Vermont School Health Profiles

2020 Report

VERMONT
DEPARTMENT OF HEALTH

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Executive Summary

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

The Profiles includes two separate questionnaires, one for principals and one for the lead health educator (LHE) at each middle and high school. The Principal Questionnaire focuses on policies and practices related to prevention, services provided, and family and community involvement, while the Lead Health Educator Questionnaire focuses on course requirements, content covered, and professional development.

Of the 145 public schools invited to participate, one or both questionnaires were received from 94% of schools (126 principals and 119 lead health educators). Among the lead health educators completing the survey, nearly eight in ten LHEs are certified, licensed, or endorsed by the state to teach health education (77%). About half of LHEs have professional preparation in health education, with or without training in physical education (45%).

School Health Coordination

- Almost all schools (87%) have at least one person who oversees or coordinates school health safety programs and activities. About three-quarters have at least one group, such as a school health council or team, that offers guidance on the development and coordination of policies and health-related activities at the school (73%). About half (46%) have at least one person who serves as a representative on a district-wide school health team that meets at least quarterly each year; 9% of SU's do not have a Whole School, Whole Community, Whole Child (WSCC) team.
- During the past year, nearly nine in ten schools communicated the importance of health and safety policies and activities (87%) and reviewed their district's local wellness policy (86%). More than three-quarters sought funding or resources to support health and safety priorities (77%) and recommended new or revised health and safety policies and activities (77%).

Health Services

- Nearly eight in ten schools have a full-time registered nurse (77%); three in ten have a part-time nurse (30%) available to provide health services to students. About a quarter have a school-based health center (26%).
- The majority of schools provide daily medication administration for students with chronic health conditions such as asthma and diabetes (96%), stock rescue or "as needed" medication for students experiencing a health emergency such as a severe allergic reaction (91%) and provide case management for students with chronic health conditions (89%).
- About half provide assessments for alcohol or other drug use, abuse, or dependency (49%).

- Seven in ten schools provide referrals to outside organizations or health care professionals for students needing alcohol or other drug abuse treatment (71%); about half have cooperative or formal agreements with an outside agency to provide assessments and treatment for alcohol or drug use issues (47%).
- Seven in ten schools (71%) have cooperative or formal agreements with community partners for mental health assessments and treatment.
- More than half of all schools (56%) provide referrals for sexual health services to an organization or health care professional not on school property. About a quarter of schools provide direct sexual health services on school property (27%). These services are primarily provided through the provision of condoms (24%).

Health and Physical Education

- Most schools require students to take at least one required health education course (91%). Two thirds require students to take two or more health education courses (67%).
- Compared to health education, schools are more likely to require physical education courses, with at least 95% requiring students take a physical education course annually through ninth grade.
- Required courses decrease among older students. About half of all schools require physical education in grades 11 (50%) and 12 (46%); a third required health education in grades 11 (32%) and 12 (36%).

Policies and practices related to health and wellness

Tobacco, Alcohol, and Other Drug Use Policies and Practices

- All schools in Vermont have a policy prohibiting tobacco use. Nearly all schools address alcohol and other drug-use prevention in a required health course (95%).
- Nearly eight in ten schools have policies that mandate a "tobacco-free environment" in which tobacco use is prohibited by students, staff, and visitors in school buildings, at school functions, in school vehicles, on school grounds and at off-site school events at all times (77%).
- Policies specifically addressing electronic vapor products significantly increased between 2018 and 2020. In 2018, about three quarters of schools prohibited the use of electronic vapor products (EVP) by students (76%), faculty (77%), or visitors (73%). By 2020 nearly all prohibited EVP use by students (96%), faculty (95%), or visitors (95%).
- Nine out of ten lead health educators specifically taught about electronic vapor products (EVPs such as e-cigarettes, vapes, vape pends, e-hookahs, mods, including JUUL). More than 85% of teachers also taught about the health consequences of tobacco product use, the addictive nature of nicotine, different tobacco products and harmful substances, reasons people use tobacco products, consequences of tobacco product use, and the effects of nicotine on adolescent brains.

- More than 85% of lead heath educators taught students about the harmful effects of alcohol and other drugs, situations that lead to substance use, using interpersonal skills to avoid use, identifying reason why individuals choose to use alcohol and other drugs, and understanding the social influences of alcohol and other drug use.

Physical Activity and Nutrition Policies and Practices

- More than eight in ten schools offer opportunities for students to be physically active during the school day through recess, lunchtime intermural activities or physical activity clubs (85%) or in other classes outside of physical education (88%). About nine in ten schools offer opportunities for students to be physically active after the school day through organized physical activities or access to facilities and equipment (91%) or interscholastic sports (88%). Just over half offer opportunities for students the be active before the school day (53%).
- Most schools have a concussion management plan (88%) and track concussions among students (83%). About half provide professional development or written information about concussions for all teachers (56%); 90% require coaches to complete a concussion education training program at least once every two years.
- Nearly all lead health educators teach physical activity and fitness in a required course (97%). More than nine in ten cover topics such as mental and social benefits of physical activity, health related fitness, short- and long-term benefits of physical activity, and increasing daily physical activity.
- A supportive school nutrition environment includes multiple elements related to how schools provide students access to nutritious meals and snacks. More than nine in ten schools serve locally or regionally grown foods in the cafeteria (91%) and place fruits and vegetables where they are easy to access (92%).
- Seven in ten have a school garden (70%). Nearly three in ten have a joint use agreement for shared access to a community garden (29%).
- Relatively few schools modify the cost of food and beverages making more healthy food and beverages available at a lower cost (14%). About four in ten prohibit less nutritious foods and beverages such as candy and baked goods, from being sold for fundraising purposes (38%) and prohibit staff from giving students food or coupons for food for good behavior or athletic performances (41%).
- Less than half of schools have vending machines, school stores, or snack bars available for students to purchase snack foods or beverages food (42%).

Sexual Health Policies and Practices

- More than nine in ten LHEs (93%) taught about human sexuality in a health education course. At least seven in ten provide students with opportunities to practice skills related to sexual health.

Creating Safe and Inclusive Environments

- Nearly all schools have a designated staff member to whom students can confidentially report student bullying and sexual harassment (98%) and use electronic, paper, or oral communication to publicize and disseminate policies, rules, or regulations on bullying and sexual harassment, including electronic aggression (98%).
- All schools prohibit harassment based on a student's perceived or actual sexual orientation or gender identity. Most have identified "safe spaces" where LBGTQ youth can receive support from administrators, teachers, or other school staff (93%). About half of all schools provide clubs that create safe, welcoming, and accepting environments for all youth such as GSA's (Gay Straight Alliances) (56%).
- Roughly three-quarters of LHEs encourage the use of gender-neutral pronouns such as "they/them" to recognize gender diversity among students (73%), provide positive examples of LGBTQ people and same-sex relationships (77%), and provide students with information about LGBTQ resources (77%) and within the community (67%).

Engaging Families and Communities

- More than eight in ten schools participate in service-learning and mentoring programs (84%). About half partnered with community-based organizations (e.g., Boys & Girls Clubs, YMCA, 4H Clubs) to provide students with before-or after-school programming (46%).
- Nearly two-thirds of schools have joint use agreements for shared use of school or community sport or physical activity facilities (64%). About one-third have joint use agreements for shared use of kitchen facilities and equipment (33%) and for shared use of school or community gardens (29%).
- The percent of school in which families help develop or implement policies and programs related to school health during the previous two years significantly decreased from 48% in 2018 to 29% in 2020. During that same period, the percent of schools who involved parents as school volunteers in the delivery of health education activities and services also significantly decreased from 28% to 18%.
- About half of all LHEs gave students in health education homework assignments or activities to do at home with their parents during the past year (52%). Just over half provided parents and families with information related to bullying and sexual harassment (54%) and tobacco-use prevention (51%).

Methodology and Background

The School Health Profiles (SHP) is a system of surveys designed to help education and health agencies at various levels monitor and assess characteristics of and trends in school health education; physical education and physical activity; school health policies related to human immunodeficiency virus (HIV), tobacco-use prevention, and nutrition; school-based health services; family engagement; community involvement; and school health coordination.* The SHP questionnaires were developed by the Division of Adolescent and School Health, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention in collaboration with representatives of state, local, and territorial departments of health and education.

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

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

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

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

Methodology & Participants

In 2020, all Vermont public schools that serve students in two or more grades 6 through 12 were invited to participate.* During the late fall / early winter, principals were notified about the SHP and were asked to designate the school's lead health education teacher or the person most knowledgeable about health education at their school. Beginning in January 2020, principals and LHEs were invited via email to complete the School Health Profiles. Each person received an individualized email with a link to access the Web-based questionnaire. Participation in the survey was confidential and voluntary; follow-up emails and telephone calls were used to encourage participation.

Due to the emerging pandemic and school closures, data collection was suspended in mid-March and resumed in June 2020. Overall, 95% of LHEs and 87% of principals completed the survey prior to the March pause, with the remaining completing it by July 2020.

Overall, of the 145 public schools, invited to participate, one or both questionnaires were received from 94% of schools. After data cleaning and editing, questionnaires were received from principals in 87% of schools and from lead health education teachers in 82% of schools.

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

PARTICIPATION AND RESPONSE RATE AMONG MIDDLE, JUNIOR / SENIOR HIGH, AND HIGH SCHOOLS, 2020

	Middle Schools[1]	Junior / Senior High Schools[2]	High Schools[3]	All Schools	Response Rate
Principals	72	29	25	126	87%
Lead Health Educators	67	29	23	119	82%

* The CDC defines the type of school as:

[1] Middle schools with a high grade of 9 or lower;

[2] Junior/senior high schools with a low grade of 8 or lower and a high grade of 10 or higher; and

[3] High schools with a low grade of 9 or higher and a high grade of 10 or higher;

In this Report

This report is divided into two main sections. Most of the results focus on what is happening at all schools regardless of grade level taught. Differences between school types, middle school, junior-senior high school, and high school, are shown in Appendix A.

The first section focuses on an overview of school health including school health teams, health services provided directly or through referrals to community organizations or other health care providers, detailed information about those serving as "lead health educators" in Vermont, and general requirements in health and physical education.

The second section includes a more in-depth look at specific the health-related topics. It focuses on aspects of school policies and programs, prevention, and education among all schools serving students in grades 6 through 12. Each sub-section includes information on "What We Know" about youth behaviors based on results of the 2019 Vermont Youth Risk Behavior Survey (YRBS), "What We are Doing – Policies and Practices" results from the SHP principal survey, "What We are Doing – in Health Education" results from the LHE survey, and key "Trends" or significant changes over the past ten years or since the question was first added to the SHP and differences between 2018 and 2020.

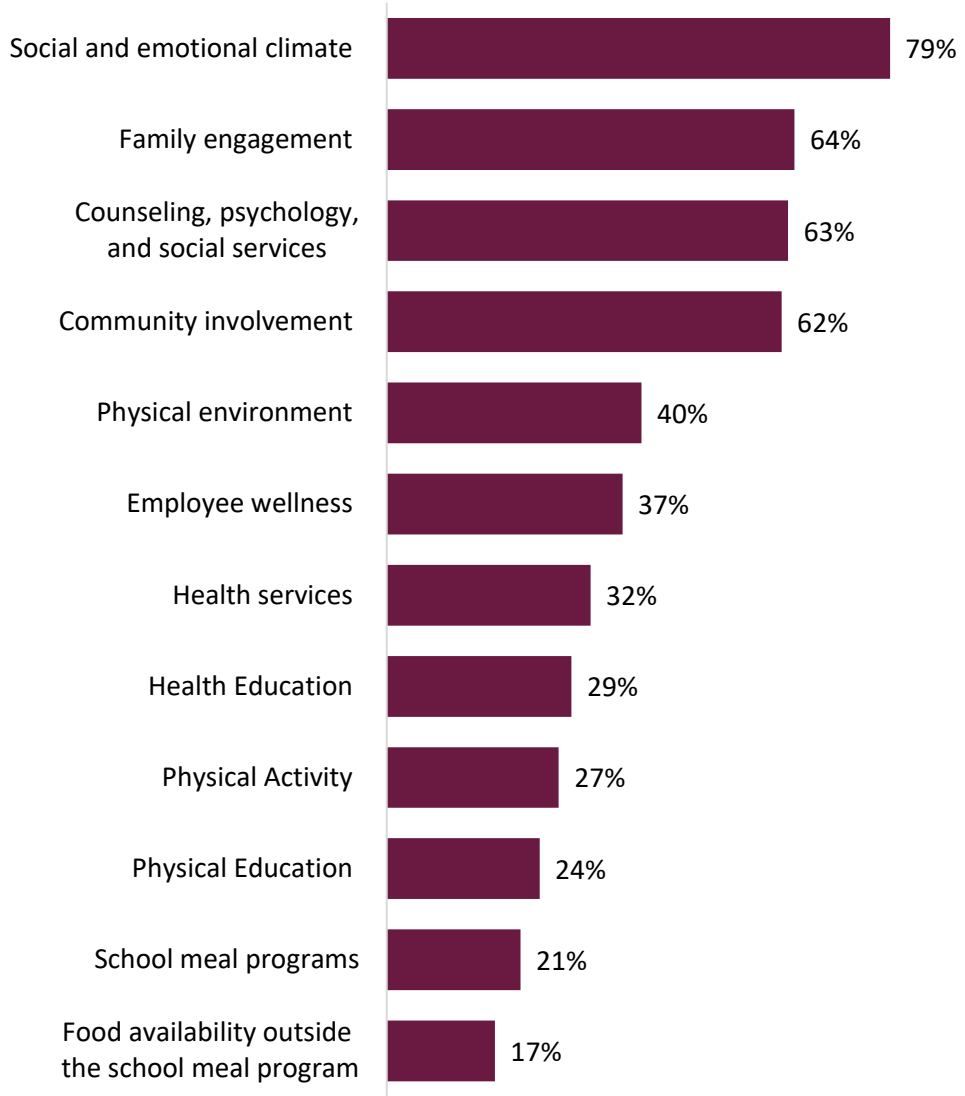
School Health Overview

School Improvement Plans and Wellness Policies

Objectives Included in School Improvement Plans

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

HEALTH-RELATED OBJECTIVES INCLUDED IN SCHOOL IMPROVEMENT PLANS



School Improvement Planning Process

Most schools (81%) reviewed health and safety data such as Youth Risk Behavior Survey data as part of the school's improvement planning process.

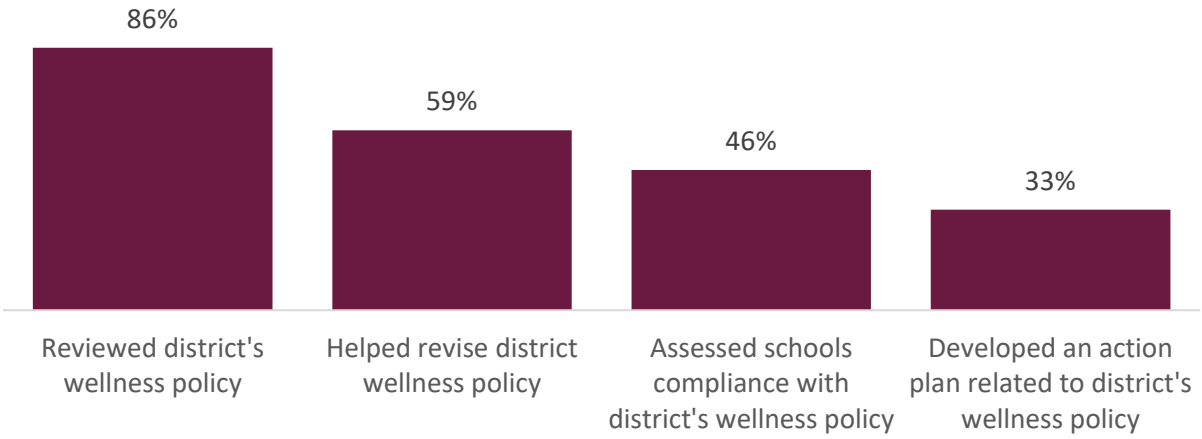
More than half of all schools used the School Health Index or other self-assessment to assess policies, activities, and programs related to physical education and activity (64%), tobacco-use prevention (64%), alcohol- and other drug-use prevention (62%), nutrition (55%), and sexual health (50%). Less than half assessed policies related to unintentional injury and violence prevention (44%) or chronic health conditions such as asthma and food allergies (36%).

Activities Related to Local Wellness Policies

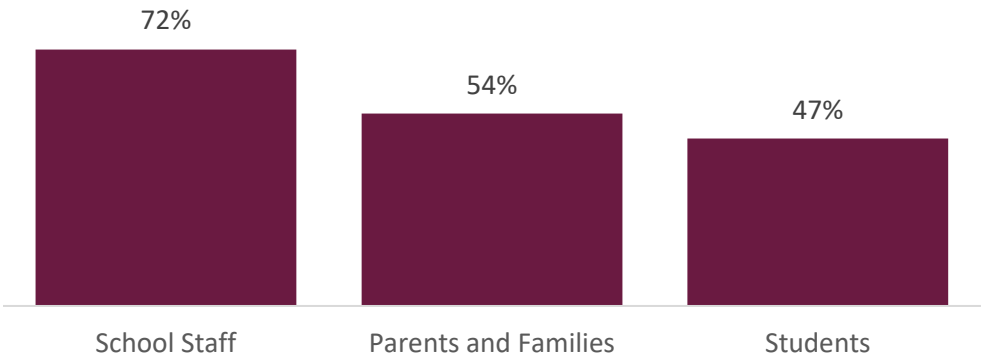
During the past year, 86% of schools reviewed their district's local wellness policy. Six in ten (59%) helped revise their local policy, almost half (46%) assessed their school's compliance and a third (33%) developed an action plan that described steps to meet the requirements set forth in the district's wellness policy.

Schools were significantly more likely to communicate information about their district's wellness policy with school staff (72%) compared to parents or families (54%) and students (47%).

LOCAL WELLNESS POLICY ACTIVITIES



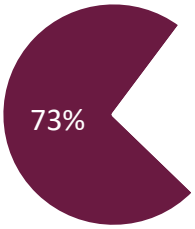
COMMUNICATED INFORMATION ABOUT LOCAL WELLNESS POLICY



School Health Teams

Nearly nine out of ten schools (87%) have at least one person who oversees or coordinates school health safety programs and activities, most (73%) have a group such as a school health council or team that offers guidance on the development and coordination of policies and health-related activities. In addition, nearly four in ten schools (39%) encouraged before- or after-school program staff or leaders to participate on school heath teams.

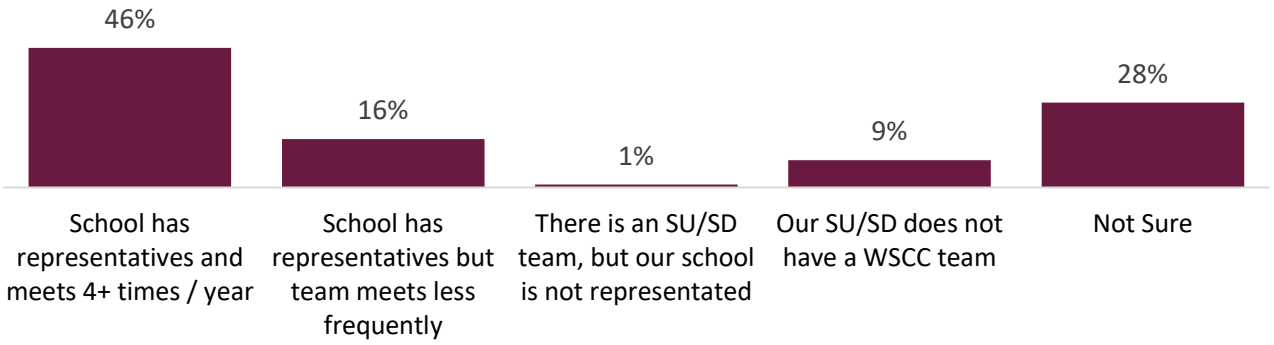
HAVE SCHOOL HEALTH TEAM OR COUNCIL



District-Wide School Health Teams.

In addition to having a school health council or team, more than six in ten school districts or supervisory unions (63%) have a Whole School, Whole Child, Whole Community (WSCC) teams. About a quarter (28%) were not sure if their district had a WSCC wellness team.

