REPORT OF THE BLUE RIBBON COMMISSION
ON SCHOOL HEALTH

FINDINGS AND RECOMMENDATIONS OF THE BLUE RIBBON COMMISSION ON SCHOOL HEALTH

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 29

COMMONWEALTH OF VIRGINIA
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COMMONWEALTH of VIRGINIA

Office of the Governor

George Allen
Governor

Robert C. Metcalf
Acting Secretary of Health and Human Resources

February 23, 1996

TO: The Honorable George Allen

and

The General Assembly of Virginia

This report contained herein is pursuant to Senate Joint Resolution 155, agreed to by the 1994 General Assembly.

This report constitutes the response of the Blue Ribbon Commission on School Health to study in depth school health programs in Virginia, in accordance with the following study objectives of the Commission contained within Senate Document 48 submitted to the 1995 General Assembly: (1) identify existing school health programs, (2) analyze existing state school health programs, (3) evaluate the performance of school health programs, (4) identify and address issues of specific groups of stakeholders, and (5) formulate the needs of stakeholders.

Respectfully Submitted,

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PREFACE

This study on developing, implementing, and evaluating school health programs in public schools in the Commonwealth was conducted by the Blue Ribbon Commission on School Health in response to Senate Joint Resolution No. 155 (1994 session). The study was conducted in 1995.

Members

The Honorable Robert S. Bloxom

Alexandra Liddy Bourne, Chair

Anthony W. Conrad

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EXECUTIVE SUMMARY

INTRODUCTION

This study was conducted during 1995 in response to Senate Joint Resolution No. 155 *Requesting the Governor to establish a Blue Ribbon Commission on School Health to collaborate in developing, implementing, and evaluating school health programs* (1994). This request was initiated by Senator L. Louise Lucas, responding to the need to protect the health and well-being of all children and ensure that each has the opportunity to grow and develop to his or her potential. The Commission was appointed in July 1994 and had a summit meeting in December 1994. It was at this summit meeting that the recommendations to the General Assembly were completed and ratified. Refer to Appendix A for Senate Joint Resolution No. 155.

The Blue Ribbon Commission on School Health recommended that school health programs in Virginia be studied in depth during 1995. The Commission prepared a workplan that outlined the course of action for this study, and that workplan is contained in Senate Document No. 48, *Developing, Implementing and Evaluating School Health Programs* (1995). For the purpose of this study a school health program is composed of the following nine components: (1) health education, (2) health services, (3) healthful school environment, (4) parent/community involvement, (5) counseling, (6) psychological and social services, (7) nutrition services, (8) physical education, and (9) health promotion for staff.

OBJECTIVES OF THE STUDY

- Identify existing state school health programs
- Analyze existing state school health programs
- Evaluate the performance of school health programs
- Identify and address issues of specific groups of stakeholders
- Formulate the needs of stakeholders

SOURCES OF INFORMATION

- Survey of personnel from selected state and nonprofit agencies
- Existing school health statues and regulations

- Position and policy statements about school health adopted by the Virginia Congress of Parents and Teachers

- Information from the Virginia Department for Rights of Virginians with Disabilities about school health issues from the perspective of parents of children with disabilities

- Survey of selected elementary, middle, and secondary schools

- Information from 1994 school health advisory board reports

- Five public hearings

MAJOR ISSUES AND FINDINGS OF STUDY

- The primary objective of state school health programs is to support instruction and to help students become successful learners and achieve high academic standards.

- There are limited data available on the total cost of each component of a school health program.

- All school divisions offer some portion of a school health program. Furthermore, the school survey revealed little difference in the success of school health programs in schools throughout the Commonwealth.

- School health advisory boards can serve as excellent vehicles for involving parents and the community in the improvement of school health programs; however, there is inconsistent utilization of school health advisory boards in the Commonwealth.

- Concerns exist regarding the management of children with special health care needs in the school setting. These concerns include the qualifications of personnel responsible for specialized health care procedures including administration of medications, liability of schools and individuals, and local policies that create barriers to self-care of children.

- Concerns exist regarding improving physical education, grades K-12.

- Although funding of school health services was identified as a concern at all public hearings, a comprehensive analysis of alternative funding sources was beyond the scope of this study.

Commission members were urged to review the recommendations of Senate Document No. 5, *Report on the Needs of Medically Fragile Students* (1995) and were advised that many issues and concerns raised by stakeholders can be addressed effectively by implementing the recommendations contained therein.

RECOMMENDATIONS

- School superintendents should recognize the importance of school health advisory boards as a means of parent and community involvement and of assisting with the development of school health policies and the evaluation of school health programs.

- The Department of Education, in collaboration with the Department of Health, should provide periodic training and technical assistance to school health advisory board members and school health administrators to assist them in strengthening the boards' effectiveness in localities.

- Recommendations 1-6 and 8 of Senate Document No. 5, *Report on the Needs of Medically Fragile Students* (1995), should be implemented:

  ◊ School divisions should develop a "health service plan" for each student who is a medically fragile child as defined by Senate Document No. 5 (1995).

  ◊ Local school divisions should develop policies that address the provision of services to students who are medically fragile, including staff selection and training and roles and responsibilities.

  ◊ Local school divisions should develop policies to address the emergency medical needs of students, including those who are medically fragile.

  ◊ The local school health advisory board, required by §22.1-275.1 of the *Code of Virginia*, should take an active role in assisting school divisions in developing policies related to children who are medically fragile.

  ◊ School divisions should provide periodic in-service or opportunities for school staff to attend programs to increase staff awareness and understanding of the general health issues faced by schools and the needs of students who are medically fragile.

  ◊ For risk management purposes, school divisions should document school health services provided to all students, including those who are medically fragile.

  ◊ School divisions should review and evaluate their policies and procedures relative to Section 504 of the Rehabilitation Act of 1973.

- Students with special health care needs and chronic illnesses should have their medical care managed at school by a professional nurse in collaboration with the child's parents and primary health care provider.

- The Virginia Board of Nursing's efforts to address delegation of nursing services in the school setting to unlicensed assistive personnel while ensuring that the professional nurse retains authority for nursing assessment, nursing evaluation, and nursing judgment should be supported.

- The Department of Health, in collaboration with the Department of Education, should distribute guidelines to assist qualified personnel in the assessment and ongoing management of students with specialized health care needs in the school setting. Such guidelines should be sent to all public and private schools in the Commonwealth.

- School divisions should require that specialized health care procedures be provided by licensed health care professionals or by personnel who have received training from persons qualified to provide such training and are certified or licensed to perform the procedure being taught.

- School divisions are encouraged to devote a portion of their professional development resources to assist staff in developing skills and strategies for working with parents and increasing parental involvement in the planning and implementation of school health programs.

- School divisions are encouraged to review physical education, grades K-12, and determine ways by which the program could be improved.

- The Department of Medical Assistance Services' studies on Virginia managed care Medicaid programs—MEDALLION II and OPTIONS—should include the impact of these programs on school health services.

- The Department of Medical Assistance Services should study the appropriateness and feasibility of contracting for school health services, including school nursing services, especially in medically underserved areas or health manpower shortage areas.

- School divisions, especially those in medically underserved areas, are encouraged to develop public-private contracts (e.g., HMO—Health Maintenance Organization, CHIP—Comprehensive Health investment Project of Virginia) which include formal reimbursement for school health services (e.g., school nursing services) provided by qualified personnel.

CHAPTER I
INTRODUCTION

BACKGROUND AND PURPOSE

This study was conducted during 1995 in response to Senate Joint Resolution No. 155, passed by the General Assembly in the 1994 session. Senate Joint Resolution No. 155, introduced by Senator L. Louise Lucas, requested the Governor to establish a Blue Ribbon Commission on School Health to collaborate in developing, implementing, and evaluating school health programs. The Commission was directed to study the following components of a school health program: health education, health services, healthful school environment, parent/community involvement, counseling, psychological and social services, nutrition services, physical education, and health promotion for staff.

OBJECTIVES

The Commission agreed to the following objectives for the study:

1. Identify existing state school health programs
2. Analyze existing state school health programs
3. Evaluate the performance of school health programs
4. Identify and address issues of specific groups of stakeholders
5. Formulate the needs of stakeholders

SOURCES OF INFORMATION

- A brief survey was conducted with personnel from selected state and volunteer agencies that serve student health needs. The survey identified objectives, costs, content, and perceived benefits and concerns associated with school health programs.
- Existing statutes and regulations were analyzed to identify those that pertain to school health.
- The Virginia Congress of Parents and Teachers provided a summary of position and policy statements on school health issues.
- Information was summarized from 1994 school health advisory board reports.

- The Virginia Department for Rights of Virginians with Disabilities provided an analysis of school health issues as viewed by parents of students with disabilities. The report was based upon the Department's discussion with various parent organizations.

- A survey of 450 randomly selected schools was conducted to measure performance in achieving certain school health program goals and to investigate factors underlying the success of those goals. The sample included an equal number of elementary, middle, and high schools and was geographically representative of the state.

- Hearings were held in five locations throughout the Commonwealth to obtain public comment on school health programs in order to formulate the needs of stakeholders. Specifically, hearings were held in Hanover County (Atlee High School - June 12), Fauquier County (Fauquier High School - June 19), Northampton County (Northampton High School - June 21), Salem City (Salem High School - July 12), and Hampton City (Thomas Eaton Middle School - July 18). A total of 121 stakeholders—including parents, teachers, school administrators, physicians, dentists, school health services providers and private citizens—addressed the Commission.

