delayed onset of sexual activity▪ Reduced frequency of sexual activity and number of sexual partners▪ Increased use of condoms and highly effective contraceptives▪ Decreased rates of teen pregnancies, STD's and HIV infections▪ Increased use of sexual health services

WHAT WE KNOW: SEXUAL HEALTH BEHAVIORS AMONG HIGH SCHOOL STUDENTS

Ever having sexual intercourse (40%) and having sexual intercourse during the past three months (31%) has not significantly changed over the past decade. However, the proportion of students having sex before age 13 significantly decreased from 6% in 2007 to 3% in 2017.

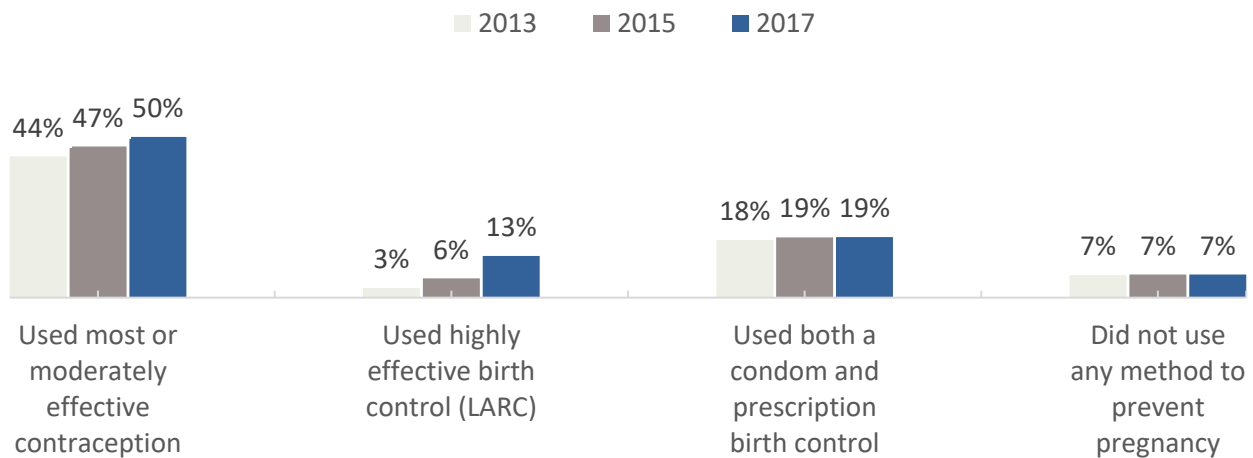
Overall, half of sexually active students (50%) used the most effective (Long Acting, Reversible Contraceptives (LARC) (i.e., implants, intrauterine device (IUD)) or moderately effective (i.e., injectables, oral pills, patch, or ring) methods of contraception* to prevent pregnancy the last time they had sexual intercourse. Use of moderate or most effective forms of prescription birth control significantly increased since 2013 and between 2015 and 2017.

Less than one in five (19%) used both a condom and prescription birth control the last time they had sexual intercourse. Not using any method to prevent pregnancy (7%) has remained unchanged over the past decade and since 2013.

In the past three months, nearly one third of high school students (31%) reported having sexual intercourse.

Condom use among sexually active students has significantly decreased over the past decade (63% in 2007) and continued to decrease between 2015 (58%) and 2017 (56%).

PREGNANCY PREVENTION AND CONDOM USE, AMONG CURRENTLY SEXUALLY ACTIVE STUDENTS

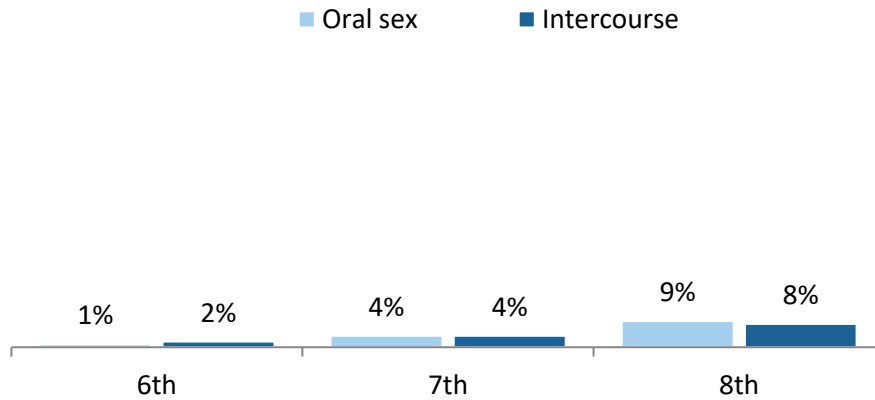


* Due to changes in question wording, long term trend data is not available for use of any prescription birth control.

WHAT WE KNOW: SEXUAL HEALTH BEHAVIORS AMONG MIDDLE SCHOOL STUDENTS

In 2017, 5% of middle school students reported having sexual intercourse during their lifetime. One in twenty (6%) have had oral sex. The percent of students who reported ever having sex doubles with each increasing grade level. Unlike the high school survey, no additional questions about current sexual activity or other sexual behaviors were asked of middle school students.

LIFETIME ORAL AND VAGINAL INTERCOURSE AMONG MIDDLE SCHOOL STUDENTS



WHAT WE ARE DOING: SEXUAL HEALTH SERVICES

Nearly eight in ten schools (78%) do not provide any direct sexual or reproductive health services and 43% do not provide referrals for sexual health services off school property. Overall, four in ten schools provide on-site or referrals for seven key sexual health services including HIV, STD, and pregnancy testing, provision of condoms, condom-compatible lubricants, and other types of contraceptives, and human papillomavirus (HPV) vaccinations.

Both direct and indirect services provided vary by type of services requested, parental notification and consent required, and school level. Types of services provided on campus and through referrals as well as parental consent needed are shown below.

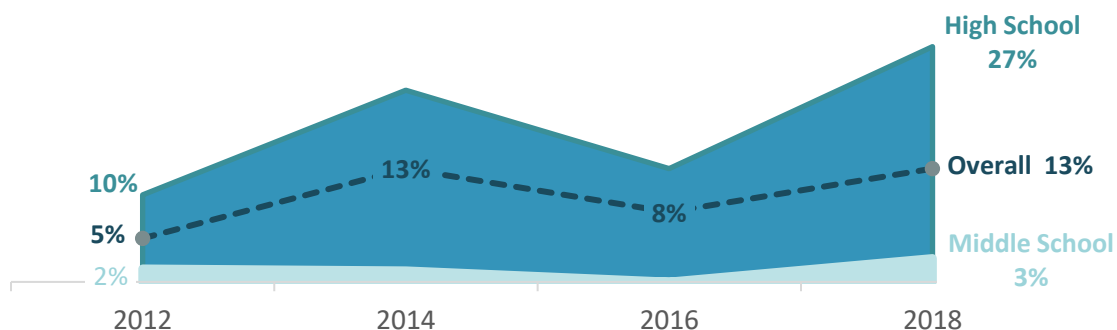
Direct Services Provided on School Property for Sexual Health Services

Excluding the provision of condoms (13%), less than one in 20 schools provide direct sexual health services on school property. Overall, 4% of schools provide pregnancy testing and HPV vaccinations, 3% of schools provide on-going HIV treatment and the provision of condom-compatible lubricants, and 2% provide STD testing, STD treatment, and prenatal care. Less than 1% provide HIV testing.

Following a decrease between 2014 (13%) and 2016 (8%), the percent of schools providing condoms significantly increased to 13% and remains significantly higher than it was when first asked in 2012 (5%). The percent of schools who can administer the HPV vaccination has more than quadrupled from less than 1% in 2012 to 4% in 2018.

High schools are more than four times as likely as middle schools to provide services such as pregnancy testing, condoms, and HPV vaccinations. Most notably, 27% of high schools provide condoms on school property compared to 3% of middle schools. Differences by school type are shown in Appendix A.

PROVISION OF CONDOMS ON SCHOOL PROPERTY



Referrals to Community Providers for Sexual Health Services

Overall, schools are more likely to provide referrals for sexual health services to an organization or health care professional not on school property than to directly provide services at school.

About half of all schools provide referrals for HIV testing, HIV treatment, nPEP, STD testing, STD treatment, pregnancy testing, prenatal care, contraceptives and HPV vaccinations. About four in ten provide referrals for condoms and condom-compatible lubricants.

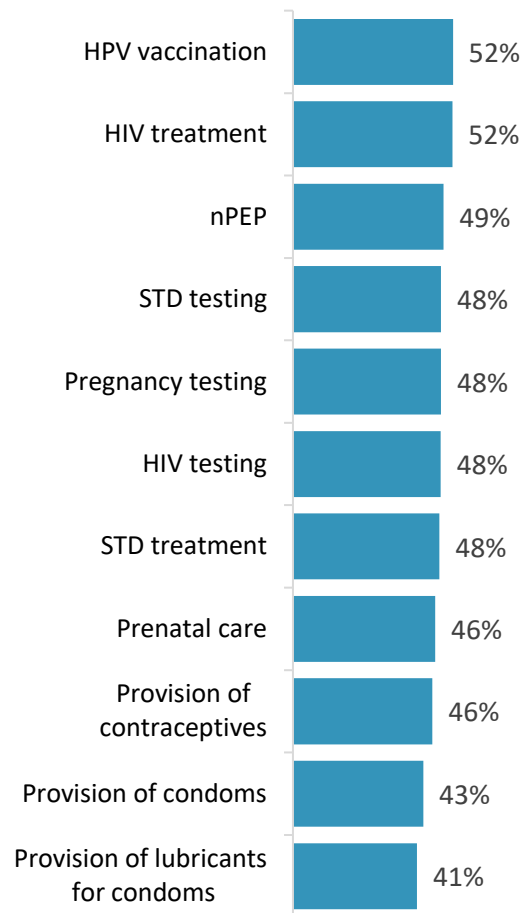
Since 2012, fewer schools have provided referrals for HIV and pregnancy testing and prenatal care (56%, 58%, and 51%, respectively in 2012). Referrals for other sexual health services have remained stable over time.

Parental Consent and Notification for Direct and Indirect Sexual Health Services

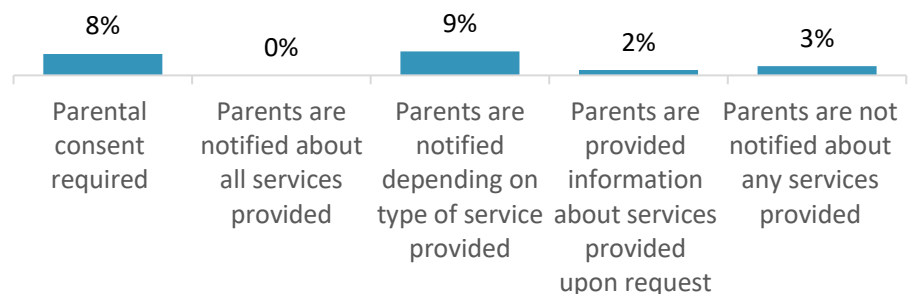
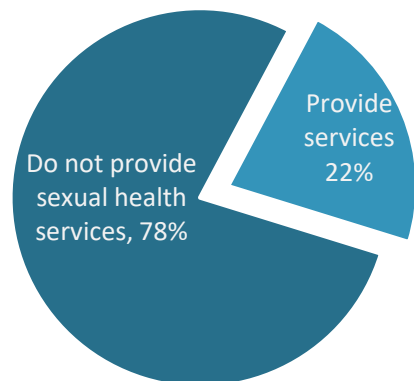
Sexual health services on school property.

Communication with parents about sexual health services provided on school property varies from requiring parental consent before any services are provided to the notification of services provided to no parental consent needed.