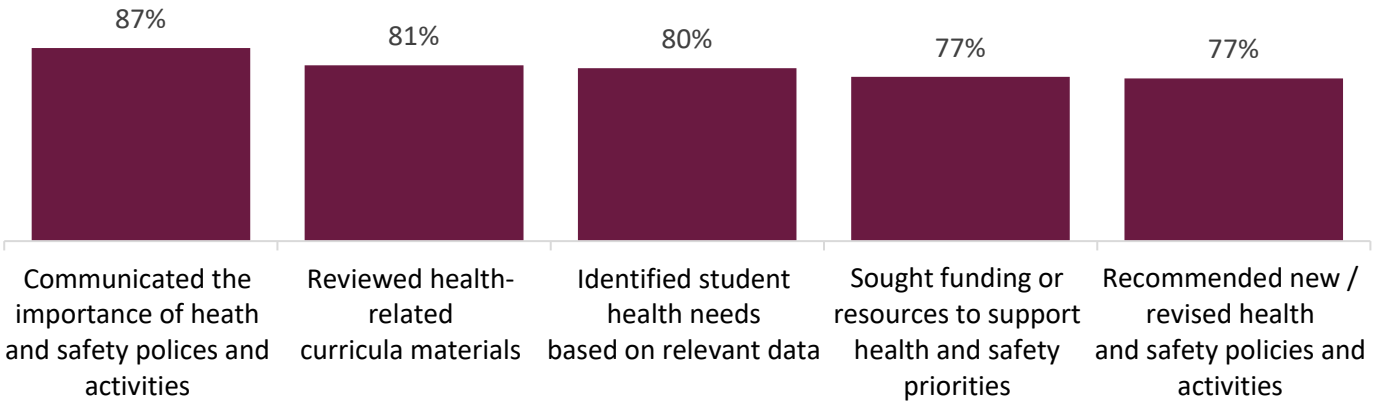
SCHOOL DISTRICT / SUPERVISORY UNION WHOLE SCHOOL, WHOLE CHILD, WHOLE COMMUNITY TEAM PARTICIPATION



Activities Performed by School Health Teams*

More than three-quarters of all schools have a school health team that performs activities such as communicating health and safety policies (87%), reviewing health-related curricula (81%), identifying student health needs (80%), seeking funding (77%), and recommending health and safety policies (77%).

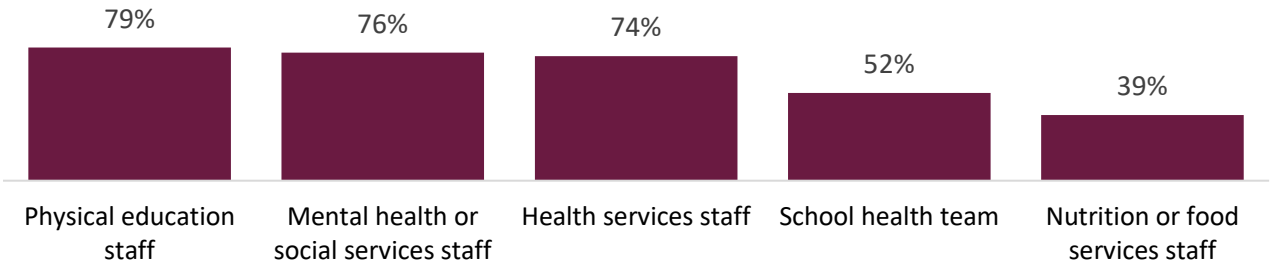
ACTIVITIES PERFORMED BY SCHOOL HEALTH TEAMS



Collaboration to Implement Health Education Activities

During the current school year, health education staff worked with physical education staff (79%), mental health or social services staff (76%), health services (74%), school health council or wellness team (52%), and nutrition staff (39%). Differences by school type are shown in Appendix A.

COLLABORATION FOR HEALTH EDUCATION ACTIVITIES



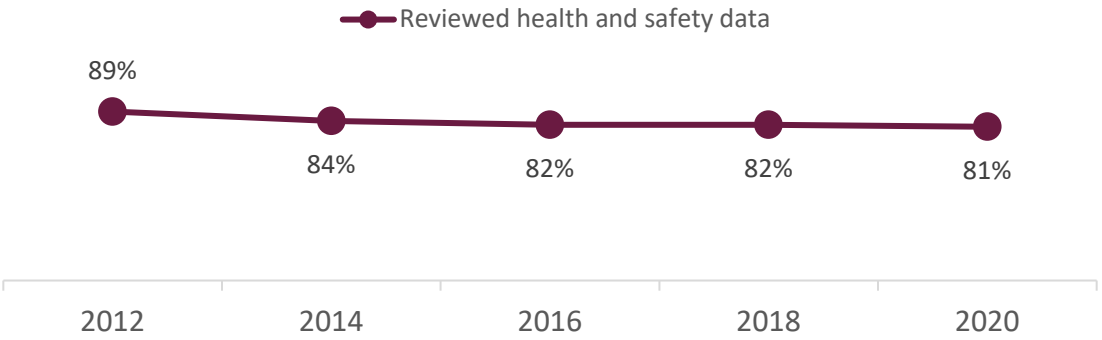
* Among schools that have a school health council or team.

Trends in School Improvement Plans, Wellness Policies, and School Health Teams

Since first asked, having a School Improvement Plan has significantly increased for objectives related to health education, physical education, physical activity, food and beverages available outside the school meal program, counseling, psychological and social services, the physical environment, social and emotional climate, community involvement and employee wellness. However, between 2018 and 2020, fewer SIPs included objectives related to health education (40% vs 29%), physical education (34% vs 24%), and school meal programs (29% vs 21%).

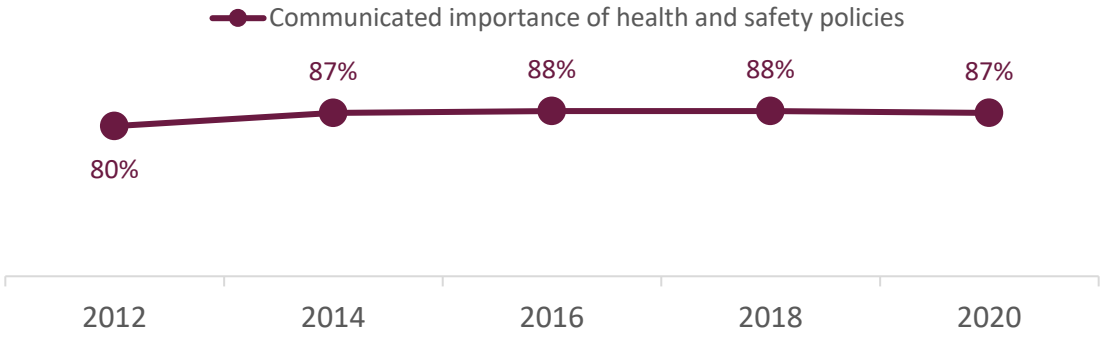
Since 2012, reviewing health and safety data has significantly decreased but remained stable between 2018 and 2020 (89% vs 82% vs 81%). Significantly fewer schools in 2020 used the School Health Index or other self-assessment tool to assess school policies, activities, and programs to assess nutrition (62% vs 55%), chronic health conditions (47% vs 36%), and unintentional injury, violence and safety prevention (50% vs 44%) compared to schools in 2018.

PERCENT OF SCHOOLS WHO REVIEWED SCHOOL HEALTH AND SAFETY DATA HAS SIGNIFICANTLY DECREASED SINCE 2012



The percent of schools with someone who oversees or coordinates school health and safety programs and activities has significantly increased from 80% in 2010 to 87% in 2020. Among activities performed by a school health council, committee, or team the percent of schools that communicated the importance of health and safety policies and activities to administrators, parent-teacher groups, or community members has significantly increased since 2012 (80% vs 87%).

PERCENT OF SCHOOL HEALTH TEAMS WHO COMMUNICATED THE IMPORTANCE OF HEALTH AND SAFETY POLICIES HAS SIGNIFCANTLY INCREASED SINCE 2012



School Health Services

Registered Nurses on Staff

Overall, 77% of schools have a full-time registered nurse available to provide health services to students; three in ten (30%) have a part time registered nurse.

Having a full-time nurse has not significantly changed over the past ten years. High schools are significantly more likely than middle schools to have a full-time school nurse (100% vs 65%); middle schools are more likely to have part-time nurses (26% vs 37%).

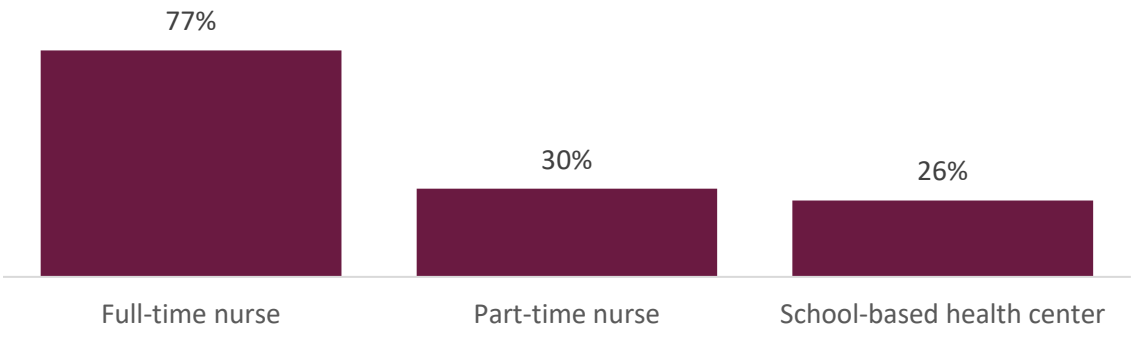
School-Based Health Centers

About two in ten Vermont schools (26%) have a school-based health center that offers health services to students.

Access to Insurance

Nearly three quarters (74%) of schools have protocols to ensure eligible students with chronic conditions are enrolled in private, state, or federally funded insurance programs.

SCHOOL HEALTH CENTERS AND STAFF



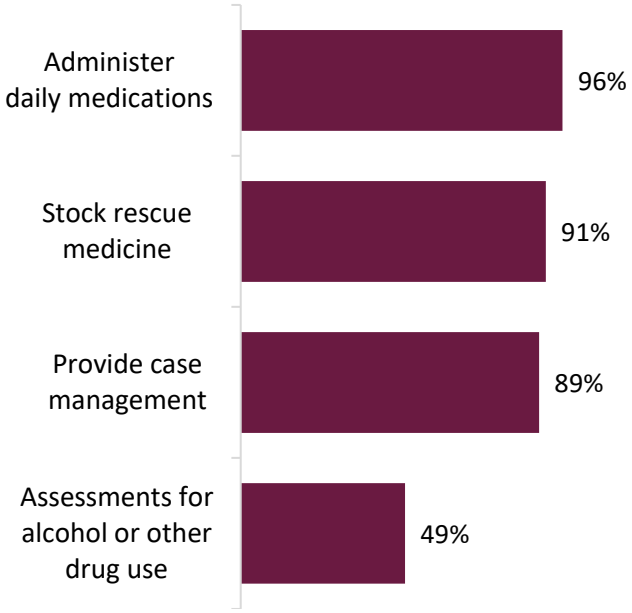
Health Services Provided

The majority of schools provide daily medication administration for students with chronic health conditions such as asthma and diabetes (96%), stock rescue or "as needed" medication for students experiencing a health emergency such as a severe allergic reaction (91%) and provide case management for students with chronic health conditions (89%). About half (49%) provide assessments for alcohol or other drug use, abuse, or dependency.

Less than a quarter of schools provide sexual health services on school property (not shown).

More detailed information about identifying and tracking students with chronic health conditions and specific sexual health services provided are shown on the following pages and within school policies, procedures, and prevention practice sections. Differences by school type are shown in Appendix A.

HEALTH SERVICES PROVIDED IN SCHOOLS

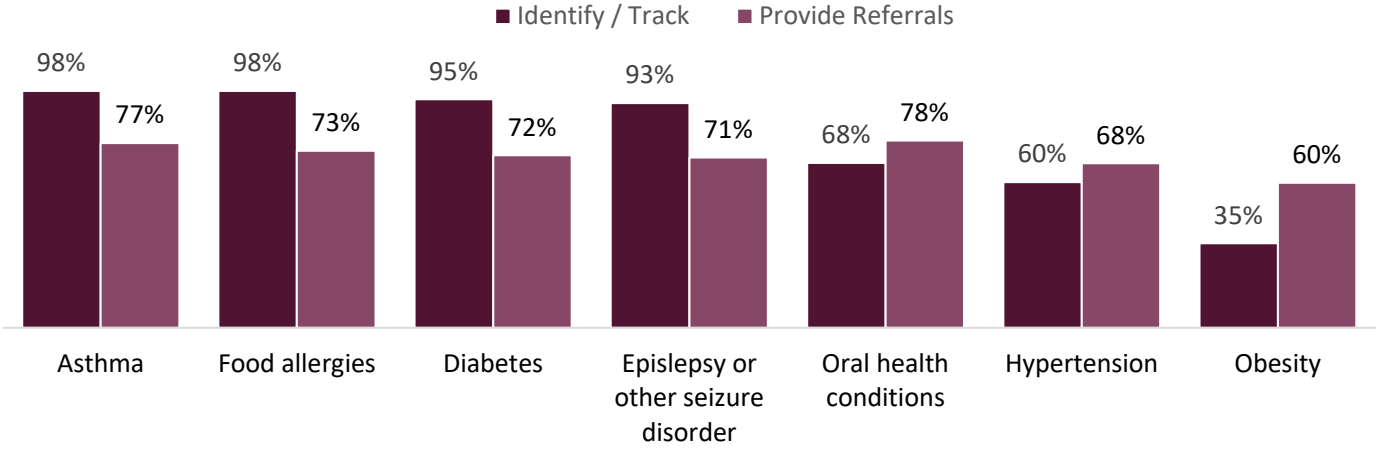


Identifying, Tracking and Providng Referrals for Chronic Health Conditions.

More than nine in ten schools use school records to identify and track students with chronic conditions such as asthma (98%), food allergies (98%), diabetes (95%), and epilepsy or seizure disorders (93%) that may require daily or emergency management. Nearly two-thirds identify and track students with oral health conditions (e.g., abscess, tooth decay) (68%) or hypertension (60%). Overall, about seven in ten provide referrals to other health care providers or organizations for students diagnosed with or suspected to have these conditions (results shown below).

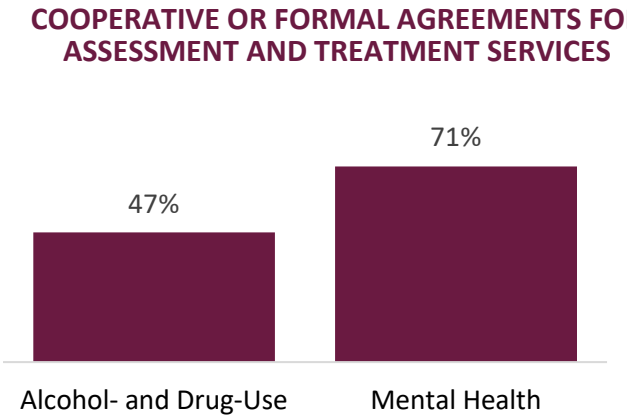
Fewer identify and track obese students (35%) or provide referrals for obese students to other health care providers (60%).

IDENTIFYING, TRACKING AND PROVIDING REFERRALS FOR CHRONIC HEALTH CONDITIONS



Cooperative and Formal Agreements

In addition to providing referrals, nearly half (47%) of schools have a cooperative or formal agreement with an outside agency to provide assessments and treatment for alcohol or drug use issues. Seven in ten schools (71%) have cooperative or formal agreements with community partners for mental health assessments and treatment.



Trends in School Health Services

Between 2018 and 2020, the percent of schools with a school-based health center significantly increased from 22% to 26%; having a part-time registered nurse significantly decreased between 2018 and 2020 (36% vs 30%).

Stocking rescue or “as needed” medicine, case management for chronic health conditions, and ensuring students with chronic conditions have health insurance have not significantly changed since first asked in 2018. Between 2018 and 2020, fewer schools provided daily medication administration (98% vs 96%)/

Identify and tracking students with hypertension significantly decreased between 2014 (76%) and between 2018 and 2020 (74% vs 60%). Tracking students with epilepsy or seizure disorders and obesity significantly decreased since first asked in 2014 (97% vs 93% and 55% and 35%, respectively) but did not change between 2018 and 2020.

Referring students with or suspected to have chronic health conditions significantly decreased between 2018 and 2020 for all health conditions assessed.

Lead Health Educator

Professional Preparation and Experience

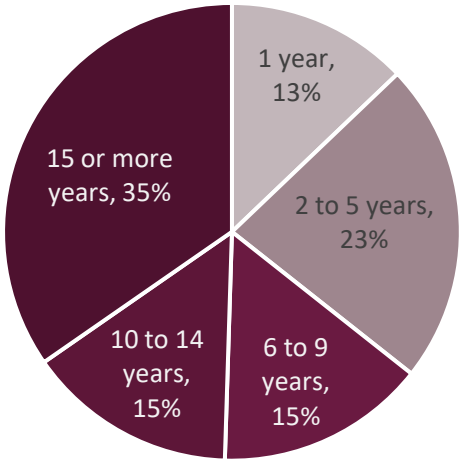
Experience, Licensure, Certification and Endorsement

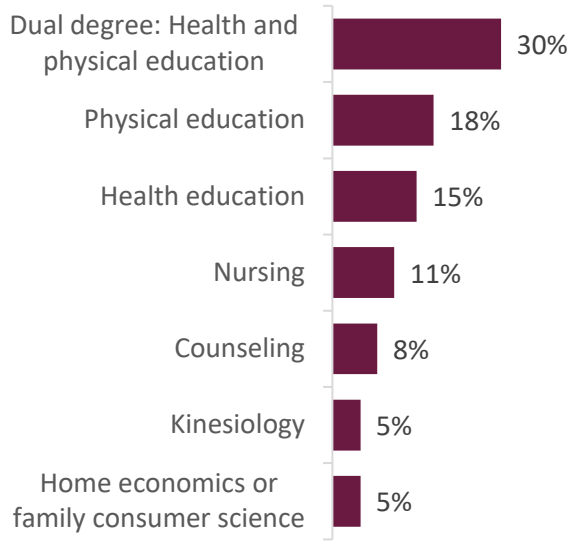
Just over a third (35%) of Vermont LHEs have 15 or more years of experience. In Vermont, nearly eight in ten LHEs (77%) are certified, licensed, or endorsed by the state to teach health education.

Preparation

About half of LHEs have professional preparation in health education, with or without training in physical education (45%); 18% have a background in physical education. Other professional preparation among LHE's include nursing (11%), counseling (8%), kinesiology or exercise science (5%), or home economics (5%). Three percent or fewer LHE's have backgrounds in biology or other science, nutrition, public health, or another educational degree (data not shown).

YEARS OF EXPERIENCE AND PROFESSIONAL PREPARATION AMONG LEAD HEALTH EDUCATORS





Professional Development

In addition to formal professional training, teachers and staff also receive professional development such as attending conferences or workshops on teaching health and sexual education. During the previous two years, almost all schools (99%) provided professional development opportunities for those teaching physical education. Among LHEs, professional development opportunities included receiving information on pedagogy and assessment, sexual health education, working with special populations, and information related to specific topics.

Pedagogical Techniques

During the past two years, more than half of LHEs received professional development related to classroom management techniques such as social skills training, environmental modification, conflict resolution and mediation, and behavioral management (63%), teaching skills for behavioral change (59%), and using interactive teaching methods such as role plays and cooperative group activities (56%). About four in ten received professional development in pedagogical topics related to sexual health education such as creating a comfortable and safe learning environment (45%), using a variety of teaching strategies (45%), assessing students (43%). One in five received professional development related to engaging parents (19%).

In addition, at least six in ten LHEs were interested in receiving more opportunities for professional development related to teaching and assessment. LHEs were most interested in learning more about assessing students in health education (78%).