The Commission met as follows:

- December 2, 1994. The following members were present: Alexandra Liddy Bourne, Anthony W. Conrad, C. Randolph Cook, H. Douglas Cox, Janet Susan Ford, Nancy C. Ford, Loretta M. Herrington, Timothy F. Joost, and Jerome W. Patchen.

- December 19, 1994 (summit meeting). The following members were present: Alexandra Liddy Bourne, Anthony Conrad, C. Randolph Cook, H. Douglas Cox, Janet Susan Ford, Nancy C. Ford, Loretta M. Herrington, Timothy F. Joost, and Jerome W. Patchen.

- June 1, 1995. The following members were present: The Honorable Robert S. Bloxom, Alexandra Liddy Bourne, C. Randolph Cook, H. Douglas Cox, Janet Susan Ford, Nancy C. Ford, Loretta M. Herrington, Timothy F. Joost, and The Honorable W. Henry Maxwell.

- June 13, 1995 (in association with the School Health Leadership Institute). The following members were present: Alexandra Liddy Bourne, Janet Susan Ford, Nancy C. Ford, Loretta M. Herrington, Timothy F. Joost, and Jerome W. Patchen.

- August 25, 1995. The following members were present: The Honorable Robert S. Bloxom, Alexandra Liddy Bourne, C. Randolph Cook, H. Douglas Cox, Janet Susan Ford, Nancy C. Ford, Loretta M. Herrington, Timothy F. Joost, and Jeff Nelson (for Jerome W. Patchen). Note: It was announced that Anthony W. Conrad resigned from Commission.

- September 29, 1995. The following members were present: The Honorable Robert S. Bloxom, Alexandra Liddy Bourne, H. Douglas Cox, Janet Susan Ford, Nancy C. Ford, Loretta M. Herrington, Timothy F. Joost, and Jeff Nelson (for Jerome W. Patchen).

CHAPTER II
IDENTIFICATION OF EXISTING SCHOOL HEALTH PROGRAMS

INTRODUCTION

This chapter provides an overview of existing state school health programs: (1) health education, (2) health services, (3) healthful school environment, (4) parent/community involvement, (5) counseling, (6) psychological and social services, (7) nutrition services, (8) physical education, and (9) health promotion for staff as reported by selected student health serving state and voluntary agencies.

METHODOLOGY

Staff members of the Virginia Department of Health and the Virginia Department of Education developed and administered a questionnaire to identify the following information: (1) objectives of current school health programs, (2) cost of each school health program, (3) content of typical regional school health programs, (4) perceived benefits received from school health programs, and (5) concerns associated with school health programs. Respondents included personnel from the Virginia Departments of Education, Health, Medical Assistance Services, Youth and Family Services, and Mental Health, Mental Retardation and Substance Abuse Services; Virginia Congress of Parents and Teachers; American Cancer Society; American Lung Association; Medical College of Virginia/Virginia Commonwealth University; and the Virginia Association of School Nurses.

FINDINGS

- The primary objective of state school health programs is to support instruction and to help students become successful learners who achieve high academic standards.

- Data are not available to determine the total cost of each component of school health programs.

- Although school health program content varies across the Commonwealth, all school divisions offer some portion of a school health program.

- Perceived benefits of school health programs include improved school attendance, readiness to learn, and improved academic achievement; increased capacity to make healthy choices and to practice health-enhancing skills and behaviors; and fewer public and private funds expended on preventable diseases and injuries.

- General concerns reported by constituents include fragmented programs, uneven funding, inconsistent staff preservice and inservice training, and lack of a standardized student health status indicator data collection system.

- There is a continuing need to involve parents in all aspects of school health programs and to develop programs that support parental responsibility.

SUMMARY OF EXISTING STATE SCHOOL HEALTH PROGRAMS

Constituents responding to the survey reported the following information pertaining to each component of existing school health programs in the Commonwealth.

Health Education

The stated primary objective of health education is to help students become successful learners and achieve high academic standards through a planned, age-appropriate, sequential, and broad curriculum that addresses the physical, mental, emotional, and social dimensions of good health.

Data are not available to determine the cost of health education.

Although programs vary across the Commonwealth, instructional content for a quality health education curriculum is based on the *Standards of Learning Objectives for Virginia Public Schools*. The Department of Education and the Department of Health collaborate to provide health education. The content addresses individual growth and development, personal health, family health, physical fitness, community and consumer health, environmental health, conflict resolution, stress management, injury prevention and safety, nutrition, prevention and control of diseases, and substance use and abuse.

Constituents responding to the survey reported the following benefits: (1) increased knowledge, skills, and efficacy related to personal health; (2) reduced health-risk behaviors; (3) improved choices that lead to good health; (4) better school attendance; (5) improved student achievement (e.g., test scores, graduation rate); and (6) fewer funds expended on intervention and treatment programs related to social problems, injury, and chronic diseases.

Constituents responding to the survey reported the following concerns: (1) no formal assessment of local school health education programs, (2) few elementary and middle school teachers receive any preservice or inservice training in health content and appropriate teaching strategies for health topics, (3) few schools teach health education at the eleventh and twelfth grades, and (4) lack of a statewide system to support school health instruction that focuses on the prevention of health problems rather than intervention and treatment.

Health Services

The stated primary objective of health services is to help students become successful learners and achieve high academic standards through health screenings, health promotion and disease prevention activities, and facilitating access to primary health care services.

The Department of Education estimates total health services expenditures for the 1992-93 school year were $34,089,677. These costs include services provided by school nurses, speech therapists, occupational and physical therapists, and clinic aides and materials and supplies. The Department of Health estimates total expenditures for school nursing services and school-based/school-linked programs are $3,938,000. Estimated expenditures for dental health prevention services are $7,200,000. The Department of Medical Assistance Services estimates the cost of Medicaid reimbursement for occupational, physical, and speech therapies for special education children is $167,000. Data are not available to determine the cost of Child Development Services or school health services for incarcerated youth.

Health services include school nursing services (e.g., medication administration, specialized health care procedures, first aid/emergency care, health screenings, communicable disease control, health counseling); speech, physical, and occupational therapy; special education medical assessment and case management; dental care (e.g., fluoride mouth rinse, sealants, oral safety, classroom instruction on proper dental care); child development services (e.g., comprehensive multi-disciplinary diagnostic evaluation, intervention, follow-up, consultation, health education for school personnel); and school-based/school-linked health programs. These health services elements are not offered statewide but vary with each school division. All school divisions offer some element of a health service program.

Constituents responding to the survey reported the following benefits: (1) increased potential for prompt diagnosis and successful treatment of acute and chronic conditions through prevention and intervention health services; (2) improved linkages among the school, home, and community by school nurses; (3) timely and accurate diagnoses and care plans for children with special health care needs; (4) increased opportunity for children of low-income families to receive dental services to enhance oral health and establish long-term dental health practices; and (5) improved access to health care.

Constituents responding to the survey reported the following concerns: (1) lack of funding to employ school nurses or contract with local health departments for nursing services, consistent with recommended professional school nurse to student ratios; (2) lack of a standardized student health status indicator data collection system for needs assessment and program monitoring and planning and evaluation at local and state levels; (3) under utilized Medicaid funds available to support health services; (4) lack of an evaluation of Child Development Services (such an evaluation may lead to enhanced services in selected school systems); (5) issues concerning the delineation of roles and responsibilities for the safe delivery of specialized health care in the educational setting; and (6) continuing need for actively involving parents in school health services, including supporting parental responsibility.

Healthful School Environment

The stated primary objective of healthful school environment is to help students become successful learners and achieve high academic standards by ensuring that school buildings and grounds are safe and free of hazardous substances.

The Department of Health estimates that $100 per school per year is expended to deliver environmental services. The Childhood Injury Prevention Program, Medical College of Virginia/Virginia Commonwealth University (MCV/VCU), reports expenditures of $1,685 per year for services provided. Data are not available from the Department of Education to determine cost.

The Department of Health and the Department of Education provide training and technical assistance services to local school divisions, including compliance with health and safety standards; prevention of bloodborne, milkborne, waterborne, and sewageborne diseases; radon abatement; control of health-risk substances such as lead and asbestos; development of crisis/emergency plans; and environmental design/adaptation strategies to reduce crime and violence in schools. The Childhood Injury Prevention Program, MCV/VCU, inspects at least five elementary school playgrounds for safety each year in a large suburban school district and provides training in playground safety. Topics include statistical data, reasons for playground injuries, hazard patterns, and solutions for making playgrounds safer.

Constituents responding to the survey reported the following benefits: (1) increased sense of security and well-being on the part of students and staff; (2) lowered incidence of injuries and environmentally-related diseases; and (3) reduced crime and violence in schools.

Constituents responding to the survey reported a concern that there is a need for ongoing initiatives to educate students, parents, and school staff about behaviors to minimize risk.

Parent and Community Involvement

The stated primary objective of parent and community involvement in school health programs is to help students become successful learners and achieve high academic standards through an organized and integrated school, parent, and community system that facilitates planning, organization, and coordination of activities to actively involve parents to prevent or reduce health-risk behaviors among children and youth.

Data are not available to determine the cost of parent/ community involvement in school health programs.

Local school health advisory boards, parent teacher associations, voluntary health organizations, agencies, and businesses are critical links in planning, organizing, and implementing content, services, and other activities related to a quality school health program. Content related to parent/community involvement addresses defining roles and responsibilities of participating individuals and groups; determining the status of local school health programs; strengthening

assessment and accountability systems; strengthening school health curricula and the delivery of instruction; enhancing school health services; improving the school health environment; enhancing nutrition, physical education, and school staff health programs; improving professional development; enhancing the use of technology; building links between families and schools; and improving teacher preparation and recruitment.