REFERRALS AVAILABLE FOR SEXUAL HEALTH SERVICES



PARENTAL CONSENT AND NOTIFICATION FOR SEXUAL HEALTH SERVICES PROVIDED ON SCHOOL PROPERTY

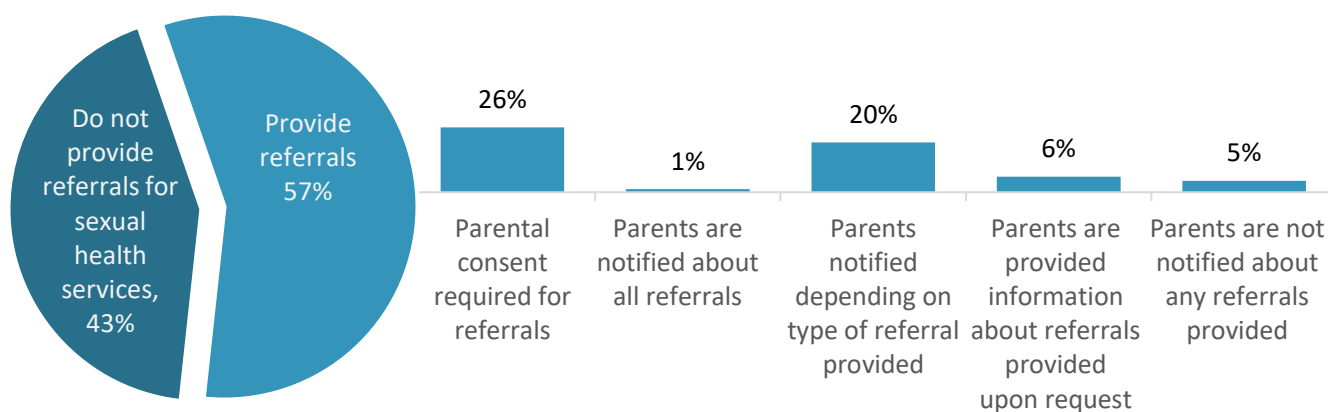


Parental Consent and Notification for Direct and Indirect Sexual Health Services

Referrals to sexual health services. Communication with parents about referrals for sexual health services follows a similar pattern to services provided on school property.

When schools provide referrals for sexual health services to off-site providers a quarter of schools (26%) require parental consent before any sexual or reproductive health services are referred. Two in ten (20%) do not require parental consent but parents may be notified depending on the referral provided. Five percent of schools do not require parental consent or provide notification about referred services; 6% will provide parents with information about referrals upon request. Few notify parents about all referrals provided (1%). See Appendix A for differences by school type.

PARENTAL CONSENT AND NOTIFICATION FOR REFERRALS TO SEXUAL HEALTH SERVICES



Trends in Parental Consent and Notification Practices

Questions related to parental consent and notification practices for sexual health services and referrals were first asked in 2016. In 2018, significantly more schools provided students with referrals for sexual health services (51% vs 57%) and required parental consent for any referrals (14% vs 26%).

WHAT WE ARE DOING: SEXUAL HEALTH EDUCATION

Lead health educators were asked about 19 sexual health topics taught in required health education courses and the assessment of student's competence in seven of those topics. These questions were asked specifically about courses in 6th through 8th grades and in courses in 9th through 12th grades.

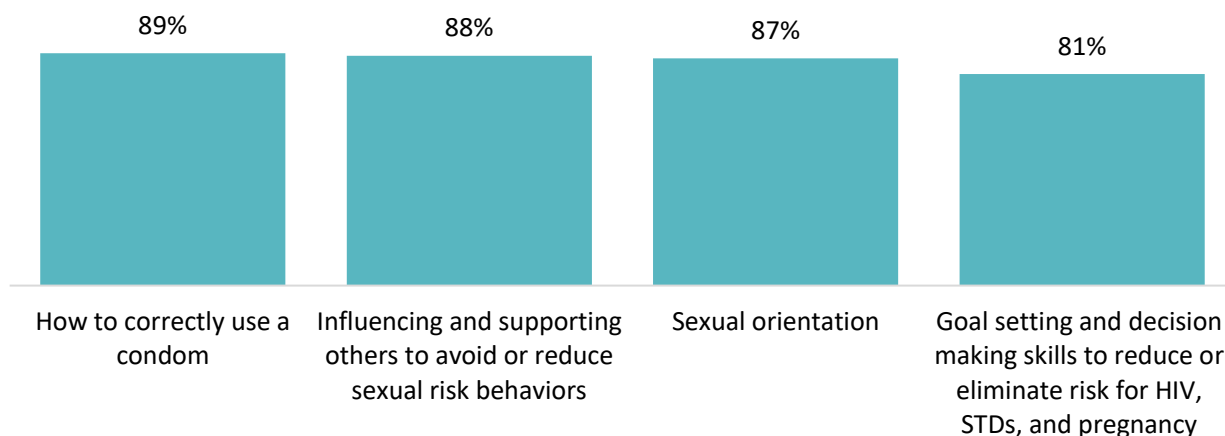
Overall, schools with students in grades 9 through 12 are nearly four times as likely to teach all 19 sexual health topics compared to schools teaching students in grades 6 through 8 (66% vs 24%). Seventy-three percent of high schools and 36% of middle schools taught at least 11 key HIV, STD, and pregnancy prevention topics in a required course. Seven in ten (71%) provided opportunities for students to practice communication, decision-making, goal-setting, or refusal skills related to sexual health.

Sexual Health Education Topics Taught

Topics taught in grades 9-12. Nearly all schools (98%) teaching required health courses for students in 9th through 12th grade taught about how HIV and other STDs are transmitted, health consequences of HIV, other STDs, and pregnancy, benefits of being sexual abstinent, the importance of using condoms consistently and correctly, and creating and sustaining healthy relationships; 96% taught about methods of contraception other than condoms, dual use of condoms and contraceptives, limiting the number of sexual partners, preventative care, efficacy of condoms, and how to access valid and reliable sexual health information and services.

Other topics covered by more than nine in ten LHEs in a required health education course included teaching students in 9th through 12th grades how to obtain condoms (95%), communication skills related to eliminating or reducing risk for HIV, STDs, and pregnancy (95%), the relationship between alcohol and other drug use and sexual risk behaviors (93%), the influence of family, peers, and society on sexual health behaviors (91%), and gender roles, gender identity, or gender expression (91%). Topics taught in less than 90% of required health education courses are shown below. Additional topics are shown in Appendix A.

SEXUAL HEALTH TOPICS COVERED IN LESS THAN NINE IN TEN REQUIRED COURSES: GRADES 9 -12

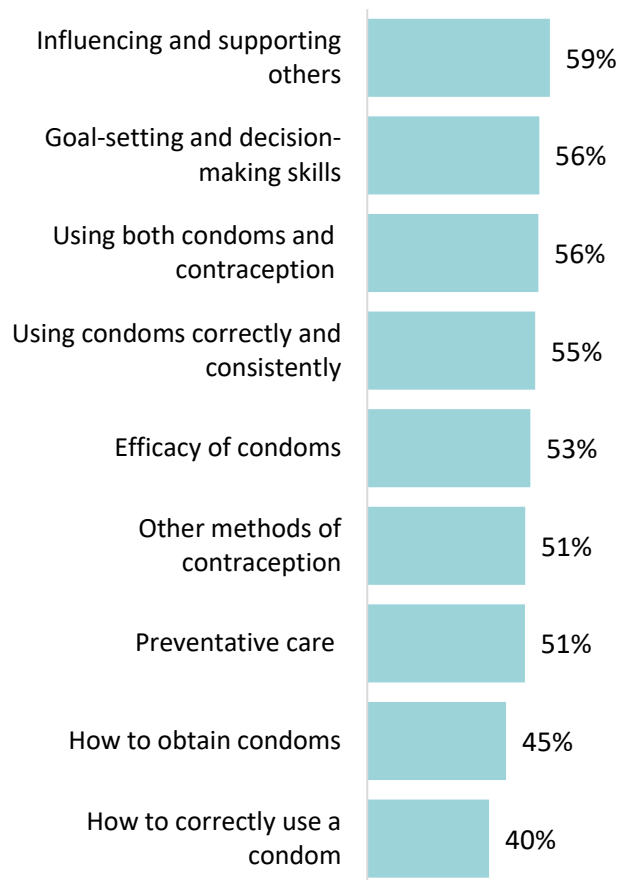


Topics taught in grades 6-8. In a required health course, nearly eight in ten teachers (78%) taught students in 6th through 8th grade how to create and sustain healthy and respectful relationships.

Roughly two-thirds of teachers covered the relationship between alcohol and other drug use and sexual risk behaviors (70%), gender roles, gender identity, or gender expression (70%), influence of family, peers, and society on sexual health behaviors (69%), how HIV and other STDs are transmitted (69%), benefits of being sexual abstinent (68%), health consequences of HIV, other STDs, and pregnancy (67%), sexual orientation (66%), communication and negotiation skills related to eliminating or reducing risk for HIV, STDs, and pregnancy (65%), how to access valid and reliable sexual health information and services (64), and the importance of limiting the number of sexual partners (63%). Other topics covered by less than six in ten teachers are shown to the right.

All topics taught in grades 6 through 8 are shown in Appendix A.

SEXUAL HEALTH TOPICS COVERED IN LESS THAN SIX IN TEN REQUIRED COURSES: GRADES 6 - 8



Trends in Teaching Sexual Health Education Topics

Most sexual health topics covered in required sexual health education courses in grades 6 through 8 have not significantly changed over time. However, covering sexual orientation (46% vs 66%) and gender roles, identity, or expression (50% vs 70%), increased from 2016, when first asked, to 2018.

Among courses for students in grades 9 through 12, significantly more schools taught about goal setting and decision making skills related to eliminating or reducing risk for HIV, other STDs, and pregnancy (98% in 2008 vs 81%), the transmission of HIV and other STDs (94% in 2010 vs 98%), health consequences of HIV, STDs, and pregnancy (92% in 2010 vs 98%), creating healthy, respectful relationships (89% in 2012 vs 98%), the importance of limiting the number of sexual partners (93% in 2014 vs 96%), and gender roles, identity, and expression (84% in 2016 vs 91%).

Sexual Health Education Assessing Student Abilities

Assessing learning in sexual health education-grades 9-12. In required courses for students in 9th through 12th grade, most teachers assessed student’s ability to access valid information, comprehend concepts, use interpersonal communication and decision-making skills. Slightly fewer taught about setting personal goals that enhance health, analyzing the influence of others, and how to influence and support others.

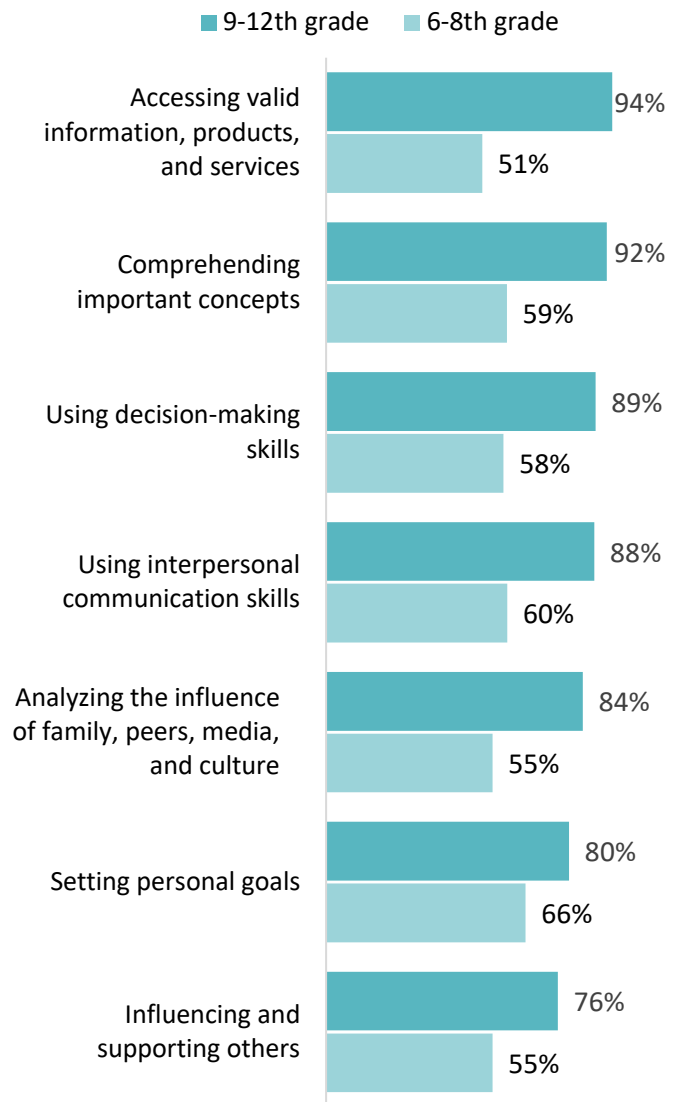
Assessing learning in sexual health education-grades 6-8. During the past year, teachers were most likely to assess the ability of students in grades 6 through 8 to set personal goals that enhance health (66%). About six in ten teachers also assessed student’s ability to comprehend concepts (59%), use interpersonal communication (60%) and decision-making skills (58%). Slightly fewer assessed student’s ability to analyze the influence of family, peers, media, and other factors (55%) and how to influence and support others (55%) to avoid or reduce sexual risk behaviors. Just over half of assessed students’ ability to access valid information, products, and services to prevent HIV, other STDS, and pregnancy (51%).