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

Professional Development: Teaching and Assessment	% who received PD, past two years	% who would like more PD opportunities
Classroom management techniques	63	60
Creating a comfortable and safe learning environment for students receiving sexual health education	45	60
Teaching skills for behavior change	59	73
Using interactive teaching methods	56	73
Using a variety of effective instructional strategies to teach sexual health education	45	71
Assessing students in health education	43	78
Assessing students in sexual health education	38	71
Encouraging community and family involvement	38	71
Engaging parents in sexual health education	19	73

Teaching Sexual Health Education

In addition to pedagogical techniques specific to sexual health education, during the past two years, fewer than four in ten LHEs also received professional development related to building student's skills in HIV, other STD, and pregnancy prevention (38%), identifying appropriate modifications to the sexual health curriculum to meet the needs of all students (36%), and connecting students to community-based sexual health services (30%).

Less than a quarter of LHEs (21%) received professional development related to understanding their district's policies or curriculum guidance related to sexual health. More, roughly one in four (37%), received training on how to align sexual health lessons and materials with the district's scope and sequence.

LHE's were about two times as likely to want additional professional development opportunities related to sexual health than received it. The percent of LHEs who recently received professional development related to sexual health education and the percent interested in more opportunities for professional development are shown below.

Professional development related to sexual health education varied by school type. See Appendix A for differences in professional development received by type of school.

Professional Development: Sexual Health Education	% who received PD past two years	% who would like more PD opportunities
Understanding district policies or curriculum guidance regarding sexual health education	21	59
Aligning lessons and materials with the district scope and sequence for sexual health education	37	64
Identifying appropriate modifications to the sexual health curriculum to meet the needs of all students	36	71
Building student skills in HIV, STD, and pregnancy prevention	38	63
Connecting students to on-site or community-based sexual health services	30	64

Working with Special Populations

More than three-quarters (77%) of LHEs received professional development on how to support lesbian, gay, bisexual, and transgender students. Roughly one in ten (13%) received training on teaching students with limited English proficiency; about half (49%) would be interested in learning how better teach students with limited English proficiency.

Processional development received during the past two years related to working with special populations as well as interest in receiving additional professional development are shown below. Differences by type of school are shown in Appendix A.

Professional Development: Working with Special Populations	% who received PD, past two years	% who would like more PD opportunities
Supporting lesbian, gay, bisexual, and transgender students	77	74
Teaching students with physical, medical, or cognitive disabilities	53	68
Teaching students of various cultural backgrounds	51	64
Teaching students with limited English proficiency	13	49

Topics Addressed through Professional Development

During the past two years, LHE's also received professional development related to specific health-related topics. More than half received training focused on alcohol and drug use prevention (59%), emotional and mental health (78%), human sexuality (59%), physical activity and fitness (54%), suicide prevention (50%), tobacco use prevention (50%), and violence prevention (55%).

At least seven in ten LHEs reported wanting additional training in: emotional and mental health (83%), human sexuality (74%), violence prevention (73%), and suicide prevention (71%).

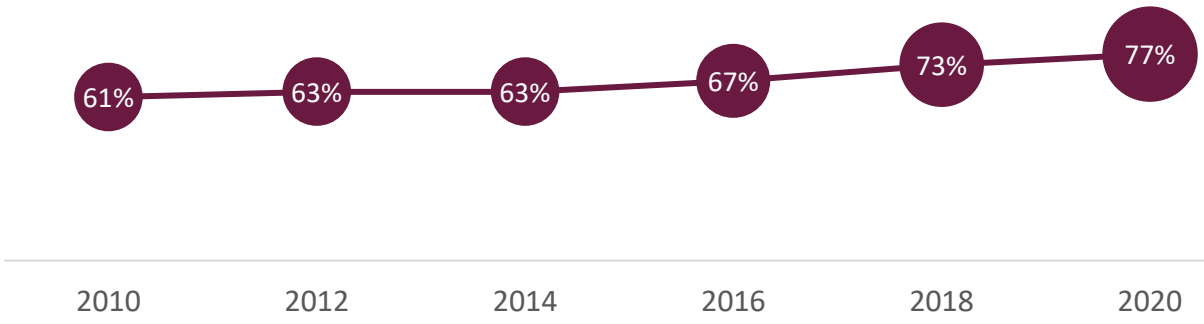
Processional development received during the past two years related to specific health topics as well as interest in receiving additional professional development are shown below. Differences by type of school are shown in Appendix A.

Professional Development: Areas of Focus	% who received PD, past two years	% who would like more PD opportunities
Alcohol / drug use prevention	59	67
Asthma	20	38
Chronic disease prevention	28	49
Emotional and mental health	78	83
Epilepsy	20	45
Food allergies	27	43
Foodborne illness prevention	14	41
HIV prevention	32	58
Human sexuality	59	74
Infectious disease prevention	30	47
Injury prevention and safety	38	46
Nutrition and dietary behavior	42	67
Physical activity and fitness	54	49
Pregnancy prevention	30	56
STD prevention	37	56
Suicide prevention	50	71
Tobacco use prevention	50	62
Violence prevention	52	73

Lead Health Educator Trends

Professional Preparation and Experience. Compared to LHEs in 2018, significantly more LHEs completing the survey had 6 to 9 years of experience (11% vs 15%), fewer had 15 or more years of experience (40% vs 35%). The percent of LHEs who are certified, licensed, or endorsed by the state to teach health education have significantly increased over the past decade from 61% in 2010 to 77% in 2020.

PERCENT OF LHES WHO ARE CERTIFIED, LICENSED, OR ENDORSED TO TEACH HEALTH EDUCATION



Having health education or health education combined with physical education has remained stable over the past decade. Being trained in physical education, kinesiology, exercise science, or exercise physiology significantly increased from 11% in 2010 and between 2018 and 2020 (12% vs 24%). Fewer LHEs were trained in home economics or family and consumer science, biology or other science, or nutrition (8%) compared to those in 2010 (22%) and 2018 (13%).

Professional Development. While receiving professional development has varied over time related to specific health topics, the percent of LHEs receiving professional development on emotional and mental health has increased since 2006 (43%) and over the past decade from 58% in 2010 to 78%) in 2020.

Compared to those in 2018, fewer LHEs received professional development related to HIV prevention (40% vs 32%), pregnancy prevention (37% vs 30%), understanding current district policies or curriculum guidance regarding sexual health (35% vs 21%), and aligning lessons and materials with the districts score and sequence for sexual health education (44% vs 37%) in 2020 compared to LHEs in 2018.

In 2020, significantly more LHEs stated they would like to receive professional development related to asthma (27% vs 38%), epilepsy or seizure disorders (31% vs 45%), food allergies (32%v s 43%), foodborne illness prevention (26% vs 41%), HIV prevention (45% vs 58%), infectious disease prevention (38% vs 47%), nutrition and dietary behaviors (60% vs 67%), pregnancy prevention (50% vs 56%), tobacco-use prevention (47% vs 62%), violence prevention (66% vs 73%), teaching students of various cultural backgrounds (58% vs 64%) and teaching students with limited English proficiency (43% vs 49%).

Health and Physical Education in Schools

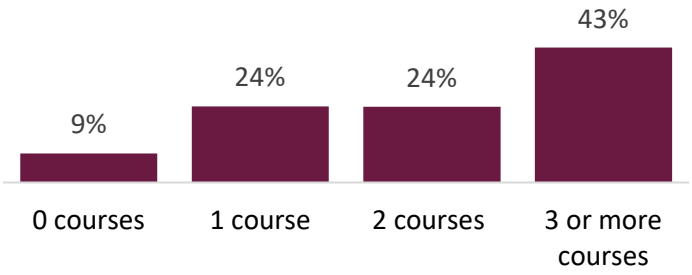
Number and Frequency of Required Courses

Required health education courses are specific courses that students must take for graduation or promotion from school and include instruction about health topics such as injuries and violence, alcohol and other drug use, tobacco use, nutrition, HIV infection, and physical activity. About half of schools (49%) require students who fail a required health course repeat it.

Most schools (91%) require students to take at least one health education course. Two thirds (67%) require students to take two or more health education courses. About three-quarters of schools require students to take a health education course in Grades 6 through 9. This significantly decreases to a third of schools requiring it in 11th and 12th grades.

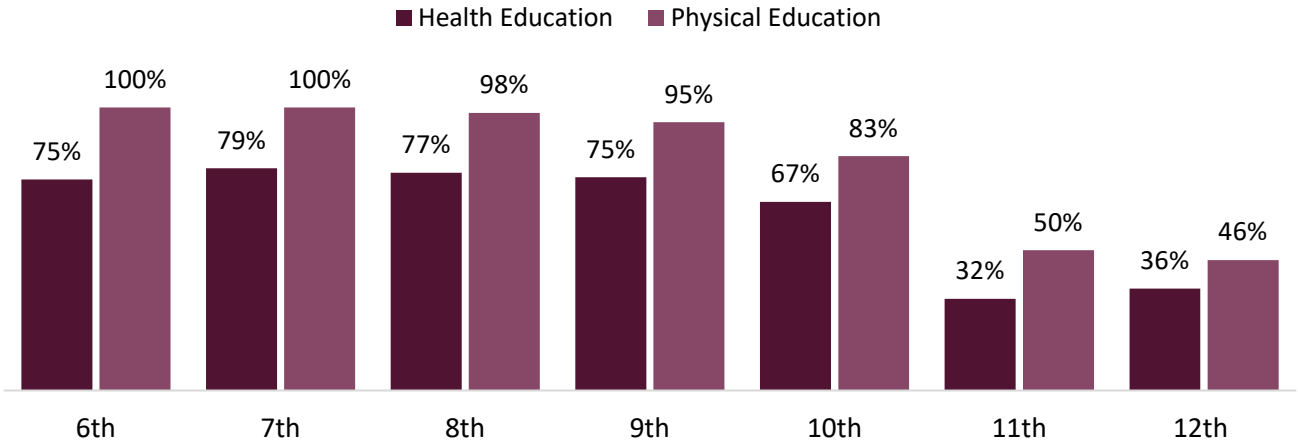
The number of courses required varies for middle and high schools with all high school requiring at least one course (see Appendix A).

NUMBER OF REQUIRED HEALTH EDUCATION COURSES



Compared to health education, schools are more likely to require physical education courses. All students are required to complete physical education courses in sixth and seventh grades. While more than nine in ten schools require physical education in eighth (98%) and ninth grades (95%), required courses for older students decrease to less than half of all schools requiring physical education among 12th grade students (46%).

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



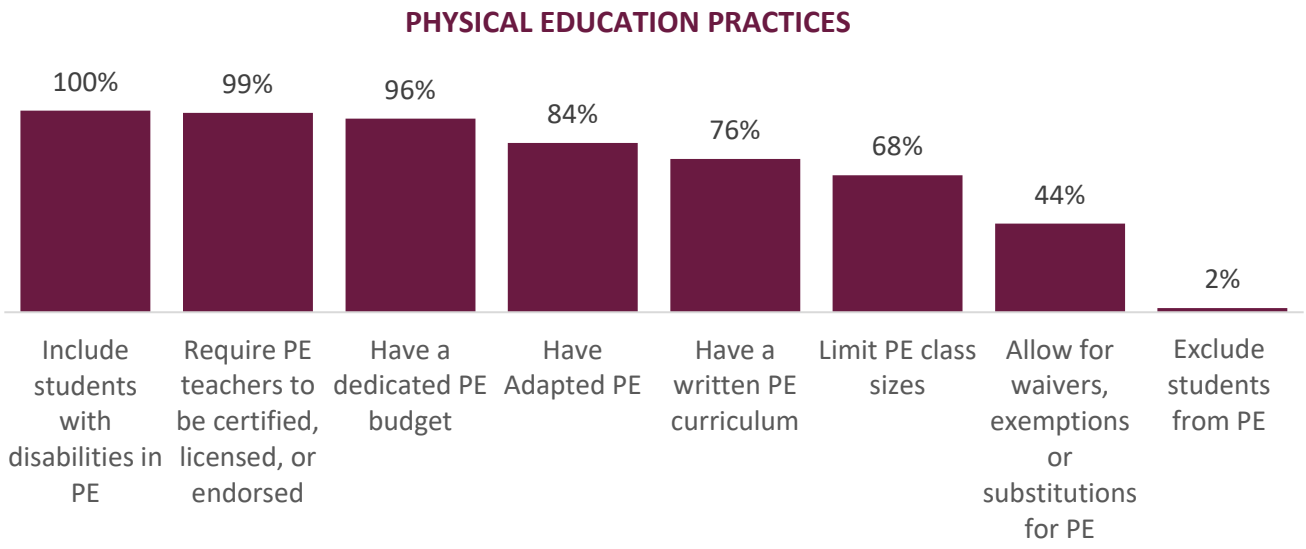
Key Physical Education Practices

Nearly all school require physical education teachers to be certified, licensed, or endorsed by the state (99%) and have a dedicated budget for physical education materials and equipment (96%). Three-quarters (76%) require physical education teachers to follow a written physical education curriculum, two-thirds (68%) limit class size so they are the same size as other subject areas.

All schools include students with disabilities in regular physical education courses as appropriate; 84% provide adapted physical education courses. Nearly half (44%) allow for the use of waivers, exemptions, or substitutions for physical education requirements.

About one in five schools (2%) allow teachers to exclude students from physical education to punish them for inappropriate behavior or failure to complete other class work.

Most notably high schools are roughly four times as likely to allow the use of waivers for physical education requirements (80% vs 22%) and allow for students to be excluded from physical education for inappropriate behavior (4% vs 1%). Differences by school type are shown in Appendix A.



Materials and Curriculum Provided for Health Education

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

Materials Provided to Those Who Teach Health and Sexual Health Education		%
A written curriculum	Health education	43
	Sexual health education	56
An annual scope and sequence of instruction including learning objectives, outcomes and content	Health education	51
	Sexual health education	59
Methods to assess student performance, knowledge, or skills in health education	Health education	56
	Sexual health education	60
Goals, objectives, and expected outcomes for health education		72
Teacher pacing guides for sexual health education		35
Teaching resources (e.g., lesson plans, handouts) to support sexual health education		67
Strategies in sexual health education are age-appropriate, relevant, and actively engage students in learning		68
Curricula or supplementary materials that include HIV, STD, or pregnancy prevention information that is relevant to LGBTQ youth		72

Content Covered in Health Education Courses

Health Education Standards focus on developing skills necessary to adopt, practice, and maintain health-enhancing behaviors as well as increasing knowledge on specific topics.[1] Health education curriculum covers a variety of topics ranging from alcohol and other drug use prevention to bullying and violence prevention. Topics included in health education courses differ by school type. These differences are shown in Appendix A.

Content Areas Covered in a Required Health Education Course			
Alcohol and other drug use	95	Infectious disease prevention	74
Asthma	34	Injury prevention and safety	83
Chronic disease prevention	79	Nutrition and dietary behavior	95
Emotional and mental health	93	Physical activity and fitness	97
Epilepsy or seizure disorder	20	Pregnancy prevention	87
Food allergies	52	STD prevention	89
Foodborne illness prevention	52	Suicide prevention	82
HIV prevention	87	Tobacco-use prevention	95
Human sexuality	93	Violence prevention (e.g., bullying, dating violence)	90

Skills Addressed in Health Education Curriculum

More than nine in ten schools have health education curriculum that includes using decision making skills, practicing behaviors to reduce risks, comprehending health concepts, analyzing the influence of others. Differences by school type are shown in Appendix A.

Components Included in Health Education Curriculum	%
Using decision making skills to enhance health	94
Practicing health-enhancing behaviors to avoid or reduce risks	92
Comprehending concepts related to health promotion and disease prevention	91
Analyzing the influence of peers, family, culture, media, technology, and other factors on health behaviors	91
Using interpersonal communication skills to enhance health and avoid or reduce health risks	89
Using goal-setting skills to enhance health	88
Accessing valid information and products and services to enhance health	87
Advocating for personal, family, and community health	85

Trends in Required Health and Physical Education

Over the past decade, the percent of schools requiring students complete two or more health education courses has significantly increased from 61% in 2010 and 2018 to 68% in 2020.

Between 2018 and 2020, fewer LHEs received materials related to teaching health education including (goals, objectives, and expected outcomes for health education (86% vs 72%), a chart describing the annual score and sequence of instruction (62% vs 51%), plans for how to assess student performance (66% vs 56%), a written health education curriculum (61% vs 43%). Excluding receiving written curriculum which has decreased over the past decade from 64% in 2010 to 44% in 2020 and receiving methods to assess student knowledge and skills related to sexual health education which decreased from 73% in 2014 to 60% in 2020, being provided with materials has remained stable since first asked in 2008.

Among LHEs who teach sexual health education, since 2014 significantly fewer LHEs received a written health education curriculum addressing sexual health (71% vs 56%), strategies that are age-appropriate, relevant and actively engage students in learning sexual health (79% vs 68%) and methods to assess student knowledge and skills related to sexual health education (73% vs 60%). Receiving methods to assess student knowledge and skills related to sexual health education also decreased between 2018 and 2020 (69% vs 60%).

Compared to topics covered in a required health education course in 2018, in 2020 significantly more LHEs taught about HIV prevention (79% vs 87%), human sexuality (89% vs 93%), injury prevention and safety (76% vs 83%), nutrition and dietary behavior (93% vs 95%), pregnancy prevention (79% vs 87%), and STD prevention (84% vs 89%). In 2020, significantly fewer LHEs taught about foodborne illness prevention (59% vs 52%) compared to LHEs in 2018 and curriculums were less likely to address using interpersonal communication skills to enhance health and avoid or reduce risks (96% vs 89%) and using goal setting skills to enhance health (94% vs 88%).

Policies, Programs, and Prevention

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

The following section addresses what schools are doing in terms of teaching specific content, polices, processes, and practices related to tobacco use prevention, alcohol and other drug prevention, nutrition, sexual health, creating safe, inclusive environments and family and community involvement. These topics are presented in the context of what we know about youth behaviors in Vermont based on the results of the 2019 Vermont Youth Risk Behavior Survey (YRBS).

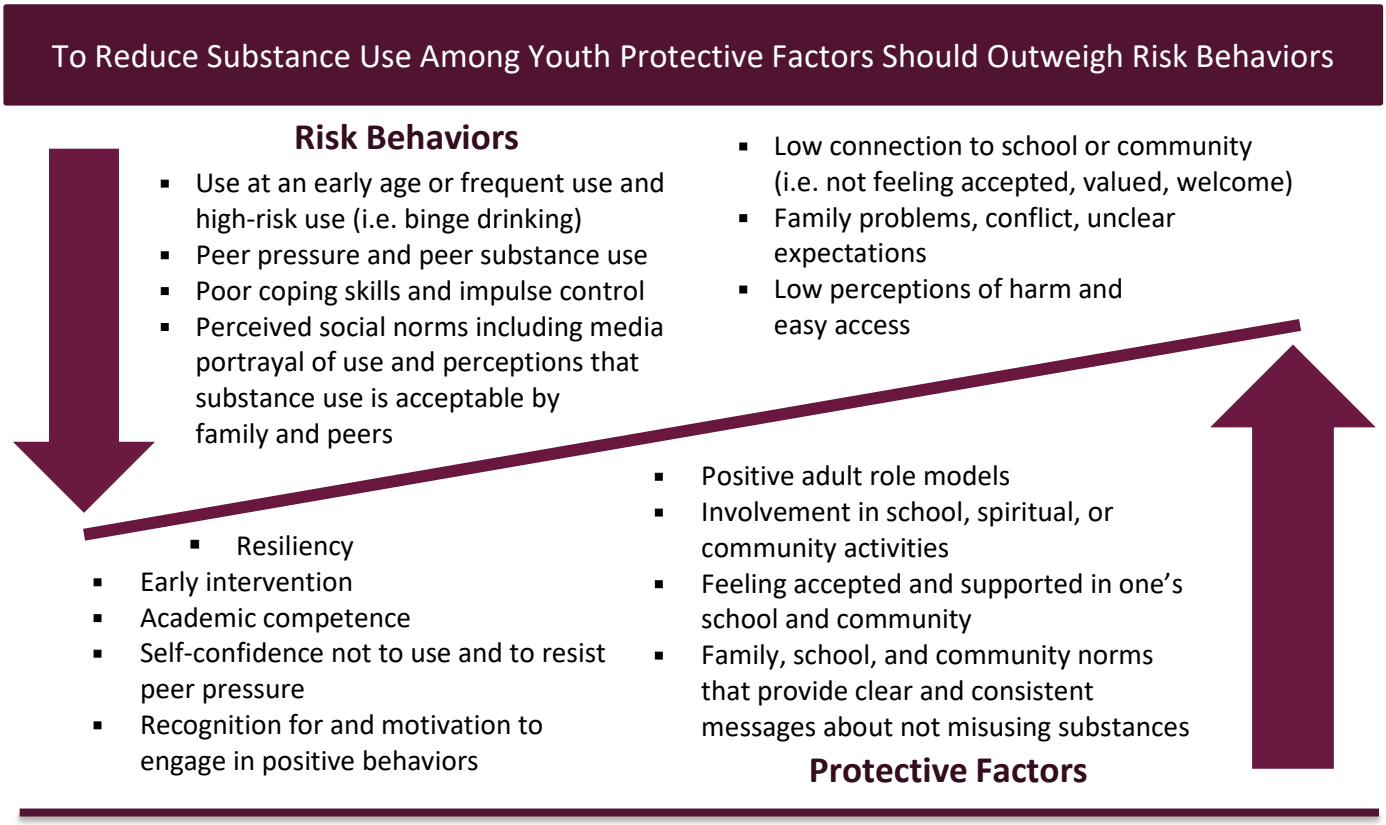
The YRBS can detect changes in risk behaviors over time and identify differences among ages, grades, and genders. With these data, we can focus prevention efforts and determine whether school policies and community programs are having the intended effect on student behaviors.