Constituents responding to the survey reported the following benefits: (1) increased parental awareness and knowledge about the importance of health, learning, and achievement; (2) increased parental support for practice of health-enhancing skills and behaviors; (3) increased community support of parent responsibility for addressing health issues of children and youth; (4) more regular school attendance by students and staff; (5) improved student academic achievement (e.g., test scores, graduation rate); (6) increased healthy behaviors becoming the societal norm; (7) more parents, community leaders, and students becoming advocates for others to practice healthy behaviors; and (8) fewer public and private funds being expended on preventable diseases and injuries.

Constituents responding to the survey reported the following concerns: (1) community members lack information about internal and external factors that affect personal health or school health issues; (2) lack of evaluation of the short-term and long-term benefits regarding some school health programs and services; (3) lack of strategic planning for school health programs; (4) need for better information about ways to access funds from a variety of sources to be used for a shared goal; (5) lack of broad-based representation on school health advisory boards, councils, and coalitions; and (6) continuing need for schools and communities to support active parental involvement in school health programs.

School Counseling

The stated primary objective of school counseling is to help students become successful learners and achieve high academic standards through a planned guidance and counseling program K-12, provided by certified school counselors.

The Department of Education reports the cost to support the state guidance and counseling program was $112,905,296 for the 1993-94 school year.

Counselors use a variety of prevention and intervention approaches to facilitate the academic success of all students. School counseling programs include career awareness, exploration and preparation; educational planning; and personal/social development. Counselors provide these services through classroom guidance, and small group and individual counseling. Counselors are involved with parents, teachers, and the local community.

Constituents responding to the survey reported the following benefits: (1) increased ability to achieve high academic standards; (2) increased ability to relate educational and vocational programs to career goals; (3) enhanced ability to select appropriate courses to prepare for career

goals; (4) improved ability to identify personal, social, and educational strengths and interests; (5) enhanced ability to acquire skills for solving problems and making decisions for effective functioning in an educational environment; and (6) better ability in managing conflict.

Constituents responding to the survey reported the following concerns: (1) lack of consistent policies and procedures that assure parental involvement in the program; (2) lack of optimal inter- and intra-agency collaboration; and (3) lack of information by school counselors about technical careers so they can adequately assist those students who plan to enter the workforce following graduation.

Psychological and Social Services

The stated primary objective of psychological and social services is to help students become successful learners and achieve high academic standards through a program that promotes a positive climate for learning, assists educators in meeting the individual needs of students, and facilitates the development of individual children.

The Department of Education reports a total cost of $24,891,033 for school social work services (1993-94). Data specific to psychological services are not available.

School psychological and social services are provided by qualified school psychologists, visiting teachers, and school social workers. Services include psychological and social assessment for special education and special services, referrals to community agencies, early identification of learning problems, counseling, crisis intervention, teacher consultation, serving as a link between the home and school, parent education, programs and initiatives aimed at reducing and preventing the use of alcohol and other drugs and violence, and prevention and intervention services to increase school attendance.

Constituents responding to the survey reported the following benefits: (1) enhanced relationships between home and school, (2) improved parent and educator understanding of individual student learning and behavioral needs, (3) enhanced student capacity to make healthy choices, (4) increased understanding on the part of educators of the growth and development of young people and the role of the family in that development, (4) better use of psychological and social information in developing intervention programs, (5) improved school climate, (6) better school attendance, (7) reduced school crime and violence, and (8) decreased use of alcohol and other drugs.

Constituents responding to the survey reported a concern that more children in public schools have learning problems and are exhibiting destructive behaviors such as substance abuse, deadly use of violence to resolve conflicts, and depression.

Nutrition Services

The stated primary objective of nutrition services is to help students become successful learners and achieve high academic standards by providing access to healthy and appealing meals and nutrition education.

The Department of Education estimates total expenditures for the 1993-94 nutrition program were $103,104,404. These costs include federal and state appropriations for school lunch and school breakfast programs, special milk programs, and nutrition education and training. Cost data are not available for Department of Health school nutrition services.

Nutrition services include nutritious meals for all students, including free and reduced-cost meals for children of low-income families; training for food service personnel and educators; consultation on nutrition needs of medically fragile children; coordination with health and nutrition education in the classroom; and linkages with nutrition-related community services.

Constituents responding to the survey reported the following benefits: (1) improved access to nutritionally balanced meals for all students; (2) increased opportunity for children of low-income families to receive balanced meals provided at schools; (3) establishment of long-term healthy nutrition practices; and (4) better trained food service and instructional staff to ensure that student meals meet US Dietary Guidelines for Americans.

Constituents responding to the survey reported a concern that there is a projected increase in the number of medically fragile students entering schools requiring increased nutrition expertise, particularly in special education programs.

Physical Education

The stated primary objective of physical education is to help students become successful learners and achieve high academic standards through a planned sequential program for developing motor skills and physical fitness.

Data are not available to determine the cost of physical education.

Instructional content for a physical education curriculum is based on the *Standards of Learning Objectives for Virginia Public Schools*. Content addresses learning experiences related to basic body management and manipulative skills, physical fitness and injury prevention, rhythms and dance, games, team and individual sports, and play and leisure activities.

Constituents responding to the survey reported the following benefits: (1) heightened individual physical and cognitive performance, (2) increased levels of physical fitness, (3) increased capacity to manage stress, (4) increased knowledge of ways to avoid injury, (5) increased opportunities for creativity and social development, and (6) fewer funds expended for treatment of injuries and chronic diseases.

Constituents responding to the survey reported the following concerns: (1) few elementary and middle school teachers receive preservice or inservice for planning/delivering age-appropriate and sequential physical education and (2) need for broader understanding of the relationship between learning and physical health.

Health Promotion for Staff

The stated primary objective of health promotion for staff is to encourage and motivate staff to pursue good health practices.

The Department of Health has allocated $13,200 for school-based staff wellness projects. The Department of Education allocated $82,000 for the 1994 Blue Ridge Conference and mini-grants which include workplace/staff wellness as one of its objectives.

Programs aimed at health promotion for staff include education about personal behavior and lifestyle risk factors, such as dietary fat reduction, moderating tobacco and alcohol consumption, stress reduction, and lack of exercise; personal health assessments; and strategies for promoting wellness activities in school buildings.

Constituents responding to the survey reported the following benefits: (1) improved productivity and staff morale, (2) enhanced capacity for teachers to become better role models for students, and (3) improved continuity of instruction due to decreased staff absenteeism.

Constituents responding to the survey reported a concern that health promotion resources are not as available in elementary schools as they are in secondary schools.

CHAPTER III
ANALYSIS OF EXISTING STATE SCHOOL HEALTH PROGRAMS

INTRODUCTION

This chapter provides an analysis of existing school health programs, including cost/benefits, statutory characteristics, and parental views as reported by selected parent representatives.

METHODOLOGY

Staff members of the Department of Education and the Department of Health analyzed existing school health program statutes and regulations. In addition, the Virginia Congress of Parents and Teachers supplied a report on PTA positions and policy statements concerning school health and related issues. Furthermore, the Department for Rights of Virginians with Disabilities provided comments from parents on school health programs in the Commonwealth.

FINDINGS

- Data are not available to compile a cost/benefit analysis of each school health program. Such an analysis would require longitudinal data.

- Parental views, as reported by the Virginia Congress of Parents and Teachers, support school health programs. The organization has position and policy statements and resolutions on school health and related heath issues, and such statements relate to various elements within each school health program component.

- Parental views, as reported by the Virginia Department for Rights of Virginians with Disabilities, support family involvement in special education services. Parents should control making medical decisions for their children, parent and community involvement is reflected in Section 3.6 of Virginia's special education regulations, and Parent Resource Centers are parent involvement models that exist in some communities. In addition, the Department noted that localities have a responsibility for the early identification of students with hearing impairments through Child Find and that the document *Regulations Governing Special Education Programs for Children with Disabilities* provides information regarding related services.

- No statutory requirements were identified regarding health promotion for staff.

SUMMARY OF LAWS AND REGULATIONS GOVERNING SCHOOL HEALTH PROGRAMS

The following citations relative to school health programs are contained in the *Code of Virginia*; *Standards and Regulations for Public Schools in Virginia*; and *Regulations Governing Special Education Programs for Children with Disabilities, Virginia Board of Education.*

Health Education

Code of Virginia

§ 22.1-204 Study of Accident Prevention
Requires instruction in accident prevention in Virginia's public schools.

§ 22.1-205 Driver Education Programs
Requires the Board of Education to establish a standardized program for driver education.

§ 22.1-206 Instruction Concerning Drugs and Drug Abuse
Requires public schools to provide instruction concerning hazards of drugs and drug abuse.

§ 22.1-207 Physical and Health Education
Requires that physical and health education be emphasized throughout the public school curriculum.

§ 22.1-207.1 Family Life Education
Requires the Board of Education to develop Standards of Learning for Family Life Education.

Standards for Accrediting Public Schools in Virginia

§ 4.2 Instructional Program in Elementary Schools
Requires each elementary school to provide instruction in health.

§ 4.3 Instructional Program in Middle Schools
Requires each middle school to provide instruction in health.

§ 4.4 Instructional Program in Secondary Schools
Requires each secondary school to offer two units of health and physical education and specifies that when health and physical education are taught as a combination class, at least 40 percent of the instructional time be devoted to health education.

§ 4.15 Family Life Education
Requires schools to implement the Standards of Learning for the family life education program promulgated by the Board of Education or a family life education program consistent with the guidelines developed by the Board of Education.

§ 7.3 Requirements for Graduation
Requires students to have two units of health and physical education for graduation from high school.