Trends in Assessing Sexual Health Education

Assessing students in grades 9 to 12 abilities to comprehend concepts, analyze the influence of others, set personal goals, and influencing and supporting others significantly decreased from 98%, 92%, 88%, and 88%, respectively in 2014.

Since 2014, the percent of schools who assessed students in grades 6 to 8 ability to perform skills related to maintaining sexual health significantly decreased by at least 10% for all skills, excluding setting personal goals and influencing others to avoid or reduce sexual risk behaviors.

SKILLS ASSESSED IN REQUIRED SEXUAL HEALTH COURSES



Safe and Inclusive Environments

While eliminating or reducing risk behaviors is important for youth development, increasing protective factors may play a greater role in youth development and success later in life.²² Assets or protective factors often reduce multiple risky behaviors and promote social and emotional development in all areas of one's life.

Positive Youth Development (PYD) is an intentional, prosocial approach that engages youth within their communities, schools, organizations, peer groups, and families in a manner that is productive and constructive; recognizes, utilizes, and enhances young people's strengths; and promotes positive outcomes for young people by providing opportunities, fostering positive relationships, and furnishing the support needed to build on their leadership strengths.^{23, 29}

PYD involves and engages the entire community.²⁷ It enhances the sense of belonging and creating strong relationships with peers, friends, and those in the community including people of difference backgrounds, cultures, or lifestyles.

Partnerships between schools, families, and communities play an integral role in school's capacity to improve the development, health, and well-being of youth.²⁹ Schools can create positive school environments which are associated with lower prevalence of substance use, violence, less stigma and discrimination and fewer absences.

Suggested policies and practices include not allowing bullying, harassment, or violence against any student, identifying "safe spaces", encouraging student-led clubs that promote school connectedness and a safe, welcoming, and accepting school environment for all students (e.g. gay/straight alliances), ensure health and educational materials include information relevant to all students and use inclusive terms, increase access for students to community-based health care providers, and promote family and community engagement through outreach efforts.

The Vermont Agency of Education believes teaching and learning begins with all students and adults feeling safe, welcome, respected, and supported while at school.²⁴ Healthy and inclusive learning environments should be free of bullying, sexual harassment, prejudice, and discrimination. These non-threatening but challenging learning environments foster student development and reduce health-risk behaviors and negative disciplinary actions.



SCHOOLS NEED TO FEEL SAFE FOR ALL STUDENTS!

IN THIS SCHOOL, REPORT POSSIBLE HARASSMENT TO:

UNLAWFUL HARASSMENT...
Believed based on or motivated by a student's (or a student's family member's)

ACTUAL OR PERCEIVED:

- Race
- Creed (religion)
- Color
- National Origin
- Marital Status
- Sex
- Sexual Orientation
- Disability
- Gender Identity

HARASSMENT:

- May be a single severe event or a pattern of conduct.
- Undermines, detracts from or interferes with a student's educational performance and/or access to school resources.
- Creates an objectively intimidating, hostile, or offensive environment.
- May be verbal, written, visual, or physical.
- May happen at school, on a school bus or at school-sponsored events.

BUT IS IT REALLY HARASSMENT?
Even if you are not sure an incident is harassment, all school staff are required to respond.

- Don't guess or ignore.
- Follow up—refer a complaint right away to a designated employee.

Teachers: Prompt action is the law! Students: Don't be a bystander!

Vt Human Rights Commission 800.416.2010
Produced by the CENTER FOR HEALTH & LEARNING 2008
Model funding from the Human Rights Commission
For more resources see: HealthandLearning.org
Addressing Harassment: Toolkit for Schools

<http://healthandlearning.org/bullying-and-harassment-prevention/>

WHAT WE KNOW: HEALTH DISPARITIES AMONG YOUTH

Health equity exists when all people have a fair and just opportunity to be healthy, especially those who have experienced socioeconomic disadvantage, historical injustice, and other avoidable systemic inequalities that are often associated with social categories of race, gender, ethnicity, social position, sexual orientation and disability.

Sexual and racial minority students have traditionally faced injustices that impact their health. For example, sexual minority youth are at risk for certain negative health outcome and may struggle with stigma, discrimination, family disapproval, social rejection, and violence.³⁰

In Vermont, 84% of high school and 74% of middle school students identified themselves as white, non-Hispanic. About nine in ten high school students (89%) identified themselves as heterosexual or cisgender, 93% of middle school students identified themselves as heterosexual. * Less than 10% of high school students have had sex only with someone of the same sex or with both males and females. Among middle school students, 6% of students were born outside of the United States.

Among Vermont youth, LGBT and students of color have higher prevalence of many risk behaviors such as physical and sexual violence, and bullying, suicide, depression and addiction and are more likely to be threatened and skip school because they feel unsafe compared to heterosexual / cisgender and white, non-Hispanic youth.

Schools and communities can reduce some of these negative outcomes by creating safe and supportive environments for all youth regardless of their sexual orientation, gender identity, race, ethnicity, culture, (dis)ability, and social class.

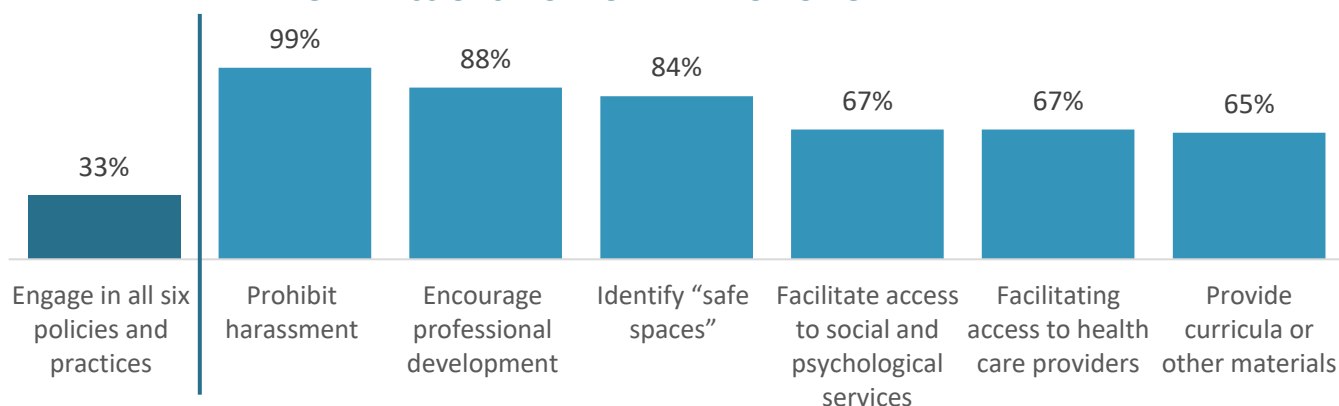
Results showing health inequities among Vermont youth by year in school, sex, sexual orientation, race and ethnicity, and geography are available in the [Vermont YRBS state and local reports](#).

* Vermont has included questions on the high school YRBS related to sex of sexual contacts since 1997 and on sexual orientation since 2005. In 2017, Vermont added a question about transgender status to the high school survey and sexual orientation to the middle school survey. www.healthvermont.gov/yrbs

WHAT WE ARE DOING: SAFE AND SUPPORTIVE SCHOOL ENVIRONMENT- SPECIAL POPULATIONS

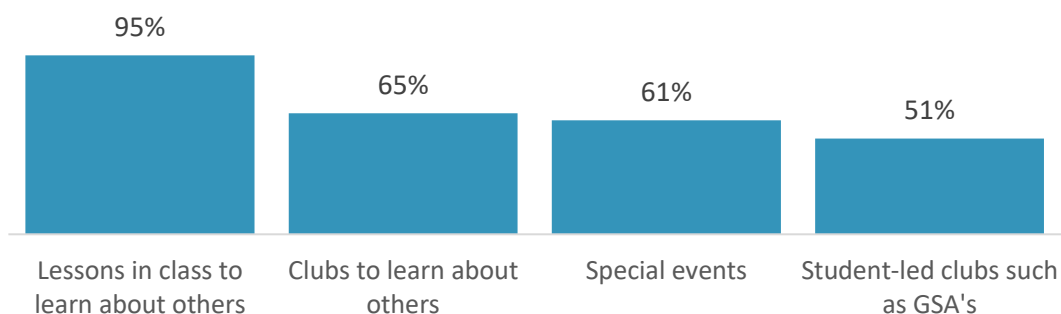
While nearly all schools (99%) prohibit harassment based on a student’s perceived or actual sexual orientation or gender identity, only a third of all schools (33%) implemented all six HIV, other STD, and pregnancy prevention strategies used to meet the needs of lesbian, gay, bisexual, transgender, and questioning youth identified on the SHP. High schools were more than two times as likely as middle schools to do so (49% vs 23%) (See Appendix A). Specific strategies employed by schools to meet the needs of lesbian, gay, bisexual, transgender, and questioning youth are shown below.

CREATING SAFE AND SUPPORTIVE ENVIRONMENTS FOR ALL YOUTH REGARDLESS OF SEXUAL ORIENTATION OR GENDER IDENTITY



In addition, two-thirds of schools have clubs that provide students with opportunities to learn about people different from them, such as students with disabilities, homeless youth, or people from different cultures; half of all schools (51%) provide clubs that create safe, welcoming, and accepting environments for all youth such as Gay Straight Alliances (GSA’s). Most schools have opportunities for students to learn about people different from them. Nearly all include lessons in class (95%); six in ten (61%) host special events at school or with community partners. These varied significantly between middle and high schools.

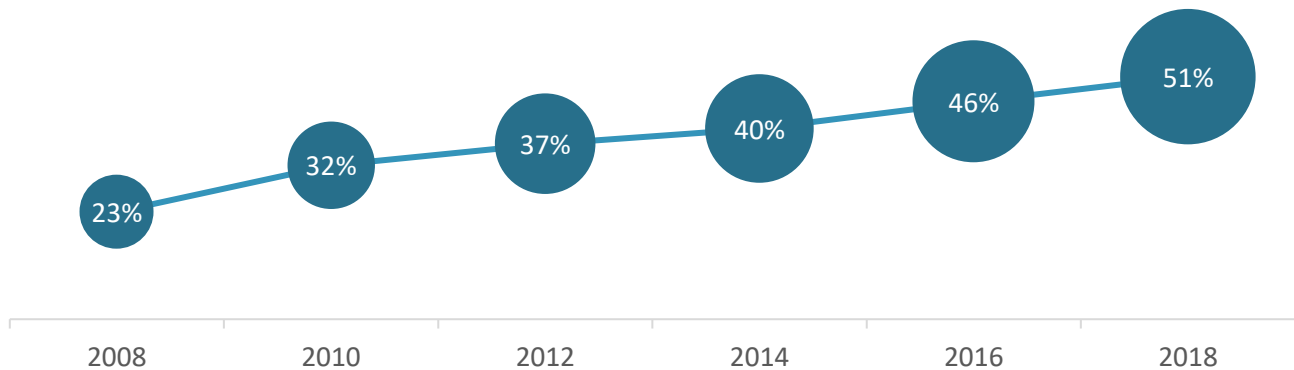
OTHER PRACTICES USED TO INCREASE MULTI-CULTURAL AWARENESS AND INCLUSIVE ENVIRONMENTS



Trends in Creating Safe and Supportive Environments

Since 2008, the percent of schools that 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 has more than doubled.

SCHOOLS THAT HAVE STUDENT-LED CLUBS SUCH AS GSA'S THAT AIM TO CREATE A SAFE, WELCOMING AND ACCEPTING ENVIROMENT



The percent of schools engaging in practices related to LGBTQ students has significantly increased since 2010. Most notably, the percent of schools who identify “safe spaces” where LGBTQ youth can receive support from administrators, teachers or other school staff increased from 67% in 2010 to 84% in 2018. The percent of schools implementing HIV, other STD and pregnancy prevention strategies that meet the needs of LGBTQ youth increased from less than one in five schools (19%) to a third of all schools (33%).

Since first asked in 2014, significantly more schools have clubs (54% vs 65%) and include lessons in the classroom (90% vs 95%) that provide students opportunities to learn about people different from them.