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

Tobacco, Alcohol, and Other Substance-Use Prevention

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

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



It has been shown that evidence-based school prevention programs can save Vermont $18 for every $1 invested.[4] The Vermont Department of Health (VDH) and Agency of Education (AOE) have invested in school- and community-based prevention grants and programs. For example, the Partnerships for Success, Regional Prevention Partnership, School-based Substance Abuse Services, and Comprehensive School-Based Tobacco Use Prevention grants have provided support for schools to reduce substance use and provide mental health services.

WHAT WE KNOW: TOBACCO USE

Lifetime Cigarette and Elecronic Vapor Product* (EVP) Use

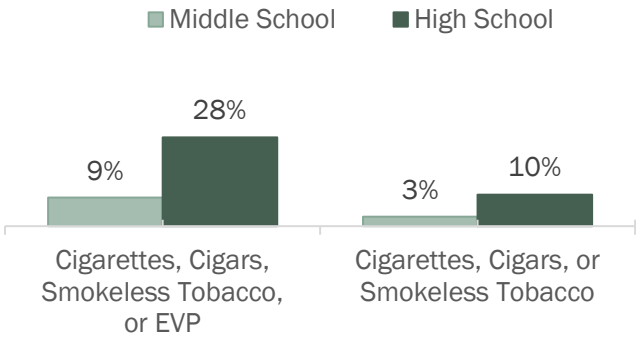
Just over one in five high school students (22%) have ever tried smoking a cigarette, even one or two puffs. One in two high school students (50%) have ever tried an EVP.

Among middle school students, 7% have tried a cigarette. More than twice as many (16%) have tried an EVP.

Current Tobacco Product Use

In 2019, nearly three in ten (28%) high school students and 9% of middle school students used cigarettes, cigars, smokeless tobacco, or EVPs on at least one day during the previous 30 days. Excluding EVPs, 10% of high school students and 3% of middle school students used either cigarettes, cigars, or smokeless tobacco products during the past 30 days.

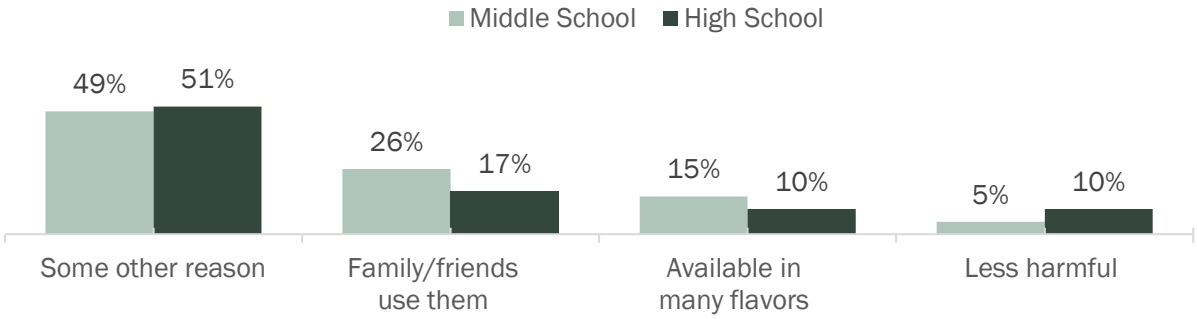
TOBACCO PRODUCT USE, PAST 30 DAYS



Use of Electronic Vapor Products. EVP use during the past 30 days doubled between 2017 and 2019 among high school (12% vs 26%) and middle school students (4% vs 8%). Eight in ten high school students who used EVPs, used a JUUL or similar type of rechargeable device with pods.

Nearly one in five high school (17%) and a quarter of middle school students (26%) who used EVPs during the past 30 days primarily used EVPs because their friends or family used them. About half used them for "some other reason" (51% high school and 49% of middle school students).

PRIMARY REASON FOR USING ELECTRONIC VAPOR PRODUCTS AMONG CURRENT USERS



* Electronic vapor products (EVP) include e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods. Common products include: JUUL, Vuse, MarkTen, and blu.

WHAT WE ARE DOING:
TOBACCO USE POLICIES

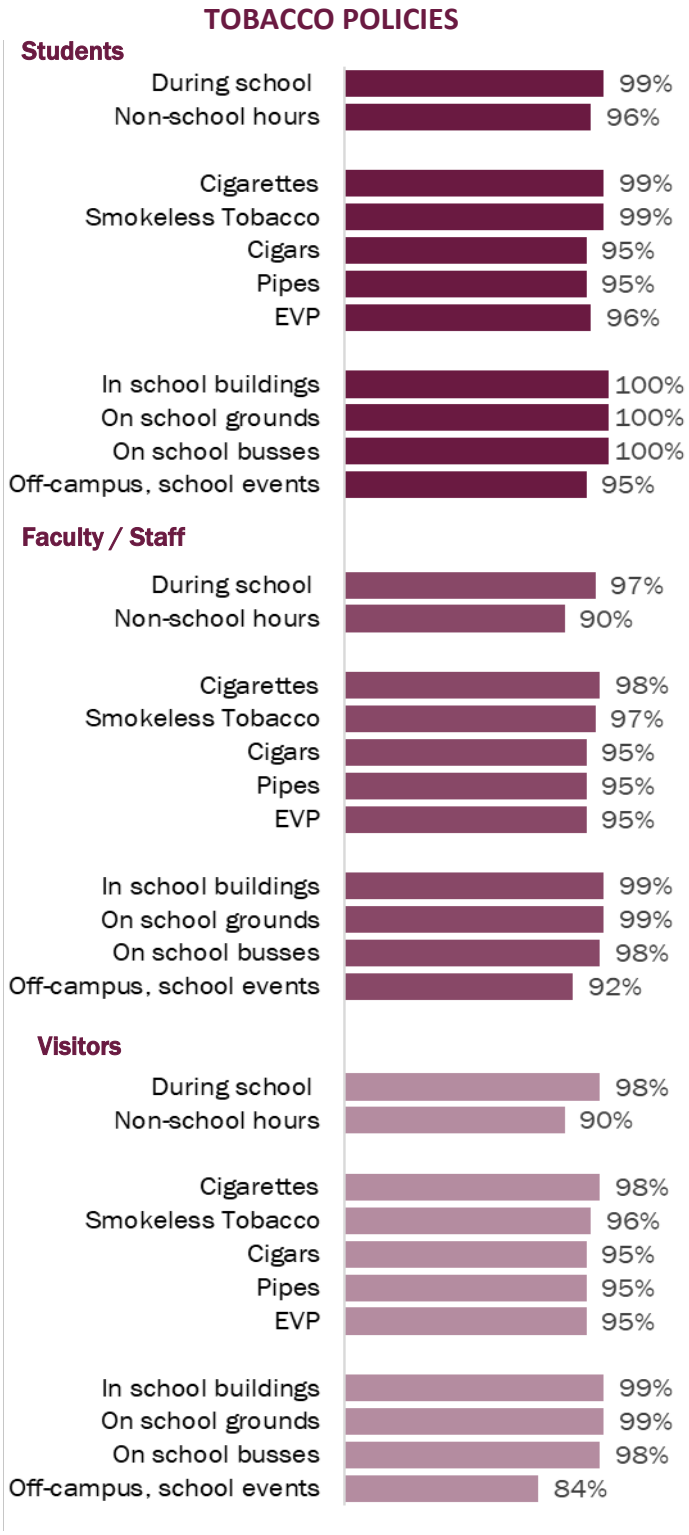
Tobacco Use Policies

All Vermont middle and high schools (100%) have policies prohibiting tobacco use. These policies vary as to the types of tobacco products, who the policies apply to, and at what times or where the policy applies. Nearly eight in ten schools (77%) have policies that mandate a "tobacco-free environment" in which tobacco use is prohibited by students, staff, and visitors in school buildings, at school functions, in school vehicles, on school grounds and at off-site school events at all times. Most (75%) "tobacco-free environment" policies include prohibiting electronic vapor products (EVP). Differences in tobacco use policies by school type are shown in Appendix A.

Products prohibited. Overall, most (>95%) schools have policies prohibiting the use of cigarettes, smokeless tobacco products, cigars, pipes, and EVPs among students, faculty and staff, and visitors. Products included in tobacco use policies among students, faculty and staff, and students are shown to the right.

Areas and time covered. More than 95% of school policies apply to everyone during school hours and for students after school hours. Nine in ten policies address tobacco use after school hours for faculty and staff and visitors.

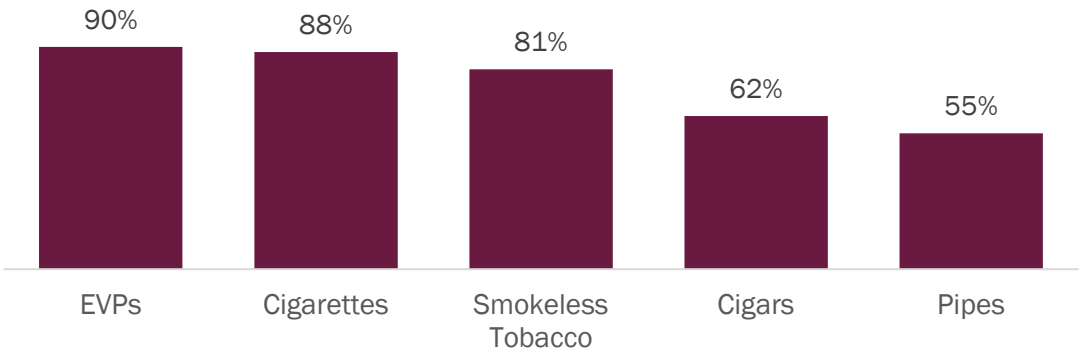
Overall, schools are less likely to include off-campus, school sponsored events in their tobacco-use policy compared to use in school buildings, on school grounds, and in school busses or other vehicles used to transport students. Location and times included in tobacco use policies among students, faculty and staff, and students are shown to the right.



WHAT WE ARE DOING:
TOBACCO USE PREVENTION IN HEALTH EDUCATION

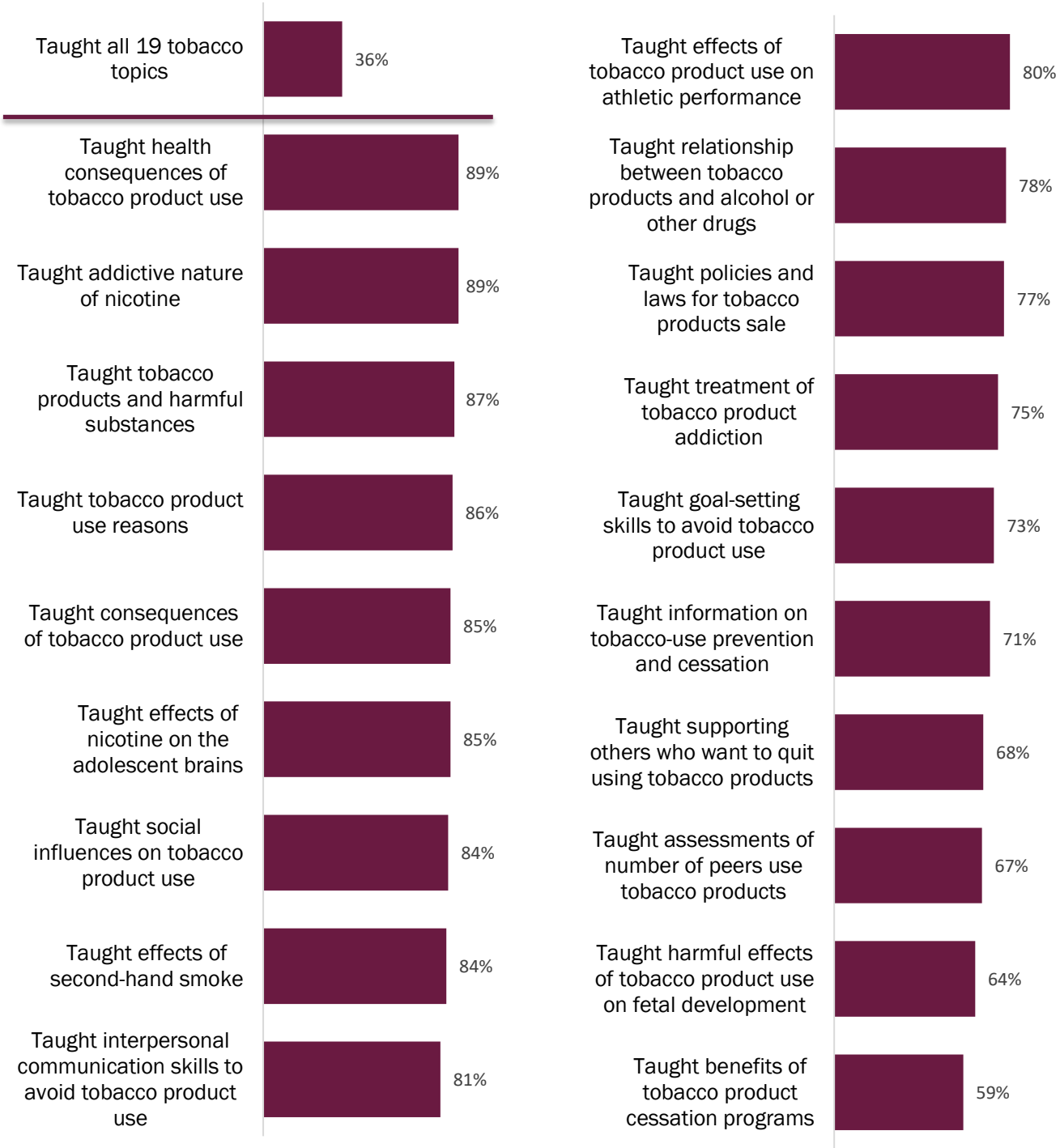
Overall, 95% of schools taught about tobacco-use prevention in a required health education course. Most LHEs taught about electronic vapor products (EVPs such as e-cigarettes, vapes, vape pends, e-hookahs, mods, including JUUL) (90%) and cigarettes (88%). Eight in ten taught about smokeless tobacco products such as chewing tobacco, snuff, dip, snus, and dissolvable tobacco). Fewer taught about cigars, little cigars, or cigarillos (62%) and pipes (55%).

TYPES OF TOBACCO PRODUCTS INCLUDED IN HEALTH EDCUATION



Of the 19 tobacco-use prevention topics included on the SHP, nearly four in ten (36%) LHEs covered all topics in a required course during the past year. Specific tobacco use prevention topics are shown on the following page. Differences by school type are shown in Appendix A.

TOBACCO-USE PREVENTION TOPICS TAUGHT IN HEALTH EDUCATION



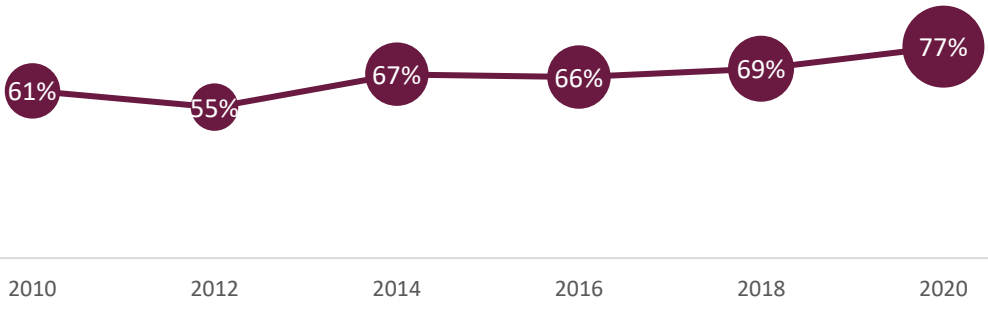
TRENDS IN TOBACCO-USE PREVENTION

Trends in Tobacco Use Policies and Prevention

Having a tobacco-free environment* has increased over the past 10 years and since 2018. Since 2016, the percent of schools mandating a tobacco-free environment prohibiting electronic vapor products has increased from 52% to 75%.

Between 2018 and 2020, policies specifically addressing electronic vapor products significantly increased. In 2018, about three quarters of schools prohibited the use of electronic vapor products (EVP) by students (76%), faculty (77%), or visitors (73%). By 2020 nearly all prohibited EVP use by students (96%), faculty (95%), or visitors (95%).

TOBACCO-FREE ENVIRONMENTS ON SCHOOL PROPERTY HAVE SIGNIFICANTLY INCREASED SINCE 2010



Trends in Tobacco Use Policies and Prevention through Health Education

Teaching about tobacco-use prevention in a required health education course has remained stable over the past decade.

* A tobacco-free environment is one that prohibits tobacco use by students, staff, and visitors in school buildings, at school functions, in school vehicles, on school grounds, and at off-site school events, 24 hours a day, 7 days a week

WHAT WE KNOW:
ALCOHOL AND OTHER SUBSTANCE USE

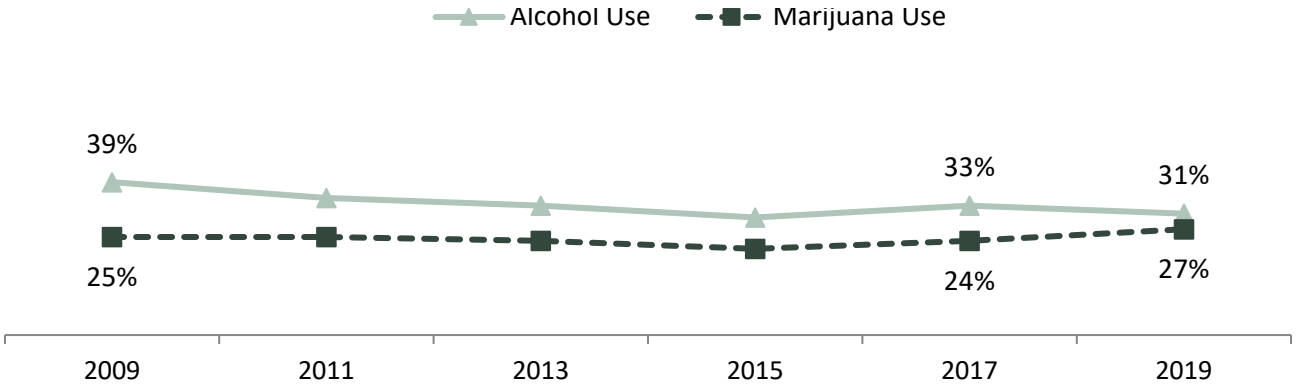
Current Alcohol Use

During the past 30 days a third of high school students (31%) drank alcohol. Alcohol use during the previous 30 days has significantly decreased among high school students over the past decade and between 2017 and 2019. Binge drinking also decreased among high school students, meeting the Healthy Vermonters 2020 Goal of 15%.* Overall, 7% of middle school students drank at least one time during the past month.