Health Services

Code of Virginia

§ 22.1-253. 13:2 Standards of Quality: Support Services
Requires school boards to provide support services, including health.

§ 22.1-270 Preschool Physical Examinations
Requires students to submit a report of a physical examination as a condition of initial enrollment into public kindergarten or elementary school.

§ 22.1-271.2 Immunization Requirements
Requires students to submit proof of proper immunization as a condition of enrollment in public and private schools.

§ 22.1-273 Sight and Hearing of Pupil to be Tested
Requires periodic vision and hearing screening of public school students.

§ 22.1-274 School Health Services
Requires school boards to provide pupil personnel and support services in compliance with the Standards of Quality; authorizes school boards to employ school nurses and other health providers.

Standards for Accrediting Public Schools in Virginia

§ 4.15 Homebound Instruction
Requires that homebound instruction be made available to students who are confined for periods of time that would prevent normal school attendance.

§ 9.1.6.d School Plant
Specifies that the school principal is responsible for ensuring that staff knowledgeable in safety procedures such as cardiopulmonary resuscitation (CPR), the Heimlich maneuver, and basic first aid are available.

Regulations Governing Special Education Programs for Children with Disabilities

Specifies that school health services are included in those related services which are to be provided to eligible children with disabilities.

Healthful School Environment

Code of Virginia

§ 10.1-1425.9 Recycling Duties of the Department of Education
Requires the Department of Education, with assistance of the Department of Waste Management, to develop guidelines for public schools relative to recycling and reduction of solid waste.

§ 15.1-291.2 Statewide Regulation of Smoking
Prohibits smoking on school buses and in public school buildings except in specified areas.

§ 22.1-136 Duty of Division Superintendent
Authorizes division superintendents to close a school building when it appears unfit for occupancy.

§ 22.1-135 Health and Decency of School Buildings
Specifies that no public school be conducted in any building which is not in such condition and provided with such conveniences as are required by a due regard for decency and health.

§ 22.1-137 Fire Drills
Specifies requirements for fire drills in school buildings.

§ 22.1-138 Minimum Standards for Public School Buildings
Requires the Board of Education to prescribe minimum standards for the erection of or addition to school buildings where not specifically addressed in Uniform Statewide Building Codes; also, requires radon testing in schools.

§ 22.1-271.3 Guidelines for School Attendance for Children Infected with Human Immunodeficiency Virus
Requires the Board of Education, in cooperation with the Board of Health, to develop and revise model guidelines for school attendance for children infected with human immunodeficiency virus, as necessary.

§ 22.1-272 Contagious and Infectious Diseases
Requires that persons suffering with contagious or infectious disease be excluded from public schools while in that condition.

§ 22.1-274.1 Criteria to Identify Toxic Art Materials; Labeling; Use in Certain Grades Prohibited
Requires the Department of Education, in cooperation with the Department of Health, to develop criteria to identify toxic art materials, to evaluate art materials against these criteria, to label all materials deemed to be toxic, and to prohibit use of such materials in kindergarten through grade five.

§ 22.1-275 Protective Eye Devices
Requires all students and teachers to wear industrial quality eye protective devices while participating in specified courses or laboratories.

§ 22.1-300 Tuberculosis Certificate
Requires all school employees to submit a certificate stating that such persons appear free of communicable tuberculosis.

§ 35.1-18 License Required: School Cafeteria or Foodservice Facility
Requires that no person shall own, establish, conduct, maintain, manage, or operate any school cafeteria or food service facility in Virginia unless the facility is licensed as provided in the *Rules and Regulations of the Board of Health, Commonwealth of Virginia, Governing Restaurants* (VR 355-35-01).

Standards for Accrediting Public Schools in Virginia

§ 9.1 School Plant
Provides standards to ensure the health and safety of students and staff.

Parent/Community Involvement

Code of Virginia

§ 22.1-207.2 Right of Parents to Review Certain Materials
Specifies that school boards are to encourage parental guidance and involvement in the instruction of students relative to family life education.

§ 22.1-275.1 School Health Advisory Boards
Requires school boards to establish a school health advisory board, representing the community, to assist with the development of health policy and the evaluation of school health programs.

Counseling

Code of Virginia

§ 22.1-253. 13.2 — Standards of Quality: Support Services
Requires school boards to provide support services, including pupil personnel services.

Standards for Accrediting Public Schools in Virginia

§ 6.3 — Guidance and Counseling
Specifies that guidance and counseling be provided to all students.

§ 8.1 — Staffing
Requires staff (including guidance counselors) to have proper certification and endorsement; also, specifies pupil-staff ratios for guidance counselors.

Psychological and Social Services

Code of Virginia

§ 2.1-745-759 — Comprehensive Services Act for At-Risk Youth and Families
Creates a collaborative system of services and funding that is child-centered, family-focused, and community-based when addressing the strengths and needs of troubled and at-risk youths and their families.

§ 22.1-253. 13:2 — Standards of Quality: Support Services
Requires school boards to provide support services, including pupil personnel services.

Standards for Accrediting Public Schools in Virginia

§ 8.1 — Staffing
Requires that school psychologists and visiting teachers/school social workers be available to all students.

Nutrition Services

Code of Virginia

§ 22.1-207.3 — School Breakfast Programs
Requires school boards, upon the appropriation and authorization of federal funds for the reimbursement of school breakfast programs, to establish a school breakfast

program in any public school in which 25 percent or more of enrolled school-age children were approved as eligible to receive free or reduced-price meals in the federally funded lunch program during the previous school year.

Physical Education

Code of Virginia

§ 22.1-207 Physical and Health Education
Requires that physical and health education be emphasized throughout the public school curriculum.

Standards for Accrediting Public Schools in Virginia

§ 4.2 Instructional Program in Elementary Schools
Requires each elementary school to provide instruction in physical education.

§ 4.3 Instructional Program in Middle Schools
Requires each middle school to provide instruction in physical education.

§ 4.4 Instructional Program in Secondary Schools
Requires each secondary school to offer at least two units of health and physical education.

§ 7.3 Requirements for Graduation
Requires students to have two units of health and physical education for graduation from high school.

Health Promotion for Staff

No statutes or regulations specific to health promotion for staff were identified.

CHAPTER IV
EVALUATION OF EXISTING SCHOOL HEALTH PROGRAMS

INTRODUCTION

This chapter provides results of a survey conducted to evaluate existing school health programs.

METHODOLOGY

A survey was developed to assess the nine components of existing school health programs. Each component was divided into four to ten elements. The survey was sent to 450 schools equally divided among elementary, middle, and secondary schools in three regions of the state. Respondents were not identified. The returning responses were then weighted by school type and region so that the sample represented all public schools.

School principals, health specialists, and teachers completed the survey; 247 schools (55 percent of those who received the survey) were included in the analysis. Fourteen surveys were returned after the analysis was in progress, and one survey was returned with no school type identifier. Those 15 surveys (totaling 3 percent) were excluded from the analysis. Returns were fairly and evenly distributed across school type and region.

Respondents were asked to identify each school's student body. The distribution of responses was as follows: mainly urban (18 percent), mainly suburban (38 percent), and mainly rural (44 percent).

Respondents were asked to rate the success of each element as "high," "moderate," or "some," or to note that the element is not addressed in their school.

DESCRIPTION OF TABLES

In subsequent sections of this chapter, tables are provided which show findings of the study relevant to each school health program component. For each school health program component, there are two tables. The first table provides the percentage of schools reporting that a specific element, within a school health program component, is met with "high success," "moderate success," or "some success." Notation is made as to the relative strength of each element. The first table also reports whether the overall school health program component is relatively high or low in success as compared to the other school health program components. The second table indicates the percentage of schools reporting that a specific element, within a school health program component, is not addressed or provided. An exception to this format is found in the ninth school health program component, health promotion for staff. Because of a relatively wide

discrepancy among the type of school (elementary, middle, secondary) and the type of area (urban, suburban, rural), additional data are reported.

FINDINGS

- The nine school health program components were placed in high, middle, or low groups based on relative success. The high success group consisted of health services, healthful school environment, psychological and social services, nutrition services, health promotion for staff, and physical education. The middle success group consisted of school counseling. The low success group consisted of health education and parent/community involvement.

- The analysis showed that, overall, there were virtually no success differences in school health program components by school type and region with the exception of health promotion for staff.

- Among all school health program components contained in the high success group, respondents reported that quality staff was a major factor in the success of each of these components.

- Respondents reported that, in addition to quality staff, success factors for many school health program components were good assessment programs and procedures.

- Staffing concerns were noted for school health program components contained in the middle and low success groups (school counseling, health education, and parent/community involvement).

- Staff training was identified as a factor in the problems of only one school health program component: nutrition services.

Overall program ratings for health education and health services components were related to a sizable number of factors, both success and problem factors, while the ratings for the other school health program components were linked to comparably fewer factors.

TABLES

Component 1: Health Education

Health education typically focuses on instruction in such topics as nutrition, prevention/safety, and drug abuse.

Table 1. SUCCESS RATINGS FOR VARIOUS ELEMENTS OF HEALTH EDUCATION

No.	Health Education The school's health education program...	Perceived Success in accomplishing selected goals in 1994-95			
		(percent of schools)			Relative Strength
		High Success	Moderate Success	Some Success	
1.01	increases physical fitness knowledge and healthful behavior	39%	**46%**	15%	
1.02	increases consumer health knowledge and healthful practices	20%	**59%**	21%	
1.03	increases community and environmental health knowledge and healthful practices	20%	**51%**	29%	weak element
1.04	improves conflict resolution skills	38%	**44%**	18%	
1.05	improves stress management skills	20%	**53%**	27%	weak element
1.06	increases injury prevention knowledge and safe behavior skills	40%	**48%**	12%	
1.07	increases nutrition knowledge and safe and healthful eating behaviors	34%	**50%**	16%	
1.08	increases disease prevention and control knowledge and healthful behavior	32%	**47%**	21%	
1.09	increases knowledge of substance use/abuse and healthful behavior	**58%**	37%	5%	strong element
1.10	increases human growth and development knowledge	36%	**52%**	12%	
OVERALL PROGRAM		34%	**49%**	17%	LOW GROUP*

* Nine programs were placed high, middle, or low groups based on relative success.