WHAT WE KNOW: VIOLENCE AND PERSONAL SAFETY

Sexual and Dating Violence

Among high school students who dated in the past year:

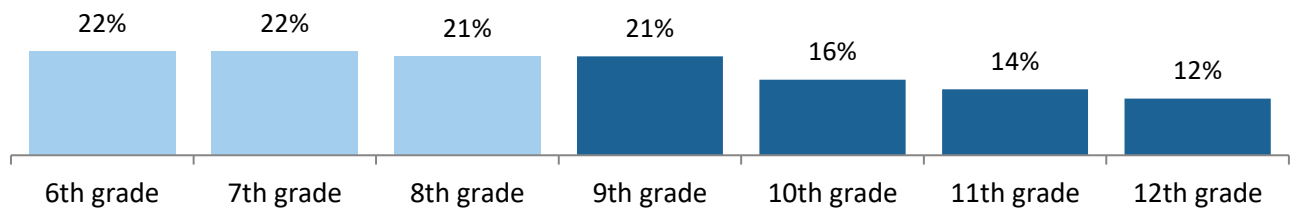
1 in 10 experienced sexual dating violence;

1 in 15 experienced physical violence by someone they were dating or going out with.

Bullying

Unlike many other risk factors, bullying tends to decrease as students get older and is more likely to occur among female students.²⁵ Bullying can happen anywhere and to anyone, however, some groups, such as LGBTQ youth, transgender youth, socially isolated youth, over- or under-weight, or those who are perceived weak, different, less popular, or have low self-esteem are more likely to experience bullying.²⁶ Youth who are bullied tend to have more depression, anxiety, suicidal ideations, drug and alcohol use, and lower academic achievement.

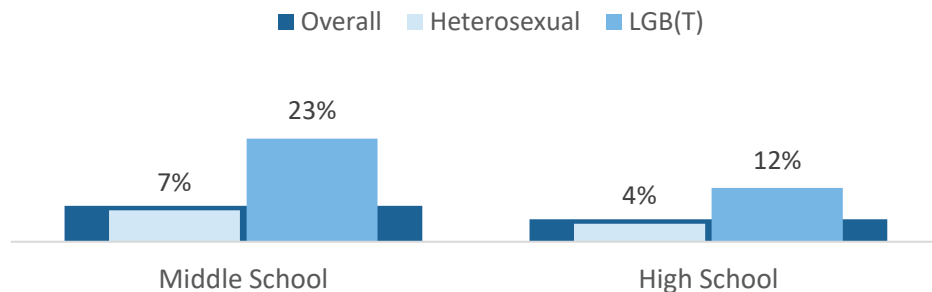
PERCENT OF STUDENTS WHO REPORTED BEING BULLIED DURING THE PAST 30 DAYS



Felt Unsafe At or On Their Way to School

During the previous 30 days, 8% of middle school students skipped school because they felt unsafe at school or on their way to or from school. Five percent of high school students skipped school at least one time during the past month. Similar to bullying, LGBTQ youth, female students are significantly more likely to report skipping school because they felt unsafe at school or on their way to or from school. Middle school students were more likely to skip school because they felt unsafe.

SKIPPED SCHOOL BECAUSE THEY FELT UNSAFE, PAST 30 DAYS



WHAT WE ARE DOING: SAFE AND SUPPORTIVE SCHOOL ENVIRONMENT- BULLYING AND SEXUAL HARASSMENT PREVENTION

Bullying and Sexual Harassment Prevention

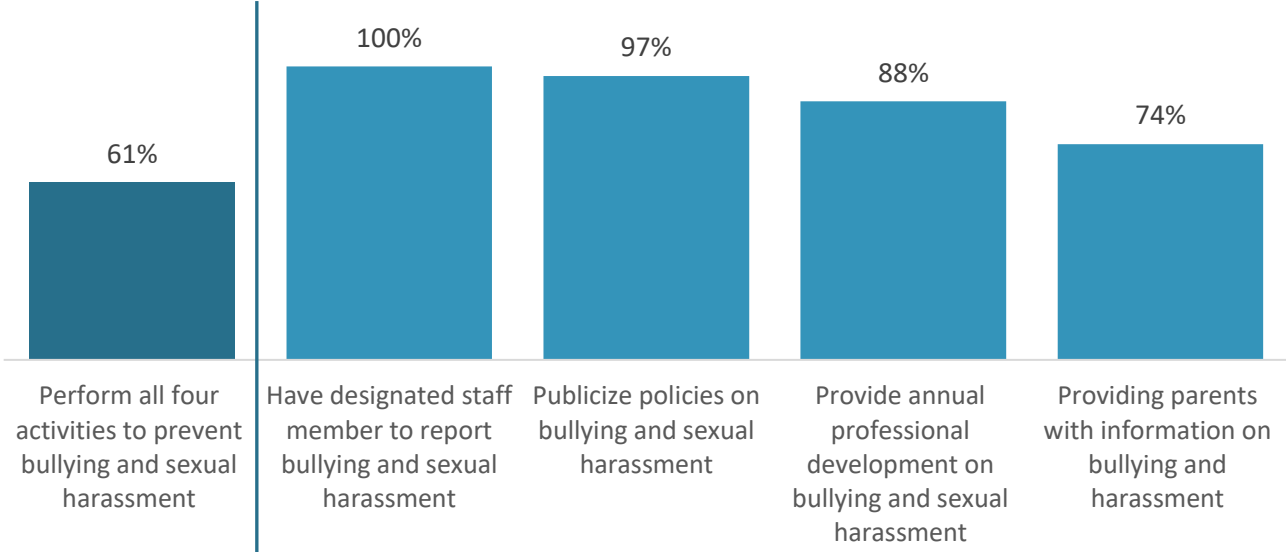
In Vermont, all schools have a designated staff member to whom students can confidentially report student bullying and sexual harassment. However, only six in ten (61%) engaged in all four activities used to prevent bullying and sexual harassment. These activities include: providing annual professional development for all school staff on preventing, identifying, and responding to student bullying and sexual harassment, publicizing and disseminating policies/rules/regulations on bullying and sexual harassment, providing confidential mechanisms for reporting student bullying and sexual harassment to a designated school staff member, and sharing information and resources on preventing student bullying and sexual harassment with parents.

The percent of schools completing individual activities to prevent bullying and sexual harassment varied. While all schools have a designated staff member for students to confidentially report bullying and sexual harassment, three-quarters provide families and parents with information on preventing student bullying and sexual harassment during a health education course (74%). In addition to these prevention strategies, most schools (93%) also taught students about violence prevention including bullying, fighting, and dating violence (data not shown below).

Overall, high schools (44%) are significantly less likely than middle schools (69%) to complete all four activities related to bullying and sexual harassment prevention. Most notably, high schools were significantly less likely than middle schools to provide information about bullying and harassment to parents (57% vs 78%). See Appendix A for differences by school type.

Implementing bullying and sexual harassment prevention strategies have not significantly changed since 2014.

BULLYING AND SEXUAL HARASSMENT PREVENTION STRATEGIES



WHAT WE KNOW: PROTECTIVE FACTORS

School and Community Engagement

During a typical week, a quarter of students spent ten hours or more participating in extracurricular activities such as sports, band, drama, or clubs run by the school or the community. Three out of five students (59%) spent less than four hours per weekday doing extracurricular activities; a third did not participate in any activities.

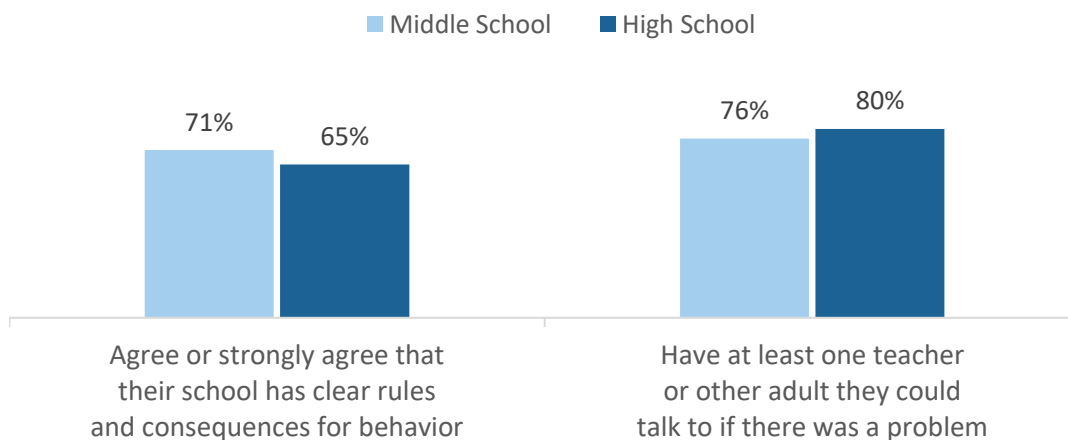
Nearly four out of five students (79%) believe they will probably or definitely complete a post high school program such as enrolling in a vocational training program, military service, or college; 12% were not sure.

School Connectedness

Seven in ten middle school students (71%) agree or strongly agree that their school has clear rules and consequences for behavior. One in eight (13%) do not believe (strongly disagree or disagree) their school has clear rules and consequences. Two-thirds (65%) of high school students agree or strongly agree that their school has clear rules and consequences for behavior; one in five were not sure if their school had clear rules and consequences for behavior.

Three quarters of middle school students have at least one teacher or other adult in their school that they can talk to if they have a problem. One in seven (14%) were not sure if there was someone they could talk to if they had a problem. Four out of five high school students (80%) had at least one teacher or adult in their school that they can talk to if they had a problem; 10% were not sure or did not have an adult at their school they could talk to if they had a problem.

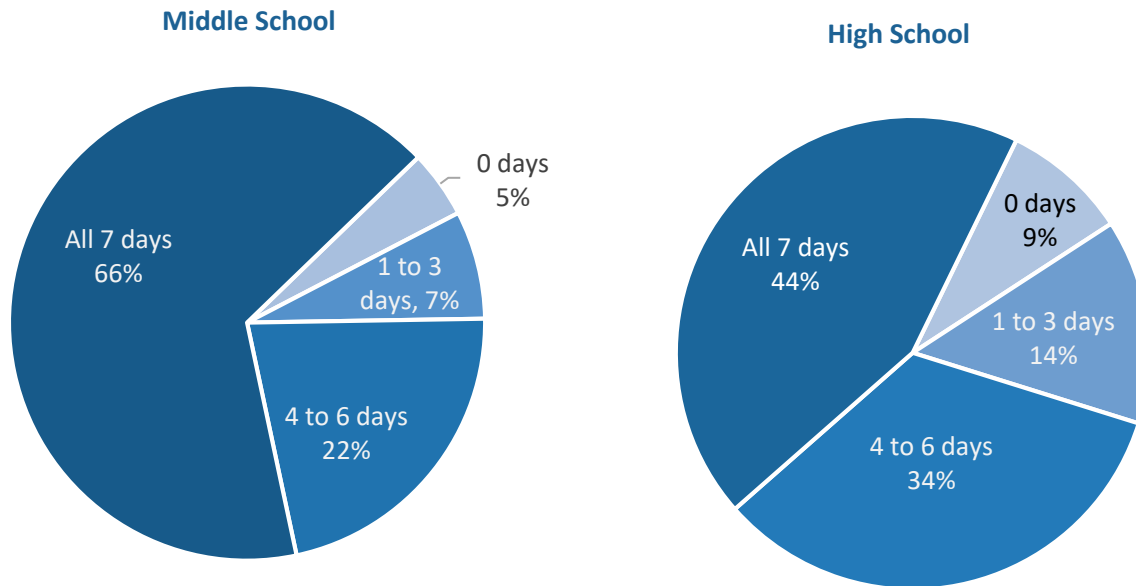
CLEAR RULES FOR BEHAVIOR & TRUSTED ADULTS AT SCHOOL



Family Engagement

Nearly nine out of ten middle school students (88%) ate dinner at home with at least one of their parents on four or more days during the previous week; slightly fewer (77%) high school students did so. Two-thirds of middle school students ate dinner with their parents every night during previous week compared to 44% of all high school students.