Current Marijuana Use

More than a quarter of high school students (27%) and one in twenty of middle school students (5%) used marijuana during the past 30 days. Among middle and high school students, current marijuana use has remained stable over the past 10 years. However, between 2017 and 2019, marijuana use significantly increased among high school students.

CURRENT ALCOHOL AND MARIJUANA USE AMONG HIGH SCHOOL STUDENTS



Lifetime Prescription Drug and Other Illicit Substance Use

Just over one in ten high school students (12%) have ever used a prescription stimulant or pain reliever that was not prescribed to them or used one in a manner different from how it was prescribed. Six percent of students have ever misused prescription medicine.†

During their lifetime, one in fifteen or fewer high school students have ever tried heroin (2%), methamphetamines (2%), cocaine (4%), and inhalants (7%). One in twenty (5%) of middle school students have used an inhalant.

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

† Prescription drug misuse includes using a medicine such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax that was not prescribed to you or using it differently than how a doctor told you to use it.

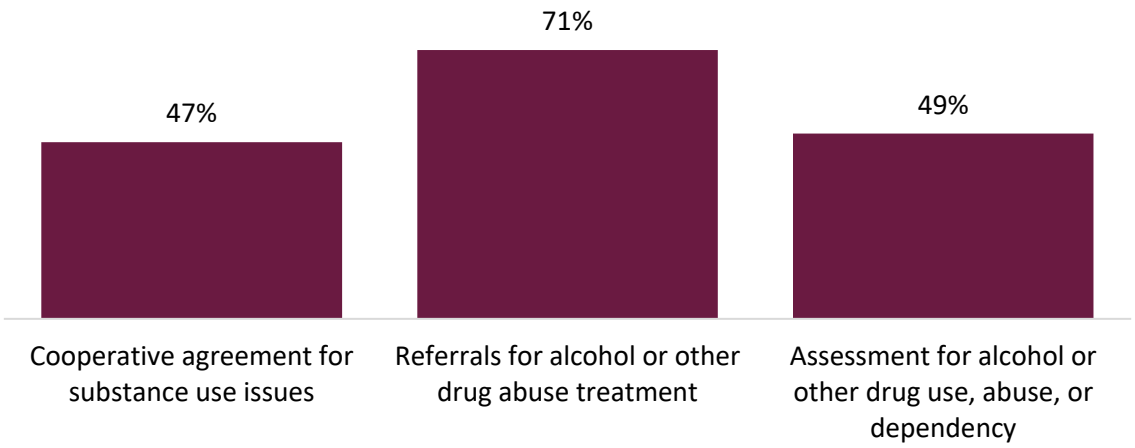
WHAT WE ARE DOING:
SUBSTANCE USE POLICIES AND SERVICES

Roughly half of all schools (47%) have a cooperative or formal agreement with an outside agency to provide services including assessments or treatment for students with suspected substance use issues.

Three-quarters of schools (71%) provide referrals to outside organizations or health care professionals for students needing alcohol or other drug abuse treatment.

About half (49%) of schools provide assessments for alcohol or other drug use, abuse, or dependency.

ALCOHOL AND OTHER DRUG-USE RELATED SERVICES

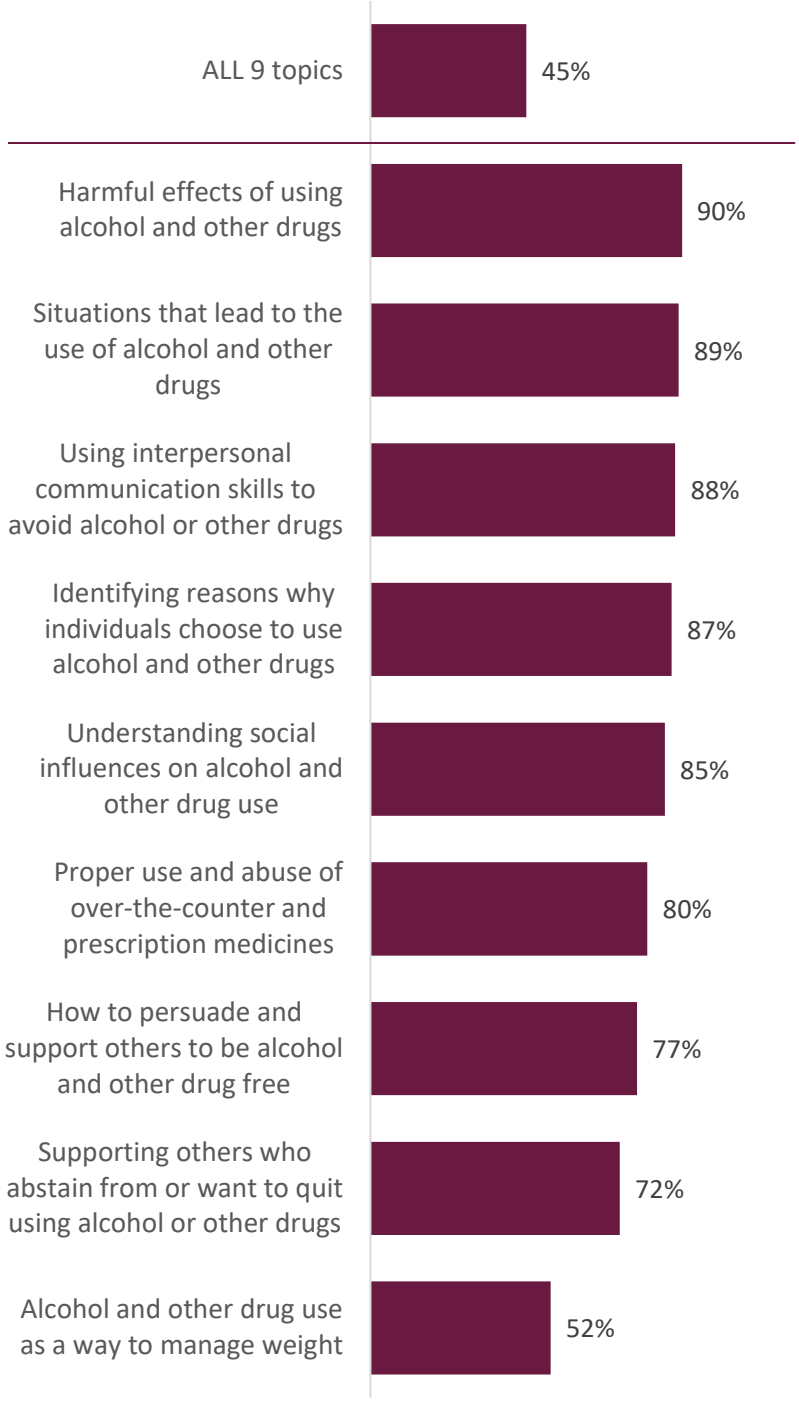


WHAT WE ARE DOING:
SUBSTANCE USE PREVENTION IN HEALTH EDUCATION

Nearly all schools (95%) address alcohol and other drug-use prevention in a required health course. Specific topics related to alcohol and other drug use prevention are shown to the right. About half (45%) of LHEs covered all nine topics in a course.

Differences by school type are shown in appendix A.

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



TRENDS IN ALCOHOL AND OTHER DRUG-USE PREVENTION

Trends in Alcohol and Other Drug-Use Policies and Prevention through Health Education

Since 2018, the percent of schools that provide referrals to organizations or health care professionals not on school property and having formal agreements for alcohol or other drug use services has significantly decreased (75% vs 71% and 56% vs 47%, respectively).

Teaching alcohol and other drug-use prevention topics has remained stable over the past decade.

Physical Education and Physical Activity

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

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

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

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

> ***"Each school shall offer options for students in grades K-12 to participate in at least 30 minutes of physical activity within or outside of the school day. Physical activity may include recess and movement built into the curriculum that does not replace physical education classes."***
>
> **Vermont Agency of Education**
> Education Quality Standards, August 2014

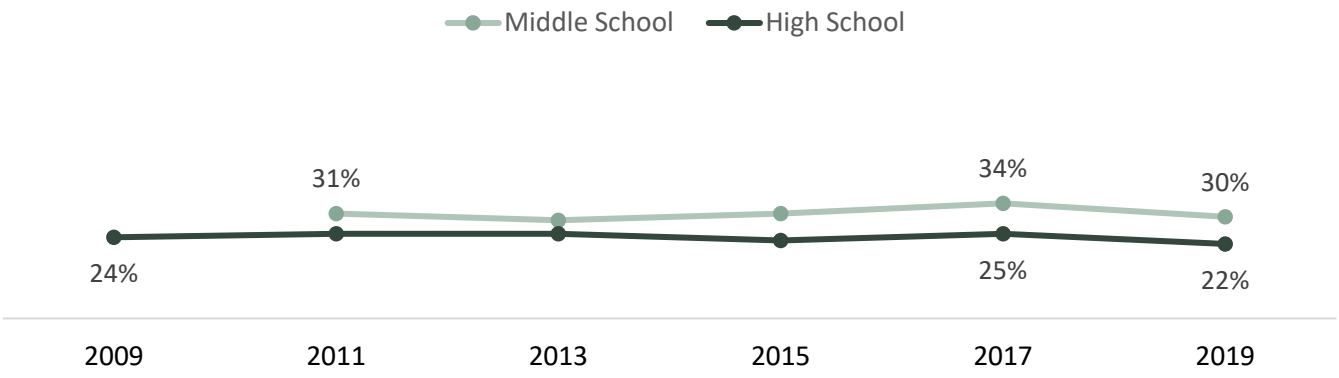
In order for schools to expand opportunities for physical activity and knowledge for sustaining physical activity, the CDC and SHAPE America collaborated to help schools develop a comprehensive plan for physical activity.[10] A Comprehensive School Physical Activity Program (CSPAP) is a multi-component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

WHAT WE KNOW:
PHYSICAL ACTIVITY AND CONCUSSIONS

In 2019, more than two in ten high school students (22%) and three in ten middle school students (30%) met physical activity guidelines, participating in at least 60 minutes of physical activity every day during the previous week. About half of all high school (46%) and middle school students (56%) participated in 60 minutes of physical activity on five or more days. About one in ten high school students (14%) and middle school students (9%) did not participate in at least 60 minutes of physical activity on any day.

The percent of high school students engaging in daily physical activity, no physical activity, and physical activity on most days has not significantly changed over the past decade. Among middle school students, engaging in physical activity on 5 or more days per week significantly decreased and not engaging in any physical activity during the past week significantly increased since 2011.

PERCENT OF MIDDLE SCHOOL AND HIGH SCHOOL STUDENTS WHOPARTICIPATED IN AT LEAST 60 MINUTES OF PHYSICAL ACTIVITY PER DAY DURING THE PREVIOUS WEEK



During the past 12 months, one in five high school students (18%) and two in ten middle school students (19%) reported experiencing symptoms of a concussion* from playing sports or being physically active. Experiencing symptoms of a concussion did not change between 2017 and 2019 among high school and middle school students.

* Concussions are defined as "when a blow or jolt to the head causes problems such as headaches, dizziness, being dazed or confused, difficulty remembering or concentrating, vomiting, blurred vision, or being knocked out".

WHAT WE ARE DOING:
PHYSICAL ACTIVITY AND PHYSICAL EDUCATION POLICIES & PROGRAMS

Comprehensive School Physical Activity Programs

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

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

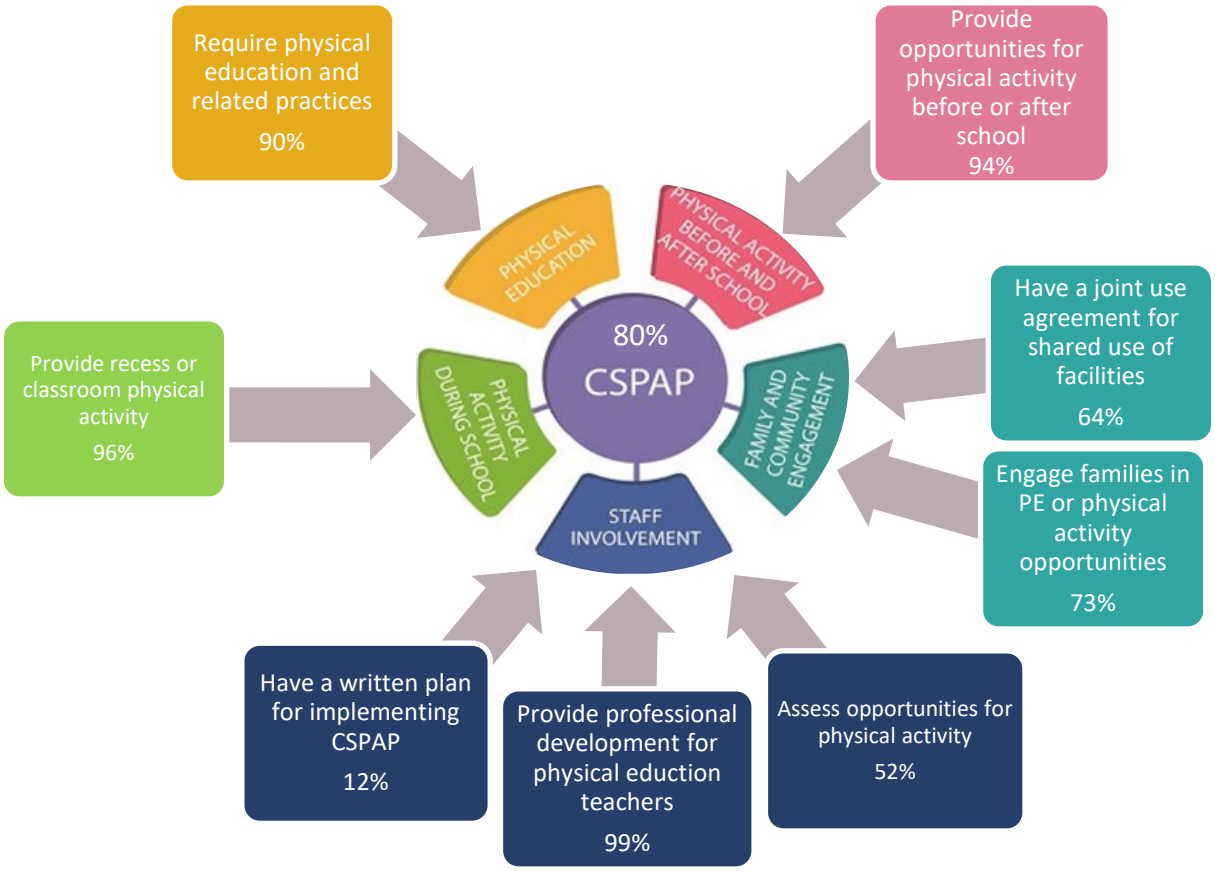
For this report, a school is defined as having established, implemented, or evaluated a CSPAP if it meets all of the following criteria:

- Students participate in physical activity breaks in classrooms or opportunities for students to engage in physical activity outside of physical education and classroom physical activity during the school day, through programs such as lunchtime intramural activities,
- Offer opportunities for students to participate in physical activity before the school day through organized physical activities or access to facilities or equipment for physical activity;
- Require physical education courses for students in grades 6, 7, 8, 9 and 10, 11, or 12 and engage in at least one related physical education practices such as requiring teachers to per certified, licensed, or endorsed by the state in physical education, and
- Engage in at least one process or element in place to support CSPAP such as:
    - Have a written plan for implementing CSPAP,
    - Have a school health council that assessed the availability of physical activity opportunities for students;
    - Engage families in PE or physical activity related programs,
    - Provide professional development opportunities on physical education or physical activity, or
    - Have a joint use agreement for shared use of school or community physical activity and sport facilities.

Overall, 80% of schools have established, implemented, or evaluated a CSPAP.

Most schools (80%) require physical education and related practices, provide physical activity opportunities during the school day or in the classroom, and provide physical activity before or after school. All (100%) engage in at least one additional activity supporting CSPAP such as having a joint use agreement for the shared use of facilities.

KEY COMPONENTS OF COMPREHENSIVE PHYSICAL ACTIVITY PROGRAMS



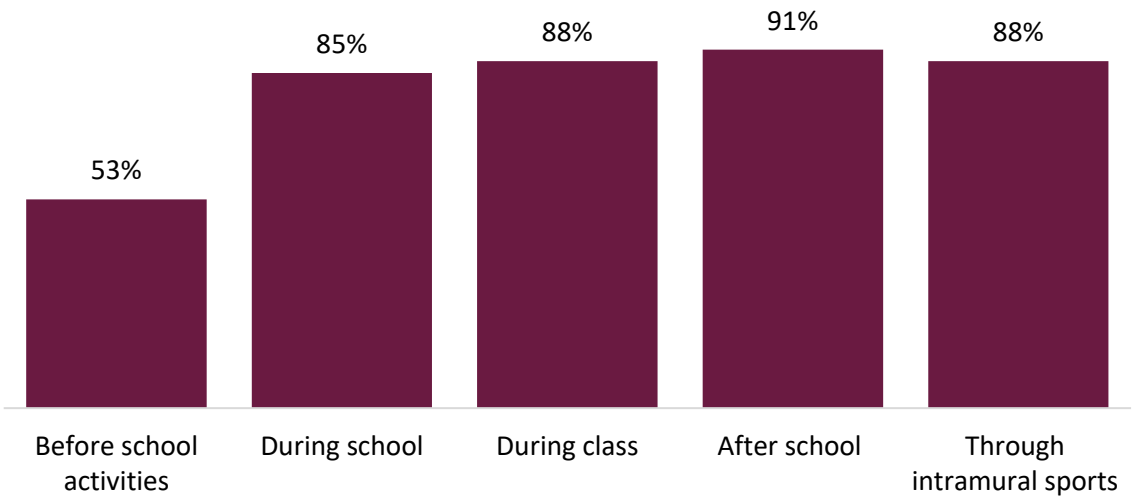
Details about the specific opportunities for students to engage in physical activity and physical education curriculum are discussed on the following pages. Specific differences by type of school are shown in Appendix A.

Opportunities for Physical Activity

More than eight in ten schools offer opportunities for students to be physically active during the school day through recess, lunchtime intermural activities or physical activity clubs (85%) or in other classes outside of physical education (88%). Nine in ten schools offer opportunities for students to be physically active after the school day through organized physical activities or access to facilities and equipment (91%). Before the school day about half (53%) provide physical activity opportunities or access to facilities. Nearly nine in ten schools (88%) offer interscholastic sports.

In addition, two-thirds of schools (64%) have joint use agreements for shared used of physical activity or sport facilities with their community (data not shown). Differences in physical activity opportunities by school type are shown in Appendix A.

OPPORTUNITIES FOR PHYSICAL ACTIVITY OUTSIDE PHYSICAL EDUCATION

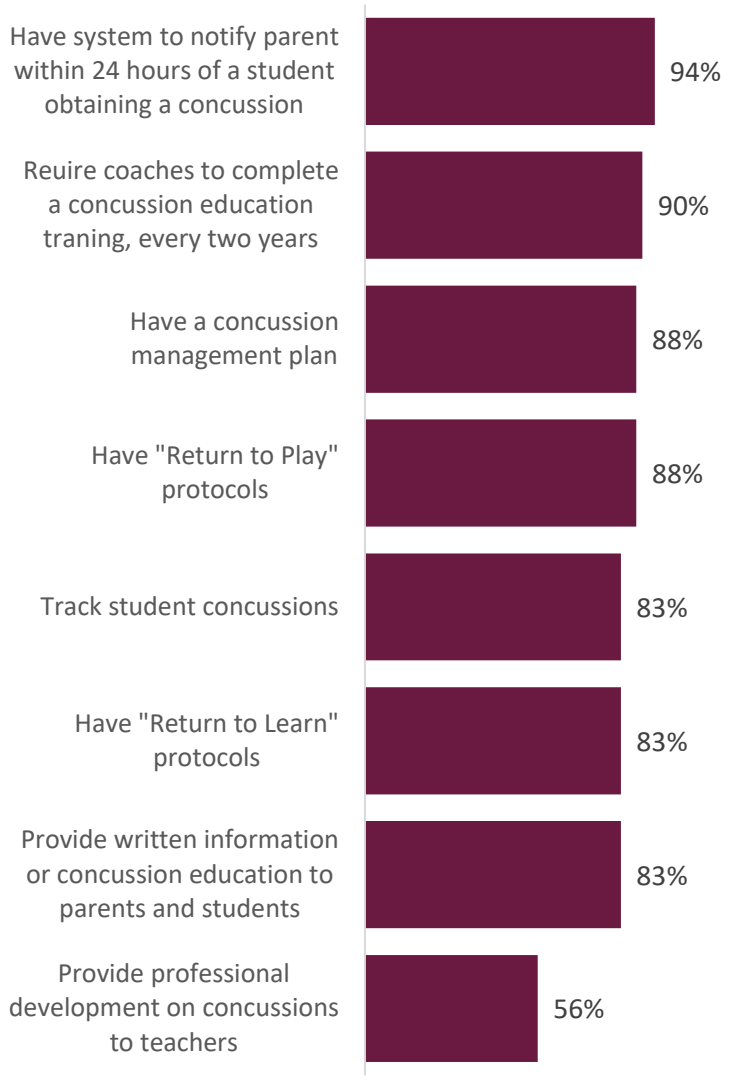


Concussion Management

Most schools have a concussion management plan (88%), track concussions among students (83%), and require coaches to complete a concussion education training program at least once every two years (90%). Roughly nine in ten schools have a system for notifying parents within 24 hours of a student sustaining a concussion (94%) and “return to play” protocols for students who have sustained a concussion (88%). Slightly fewer provide written information or concussion education materials to parents and students every year (83%) and have “return to learn” protocols (83%).