Table 2. SCHOOLS REPORTING "NOT ADDRESSED" FOR VARIOUS ELEMENTS OF HEALTH EDUCATION

No.	Health Education.... The school's health education program...	Overall percent of schools reporting "Not Addressed"
1.01	increases physical fitness knowledge and healthful behavior	1%
1.02	increases consumer health knowledge and healthful practices	7%
1.03	increases community and environmental health knowledge and healthful practices	7%
1.04	improves conflict resolution skills	9%
1.05	improves stress management skills	14%
1.06	increases injury prevention knowledge and safe behavior skills	1%
1.07	increases nutrition knowledge and healthful eating behaviors	3%
1.08	increases disease prevention and control knowledge and healthful behavior	2%
1.09	increases knowledge of substance use/abuse and healthful behavior	1%
1.10	increases human growth and developmental knowledge	4%

Overall program ratings indicated that the health education component was perceived to be moderately successful in the schools. Element 1.09, increasing knowledge of substance use/abuse and healthful behavior, was the most successful element.

Component 2: Health Services

Health services involves facilitating students' access to primary health care, providing for the early identification of health problems that interfere with learning, and managing health problems.

Table 3. SUCCESS RATINGS FOR VARIOUS ELEMENTS OF HEALTH SERVICES

No.	Health Services The school's health services program...	Perceived Success in accomplishing selected goals in 1994-95			
		(percent of schools)			Relative Strength
		High Success	Moderate Success	Some Success	
2.01	provides early detection of health problems that can interfere with learning	**47%**	39%	14%	
2.02	provides information to families to facilitate access to primary health care services	33%	**40%**	27%	weak element
2.03	provides expert handling of emergency/crisis medical situations	**61%**	27%	12%	
2.04	provides record keeping needed to facilitate timely immunization of students	**77%**	18%	5%	strong element
2.05	provides screening for identifying student health deficits (e.g., vision, hearing, motor, and speech deficits) to ensure timely linkage to appropriate remediation services	**79%**	17%	4%	strong element
2.06	provides monitoring of communicable diseases to prevent their spread	**56%**	30%	14%	
2.07	provides case management services to address changing health and education needs of students with chronic medical conditions and/or disabilities	**50%**	35%	15%	
OVERALL PROGRAM		**58%**	29%	13%	HIGH GROUP*

* Nine programs placed in high, middle, and low groups based on relative success

Table 4. SCHOOLS REPORTING "NOT PROVIDED" FOR VARIOUS ELEMENTS OF HEALTH SERVICES

No.	Health Services The school's health services program...	Overall percent of Schools Reporting "Not Provided"
2.01	provides for early detection of health problems that interface with learning	3%
2.02	provides information to families to facilitate access to primary health care services	8%
2.03	provides expert handling of emergency/crisis medical situations.	4%
2.04	provides record keeping needed to facilitate timely immunization of students.	3%
2.05	provides screenings for identifying student health deficits (e.g., vision, hearing, motor, and speech deficits) to ensure timely linkage to appropriate remediation services	1%
2.06	provides monitoring of communicable diseases to prevent their spread	6%
2.07	provides case management services to address changing health and education needs of students with chronic medical conditions and/or disabilities	12%

Overall program ratings indicated that respondents perceived the health services component to be highly successful. Furthermore, many elements of health services received high success ratings. Specifically, expert handling of emergency/crisis medical situations, record keeping to facilitate timely immunization of students, and screening for identifying student health deficits attained the highest possible ratings in the survey.

Component 3: Healthful School Environment

A healthful school environment involves maintenance and improvement efforts performed to ensure that schools are safe and free of hazardous substances and provide the physical conditions (e.g., quiet, temperature, lighting) necessary for learning.

Table 5. SUCCESS RATINGS FOR VARIOUS ELEMENTS OF HEALTHFUL SCHOOL ENVIRONMENT

No.	School Environment Improvement Program School maintenance and improvement efforts ensure...	Perceived Success in accomplishing selected goals in 1994-95			
		(percent of schools)			Relative Strength
		High Success	Moderate Success	Some Success	
3.01	safe physical plant (e.g., toxic substance management, building requirements) **				
3.02	safe equipment (e.g., classroom and playground equipment) **				
3.03	safety of school area (e.g., crime prevention efforts, safety practices)	**67%**	29%	4%	strong element
3.04	appropriate physical learning conditions (e.g., temperature, lighting, auditory conditions)	**46%**	43%	11%	weak element
3.05	environment for meeting privacy needs in restrooms and locker rooms	**53%**	31%	16%	
OVERALL PROGRAM		**55%**	35%	10%	HIGH GROUP*

* Nine programs were placed in high, middle, or low groups based on relative success.

** The first two elements, 3.01 and 3.02, were deleted because expert knowledge may be required to make these determinations.

Table 6. SCHOOLS REPORTING "NOT ADDRESSED" FOR VARIOUS ELEMENTS OF HEALTHFUL SCHOOL ENVIRONMENT

No.	School Environment Improvement Program School maintenance and improvement efforts ensure...	Overall percent of schools reporting "Not Addressed"
3.01	safe physical plant (e.g., toxic substance management, building meets code requirements) **	
3.02	safe equipment (e.g., classroom and playground equipment) **	
3.03	safety of school area (e.g., crime prevention efforts, safety practices)	0%
3.04	appropriate physical learning conditions (e.g., temperature, lighting, auditory conditions)	2%
3.05	environment for meeting privacy needs in restrooms and locker rooms	2%

** The first two items, 3.01 and 3.02, were deleted because expert knowledge may be required to make these determinations.

Overall program ratings indicated that respondents perceived the healthful school environment component to be highly successful. The highest rated element was safety of school area (e.g., crime prevention efforts and safety practices).

Component 4: Parent And Community Involvement

The fourth component, a system of parent and community involvement, involves engaging a wide variety of resources and support to promote the health and well-being of students. A major goal is a consistent, proactive approach for involving parents/families in all student health programs. Another important feature is support of the health curriculum from community agencies and organizations.

Table 7. SUCCESS RATINGS FOR VARIOUS ELEMENTS OF PARENT/COMMUNITY INVOLVEMENT

No.	Parent/Community Involvement Activities School has...	Perceived Success in accomplishing selected goals in 1994-95			
		(percent of schools)			Relative Strength
		High Success	Moderate Success	Some Success	
4.01	consistent, proactive approaches for involving parents/families	31%	**50%**	19%	
4.02	effective ways of communicating with parents about student and school health issues	**49%**	40%	11%	strong element
4.03	cooperative ventures between the community and school to ensure health problems do not interfere with learning	37%	**46%**	17%	
4.04	student participation in community projects/programs designed to promote health	24%	**45%**	31%	weak element
4.05	health curriculum support from community agencies and/organizations	36%	**39%**	25%	weak element
OVERALL PROGRAM		35%	**44%**	21%	LOW GROUP*

* Nine programs placed in high, middle, and low groups base on relative success.

Table 8. SCHOOLS REPORTING "NOT ADDRESSED" FOR VARIOUS ELEMENTS OF PARENT/COMMUNITY INVOLVEMENT

No.	Parent/Community Involvement Activities School has...	Overall percent of school reporting "Not Addressed"
4.01	consistent proactive approaches for involving parents/families in all student health promotion programs	10%
4.02	effective ways of communicating with parents about student and school health issues	2%
4.03	cooperative ventures between the community and school to ensure health problems do not interfere with learning	10%
4.04	student participation in community projects/programs designed to promote health	15%
4.05	health curriculum support from community agencies and/or organizations	11%

Overall program ratings indicated that respondents perceived parent/community involvement in school health programs to be moderately successful. Of the five elements rated, only one was viewed by a sizable percentage of respondents (49 percent) as deserving a high success rating: effective ways of communicating with parents about student and school health issues.

Component 5: School Counseling

School counseling involves facilitating academic and career planning and helping resolve developmental problems that interfere with academic achievement.

Table 9. SUCCESS RATINGS FOR VARIOUS ELEMENTS OF SCHOOL COUNSELING

No.	School Counseling Service Goals School's counseling program...	Perceived Success in accomplishing selected goals in 1994-95			
		(percent of schools)			Relative Strength
		High Success	Moderate Success	Some Success	
5.01	helps students identify their educational goals	**48%**	42%	10%	
5.02	helps students identify their career goals **				
5.03	helps students identify their social goals	**47%**	42%	11%	
5.04	prepares students to function more effectively in the educational communities of their choice	**44%**	39%	17%	weak element
5.05	provides services to help students resolve developmental problems	**55%**	39%	6%	strong element
OVERALL PROGRAM		**48%**	41%	11%	MIDDLE GROUP*

* Nine programs placed in high, middle, and low groups based on relative success.

** The second element, 5.02, was deleted because the concept of "career goals" is more specific to high school students although career exploration is an important element throughout the counseling program.