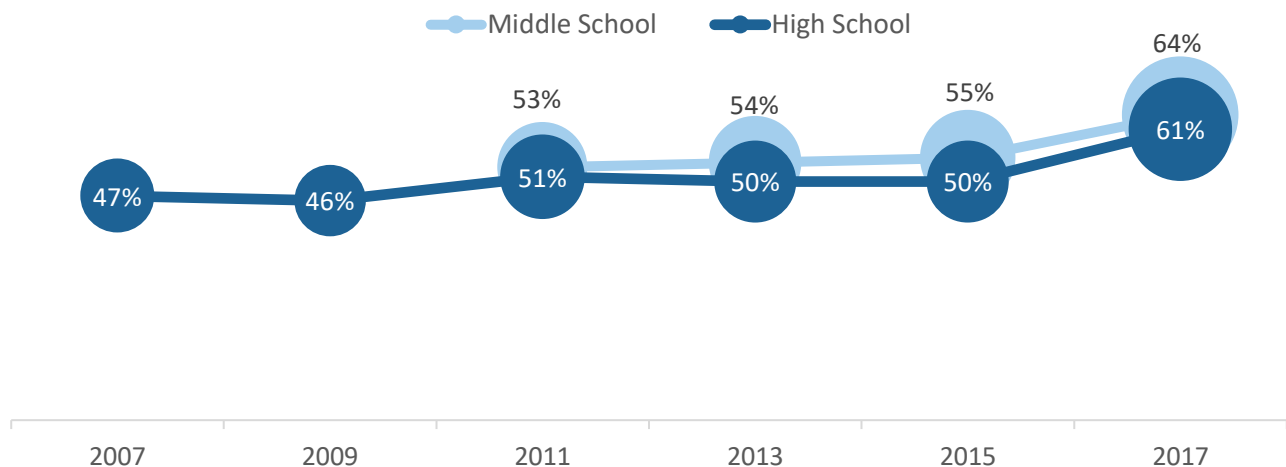
ATE DINNER AT HOME WITH PARENTS, PAST WEEK



Community Connectedness

Nearly two-thirds (64%) of middle school students agree or strongly agree that they matter to people in their community. Similarly, three out of five high school students (61%) think that in their community they matter to people. Feeling like one matters to the people in their community has significantly increased over the past decade and since 2015.

FEEL LIKE THEY MATTER BY PEOPLE IN THEIR COMMUNITY



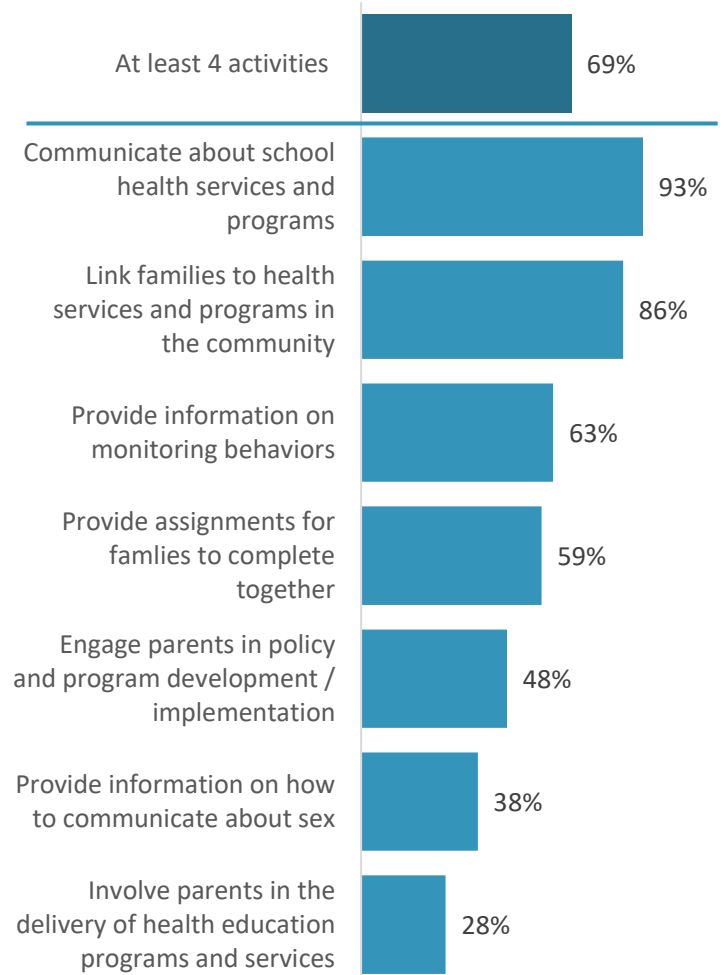
WHAT WE ARE DOING? ENGAGING SCHOOLS, FAMILIES, AND COMMUNITIES

Working with Families

Schools can increase parent and family engagement through a variety of strategies. Specific strategies are shown to the right.

Overall, 69% of schools engage in at least four strategies, shown to the right, to increase parent and family engagement. High schools are significantly less likely than middle schools to implement parent engagement strategies (55% vs 75%). Differences by school type are shown in Appendix A.

FAMILY ENGAGEMENT STRATEGIES

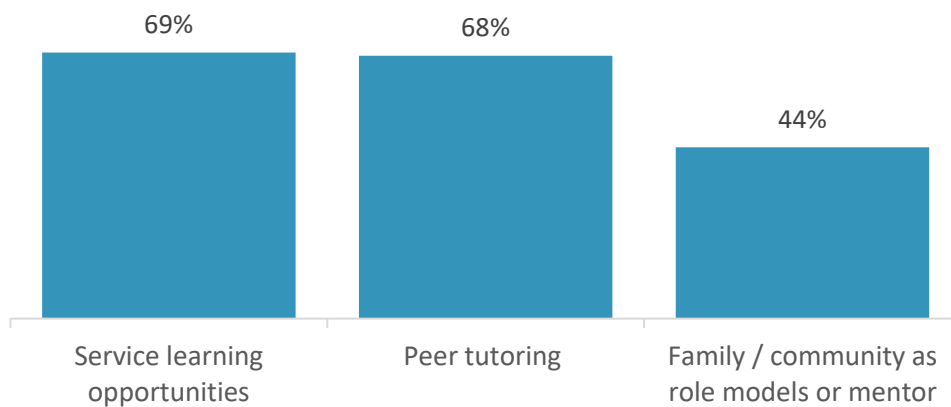


Engaging Communities

In addition to engaging parents and families, nearly eight in ten schools (79%) implemented at least three school connectedness strategies such as providing students with opportunities to be involved in mentoring programs, service learning, and peer tutoring, providing students with opportunities to be involved in service learning clubs or activities to learn about people different from them, and providing a lead health education teacher with professional development on classroom management techniques. Results related to [clubs \(65%\), lessons \(95%\) and activities \(61%\) to learn about others](#) and [professional development](#) on classroom management (56%) were previously discussed and are not shown below.

Half of all middle schools (51%) participate in programs such as Big Brother Big Sisters where families or community members serve as role models or mentors for students. Significantly fewer high schools had community-based mentors for students (35%). However, the majority of high schools provided peer tutoring (90%) and service-learning opportunities for students (85%) compared to about half of middle schools (50% and 58% respectively). See Appendix A for additional differences by school type.

ADDITIONAL OPPORTUNITIES TO INCREASE COMMUNITY ENGAGEMENT



Trends in Family and Community Involvement

Strategies used to engage families and communities were first asked in 2014. Overall, the percent of schools that implemented at least four parent engagement strategies increased from 65% in 2014 to 69% in 2018. Community connectedness strategies decreased from 86% in 2014 to 79% in 2018.

WHAT WE ARE DOING? ENGAGING SCHOOLS, FAMILIES, AND COMMUNITIES IN HEALTH EDUCATION

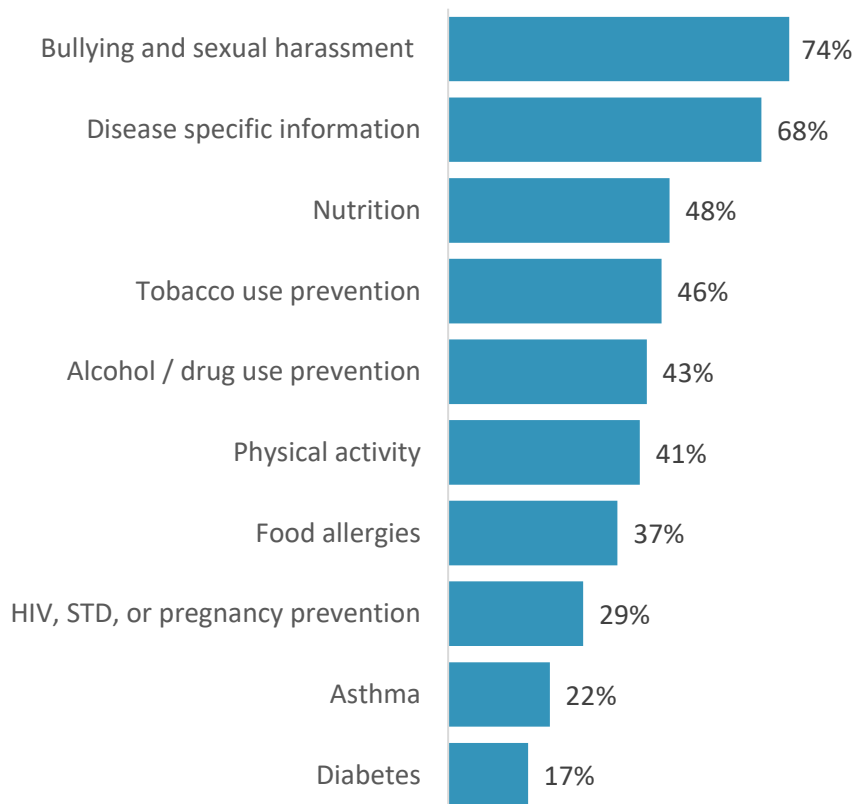
Increasing Parent and Family Knowledge on Health-Related Topics

In addition, schools frequently provide parents and families with disease-specific education when a student has a chronic condition such as asthma or diabetes (68%). In the classroom, health educators provide parents and families with content specific information to increase their knowledge on various health-related topics.

Excluding providing information about diabetes, high schools are significantly more likely to provide parents and families with information about HIV, STD, or pregnancy prevention (36% vs 30%) but are less likely than middle schools to cover all other topics. See Appendix A.

Since 2008, fewer teachers provided parents and families with health information designed to increase their knowledge on physical activity (46% vs 41%) and nutrition (57% vs 47%), however, teachers were more likely to provide parents with information related to HIV, STD, and pregnancy prevention (21% vs 29%). In 2018, fewer teachers provided students in health education homework to complete with their families compared to those in 2014 (70% vs 59%).

ENGAGING FAMILIES TO INCREASE KNOWLEDGE: HEALTH RELATED TOPICS DISCUSSED



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For more information about the School Health Profiles:

Visit:

Vermont Department of Health: School Health Profiles

<http://www.healthvermont.gov/stats/surveys>

Centers for Disease Control and Prevention (CDC):

Division of Adolescent and School Health (DASH)

<https://www.cdc.gov/healthyyouth/data/profiles/index.htm>

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Vermont School Health Profiles: 2018 Report

Appendix A: Results by School Type



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School Health Overview

School Improvement Plans

Percent of schools who reviewed local health and safety data such as the Youth Risk Behavior Survey (YRBS) or fitness data as part of the school's improvement planning process.

	Overall	MS	JR/SR	HS	
Reviewed health and safety data	82	80	96	71	

Percent of schools who used the School Health Index (SHI) to assess their school's policies, activities and programs in the following areas.

	Overall	MS	JR/SR	HS	
Physical education and physical activity	66	65	69	66	
Nutrition	62	59	69	61	
Tobacco-use prevention	65	59	69	76	
Chronic health conditions	47	45	57	38	
Unintentional injury and violence prevention (safety)	50	49	48	52	
Sexual health	53	49	54	61	

Percent of schools who include the following health-related objectives in their School Improvement Plan (SIP).

	Overall	MS	JR/SR	HS	
Health education	40	38	41	46	
Physical education	34	32	36	36	
Physical activity	30	31	30	31	
School meal programs	29	29	33	22	
Foods and beverages available	20	22	22	10	
Health services	32	31	41	26	
Counseling, psychological, and social services	55	53	61	55	
Physical environment	34	37	27	35	
Social and emotional climate	71	75	69	60	
Family engagement	61	60	60	66	
Community involvement	55	54	55	55	
Employee wellness	30	33	24	28	

Percent of schools who performed the following activities related to their local wellness policy.

	Overall	MS	JR/SR	HS	
Reviewed district's wellness policy	89	85	92	95	
Helped revise district's wellness policy	67	56	89	72	
Communicated district's wellness policy to school staff	72	69	85	66	
Communicated district's wellness policy to parents and families	43	43	45	38	
Communicated district's wellness policy to students	46	43	54	44	
Measured school's compliance with the district's wellness policy	50	52	52	42	
Developed an action plan that describes steps to meet requirements of the local wellness policy	36	27	47	47	

School Health Teams

Percent of schools who have at least one person or a group of people who oversees or coordinates the development and implementation of health-related policies and activities.