Just over half (56%) provide professional development or written information about concussions for all teachers.

CONCUSSION MANAGEMENT PLANS AND POLICIES



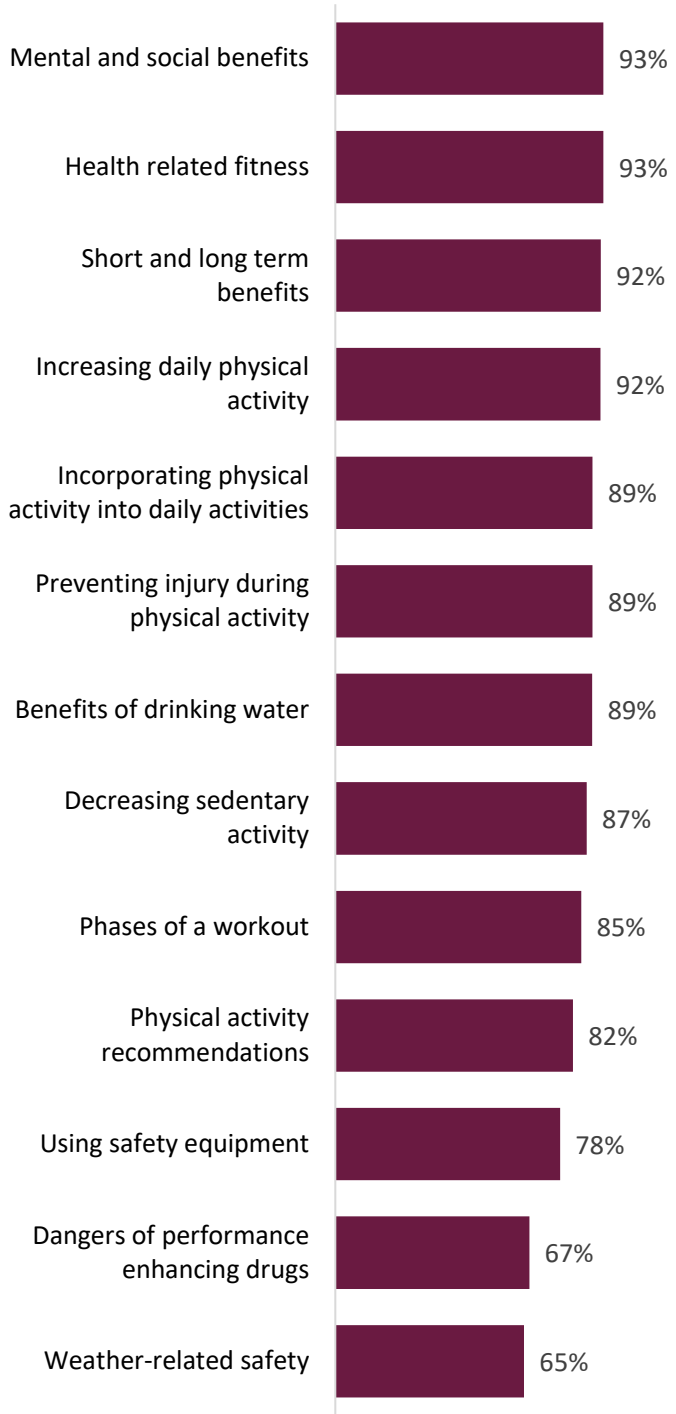
WHAT WE ARE DOING:
PHYSICAL ACTIVITY IN HEALTH EDUCATION

Nearly all (97%) schools teach physical activity and fitness in a required health course.

Most physical activity topics addressed on the SHP are taught by at least eight in ten LHEs. Less than half (45%) covered all 13 physical activity topics. Individual topics are shown to the right.

Differences by school type are shown in Appendix A.

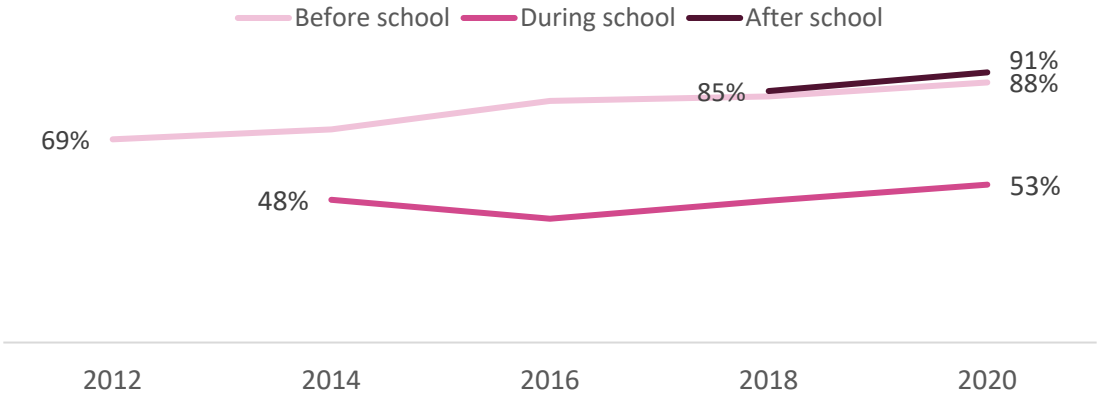
PHYSICAL ACTIVITY TOPICS TAUGHT IN HEALTH EDUCATION



TRENDS IN POLICES AND OPPORTUNITIES RELATED TO PHYSICAL ACTIVITY

Trends in Physical Education and Physical Activity Policies. Opportunities for physical activity before, during, and after school significantly increased since first asked on the School Health Profiles and between 2018 and 2020.

OPPORTUNITIES FOR PHYSICAL ACTIVITY – BEFORE, DURING, AND AFTER SCHOOL – HAVE SIGNIFICNALTY INCREASED



While having joint use agreements for shared used of facilities significantly increased since 2012 (50%), it remained stable between 2018 (67%) and 2020 (64%). Nearly all (99%) physical education teachers received professional development related to physical activity, a significant increase from 2018 (97%) and since 2014 (95%).

Trends in Teaching Physical Activity and Fitness in Health Education. Following an increase in the percent of LHEs teaching all 13 physical activity topics between 2014 (58%) and 2018 (60%), significantly fewer LHEs taught all 13 topics in 2020 (45%).

Nutrition Environment and Services

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

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

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

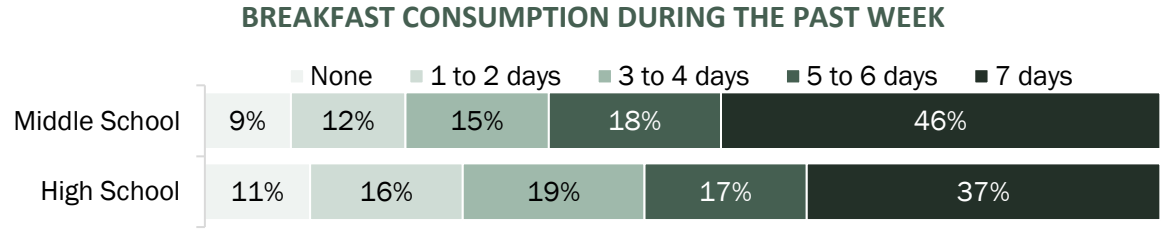
The Vermont Agency of Education administers federal programs that support nutritious high-quality meals and snacks in schools.[15] Federal programs include: National School Lunch Program, School Breakfast Program, After School Snack Program, Community Eligibility Provision, Seamless Summer Option and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

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

WHAT WE KNOW: NUTRITION

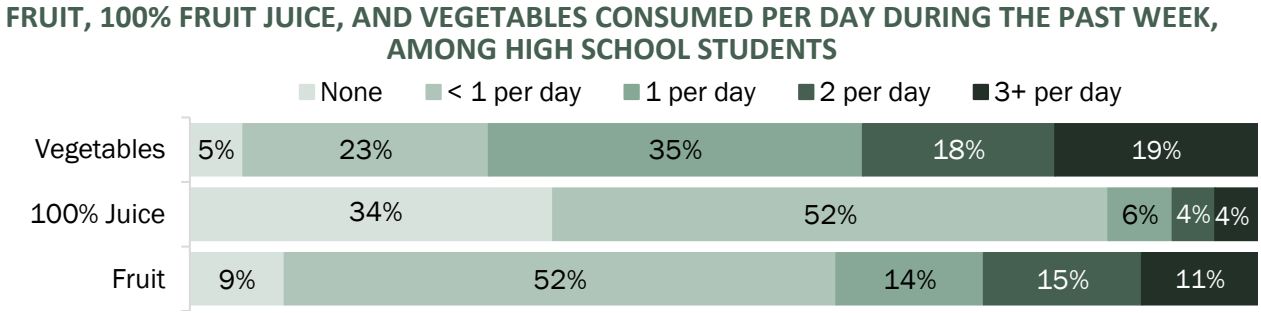
Breakfast Consumption

Most students eat breakfast at least five times per week; more than a third reported eating breakfast every day during the past week. About one in ten did not eat breakfast during the past seven days.



Fruit and Vegetable Consumption[ε]

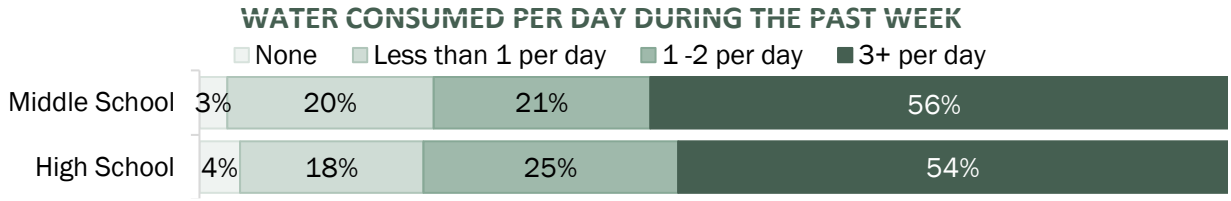
About one in five high school students (21%) ate five or more fruits or vegetables every day during the past week.



Water, Soda and Sugar-Sweetened Beverage[ε] Consumption

Nearly a quarter of high school students (23%) did not drink any soda or sugar-sweetened beverages during the past week. About one in five (18%) had at least one every day during the past week.

Just over half of all high school (54%) and middle school (56%) drank three or more bottles or glasses of plain water per day.



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

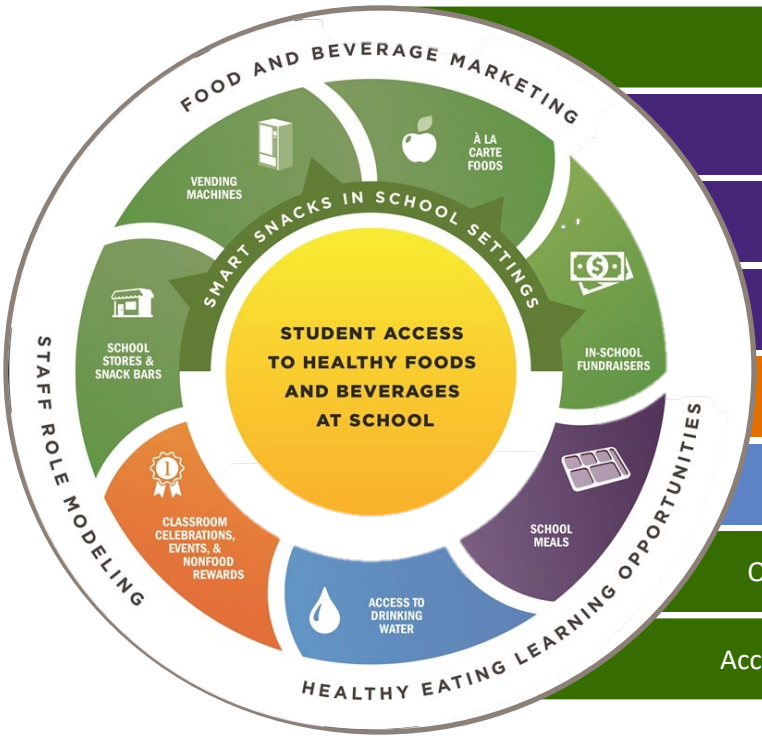
WHAT WE ARE DOING:
SCHOOL NUTRITION ENVIRONMENT

Key Components of a Supportive School Nutrition Environment

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

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

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



Allow students to purchase food or beverages outside the meal program, 42%

Place fruit / veg near the cafeteria cashier, where they are easy to access, 92%

Prohibit sale of less healthy foods, 75%

Provide nutrition, caloric, and sodium content information for available foods, 58%

Modify costs, 14%

Prohibit advertisments for candy, fast food restaurants, or soft drinks , 71%

Offer fruit / veg during school celebrations, 52%

Access to free source of water, any location, 100%

Access to Water

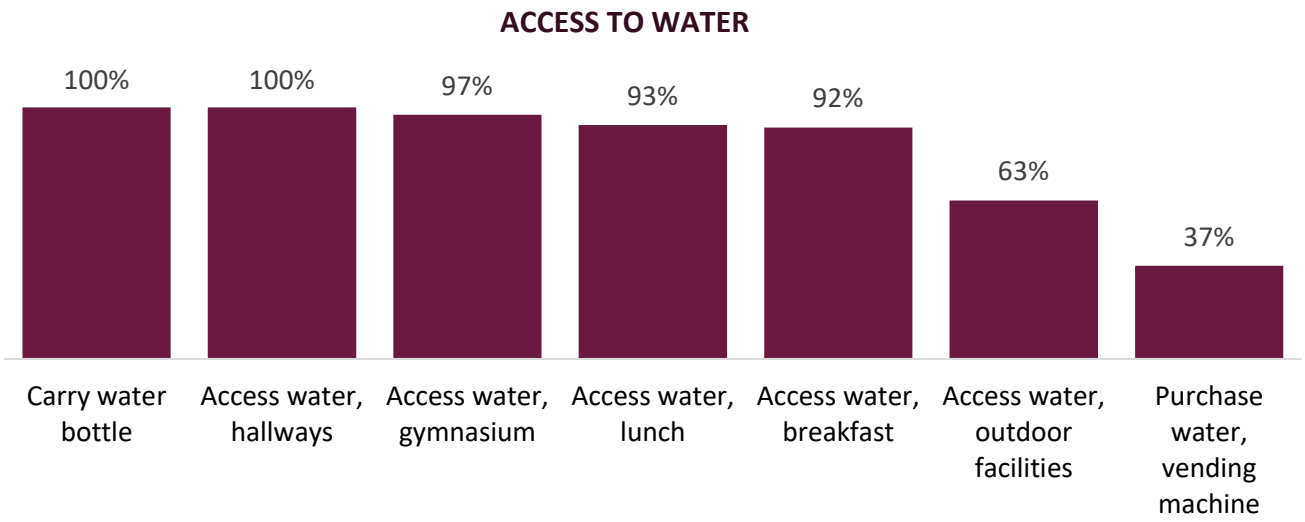
Providing easy access to drinking water helps to increase students' overall water consumption and can provide students a healthy alternative to sugar-sweetened beverages. To help students increase their water intake schools should:

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

Most schools (92%) encourage students to drink water throughout the day. All Vermont schools allow students to have a water bottle with them during the school day with one percent limiting them in certain locations.

Access to a free source of water is provided by all schools in hallways. Most also provide it during breakfast (92%), lunch (93%), or in a gymnasium or indoor physical activity facility (97%). However, fewer schools (63%) provide students access to water when they are at an outdoor physical activity facility or sport field. Nearly four in ten schools (37%) allow students to purchase water in a vending machine or at a school store.

See Appendix A for additional differences by type of school.



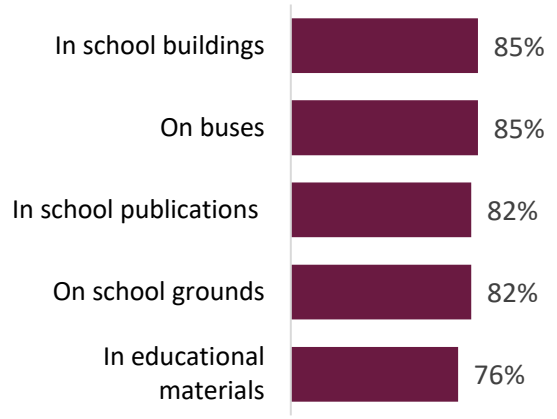
* https://www.cdc.gov/healthyschools/npao/wateraccess.htm

Food and Beverage Marketing

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

Eight out of ten schools prohibit advertisements for candy, fast food restaurants and soft drinks throughout the school and on school grounds. Specific locations where advertisements are prohibited are shown to the right. Differences by school type are shown in Appendix A. advertisements.

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

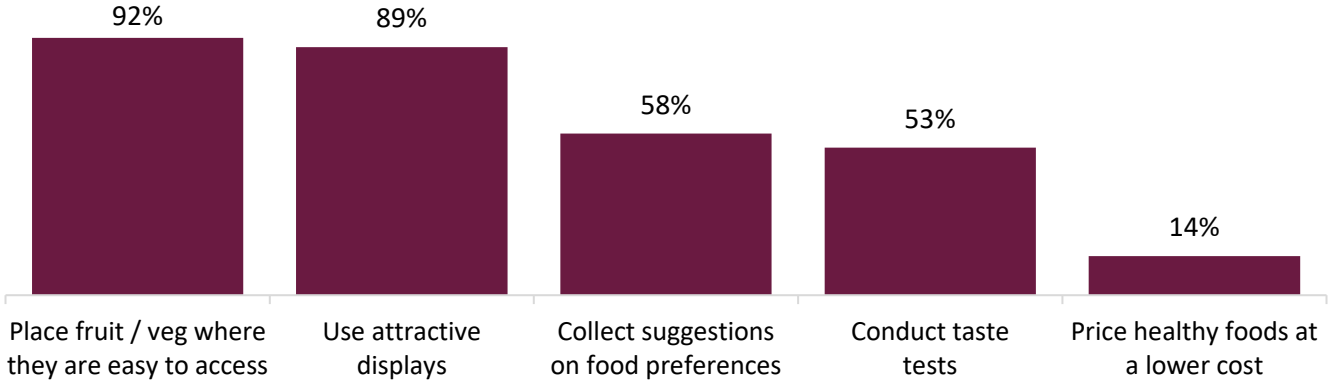


Strategies used. In addition, schools can promote healthful foods and beverages through "low-cost" strategies such as:

- Collecting suggestions from students, families, and staff on food preferences and strategies to promote heathy eating
- Conducting taste tests to determine food preferences
- Placing nutritious items where they are easy for students to select
- Pricing nutritious foods and beverages at a lower cost while increasing the cost of less healthy items
- Using attractive displays for fruits and vegetables, and
- Using signs or verbal prompts to encourage students to try healthy foods.*

Overall, most schools place fruits and vegetables near the cashier where they are easy to access (92%) and use attractive displays (89%). More than half collect suggestions on food preferences and strategies to promote healthy eating (58%) and conduct taste tests (53%). Less than one in five modify the prices of food and beverages making healthy foods cost less while increasing the cost of less healthy foods and beverages (14%). Differences by school type are shown in Appendix A.