Table 10. SCHOOLS REPORTING "NOT ADDRESSED" FOR VARIOUS ELEMENTS OF SCHOOL COUNSELING

No.	School Counseling Service Goals School's counseling program...	Overall percent of schools reporting "Not Addressed"
5.01	helps students identify their educational goals	6%
5.02	helps students identify their career goals **	
5.03	helps students identify their social goals	2%
5.04	prepares students to function more effectively in the educational communities of their choice	10%
5.05	provides services to help students resolve developmental problems	3%

** The second element, 5.02, was deleted because "career goals" applies only to high school students.

Overall program ratings indicated that opinions varied on the success of the school counseling component. While a moderate success overall program rating was endorsed by 41 percent of the respondents and a high success overall program rating was given by a similar percentage of responses (48 percent), a low success overall program rating was endorsed by 11 percent of respondents. Furthermore, the high success and moderate success ratings for the individual elements of school counseling were similar. The element of providing services to help students resolve developmental problems appears to be strong.

Component 6: Psychological And Social Services

Psychological and social services complement the efforts of instructional and administrative staff to meet students' needs, particularly their learning needs.

Table 11. SUCCESS RATINGS FOR VARIOUS ELEMENTS OF PSYCHOLOGICAL AND SOCIAL SERVICES

No.	Psychological and Social Services Linkages School staff...	Perceived Success in accomplishing selected goals in 1994-95			
		(percent of schools)			Relative Strength
		High Success	Moderate Success	Some Success	
6.01	ensure that students showing early signs of needing social/psychological services are diagnosed	**57%**	35%	8%	
6.02	ensure that special needs students (disabled) have access to appropriate psychological and social services	**71%**	24%	5%	strong element
6.03	ensure that students in crisis are linked with appropriate psychological and social issues	**62%**	34%	4%	
6.04	facilitate linkages with case management services for students/families with complex psychological and social health needs	**49%**	42%	9%	weak element
OVERALL PROGRAM		**60%**	33%	7%	HIGH GROUP*

* Nine programs placed in high, middle, low groups based on relative success.

Table 12. SCHOOLS REPORTING "NOT ADDRESSED" FOR VARIOUS ELEMENTS OF PSYCHOLOGICAL AND SOCIAL SERVICES

No.	Psychological and Social Services Linkages School staff...	Percent of school reporting "Not Addressed "
6.01	ensure that students showing early signs of needing social/psychological services are diagnosed	1%
6.02	ensure that special needs students (disabled) have access to appropriate psychological and social services	1%
6.03	ensure that students in crisis are linked with appropriate psychological and social services	1%
6.04	facilitate linkages with case management services for students/families with complex psychological and social health needs	

Overall program ratings indicated that respondents perceived linkages to psychological and social services to be highly successful. Furthermore, the ratings for all service linkages were rated highly successful with the highest rating given to the following element: ensure that special needs students (disabled) have access to appropriate psychological and social services.

Component 7: Nutrition Services

Nutrition services involves providing access to a variety of nutritious and appealing meals, promoting healthful food choices, and providing support for nutrition instruction.

Table 13. SUCCESS RATINGS FOR VARIOUS ELEMENTS OF NUTRITION SERVICES

No.	Nutrition Services School has...	Perceived Success in accomplishing selected goals in 1994-95			
		(percent of schools)			Relative Strength
		High Success	Moderate Success	Some Success	
7.01	meal time long enough to accommodate healthy eating habits for all children	**68%**	28%	4%	strong element
7.02	meal time long enough to accommodate children with special feeding problems **				
7.03	balanced selections of foods that enable healthy eating practices at mealtime	**59%**	26%	15%	
7.04	a nutrition program that provides a variety of healthy food choices to meet individual needs and preferences	**56%**	30%	14%	
7.05	nutritional drink and snack alternatives available in school's vending machines **				
7.06	staff trained to obtain/provide modified meals and nutrition support for children with special needs **				
OVERALL PROGRAM		**61%**	28%	11%	HIGH GROUP*

* Nine programs placed in high, middle and low groups based on relative services.

** Results are not provided for elements 7.02, 7.05, and 7.06 due to many possible interpretations of each element which could be made

Table 14. SCHOOLS REPORTING "NOT ADDRESSED" FOR VARIOUS COMPONENTS OF NUTRITION SERVICES

No.	Nutrition Services School has...	Overall Percent of school reporting "Not Addressed"
7.01	meal time long enough to accommodate healthy eating habits for all children	5%
7.02	meal time long enough to accommodate children with special feeding problems **	
7.03	balanced selections of foods that enable healthy eating practices at mealtime.	1%
7.04	a nutrition program that provides variety of healthy food choices to meet individual needs and preference	6%
7.05	nutritional drink and snack alternatives available in school's vending machines **	
7.06	staff trained to obtain/provide modified meals and nutrition support for children with special needs **	

** Results are not reported for elements 7.02, 7.03, and 7.06 due to more than one possible interpretation of "Not Addressed."

Surveys from a sizable percentage (61 percent) of the responding schools gave nutrition services a high success overall program rating. Furthermore, all the individual elements of nutrition services received ratings in the high success category.

Component 8: Physical Education Program

Physical education involves providing instruction to help students develop motor skills and physical fitness and maintain these skills into adulthood.

Table 15. SUCCESS RATINGS FOR VARIOUS ELEMENTS OF PHYSICAL EDUCATION

No.	Physical Education Program The school's physical education program...	Perceived Success in accomplishing selected goals in 1994-95			
		(percent of schools)			Relative Strength
		High Success	Moderate Success	Some Success	
8.01	helps students develop life skills to promote optimal health	**51%**	41%	8%	weak element
8.02	promotes the physical fitness of all students	**62%**	33%	5%	strong element
8.03	promotes in-class benefits for all students	**58%**	37%	5%	
8.04	accommodates the special needs of all students	**59%**	32%	9%	
OVERALL PROGRAM		**57%**	36%	7%	HIGH GROUP*

* Nine programs placed in high, middle, and low groups based on relative success.

Table 16. SCHOOLS REPORTING "NOT PROVIDED" OF VARIOUS ELEMENTS OF PHYSICAL EDUCATION

No.	Physical Education Program The school's physical education program...	Overall percent of schools reporting "Not Provided"
8.01	helps students develop life skills to promote optional health	1%
8.02	promotes the physical fitness of all students	0%
8.03	promotes in-class benefits for all students	3%
8.04	accommodates the special needs of all students	2%

A sizable percentage of respondents (57 percent) gave the physical education component a high success overall program rating, with all elements rated highly successful.

Component 9: Health Promotion For Staff

Health promotion for staff involves school practices that help faculty and administration adopt healthy lifestyles.

Table 17. SUCCESS RATINGS FOR VARIOUS ELEMENTS OF HEALTH PROMOTION FOR STAFF

No.	Health Promotion for Staff School improves...	Perceived Success in accomplishing selected goals in 1994-95			
		(percent of schools)			Relative Strength
		High Success	Moderate Success	Some Success	
9.01	faculty and staff health by providing adequate smoke-free space	**95%**	4%	1%	strong element
9.02	faculty and staff by providing access to lockers and exercise	**35%**	32%	33%	weak element
9.03	faculty and staff health by providing them access to food choices	**45%**	38%	17%	
9.04	faculty and staff health by providing health promotion (wellness) programs	**48%**	25%	27%	
9.05	faculty and staff health by having a staff wellness program that spans the entire school year	**43%**	32%	25%	
9.06	faculty and staff health by providing an employee assistance program (EAP) that enables early access to treatment services (e.g., financial counseling, stress reduction, and psychological services)	**54%**	23%	23%	
OVERALL PROGRAM		**54%**	26%	20%	HIGH GROUP*

* Nine programs were placed in high, middle, and low groups based on relative success.

Table 18. SCHOOLS REPORTING "NOT PROVIDED" FOR VARIOUS ELEMENTS OF HEALTH PROMOTION FOR STAFF

No.	Health Promotion for School Staff improves... School improves...	Overall percent of schools reporting "Not Provided"
9.01	faculty and staff health by providing adequate smoke-free space	4%
9.02	faculty and staff health by providing access to lockers and exercise facilities	57%
9.03	faculty and staff health by providing them access to food choices	13%
9.04	faculty and staff health by providing health promotion (wellness) programs	22%
9.05	faculty and staff health by having a staff wellness program that spans the entire school year	41%
9.06	faculty and staff health by providing an employee assistance program (EAP) that enables early access to treatment services (e.g., financial counseling, stress reduction, and psychological services)	41%

With the exception of the smoke-free space, a sizable percentage of schools reported not providing any of the other health promotion activities for staff. For each of the elements having a sizable percentage of schools reporting "Not Provided," the estimated number of schools not providing an element was calculated. There was a sizable range in the estimated number of schools not providing an element, as indicated on the following page in Table 19.

Table 19. ESTIMATED NUMBER OF SCHOOLS WITH "NOT PROVIDED" FOR VARIOUS COMPONENTS OF HEALTH PROMOTION FOR STAFF

No.	Health Promotion for Staff School improves...	Estimated number of schools reporting "Not Provided"
9.02	faculty and staff health by providing access to lockers and exercise facilities	982
9.03	faculty and staff health by providing them access to food choices	227
9.04	faculty and staff health by providing health promotion (wellness) programs	371
9.05	faculty and staff health by having a staff wellness program that spans the entire school year	669
9.06	faculty and staff health by providing an employee assistance program (EAP) that enables early access to treatment services (e.g., financial counseling, stress reduction, and psychological services)	708

Table 20 NOTABLE DIFFERENCES IN VARIOUS ELEMENTS OF HEALTH PROMOTION FOR STAFF BY SCHOOL AND AREA TYPE

No.	Health Promotion for Staff School improves...	Percent of Schools reporting "Not Provided"					
		Notable differences by school type *				Notable differences by area type*	
		Elem	Middle	High	Urban	Suburban	Rural
9.02	faculty and staff health by providing access to lockers and exercise facilities	69%	42%*	21%			
9.03	faculty and staff health by providing them access to food choices				6%	7%	22%*
9.04	faculty and staff health by providing health promotion (wellness) programs				25%	11%	29%*
9.05	faculty and staff health by having a staff wellness program that spans the entire school year				41%	29%	47%*
9.06	faculty and staff health by providing an assistance program (EAP) that enables early access to treatment services (e.g., financial counseling, stress reduction, and psychological services)				27%	20%	66%*

* Results are listed only when the difference between the two breakout groups (e.g., elementary versus secondary) is at least fifteen percentage points.