	Overall	MS	JR/SR	HS	
Person to oversee school health/safety programs	87	89	86	81	
Group (e.g., school health council, committee, team) that offers guidance on the development of policies or activities on health topics	77	80	72	76	

Percent of schools who have representation on school district or supervisory union “Whole School Whole Community Whole Child” (WSCC) school health team.

	Overall	MS	JR/SR	HS	
School participates on a SU/SD WSCC team that meets 4+ times a year	53	49	58	57	
SU/SD has a WSCC team with representatives from our school, but it meets less frequently	14	13	17	14	
There is an SU/SD committee or team, but our school is not represented	2	3	-	-	
Our SU/SD does not have a WSCC team	6	5	6	5	
Not sure	26	29	18	24	

Percent of schools whose “School Health Team” performed the following activities.

	Overall	MS	JR/SR	HS	
Identified student health needs based on a review of relevant data	76	75	74	81	
Recommended new or revised health and safety policies and activities	79	75	86	82	
Sought funding or leveraged resources to support health and safety	80	75	86	87	
Communicated the importance of health and safety policies and activities	88	88	89	88	
Reviewed health-related curricula or instructional materials	75	73	80	75	
Assessed the availability of physical activity opportunities	80	82	85	71	
Developed a written plan for implementing a Comprehensive School Physical Activity Plan (CSPAP)	21	25	21	6	

School Health Services

Percent of schools with full- and part-time registered school nurses and school-based health centers.

	Overall	MS	JR/SR	HS	
Full-time nurse	78	66	86	100	
Part-time nurse	36	42	33	24	
School-based health center	22	23	22	19	
School-based dental services program (e.g. on-site dental chair, dental van)	25	27	36	9	

Percent of schools with joint-use, cooperative or formal agreements with their community or an outside agency to provide the following services.

	Overall	MS	JR/SR	HS	
Mental health services	82	83	72	95	
Have joint use agreement for physical activity or sports facilities	67	67	75	57	
Have joint use agreement for kitchen facilities and equipment	41	45	46	24	

Percent of schools who provide the following health services.

	Overall	MS	JR/SR	HS	
Have protocol to ensure students with a chronic condition are enrolled in an insurance program	72	66	86	74	
Assessment for alcohol or other drug use, abuse, or dependency	47	30	76	62	
Daily medication administration	98	96	100	100	
Stock rescue or "as needed" medication	92	93	96	85	
Case management for students with chronic health conditions	88	85	93	90	

Percent of schools who routinely use school records, including student emergency cards, medication records, health room visit information, emergency care and daily management plans, physical exam forms, or parent notes, to identify and track students with a current diagnosis of the following chronic conditions.

	Overall	MS	JR/SR	HS	
Asthma	97	99	93	95	
Food allergies	97	99	93	95	
Diabetes	95	96	93	95	
Epilepsy or seizure	95	96	93	95	
Obesity	39	41	38	33	
Hypertension/high blood pressure	74	72	76	76	
Oral health conditions	64	75	63	33	

Percent of schools who 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.


	Overall	MS	JR/SR	HS	
Asthma	82	80	85	85	
Food allergies	81	79	85	85	
Diabetes	82	80	85	85	
Epilepsy or seizure	81	79	85	85	
Obesity	72	68	82	69	
Hypertension/high blood pressure	80	78	82	85	
Oral health conditions	82	82	85	80	

Percent of schools who provide referrals to any organizations or health care professionals not on school property for students in need of the following services













	Overall	MS	JR/SR	HS	
Comprehensive oral health care including preventative services	38	44	40	18	
Urgent dental needs only	13	12	12	19	
Mental health issues	81	78	79	90	
Alcohol or other drug abuse treatment	75	66	80	100	

Lead Health Educator

Percent of lead health educators who are certified, licensed, or endorsed by the state to teach Health Education.

	Overall	MS	JR/SR	HS	
LHE certified to teach health education	73	60	87	95	

Percent of lead health educators whose major emphasis of their professional preparation was focused on the following area of study.

	Overall	MS	JR/SR	HS	
Health and physical education combined	32	25	42	41	
Health education	19	12	16	45	
Physical education	11	17	3	5	
Other education degree	2	3	0	0	
Kinesiology, exercise science, or exercise physiology	1	2	0	0	
Home economics or family and consumer science	8	7	13	5	
Biology or other science	2	3	3	0	
Nursing	14	18	16	0	
Counseling	7	11	0	0	
Public health	1	1	0	0	
Nutrition	2	0	7	5	
Other	2	3	0	0	



















Percent of lead health educators who had 1 to 15+ years of experience teaching Health Education or related topics.










	Overall	MS	JR/SR	HS	
1 year	10	14	9	0	
2 to 5 years	27	33	19	18	
6 to 9 years	11	13	13	5	
10 to 14 years	12	15	0	18	
15+ years	40	25	60	59	

Percent of lead health educators whose staff collaborated with the following school personnel to implement health education activities.

	Overall	MS	JR/SR	HS	
Physical education staff	88	89	89	83	
Health services staff (e.g. nurses)	77	86	72	59	
Mental health or social services staff	79	85	69	76	
Nutrition or food services	35	39	37	18	
School health council or wellness team	62	63	77	41	

Percent of lead health educators who received professional development (e.g., workshops, conferences, continuing education, any other kind of in-service) during the past two years on the following topics.

Received PD	Overall	MS	JR/SR	HS	
TOPIC-SPECIFIC					
Alcohol or drug use prevention	51	49	59	46	
Asthma awareness	16	17	22	5	
Chronic disease prevention	24	29	22	14	
Emotional and mental health	72	76	66	68	
Epilepsy or seizure disorder	14	13	22	5	
Food allergies	21	24	22	9	
Foodborne illness prevention	11	12	16	5	
HIV prevention	40	32	56	41	
Human sexuality	56	51	59	69	
Infectious disease prevention	31	30	43	18	
Injury prevention and safety	41	39	50	37	
Nutrition and dietary behavior	36	33	41	41	
Physical activity and fitness	52	50	53	55	
Pregnancy prevention	37	30	49	41	
STD prevention	39	31	51	46	
Suicide prevention	43	38	56	41	
Tobacco-use prevention	37	38	44	23	
Violence prevention	55	55	50	59	

Received PD	Overall	MS	JR/SR	HS	
PEDAGOGICAL TECHNIQUES AND WORKING WITH SPECIAL POPULATIONS					
Teaching students with physical, medical, cognitive disabilities	44	41	40	59	
Teaching students of various cultural backgrounds	32	34	19	45	
Teaching students with limited English proficiency	15	14	16	18	
Teaching students of different sexual orientations or gender identities	58	52	56	82	
Using interactive teaching methods	51	50	53	50	
Encouraging family or community involvement	34	34	35	32	
Teaching skills for behavior change	56	56	56	55	
Classroom management techniques	56	57	56	50	
Assessing or evaluating students in health education	46	34	60	64	

(Professional development received, cont.)



















Received PD	Overall	MS	JR/SR	HS	
TEACHING SEXUAL HEALTH EDUCATION					
Aligning lessons and materials with district scope and sequence for sexual health education	44	37	57	47	
Creating a comfortable and safe learning environment for students receiving sexual health education	50	44	53	62	
Connecting students to on-site or community-based sexual health services	28	25	28	38	
Using a variety of effective instructional strategies to deliver sexual health education	49	45	51	57	
Building student skills in HIV, other STD, and pregnancy prevention	38	34	41	48	
Assessing student knowledge and skills in sexual health education	42	34	53	52	
Understanding current district or school board policies or curriculum guidance regarding sexual health education	35	33	41	33	










(Professional development received, cont.)

Percent of schools who provided professional development on physical education or physical activity for physical educators during the past year.








	Overall	MS	JR/SR	HS	
Physical Education	97	95	100	100	

Percent of lead health educators who would like to receive additional professional development in the following areas:

Desire Additional PD	Overall	MS	JR/SR	HS	
TOPICS OF INTEREST					
Alcohol- or other drug-use prevention	65	62	71	68	
Asthma	27	30	34	9	
Chronic disease prevention	46	48	47	37	
Emotional and mental health	82	79	87	82	
Epilepsy or seizure disorder	31	35	34	14	
Food allergies	32	40	31	9	
Foodborne illness prevention	26	31	25	14	
HIV prevention	45	49	46	32	
Human sexuality	72	71	78	64	
Infectious disease prevention	38	41	44	23	
Injury prevention and safety	46	48	47	41	
Nutrition and dietary behavior	60	58	72	50	
Physical activity and fitness	50	50	59	38	
Pregnancy prevention	50	49	62	36	
STD prevention	54	53	56	51	
Suicide prevention	70	70	75	64	
Tobacco-use prevention	47	51	47	38	
Violence prevention	66	65	69	64	

Desire Additional PD	Overall	MS	JR/SR	HS	
PEDAGOGICAL TECHNIQUES AND WORKING WITH SPECIAL POPULATIONS					
Teaching students with physical, medical, cognitive disabilities	66	64	75	60	
Teaching students of various cultural backgrounds	58	58	63	50	
Teaching students with limited English proficiency	43	40	41	55	
Teaching students of different sexual orientations or gender identity	71	69	82	62	
Using interactive teaching methods	69	70	78	50	
Encouraging family or community involvement	70	66	78	69	
Teaching skills for behavior change	76	73	84	73	
Classroom management techniques	64	71	65	41	
Assessing or evaluating students in health education	76	73	85	71	

(Professional development wanted, cont.)

Desire Additional PD	Overall	MS	JR/SR	HS	
TEACHING SEXUAL HEALTH EDUCATION					
Aligning lessons and materials with district scope and sequence for sexual health education	66	69	72	46	
Creating a comfortable and safe learning environment for students receiving sexual health education	59	64	56	45	
Connecting students to on-site or community-based sexual health services	63	59	75	59	
Using a variety of effective instructional strategies to deliver sexual health education	70	68	81	59	
Building student skills in HIV, other STD, and pregnancy prevention	65	64	72	54	
Assessing student knowledge and skills in sexual health education	72	66	87	68	
Understanding current district or school board policies or curriculum guidance regarding sexual health education	60	61	72	36	

(Professional development wanted, cont.)

Required Health and Physical Education

Percent of schools who require health education courses in grades 6 - 12.

	Overall	MS	JR/SR	HS
In any grades 6-12	92	86	100	100











Number of health courses students take.

Number of courses required	Overall	MS	JR/SR	HS
0 courses	9	18	0	0
1 course	30	15	35	64
2 courses	18	15	19	27
3 courses	31	40	32	5
4 or more courses	11	12	15	4

Percent of schools who require students to repeat health education if they fail it.

	Overall	MS	JR/SR	HS
	52	9	90	95

Percent of lead health educators who are provided materials for teaching health and sexual health education.

Materials Provided	Overall	MS	JR/SR	HS	
HEALTH EDUCATION					
Goals, objectives, and expected outcomes for health education	86	82	90	90	
A chart describing the annual scope and sequence of instruction	62	56	65	76	
Plans for how to assess student performance in health education	66	61	69	76	
Provided a written health education curriculum	61	61	55	71	
SEXUAL HEALTH EDUCATION					
Goals, objectives, and expected outcomes for sexual health education	77	68	86	90	
A written health education curriculum that includes objectives and content addressing sexual health education	62	58	60	75	
A chart describing the annual scope and sequence of instruction for sexual health education	52	45	47	80	
Strategies that are age-appropriate, relevant, and actively engage students	69	61	70	90	
Methods to assess student knowledge and skills related to sexual health education	69	61	73	85	
Curricula specific for LGBTQ youth	65	52	74	95	

Percent of schools who provide physical educators or other specialists with materials for physical education.

Materials Provided for Physical Education	Overall	MS	JR/SR	HS
Goals, objectives, and expected outcomes for physical education	95	96	93	95
A chart describing the annual scope and sequence of instruction	75	78	68	76
Plans for how to assess student performance in physical education	87	84	85	95
Provided a written physical education curriculum	73	68	71	90
Resources for fitness testing	97	96	100	95
Physical activity monitoring devices, such as pedometers or heart rate monitors	82	81	86	76









Percent of schools with Proficiency-Based Graduation Requirements (PBGRs) for Health Education.

	Overall	MS	JR/SR	HS
Have PBGRs	51	31	72	81
In the process of identifying PBGRs	32	38	28	19
Have not identified PBGRs	18	31	---	---

Percent of schools with Proficiency-Based Graduation Requirements (PBGRs) for Physical Education.