ADDITIONAL STRATEGIES USED TO PROMOTE HEALTHFUL EATING



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

School Meal Program and Smart Snacks

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

School Meals. During the past two years, nearly all schools (92%) used recipes that were low in sodium, served more than half of grains as whole grains, and only offered fat-free or low-fat milk as part of the school meal program. Half (50%) were not sure if they will make changes to the school meal program over the next two years while 14% planned on decreasing the amount of whole grains served, serving items or using recipes that are not low in sodium or offering 2% or whole milk (data not shown).

Nine in ten schools serve locally or regionally grown foods in the cafeteria (91%) and offer a self-serve salad bar to students (90%).

Fundraisers and Rewards.‡ Roughly four in ten schools (38%) prohibit less nutritious foods and beverages such as candy and baked goods, from being sold for fundraising purposes. Similarly, 41% prohibit school staff from giving students food or coupons for food for good behavior or athletic performances.

Vending machines, school stores, and snack bars. Overall, about four in ten schools (42%) allow students to purchase snack foods or beverages from one or more vending machines in the school or at a school store, canteen, or snack bar. Specific snack food and beverages students can purchase outside the school meal program are shown on the following page.

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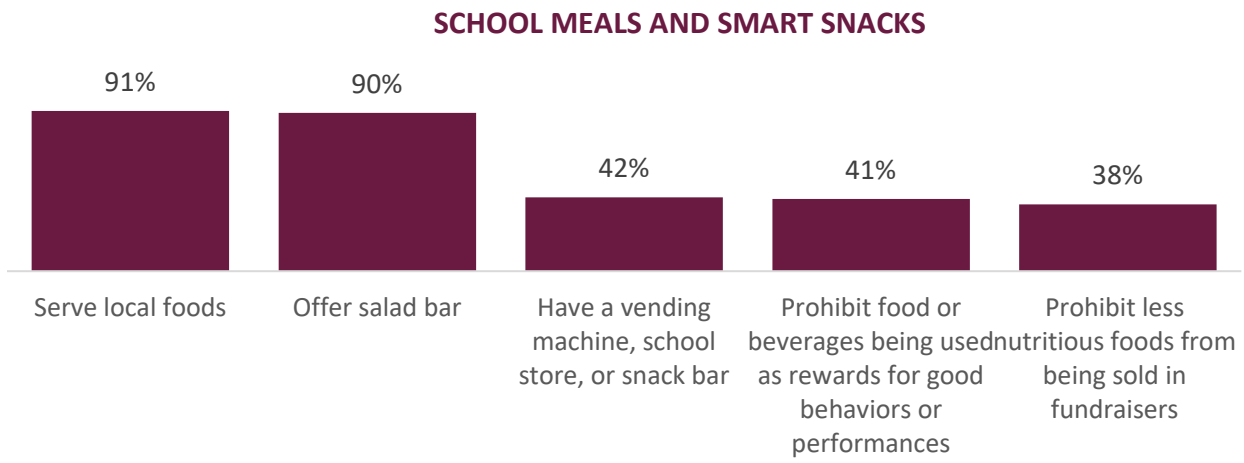


* https://www.cdc.gov/healthyschools/npao/schoolmeals.htm
† https://www.cdc.gov/healthyschools/npao/smartsnacks.htm
‡ While food sold in fundraisers is included as a competitive food and required to meet smart snack standards, schools may exempt an infrequent number of fundraisers from meeting these standards each year.

Vending machines, school stores, and snack bars cont.

About four in ten schools allow students to purchase snack foods or beverages outside of the school meal program (42%). These are typically available in vending machines, school stores, canteens, or snack bars.*

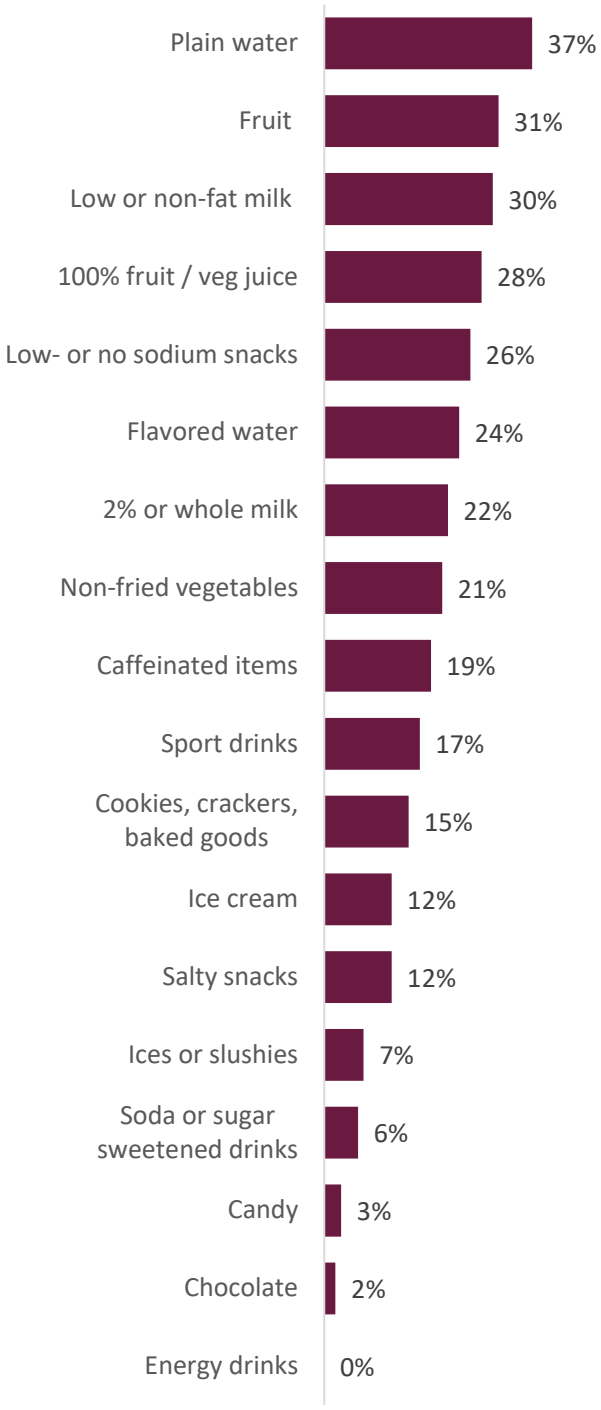
Overall, three-quarters of schools (75%) do not sell less healthy foods and beverages such as candy, including chocolate candy, salty snacks that are not low in fat, cookies, crackers, cakes, pastries, other baked goods that are not low in fat, soda or sugar-sweetened fruit drinks, and sport drinks.

No Vermont schools allow students to purchase energy drinks such as Red Bull or Monster, however, two in ten schools (19%) allow students to purchase other caffeinated items; one in 15 (6%) permit the sale of soda or fruit drinks that are not 100% juice.

Other items sold in school vending machines, school stores, canteens, or snack bars are shown to the right.

Overall, high schools are four times as likely to allow students to purchase snack foods and beverages form vending machines, school stores, canteens, or snack bars compared to middle schools (84% vs 21%). Differences in products available for sale by school type are shown in Appendix A.

SNACK FOOD AND BEVERAGES SOLD OUTSIDE THE SCHOOL MEAL PLAN



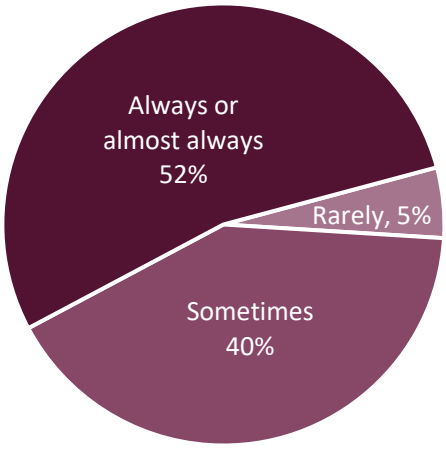
* Includes schools with and without vending machines, school stores, and snack bars. Schools without vending machines, school stores, and snack bars are counted as not selling foods and beverages.

Using Food and Drinks as Rewards and in School Celebrations

Most schools allow food and beverages to be offered during school celebrations (97%). When food is available, half (52%) schools always or almost always include fruit or non-fried vegetable options. See Appendix A for differences by school type.

Four in ten schools (41%) prohibit school staff from giving students food or food coupons as a reward for good behavior or academic performance.

AVAILABILITY OF FRUITS AND NON-FRIED VEGETABLES DURING SCHOOL CELEBRATIONS

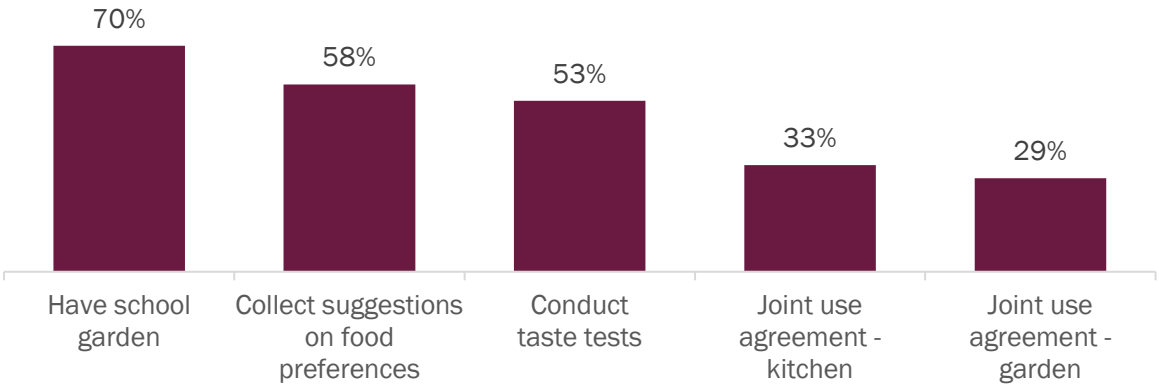


Healthy Learning Opportunities

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

Seven in ten (70%) planted a school garden. Just over half collected suggestions from students, families and staff on nutritious food preferences and strategies to promote healthy eating (58%) and conducted taste tests to determine food preferences (53%). A third or fewer schools have a joint use agreement for shared kitchen facilities or equipment (33%) or a garden (29%) with their community.

HEALTHY LEARNING OPPORTUNITIES

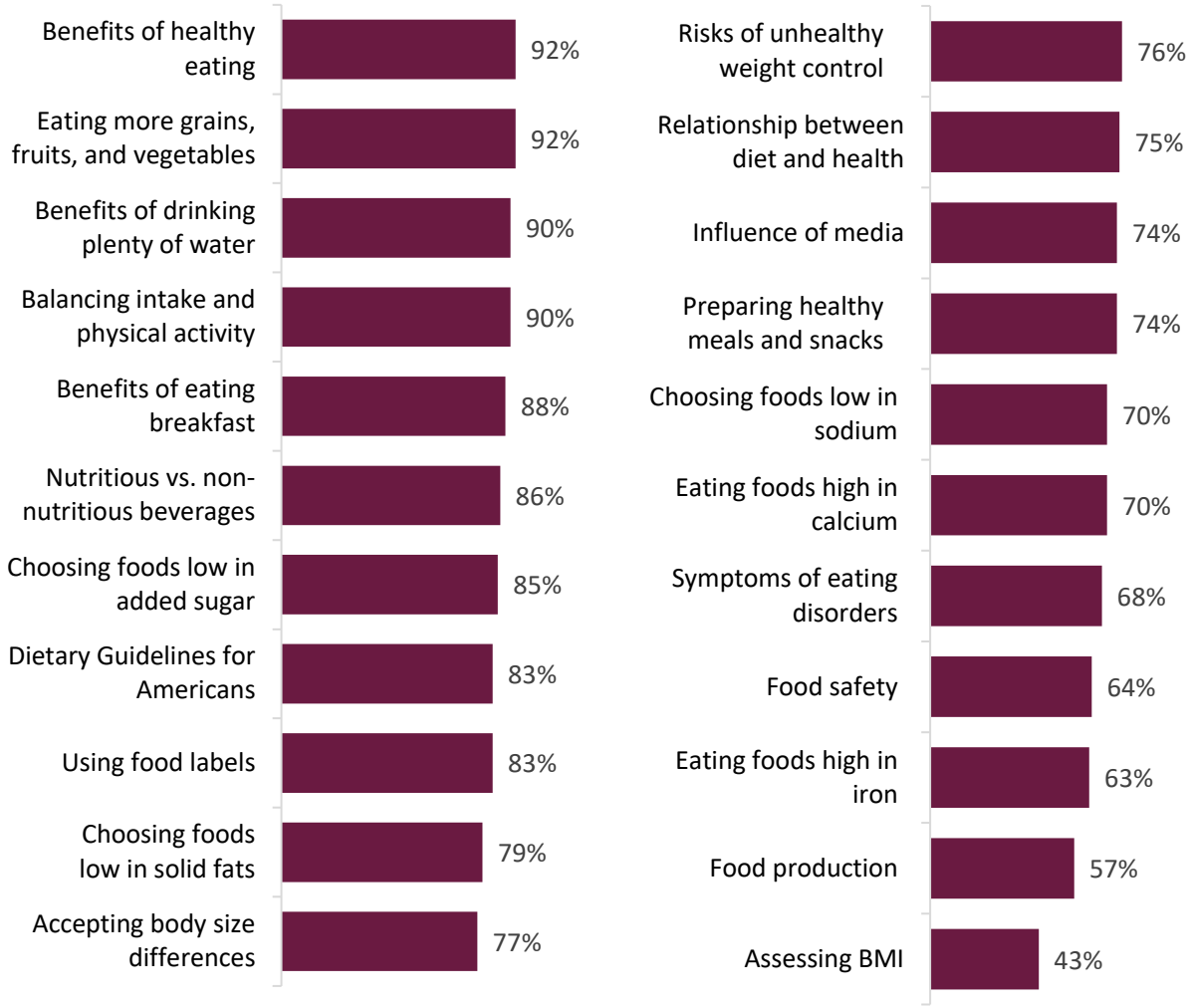


* https://www.cdc.gov/healthyschools/npao/healthy_eating_learning_opportunities.htm

THE WHAT WE ARE DOING: NUTRITION IN HEALTH EDUCATION

During the current school year, less than a quarter (23%) of LHEs taught about all 22-key nutrition and dietary behavior topics measured. Individual topics included in health education curriculum are shown below. Overall high schools were more likely to cover topics related to nutrition compared to middle schools. Differences by school type are shown in Appendix A.

NUTRITION RELATED TOPICS TAUGHT IN HEALTH EDUCATION



TRENDS IN SUPPORTIVE SCHOOL NUTRITION ENVIRONMENT POLICIES AND PRACTICES

Significant changes in nutrition policies and practices. Over the past decade, the percent of schools in which students can purchase snack foods or beverages from vending machines, school stores, or snack bars has decreased from 70% to 42%. This did not significantly change between 2018 (44%) and 2020. Overall selling less healthy foods did not significantly change between 2018 and 2020. Between 2018 and 2020 significant more schools allowed students to purchase food or beverages containing caffeine (13% vs 19%), fruit (22% vs 31%), non-fried vegetables (16% vs 21%), and non-fat or 1% milk (24% vs 30%).

Between 2018 and 2020, fewer schools conducted taste tests to determine food preferences (63% vs 53%), planted a garden (77% vs 70%), served local or regional foods (95% vs 91%) and always or almost always offer fruits or non-fried vegetables at school celebrations (59% vs 52%). More schools offered a salad bar (83% vs 90%), encouraged students to drink water (89% vs 92%, and prohibited staff from giving students food or food coupons as a reward for good behavior or academic performances (31% vs 41%).

During the past two years, the percent of schools who offer water in indoor and outdoor physical activity facilities significantly increased from 94% to 97% and 57% to 63%, respectively. Offering water in school hallways also increased from 97% in 2018 to 100% in 2020.

Significant trends in teaching nutrition. Overall, fewer LHEs taught all 22 nutrition and dietary behavior topics in 2020 (23%) compared to those in 2018 (37%). Specifically, in 2020 fewer LHEs taught about food production (65% vs 57%), assessing BMI (49% vs 43%), food safety (71% vs 64%), choosing foods low in solid fats (85% vs 79%), and eating foods that are high in calcium (80% vs 70%), iron (75% vs 63%), and low in sodium (80% vs 70%) compared to those in 2018.

Sexual Health

Exemplary Sexual Health Education

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

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

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

Exemplary Sexual Health Education Programs

Key Features	Supported Outcomes
▪ Medically accurate ▪ Based on scientific evidence ▪ Developmentally appropriate ▪ Inclusive of all youth regardless of gender or sexual orientation ▪ Comprehensive classroom instruction that focuses on increasing student knowledge, developing critical skills, and practices and attitudes needed to avoid negative health outcomes ▪ Expands beyond classroom instruction to include access to sexual health services, on and off school property	▪ Delayed onset of sexual activity ▪ Reduced frequency of sexual activity and number of sexual partners ▪ Increased use of condoms and highly effective contraceptives ▪ Decreased rates of teen pregnancies, STD's and HIV infections ▪ Increased use of sexual health services

WHAT WE KNOW:
SEXUAL HEALTH BEHAVIORS AMONG HIGH SCHOOL STUDENTS

Ever having sexual intercourse (40%) and having sexual intercourse during the past three months (31%) has not significantly changed over the past decade.

Condom use among sexually active students has significantly decreased over the past decade from 63% in 2007 and continued to decrease between 2017 (56%) and 2019 (54%).

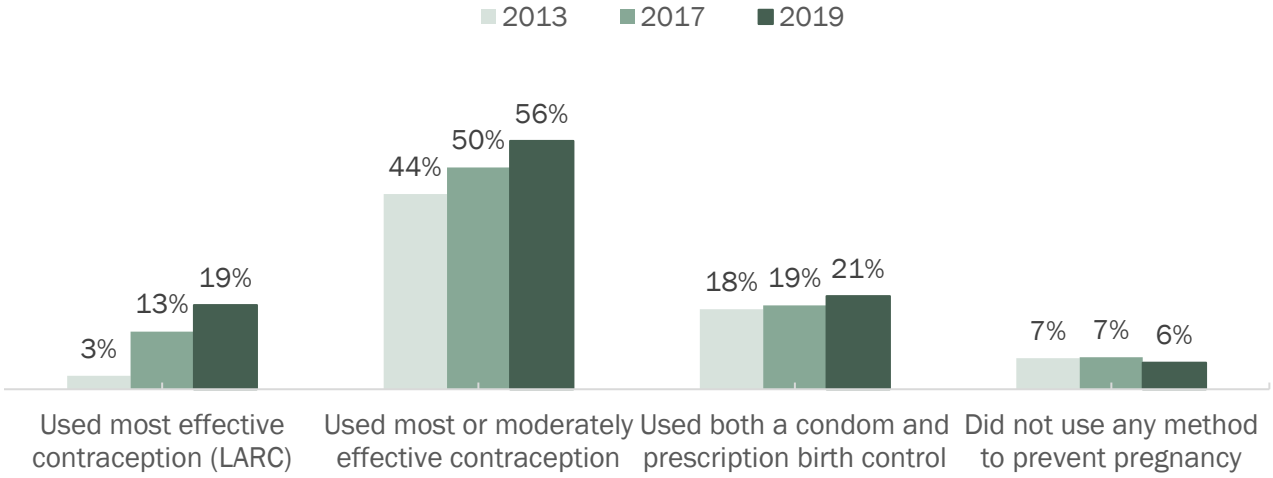
Use of most effective (Long Acting, Reversible Contraceptives (LARC) (i.e., implants, intrauterine device (IUD)), most or moderately effective (i.e., injectables, oral pills, patch, or ring), and dual use of a condom and birth control have significantly increased since first asked in 2013.*

Overall, more than half of sexually active students (56%) used the most effective or moderately effective methods of contraception to prevent pregnancy the last time they had sexual intercourse.