Overall program rating for health promotion for staff was in the high success range. Similarly, ratings of all elements were in the high success range. The availability of particular programs and options was viewed as a success factor in health promotion for staff. Wellness programs were highlighted in survey responses along with prevention programs (e.g., blood pressure screening, and exercise/faculty access). Leadership and planning were also mentioned as success factors. Policies prohibiting smoking were identified overwhelmingly as the success factor for adequacy of smoke-free spaces.

CHAPTER V
PUBLIC HEARINGS: FORMULATING THE NEEDS OF STAKEHOLDERS

INTRODUCTION

This chapter provides an overview of public hearings held to formulate the needs of the following stakeholders concerning school health programs: students, parents, parents of students, educators who work with students, and adults and recent graduates.

METHODOLOGY

Schedule and Location

Staff members of the Department of Health and the Department of Education convened five public hearings. Those public hearings were held June 12, 1995, at Atlee High School (Hanover); June 19, 1995, at Fauquier High School (Warrenton); June 21, 1995, at Northampton High School (Eastville); July 12, 1995, at Salem High School (Salem); and July 18, 1995, at Thomas Eaton Middle School (Hampton).

Notification

Notice of the public hearings was sent to individuals, groups, and organizations as recommended by the Commission and staff and published in the *Virginia Register of Regulations*. In addition, a press release was sent to all daily newspapers and most weekly newspapers, all television stations, and major radio stations in the areas in which the hearings were held. The notice also was sent to the Associated Press, Virginia News Network, and all members of Superintendent's Professional Organization Advisory Committee and Superintendent's Parent/Community Advisory Committee. Specific strategies were not developed to notify all parents of school-aged children about the public hearings.

Testimony

During the public hearings, individual stakeholders were granted three minutes and organizations/associations were granted five minutes to present their testimony. A total of 121 speakers testified. Of those giving testimony, 27 percent were individuals and 73 percent represented organizations/associations.

Stakeholders were asked to respond to the following questions:

1. What is the current status of school health programs?
2. What are the positive aspects of school health programs that should be continued?
3. What are the unmet needs relative to school health programs?
4. Other comments related to school health programs.

During each public hearing, statements were recorded by the use of a lap top computer. In many cases, the testimony was recorded verbatim. However, it was not possible to capture every word spoken by speakers; hence they were asked to leave a written copy of their testimony; some did not do so. The computer generated printout was compared with the written testimony to determine its accuracy. When omissions or discrepancies were identified, the information from the written testimony was determined to be the most accurate account and was included in the report.

Limitations of Study

The Commission learned that a combination of factors were critical to conducting successful public hearings. First, in order to obtain significant input from all stakeholders—including parents—it is necessary to go beyond the regular notification modes of public notice, such as *Virginia Register of Regulations* and announcements in newspapers and on television and radio stations. Second, notification of public hearings should be done well in advance of the scheduled meetings to ensure that the public is adequately notified.

The Commission is also mindful that the series of public hearings did not capture the views and concerns about school health programs from all possible stakeholders. In addition, the Commission is aware that the information gained from stakeholders who testified at the public hearings reflects a self-selected group of individuals and organizations/associations. This report only reflects the views and comments of the 121 stakeholders—33 individuals and 88 representatives of various organizations and associations. The comments presented in this report are raw data; they are not prescriptive. The Commission developed recommendations for its final report using all information obtained through all phases of information gathering.

Summary of Testimony

A brief summary of the testimony relative to each school health program component is presented on the following pages. The summary reflects an attempt to capture the topics addressed by stakeholders.

SUMMARY OF PUBLIC HEARINGS

Program Component: Health Education

Public testimony was generally supportive of health education programs, although some commentators said improvements are needed in the program. Health education was addressed at each of the five hearings. Aside from comments indicating support, several specific topics emerged.

Family life education (FLE) generated remarks at four of the five hearings. FLE reflected a range of opinions from support for the program to concern about its value and the need for local control. A related issue, that of HIV/AIDS education, was addressed at three of the hearings.

At four of the five hearings, testimony was given regarding the need for quality staff training for health education personnel.

Program Component: Health Services

The most widely addressed topic within the health services component was that of school nurses. At all five of the hearings, testimony supporting school nursing services was given. However, some stakeholders stated concern that such services drain fiscal resources for instruction and that schools cannot provide for all the needs of children.

Health services for children with special medical needs were also addressed at each hearing, particularly, the care of children who may require immediate medical treatment. At each hearing, stakeholders stressed the importance of school policies that allow for the appropriate management of children with diabetes. Also, at two of the hearings the value of dental services was noted.

While health services were generally supported by the testimony, the Commission was reminded of the funding needs which accompany such services.

Some stakeholders requested that the Commission consider recommendations from previous school health legislative studies.

Program Component: Healthful School Environment

No single topic related to a healthful school environment was addressed at all hearings. The most agreed-upon issues, which emerged at three of the hearings, was the need for continuing emphasis regarding the hazards of tobacco use. Support for a tobacco-free school environment twenty-four hours a day was voiced at two of the hearings.

Program Component: Parent/Community Involvement In School Health Programs

No single issue was common to all hearings. However, at all five hearings there was general agreement as to the importance of parental involvement in school health programs and the need for schools to encourage and support such involvement. At one hearing, the usefulness of community partnerships was addressed

Program Component: School Counseling Programs

School counseling was addressed by stakeholders at four of the five hearings. There was overall support for the program. At three of the hearings, examples were given of the specific roles that school counselors play in students' education. Comments were also made reflecting concern that guidance programs may divert resources from basic instruction.

At two of the hearings, concerns were expressed about parental involvement. Some stakeholders, including parents and others, expressed concern and doubt about the value and appropriateness of psychological counseling in schools. At one hearing, it was noted that issues students discuss with counselors should be available for parents to review. At another hearing, the need for parental permission to enroll students in counseling programs of mental health and substance abuse problems was stated.

Program Component: Psychological And Social Services

Comments were made by stakeholders about psychological and social services at each hearing. Generally, comments were supportive; at two hearings, specific roles played by school psychologists, visiting teachers, and school social workers were cited. The connections that school psychologists, visiting teachers, and school social workers make with parents were also noted.

Program Component: Nutrition Services

School nutrition was addressed at each of the hearings. Generally, comments indicated support for the program and acknowledged its importance. Beyond that, no other topics were common to the five hearings.

Program Component: Physical Education

Stakeholders commented on physical education at each hearing. Comments were generally positive about the value of physical education to the total school program. At two hearings, concerns were expressed about class size reducing the effectiveness of the program as was the issue of properly trained instructors, especially at the elementary level.

Program Component: Health Promotion For Staff

Health promotion for staff was addressed at only two of the hearings. Support for employee wellness programs was indicated at both.

CHAPTER VI
FINDINGS AND RECOMMENDATIONS

FINDINGS

The findings of the Blue Ribbon Commission on School Health are based upon the sources of information described in Chapter I. The following major findings were identified by the Commission.

- The primary objective of school health programs is to support instruction and to help students become successful learners and achieve high academic standards.

- Limited data are available on the total cost of each component of a school health program.

- Although school health program content and success vary across the Commonwealth, all school divisions provide some portion of a school health program. Furthermore, the school survey revealed little difference in the success of school health programs among elementary, middle, and high schools or among geographic regions of the state.

- Comments heard by the Commission during the public hearings indicate that local school health advisory boards (SHABs) can serve as an excellent vehicle for involving parents and community members in the improvement of school health programs. However, reports revealed inconsistent use of SHABs throughout the Commonwealth and the need for strengthening the board's role in some localities. Refer to Appendix B for SHAB reports.

- Issues surrounding health services were noted in the public hearings and the school survey. At the public hearings, general support for school health services was expressed as well as the need for additional resources. One element that was particularly notable involved the specialized care of children with serious or chronic health problems, including the administration of medication. While there were differences of opinion as to how the problems might be solved, there was agreement that qualifications of personnel responsible for providing specialized health care procedures, liability of schools and individuals, and local policies that may be barriers to self-management of children with chronic health problems are all issues of concern. Furthermore, the school survey revealed that one of the relatively weak elements of the school health program is that of "management of the health and education needs of students with chronic medical conditions and/or disabilities." Only 50 percent of the respondents considered this element to be highly successful. Moreover, 12 percent of the respondents indicated that this element is not addressed in their school.

- Concern was noted during public hearings about the need to improve physical education programs in some school divisions, especially at the elementary level.

- Although funding of school health services was identified as a concern at all public hearings, a comprehensive analysis of alternative funding sources was beyond the scope of this study.

- Commission members were urged to review the recommendations of Senate Document No. 5, *Report on the Needs of Medically Fragile Students* (1995) and were advised that many issues and concerns raised by stakeholders can be effectively addressed by implementing the recommendations contained therein.