	Overall	MS	JR/SR	HS
Have PBGRs	56	38	79	81
In the process of identifying PBGRs	29	35	21	19
Have not identified PBGRs	15	27	---	---

Percent of schools whose health education curriculum addresses the following skills:

	Overall	MS	JR/SR	HS	
Comprehending concepts related to health promotion and disease prevention	93	88	100	100	
Analyzing the influence of family, peers, culture, media, technology and other factors on health behaviors	93	89	100	96	
Accessing valid information and products and services to enhance health	90	83	100	96	
Using interpersonal communication skills to enhance health and avoid or reduce health risks	96	92	100	100	
Using decision-making skills to enhance health	95	91	100	100	
Using goal-setting skills to enhance health	94	91	100	95	
Practicing health-enhancing behaviors to avoid or reduce risks	93	89	100	95	
Advocating for personal, family, and community health	89	85	93	95	

Percent of schools who tried to increase student knowledge by addressing the following topics in a required health education course.

Topic	Overall	MS	JR/SR	HS
Alcohol- or drug-use prevention	94	89	100	100
Asthma	32	33	39	18
Chronic disease prevention	79	73	84	91
CPR/ AED use	48	33	70	62
Emotional and mental health	92	86	100	100
Environmental health	43	40	44	48
Epilepsy or seizure disorder	20	18	27	18
Food allergies	55	62	58	28
Foodborne illness prevention	59	57	62	59
Health practices that maintain the health of self and others	91	85	97	100
Human immunodeficiency virus (HIV) prevention	79	68	93	92
Human sexuality	89	82	97	100
Infectious disease prevention	74	71	77	77
Injury prevention and safety	76	68	87	87
Nutrition and dietary behavior	93	88	100	96
Personal Healthy Fit Zones (e.g. How to track, assess and evaluate fitness levels)	67	63	84	57
Physical activity and fitness	98	96	100	100
Pregnancy prevention	79	68	97	87
Sexually transmitted disease (STD) prevention	84	71	100	100

Topic	Overall	MS	JR/SR	HS
Suicide prevention	82	72	93	100
Tobacco-use prevention	93	89	100	96
Violence prevention	93	87	100	100

(Health education topics, cont.)

Policies, Programs, and Prevention

Tobacco, Alcohol, and Other Substance-Use Prevention

Tobacco-Use Prevention

Percent of schools with tobacco use policies

	Overall	MS	JR/SR	HS	
Any policy prohibiting tobacco use	99	97	100	100	
Limit tobacco use in all locations, all the time ("tobacco-free environment")	69	64	81	68	
Have signs indicating "Tobacco-free school zone"	80	78	85	80	

Percent of schools whose tobacco use policy prohibits tobacco use during school and non-school hours.

	Overall	MS	JR/SR	HS	
FOR STUDENTS					
During school hours	98	97	97	100	
During non-school hours	93	90	94	100	
FOR FACULTY / STAFF					
During school hours	96	96	97	95	
During non-school hours	90	89	90	90	
FOR VISITORS					
During school hours	95	95	97	95	
During non-school hours	89	87	90	95	





Percent of schools whose tobacco use policy prohibits tobacco use in the following locations.

	Overall	MS	JR/SR	HS			
FOR STUDENTS							
In school buildings	99	96	97	100			
Outside on school grounds	99	96	97	100			
On school buses or other vehicles	99	96	97	100			
At off-campus, school-sponsored	95	89	97	100			
FOR FACULTY / STAFF							
In school buildings	96	95	97	100			
Outside on school grounds	96	95	97	100			
On school buses or other vehicles	96	95	97	100			
At off-campus, school-sponsored	87	81	97	100			
FOR VISITORS							
In school buildings	96	93	97	100			
Outside on school grounds	96	93	97	100			
On school buses or other vehicles	94	90	97	100			
At off-campus, school-sponsored	79	73	90	85			

Percent of schools who prohibit specific types of tobacco products in their tobacco policy.

	Overall	MS	JR/SR	HS			
FOR STUDENTS							
Cigarettes	95	92	97	100			
Smokeless tobacco	95	92	97	100			
Cigars	93	89	97	100			
Pipes	94	91	97	100			
Electronic Vapor Products	76	70	80	91			
FOR FACULTY/STAFF							
Cigarettes	94	91	97	100			
Smokeless tobacco	92	89	97	95			
Cigars	93	88	97	100			
Pipes	93	88	97	100			
Electronic Vapor Products	77	69	83	91			
FOR VISITORS							
Cigarettes	94	91	97	100			
Smokeless tobacco	90	85	97	95			
Cigars	92	88	97	100			
Pipes	92	88	97	100			
Electronic Vapor Products	73	68	76	86			

Percent of lead health educators who taught the following topics related to tobacco use prevention.

	Overall	MS	JR/SR	HS	
Identifying tobacco products and the harmful substances they contain	88	87	90	87	
Identifying short- and long-term health consequences of tobacco use	89	87	90	91	
Identifying social, economic, and cosmetic consequences of tobacco use	86	87	87	82	
Understanding the addictive nature of nicotine	90	87	93	91	
Effects of nicotine on the adolescent brain	79	77	87	73	
Effects of tobacco use on athletic performance	74	75	83	59	
Effects of second-hand smoke and benefits of a smoke-free environment	87	87	86	87	
Understanding the social influences on tobacco use	85	84	87	87	
Identifying reasons why students do and do not use tobacco products	85	84	90	82	
Making accurate assessments of how many peers use tobacco products	73	70	74	82	
Using interpersonal communication skills to avoid tobacco use	87	87	90	82	
Using goal-setting and decision-making skills to not use tobacco	82	81	83	82	
Finding valid information and services related to prevention and cessation	74	74	72	77	
Supporting others who abstain from or want to quit using tobacco	67	65	72	64	
Identifying harmful effects of tobacco use on fetal development	61	54	77	59	
Relationship between using tobacco and alcohol or other drugs	80	76	85	87	
How addiction to tobacco use can be treated	74	71	76	77	

	Overall	MS	JR/SR	HS	
Understanding school policies and community laws related to the sale and use of tobacco products	69	66	76	69	
Benefits of tobacco cessation programs	57	50	69	59	
Taught all 19 tobacco-use prevention topics	36	29	56	32	

(Tobacco use prevention topics, cont.)

Alcohol and Other Substance Use Prevention

Percent of schools who provide services or referrals for services related to alcohol or other drug use, abuse, or dependency

	Overall	MS	JR/SR	HS	
Provide assessments for alcohol or other drug use problems	48	30	77	63	
Provide referrals for alcohol or other drug use treatment	76	66	80	100	
Do not have screening or referral procedures for students suspected to have alcohol or other drug use issues	22	33	11	5	
Have cooperative or formal agreement with an outside agency to provide assessment and treatment services	56	48	65	69	

Percent of lead health educators who taught the following topics related to substance use prevention.

	Overall	MS	JR/SR	HS	
Signs and symptoms of alcohol and other drug use, including the progression from non-use through addiction	79	65	94	100	
Short and long-term effects of alcohol, tobacco, and other drugs on health	90	84	97	100	
Health benefits of abstaining from use of alcohol, tobacco, and other drugs	91	84	100	100	
How messages from the media, friends, family, and culture influence young people to use alcohol, tobacco, and other drugs	90	86	97	95	
Use of effective interpersonal communication skills to counter influences and resist pressures to use alcohol and other drugs	92	87	100	95	
Finding valid information and services related to health issues related to alcohol, tobacco, and other drugs	86	77	97	100	

Physical Education and Physical Activity

Percent of schools with a Comprehensive School Physical Activity Program (CSPAP)*.















	Overall	MS	JR/SR	HS	
Developed a written plan for implementing a CSPAP	21	25	21	6	
Implemented a CSPAP	12	15	16	0	

Percent of schools who provide opportunities for physical activity and sport participation.

	Overall	MS	JR/SR	HS	
Physical activity before school day	48	41	57	57	
Physical activity after school day	85	84	90	81	
Physical activity breaks	83	96	82	47	
Offer interscholastic sports	90	85	96	95	
Offer all students intramural sports or physical activity clubs	78	87	70	62	
Have joint use agreement for physical activity or sports facilities	67	67	75	57	

* Implementing a CSPAP was calculated to include schools that (a) have physical activity breaks in the classroom during the school day; offer opportunities for physical activity before the school day as well as afterschool via intramural and interscholastic sports, require physical education courses in each grade level, have joint-use agreements for shared use of facilities, and had a school health council or team that assessed the availability of physical activity opportunities available.

Percent of lead health educators who taught the following topics related to physical activity.












	Overall	MS	JR/SR	HS	
Short-term and long-term benefits of physical activity, including reducing the risks for chronic disease	93	91	97	95	
Mental and social benefits of physical activity	96	93	100	100	
Health-related fitness	96	94	100	95	
Phases of a workout	90	90	94	84	
Recommended amounts and types of moderate, vigorous, muscle-strengthening, and bone-strengthening physic	88	86	94	89	
Decreasing sedentary activities	94	93	97	95	
Preventing injury during physical activity	93	96	94	84	
Weather-related safety	74	72	81	67	
Dangers of using performance-enhancing drugs such as steroids	75	68	90	77	
Increasing daily physical activity	95	93	100	95	
Incorporating physical activity into daily life	94	93	100	89	
Using safety equipment for specific physical activities	86	83	97	79	
Benefits of drinking water before, during, and after physical activity	94	94	90	100	
Taught all 13 physical activity related topics	60	55	78	48	

Nutrition Environment and Services


Percent of schools who implemented key components for creating a supportive school nutrition environment.

	Overall	MS	JR/SR	HS	
Do not sell less healthy foods and beverages such as soda, baked goods, salty snacks, candy	72	91	48	45	
Prohibit all forms of advertising and promotion for candy, fast food restaurants, or soft drinks	71	69	78	67	
Price nutritious foods and beverages at a lower cost while increasing the price of less nutritious foods and beverages	12	12	13	10	
Provide information to students or families on the nutrition, caloric, and sodium content of foods available	57	59	47	64	
Place fruits and vegetables near the cafeteria cashier, where they are easy to access	92	91	90	100	
Allow students to have access to drinking water in all locations	52	43	62	67	
Offer fruits or non-fried vegetables when foods or beverages are offered at school celebrations	59	54	71	57	
Allow students to purchase fruits and vegetables from vending machines or at the school store, canteen, or snack bar, or as a la carte items	15	--	33	35	

Percent of schools who performed the following activities in order to increase health eating.

	Overall	MS	JR/SR	HS	
Collected suggestions from students, families, and school staff on nutritious food preferences	55	51	68	50	
Provided information to students or families on food nutrition	57	59	47	64	
Conducted taste tests to determine food preferences for nutritious items	63	68	48	65	
Provided students opportunities to visit cafeteria to learn nutrition-related information	37	41	38	20	
Served locally or regionally grown foods in cafeteria or classrooms	95	96	93	95	
Planted a school garden	77	80	75	69	
Placed fruits and vegetables near the cafeteria cashier for easy access	92	91	90	100	
Used attractive displays for fruits and vegetables in cafeteria	87	83	93	95	
Offered a self-serve salad bar to students	83	81	82	90	
Labeled healthful foods with appealing names	48	49	44	50	
Encouraged students to drink plain water	89	90	93	85	

Percent of schools who allow students to purchase items in vending machines, school stores, snack bars, or school canteens.

	Overall	MS	JR/SR	HS	
Have vending machines	44	23	62	81	

Percent of schools who allow students to purchase the following items in vending machines, school stores, snack bars, or school canteens.

	Overall	MS	JR/SR	HS	
Chocolate candy	6	5	0	12	
Other kinds of candy	8	5	6	12	
Salty snacks not low in fat	22	23	12	30	
Low sodium or 'no added salt' pretzels, chips, or crackers	68	59	49	94	
Baked goods not low in fat	28	22	31	29	
Ice cream or frozen yogurt	23	17	23	29	
2% or whole milk	42	34	46	46	
Nonfat or % milk	56	39	60	68	
Water ices or frozen slushes	15	16	11	18	
Soda pop or fruit drinks	13	5	12	19	
Sports drinks	48	11	71	58	
Energy drinks	
Plain water, with or without carbonation	88	66	100	95	
Calorie-free, flavored water, with or without carbonation	55	28	70	65	
100% fruit or vegetable juice	66	28	83	82	
Foods or beverages containing caffeine	30	22	19	50	
Fruits (not fruit juice)	51	27	60	62	
Non-fried vegetables (not vegetable juice)	38	5	54	50	

Percent of schools who provide access to free water in the following locations or allow students to carry water bottle.

	Overall	MS	JR/SR	HS	
Cafeteria during breakfast	93	94	89	95	
Cafeteria during lunch	95	96	93	95	
Gymnasium	94	95	97	90	
Outdoor physical activity facilities	57	46	69	75	
Hallways throughout school	97	96	97	100	
Allow student to carry water bottles in all locations	91	89	97	90	



Percent of schools who provide access to free water in all locations.

	Overall	MS	JR/SR	HS	
	52	43	62	67	




Percent of schools who prohibit advertising in the following locations.

	Overall	MS	JR/SR	HS	
In school buildings	81	76	85	91	
On school grounds	77	73	81	81	
On school buses	77	71	85	86	
In school publications	79	75	82	86	
In curricula or other publications	78	75	85	81	


























































Percent of schools who prohibit using less nutritious food and drinks as rewards and in school fundraisers.





	Overall	MS	JR/SR	HS	
Prohibit less nutritious foods and beverages from being sold for fundraising	43	46	49	24	
Prohibit school staff from giving students food or food coupons as a reward	31	36	25	20	

Percent of schools who offer fruits and vegetables during celebrations, when food is available.

	Overall	MS	JR/SR	HS	
Rarely	3	4	3	0	
Sometimes	38	42	26	43	
Always	59	54	71	57	

Percent of lead health educators who taught the following topics related to nutrition.

	Overall	MS	JR/SR	HS			
Benefits of healthy eating	91	85	100	96			
Benefits of drinking plenty of water	90	86	97	91			
Benefits of eating breakfast ever day	87	82	97	91			
Food guidance using current Dietary Guidelines (e.g. MyPlate)	85	85	87	82			
Using food labels	84	78	97	87			
Differentiating between nutritious and less nutritious beverages	87	81	100	91			
Balancing food intake and physical activity	87	81	97	91			
Eating more fruits, vegetables, and whole grain products	90	85	100	91			
Choosing foods and snacks low in solid fats	85	82	90	87			
Choosing foods, snacks, and beverages that are low in added sugar	87	81	100	87			
Choosing foods and snacks low in sodium	80	75	90	82			
Eating a variety of foods high in calcium	80	77	87	78			
Eating a variety of foods high in iron	75	71	84	73			
Food safety	71	68	87	59			
Preparing healthy meals and snacks	71	66	87	62			
Risks of unhealthy weight control practices	75	67	90	77			
Accepting body size differences	76	69	87	82			
Signs, symptoms, and treatment for eating disorders	68	58	84	80			
Relationship between diet and chronic diseases	78	68	93	86			

	Overall	MS	JR/SR	HS	
Assessing body mass index (BMI)	49	40	67	55	
Influence of media on dietary behaviors	75	67	90	78	
Food production	65	62	72	64	
Taught all 22 nutrition and dietary related topics	37	28	52	41	

(Nutrition and dietary related topics, cont.)

Sexual Health

Percent of schools who provide the following sexual health services on school property

	Overall	MS	JR/SR	HS	
HIV testing	1	1	0	0	
HIV treatment	3	1	10	0	
STD testing	2	1	4	0	
STD treatment	2	1	4	0	
Pregnancy testing	4	1	12	5	
Provision of condoms	13	3	36	27	
Provision of condom-compatible lubricants	3	0	8	4	
Provision of contraceptives other than condoms	0	0	0	0	
Prenatal care	2	1	4	0	
Human papillomavirus (HPV) vaccine administration	4	1	10	5	

Percent of schools who provide referrals to community providers for the following sexual health services

	Overall	MS	JR/SR	HS	
Referral for HIV testing	48	33	71	64	
Referral for HIV treatment	52	39	69	69	
Referral for nPEP	49	37	65	65	
Referral for STD testing	48	33	71	68	
Referral for STD treatment	48	33	71	64	
Referral for pregnancy testing	48	32	71	68	
Referral for provision of condoms	43	26	69	62	
Referral for provision of condom-compatible lubricant	41	24	72	53	
Referral for provision of contraceptives	46	28	71	68	
Referral for prenatal care	46	30	70	73	
Referral for Human papillomavirus (HPV) vaccinations	52	38	72	69	






























Percent of schools who require the following parental consent and notification for sexual health services provided on school property.





	Overall	MS	JR/SR	HS	
Do not provide any sexual or reproductive health services	78	86	49	74	
Parental consent is required before any services are provided	8	10	6	0	
Parents are provided with information about sexual health services provided only upon request	2	1	0	8	
Parents may be notified depending on the sexual health service provided	9	3	26	18	
Parents are notified about all sexual health services provided	0	0	0	0	
Parents are not notified about any sexual health services provided	3	0	19	0	

Percent of schools who require the following parental consent and notifications when providing referrals for sexual health services.

	Overall	MS	JR/SR	HS	
Do not refer any sexual or reproductive health services	43	59	19	27	
Parental consent is required before any services are referred	26	30	23	13	
Parents are provided with information about sexual health referrals only upon request	6	3	8	13	
Parents are notified about all sexual health referrals provided	20	8	37	33	
Parents may be notified depending on the referral provided	1	0	0	7	
Parents are not notified about any sexual health referrals provided	5	0	13	7	








Percent of lead health educators who taught the following topics related to sexual health for students in grades 6-8 and in grades 9-12.

	Grades 6-8	Grades 9-12		
How HIV and other STDs are transmitted	69	98		
Health consequences of HIV, other STDs	67	98		
Benefits of being sexually abstinent	68	98		
How to access valid and reliable health information related to HIV, STDS, or pregnancy	64	96		
Influences of family, peers, media, technology and other factors on sexual risk behaviors	69	91		
Communication and negotiation skills related to eliminating or reducing risks for HIV, STDS, or pregnancy	65	95		
Goal-setting and decision-making skills related to eliminating or reducing risks for HIV, STDS, or pregnancy	56	81		
Influencing and supporting others to avoid or reduce sexual health risks	59	88		
Efficacy of condoms	53	96		
Importance of using condoms consistent	55	98		
How to obtain condoms	45	95		
How to correctly use a condom	40	89		
Methods of contraception other than condoms	51	96		
Importance of using a condom at the same time as other forms of contraception	56	96		
How to create and sustain healthy and respectful relationships	78	98		
Importance of limiting the number of sexual partners	63	96		

	Grades 6-8	Grades 9-12		
Preventive care to maintain reproduce and sexual health	51	96		
Sexual orientation	66	87		
Gender roles, gender identity, or gender expression	70	91		
Relationship between alcohol and other drug use and sexual risk behaviors	70	93		

(Sexual health topics, cont.)

Percent of lead health educators who assessed the following skills related to sexual health among students in grades 6-8 and in grades 9-12.

	Grades 6-8	Grades 9-12		
Comprehend concepts important to prevent HIV, other STDs and pregnancy	59	92		
Analyze influence of family, peers, culture, media, technology, and other factors	55	84		
Access valid information, products, and services to prevent HIV, other STDs, and pregnancy	51	94		
Use interpersonal communication skills to avoid or reduce sexual risk behaviors	60	88		
Use decision-making skills to prevent HIV, other STDs and pregnancy	58	89		
Set personal goals, take steps, and monitor to achieve goals that enhance health	66	80		
Influence and support others to avoid or reduce sexual risk behaviors	55	76		

Percent of lead health educators who provided students with the opportunity to practice communication, decision-making, goal-setting, or refusal skills related to sexual health during the current school year






	Overall	MS	JR/SR	HS
	71	61	87	82

Percent of schools who taught or assessed multiple HIV, STD, and pregnancy prevention topics


	Grades 6-8	Grades 9-12
Taught all 20 HIV, STD, and pregnancy prevention topics	24	66
Taught at least 11 topics HIV, STD, and pregnancy prevention topics	36	73
Assess all 7 skills related to sexual health	41	50

Safe and Inclusive Environments

Percent of schools who provide opportunities and have policies to create safe and supportive environments for all youth regardless of gender or sexual orientation.

	Overall	MS	JR/SR	HS	
Identifies 'safe spaces' where LGBTQ youth can receive support from administrators, teachers, or other school staff	84	77	87	100	
Prohibits harassment based on a student's perceived or actual sexual orientation or gender identity	99	99	97	100	
Encourages staff to attend professional development on safe and supportive school environments for all students	88	85	90	95	
Facilitates access to providers not on school property who have experience in providing health services to LGBTQ youth	67	65	76	61	
Facilitates access to providers not on school property who have experience in providing social and psychological services to LGBTQ youth	67	60	74	76	

Percent of schools that implement HIV, STD, and pregnancy prevention strategies that meet the needs of LGBTQ youth.

	Overall	MS	JR/SR	HS	
	33	23	46	49	

Percent of schools that perform the following bullying and sexual harassment prevention strategies.

	Overall	MS	JR/SR	HS	
Provided professional development on bullying/harassment for all teachers and staff	88	88	86	90	
Have designated staff members to whom students can confidentially report bullying/harassment	100	100	100	100	
LHEs provide parents information on bullying and sexual harassment	74	78	75	57	
Publicize bullying/harassment rules and policies	97	97	97	95	

Percent of schools that engage in all four bullying and sexual harassment prevention strategies.








	Overall	MS	JR/SR	HS	
	61	68	52	44	

Percent of schools who offer clubs and other opportunities to learn about others




	Overall	MS	JR/SR	HS	
Have student led clubs such as Gay/straight alliance (GSAs)	51	30	71	85	
Clubs to learn about people different from them	65	58	66	81	
Lessons in class about different people and cultures	95	92	100	100	
Hosts special events such as multicultural week or family nights	61	52	67	80	

Family and Community Engagement



Percent of schools who engage in the following strategies to connect with parents and families.

	Overall	MS	JR/SR	HS	
Provide parents and families with information about how to communicate with their child about sex	38	46	27	30	
Provide parents with information about how to monitor their child	63	72	50	52	
Provide disease-specific education for parents and families of students with or at-risk for chronic conditions	68	71	67	58	
Link parents and families to health services and programs in community	86	87	86	85	
Inform parents about health services	93	95	86	95	
Involve parents as school volunteers in delivery of health education activities and services	28	31	35	10	
Have families help develop school health policies	48	42	61	50	

Percent of schools who provide the following opportunities for students to engage with others in their community.

	Overall	MS	JR/SR	HS	
Program to mentor students	44	51	36	35	
Provide service-learning opportunities	69	58	82	85	
Peer tutoring	68	50	93	90	

Percent of schools that implement family* and community engagement† strategies.

	Overall	MS	JR/SR	HS	
Community engagement	79	70	89	95	
Family engagement	69	75	65	55	

* Percentage of schools that implement parent engagement strategies for all students by doing at least four of the following: Providing parents and families with information about how to communicate with their child about sex; Providing parents and families with information about how to monitor their child; Establishing one or more communication channels (e.g., electronic, paper, or oral) with parents about school health services and programs; Involving parents as school volunteers in the delivery of health education activity and services; Engaging parents and students in health education activities at home; Engaging parents in the development and implementation of school health policies and programs; Linking parents and families to health services and programs in the community.

† Percentage of schools that implement school connectedness strategies by doing at least three of the following: Providing students with opportunities to be involved in mentoring programs; Providing students with opportunities to be involved in service learning; Providing students with opportunities to be involved in peer tutoring; Having a lead health education teacher who received professional development on classroom management techniques during the past 2 years; Providing clubs or activities that give students opportunities to learn about people different from them (e.g., students with disabilities, LGBTQ youth, homeless youth, or people from different cultures).

Percent of lead health educators who provide parents with information in order to increase knowledge on the following health-related topics.

	Overall	MS	JR/SR	HS	
HIV, other STD, or pregnancy prevention	29	30	22	36	
Tobacco-use prevention	46	46	52	38	
Alcohol- or other drug-use prevention	43	43	45	38	
Physical activity	41	49	35	27	
Nutrition and healthy eating	48	56	41	32	
Asthma	22	21	31	13	
Food allergies	37	42	37	18	
Diabetes	17	17	16	18	
Preventing student bullying and sexual harassment	73	78	75	57	

Percent of lead health educators who provide students with homework to engage families in health-related behaviors.

	Overall	MS	JR/SR	HS	
Homework to do with parents	59	57	78	41	

For more information about the School Health Profiles:

Visit:

Vermont Department of Health: School Health Profiles

<http://www.healthvermont.gov/stats/surveys>

Centers for Disease Control and Prevention (CDC):

Division of Adolescent and School Health (DASH)

<https://www.cdc.gov/healthyyouth/data/profiles/index.htm>

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