RECOMMENDATIONS

- School superintendents should recognize the importance of school health advisory boards as a means of parent and community involvement and of assisting with the development of school health policies and the evaluation of school health programs.

- The Department of Education, in collaboration with the Department of Health, should provide periodic training and technical assistance to school health advisory board members and school health administrators to assist them in strengthening the boards' effectiveness in the various localities.

- Recommendations 1-6 and 8 of Senate Document No. 5, *Report on the Needs of Medically Fragile Students* (1995), should be implemented:

  ◊ Recommendation 1: School divisions should develop a "health service plan" for each student who is a medically fragile child as defined by this study. This plan is in addition to an existing IEP (individualized education plan) for students eligible for services under the Individuals with Disabilities Education Act or 504 service plan for students who qualify for services under Section 504 of the Rehabilitation Act of 1973, although it may be developed in conjunction with either of these plans. It is recommended that the planning team consist of the following:

  - parents,
  - child, if appropriate,
  - teacher,
  - school health coordinator,
  - special education administrator, if the child receives special education,
  - Section 504 coordinator, if the child receives services under Section 504 guidance counselor,
  - building principal,
  - transition nurse, if applicable, and
  - other service providers (e.g., occupational or physical therapist).

The length and complexity of this plan should vary depending on the student's needs. The plan should include information addressing the following:

- description of the child's medical condition,
- limitations of the child in the school setting,
- specific transportation needs, if any,
- provision of medication, if applicable,
- procedures to be performed by school personnel,
- where and when the procedures are to be performed,
- who will perform each procedure,
- training,
- schedule for review and monitoring of training,
- emergency procedures, and
- handling of teacher/paraprofessional absences,

◊ Recommendation 2: Local school divisions should develop policies that address the provision of services to students who are medically fragile to include staff selection and training, roles and responsibilities.

◊ Recommendation 3: Local school divisions should develop policies to address the emergency medical needs of students, including those who are medically. Topics include medication administration, cardiopulmonary resuscitation certification, first aid certification, and implementation of the bloodborne pathogen standards (universal precautions) promulgated by the Occupation Health and Safety Administration. These policies should include provisions for dissemination and training to ensure that teachers are reminded of procedures and new teachers receive necessary training.

◊ Recommendation 4: The local school health advisory board, required by §22.1-275.1 of the *Code of Virginia*, should take an active role in assisting school divisions in developing policies related to children who are medically fragile. These advisory boards are required by law to assist schools with the development of health policy in the school division and the evaluation of the status of school health, health education, the school environment, and health services. Prior to policy development, local school health advisory boards may want to first determine the prevalence range of student health care needs and identify key issues that need to be addressed concerning the delivery of school health services to students.

◊ Recommendation 5: School divisions should provide periodic in-service or opportunities for schools staff to attend programs to increase staff awareness ands understanding of the general health issues faced by schools and the needs of medically fragile students, specifically. Communication and coordination with school board attorneys and local risk management departments is also recommended. Possible topics include:

- ♦ legal issues and responsibilities related to students who are medically fragile or who have chronic health care needs;
- ♦ role of the school division in providing health services to students who are medically fragile or who have chronic health care needs;
- ♦ working with students who have contagious diseases;
- ♦ educational implications for students with special health care needs;
- ♦ working with health service providers, parents and families of children with special health care needs;
- ♦ safety issues related to medically-fragile children; and
- ♦ service delivery models for medically fragile children.

◊ Recommendation 6: For risk management purposes, school divisions should document the health services provided to any medically fragile or other students. Services should be documented as frequently as they are provided.

◊ Recommendation 8: School divisions should review and evaluate their policies and procedures relative to Section 504 of the Rehabilitation Act of 1973. School divisions should conduct these activities with the assistance of the "504 Coordinator," required by 34 Code of Federal Regulations Section 104.7. As part of this review and evaluation, school divisions should pay close attention to those students who receive health services but have not been found eligible for services under the Individuals with Disabilities Education Act or Section 504 of the Rehabilitation Act of 1973.

- Students with special health care needs and chronic illnesses should have their medical care managed at school by a professional nurse in collaboration with the child's parents and primary health care provider.

- The Virginia Board of Nursing's efforts to address delegation of nursing services in the school setting to unlicensed assistive personnel while ensuring that the professional nurse retains authority for nursing assessment, nursing evaluation, and nursing judgment should be supported.

- The Department of Health, in collaboration with the Department of Education, should distribute guidelines to assist qualified personnel in the assessment and ongoing management of students with specialized health care needs in the school setting. Such guidelines should be sent to all public and private schools in the Commonwealth.

- School divisions should require that specialized health care procedures be provided by licensed health care professionals or by personnel who have received training from persons who are qualified to provide such training and certified or licensed to perform the procedure being taught.

- School divisions are encouraged to devote a portion of their professional development resources to helping school health professionals develop skills and strategies in working closely with parents and increasing parental involvement in planning and implementing school health programs.

- School divisions are encouraged to review physical education, grades K-12, and determine ways by which the program could be improved.

- The Department of Medical Assistance Services' studies on Virginia managed care Medicaid programs—MEDALLION II and OPTIONS—should include the impact of these programs on school health services.

- The Department of Medical Assistance Services should study the appropriateness and feasibility of contracting for school health services, including school nursing services, especially in medically underserved areas or health manpower shortage areas.

- School divisions, especially those in medically underserved areas, are encouraged to develop public-private contracts (e.g., HMO—Health Maintenance Organization, CHIP—Comprehensive Health investment Project of Virginia) which include formal reimbursement for school health services (e.g., school nursing services) provided by qualified personnel.

APPENDICES

1994 SESSION

LD2318695

SENATE JOINT RESOLUTION NO. 155
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the Senate Committee on Rules
on February 4, 1994)
(Patron Prior to Substitute—Senator Lucas)

Requesting the Governor to establish a Blue Ribbon Commission on School Health to collaborate in developing, implementing, and evaluating school health programs.

WHEREAS, children are Virginia's most precious resource, representing the hopes for the future of the Commonwealth; and

WHEREAS, it is essential to protect the children, contribute to their well-being, and ensure that each has the opportunity to grow and develop to his or her potential; and

WHEREAS, Virginia and the rest of the nation are facing an unprecedented crisis in health care; and

WHEREAS, nowhere is that crisis more apparent than in the health and well-being of children; and

WHEREAS, the major goal of a comprehensive school health program is to lead students and school staff toward a healthy, productive lifestyle; and

WHEREAS, the School Health Subcommittee of the Maternal and Child Health Council recognizes the need for involving citizens throughout the Commonwealth in comprehensive school health programs; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Governor be requested to establish a Blue Ribbon Commission on School Health to collaborate in developing, implementing, and evaluating statewide comprehensive school health programs. The Commission shall be composed of 15 members as follows: two members of the Senate to be appointed by the Senate Committee on Privileges and Election; two members of the House of Delegates to be appointed by the Speaker; one member each from the Departments of Education, Health, Youth and Family Services, and Medical Assistance Services, all to be appointed by the Governor; and two members representing the business sector, two members representing health care associations, two members representing local education associations and one member representing Parent-Teacher Associations, all to be appointed by the Governor. The Commission shall study and make recommendations on all components of a comprehensive school health program, including health education; health services; healthful school environment; parent/community involvement; counseling, psychological and social services; nutrition services; physical education; and health promotion for staff; and, be it

RESOLVED FURTHER, That the Governor be requested to conduct a summit meeting, involving citizens from across the Commonwealth, on comprehensive school health programs by December 1994, so that the issues before the Commission can be addressed by all interested persons.

The Governor's Office and the Secretaries of Education and Health and Human Resources shall ensure that the Commission is appropriately staffed.

The direct costs of this study shall not exceed $3,000.

The Commission shall complete its work in time to submit its recommendations to the Governor and the 1995 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution shall be subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

* Appendix B

School Health Advisory Board Membership by Category

PARENTS

Category	Number 1994	Number 1995
Parent of School Age Child	640	578
Parent of a Medically Fragile Child	41	41
Parent of a Special Education Child	48	42
PTA Representative	83	84
Total Parents	***812***	***745***

STUDENTS

Category	Number 1994	Number 1995
High School Students	*103*	*92*
Total Students	***103***	***92***

HEALTH PROFESSIONALS

Category	Number 1994	Number 1995
Physician	157	138
Dentist	56	43
Mental Health	46	46
Public Health	147	126
Other Health Professions	*181*	*166*
Total Health Professionals	***587***	***519***

COMMUNITY GROUPS

Category	Number 1994	Number 1995
Civic Group	87	92
Religious Group	55	40
Human Services	110	71
Youth Services	*72*	*58*
Total Community Groups	*324*	*261*

School Health Advisory Board Membership by Category (continued)

EDUCATORS

Category	Number 1994	Number 1995
School Nurse	155	144
Health Teacher	154	132
Other Teacher	145	224
School Administrator	281	257
School Counselor	99	104
Food Services	39	72
Total Educators	***873***	***933***

OTHER

Category	Number 1994	Number 1995
Business	45	42
Government	40	33
Other Professions	70	48
Other	96	122
Total Other	***251***	***245***

Total Members	***2,116***	***2,745***

Meeting Frequency of School Health Advisory Boards

Number of Meetings	Percent of SHABs 1994	Percent of SHABs 1995
None	4.2	6.2
One	10.0	10.8
Two	21.7	28.3
Three	16.7	13.8
Four	17.5	16.2
Five	13.3	11.5
Six	6.7	3.8
Seven	2.5	3.8
Eight	2.5	1.0
Nine	2.5	2.3
Ten	2.5	2.3

* *Copies of full School Health Advisory Board Reports are available at the Virginia Department of Education.*