More than one in five (21%) used both a condom and prescription birth control the last time they had sexual intercourse. Six percent reported not using any method to prevent pregnancy.

During the past 12 months, 11% of students were tested for a sexually transmitted disease (STD) such as chlamydia or gonorrhea.

PREGNANCY PREVENTION AND CONDOM USE, AMONG CURRENTLY SEXUALLY ACTIVE HIGH SCHOOL STUDENTS



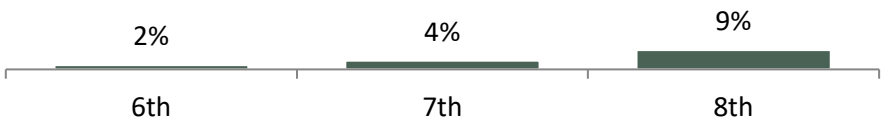
* Due to changes in question wording, long term trend data is not available for use of any prescription birth control.

WHAT WE KNOW:
SEXUAL HEALTH BEHAVIORS AMONG MIDDLE SCHOOL STUDENTS

Overall, 5% of middle school students have ever had sexual intercourse. Among students who have ever had sexual intercourse, nearly six in ten (58%) used a condom the last time they had sexual intercourse.

No additional questions about current sexual activity or other sexual behaviors were asked of middle school students.

LIFETIME SEXUAL INTERCOURSE AMONG MIDDLE SCHOOL STUDENTS DOUBLES WITH EACH INCREASING GRADE LEVEL



WHAT WE ARE DOING: SEXUAL HEALTH SERVICES

Three-quarters of schools (73%) do not provide any direct sexual or reproductive health services; about half (44%) do not provide referrals for sexual health services off school property.

Both direct and indirect services provided vary by type of services requested, parental notification and consent required, and school type. Differences in sexual health services by school type are shown in Appendix A

Direct and Indirect Sexual Health Services

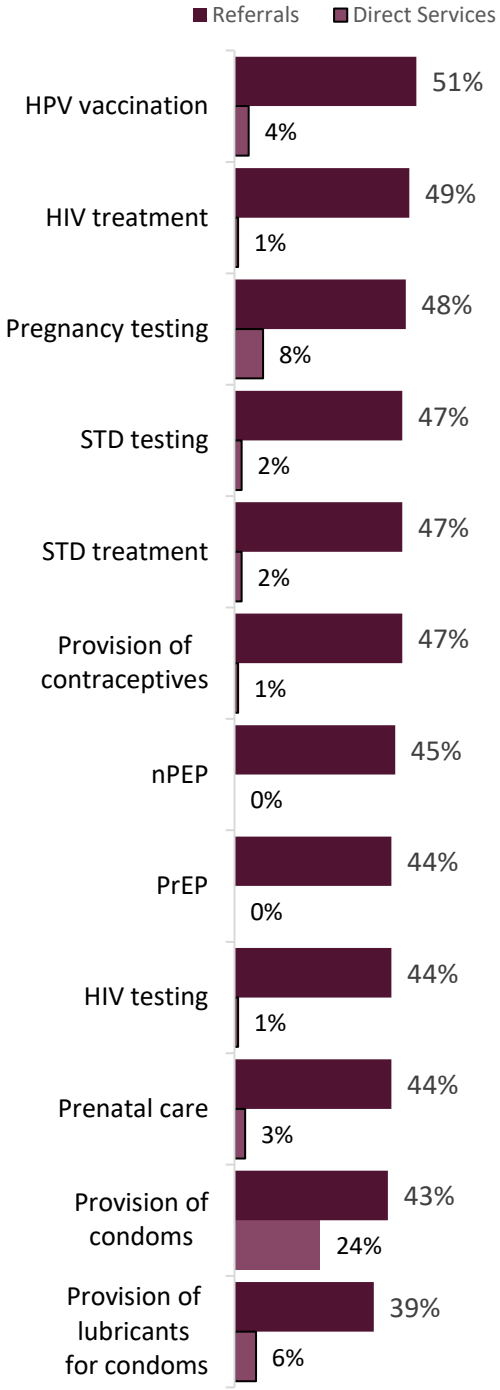
Direct Services Provided on School Property for Sexual Health Services.

Over a quarter of schools (27%), provide at least one sexual health service on school property primarily through the provision of condoms (24%). Less than one in ten schools provide other direct sexual health services on school property (shown to the right).

Referrals to Community Providers for Sexual Health Services.

More than half of all schools (56%) provide referrals for sexual health services to an organization or health care professional not on school property.

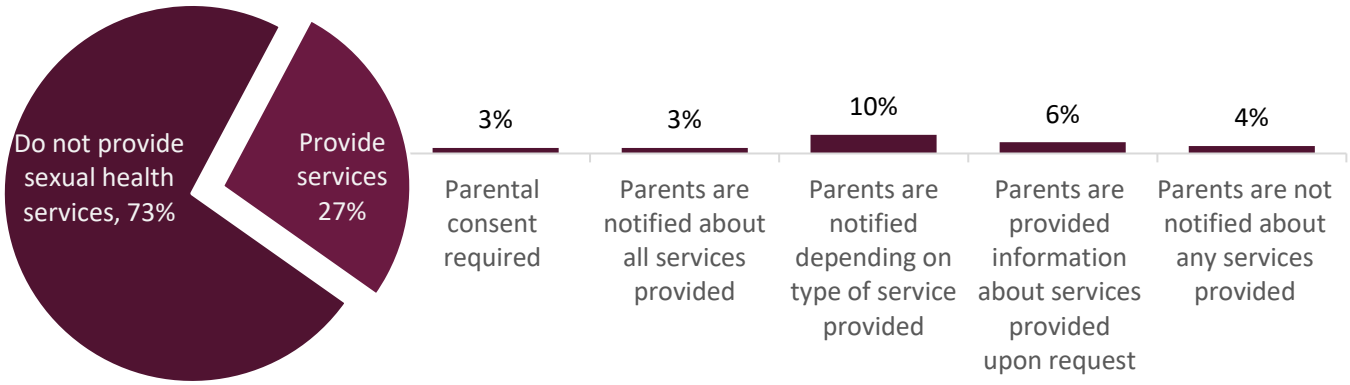
SEXUAL HEALTH SERVICES: REFERRALS AND DIRECT SERVICES



Parental Consent and Notification for Direct and Indirect Sexual Health Services

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

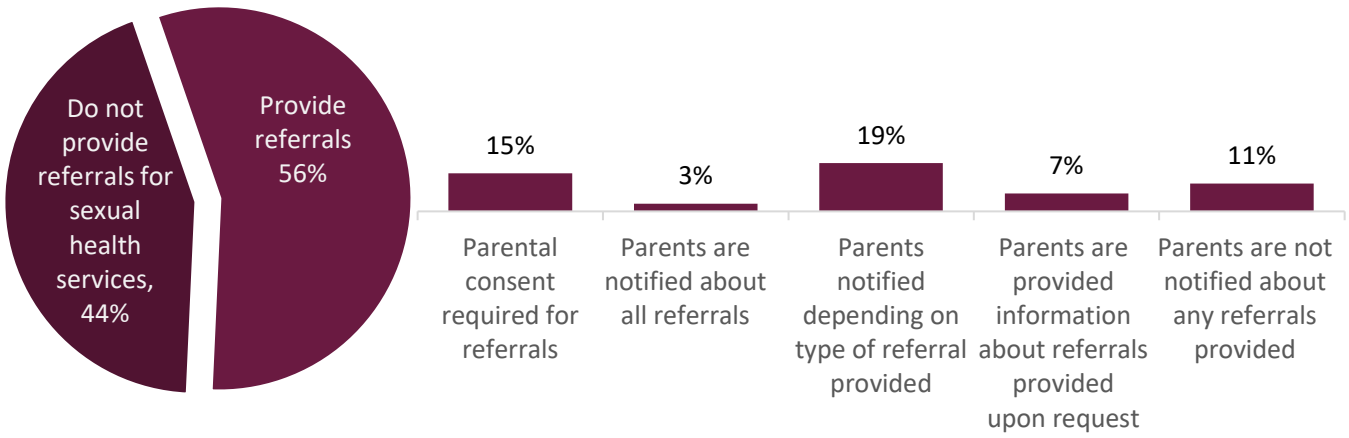
PARENTAL CONSENT AND NOTIFICATION FOR SEXUAL HEALTH SERVICES PROVIDED ON SCHOOL PROPERTY



Referrals to sexual health services. Communication with parents about referrals for sexual health services follows a similar pattern to services provided on school property with most schools requiring parental notification depending on type of referral provided.

Middle schools were significantly less likely to provide referrals for sexual health services and are more likely to require parental consent for any referral. See Appendix A for differences by school type.

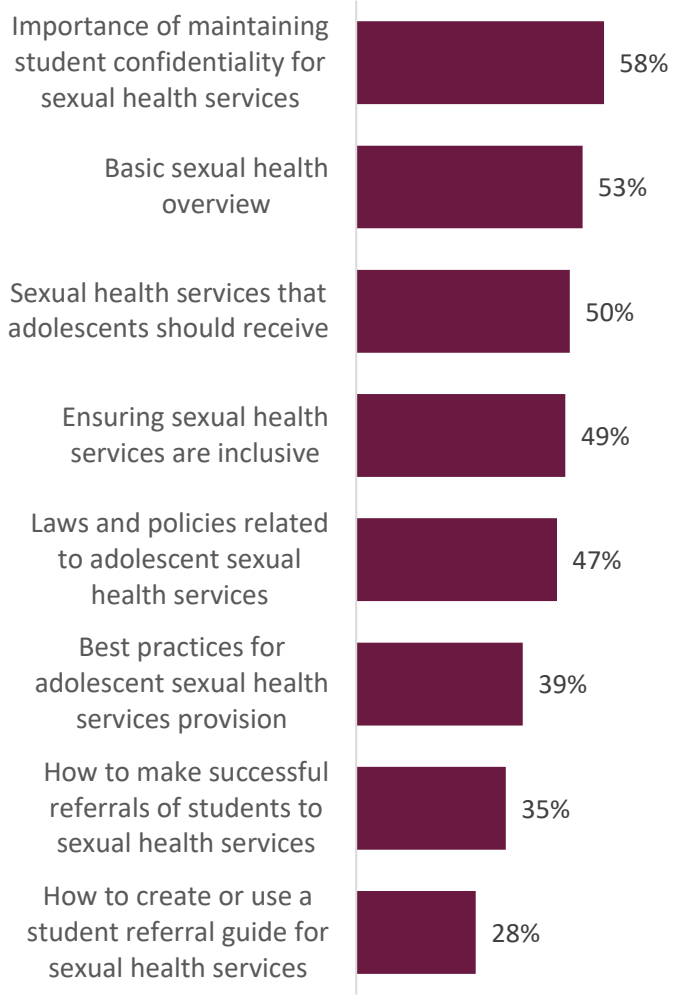
PARENTAL CONSENT AND NOTIFICATION FOR REFERRALS TO SEXUAL HEALTH SERVICES



Professional Development Related to Sexual Health Services

Staff at a quarter of schools (25%) received professional development related to all eight sexual health services topics during the past two years. Specific topics are shown below. Differences by school type are shown in Appendix A.

PROFESSIONAL DEVELOPMENT RECEIVED BY ANY STAFF RELATED TO SEXUAL HEALTH SERVICES



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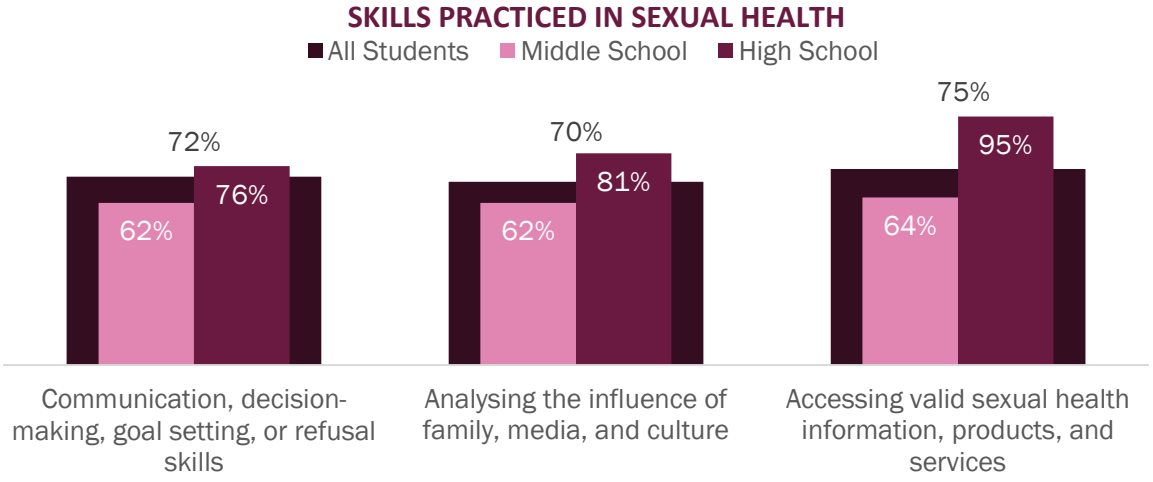
WHAT WE ARE DOING:
SEXUAL HEALTH EDUCATION

More than nine in ten LHEs (93%) taught about human sexuality in a health education course. At least seven in ten provide students with opportunities to practice skills related to sexual health.



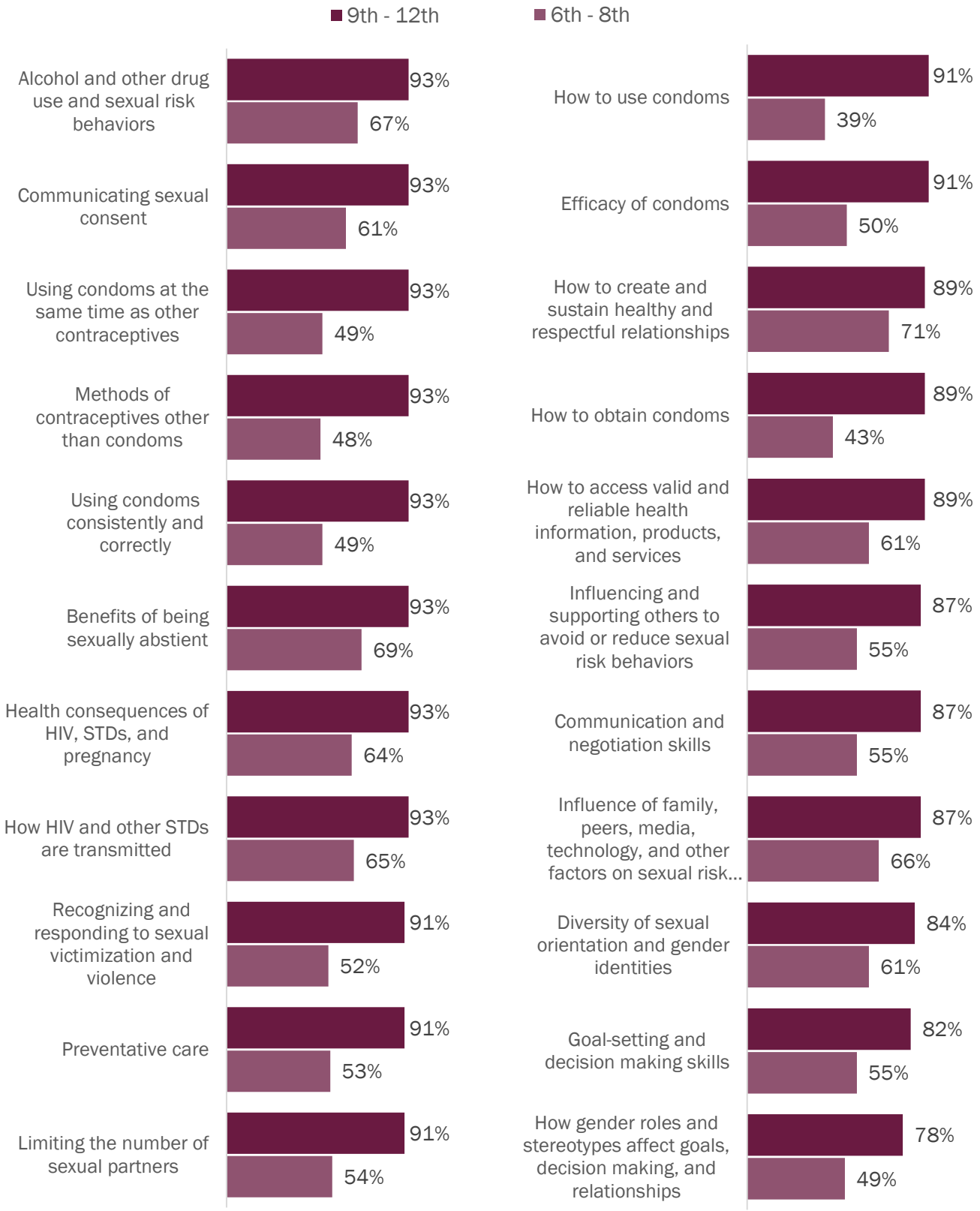
Sexual Health Education Topics Taught

Specific sexual health topics covered in a required course and assessing skills related to sexual health were asked separately for students in grades 6 through 8 and grades 9 through 12. Topics by grade levels are shown on the following page.

Grades 9 - 12. Just over half of all LHEs (52%) taught all 22 sexual health topics in a required health course for students in grades 9 through 12. More than half of these topics were taught by more than nine in ten LHEs.

Grades 6 - 8. A quarter of all LHEs (25%) taught all 22 sexual health topics in a required health course for students in grades 6 through 8. No topics were covered by more than 75% of LHEs. In a required 6th through 8th grade health course, a third were covered by less than half.

SEXUAL HEALTH TOPICS TAUGHT IN A REQUIRED HEALTH EDUCATION COURSE

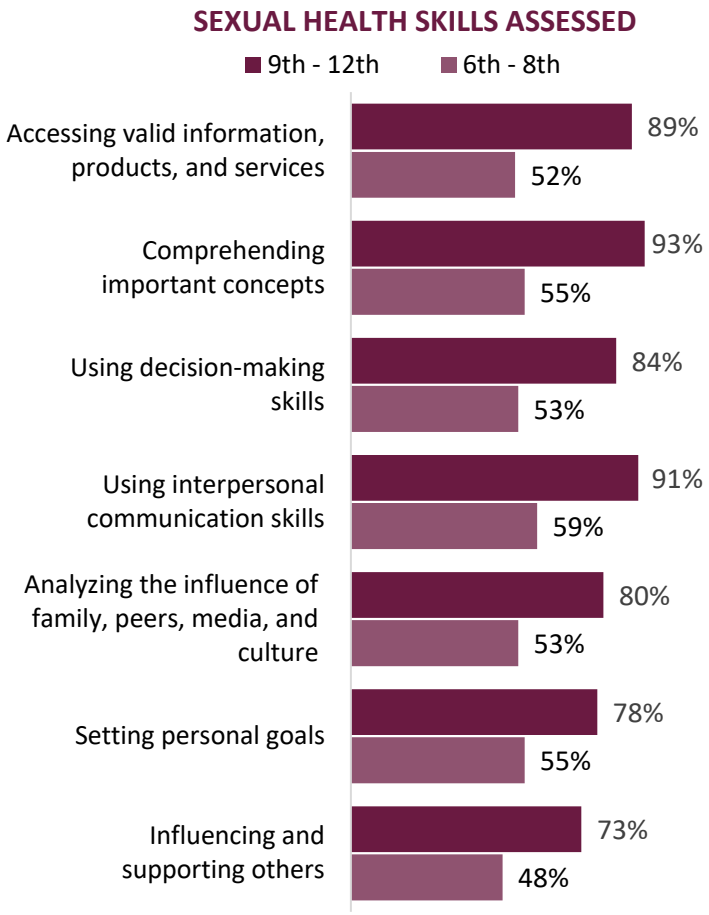


Assessing Skills Related to Sexual Health

Skills assessed in a required health education course for student in grades 6 through 8 and grades 9 through 12 are shown to the right.

Grades 9 - 12. Nearly half (48%) of LHEs assessed the ability of students to perform all seven skills in a required course for students in grades 9 through 12. More than nine in ten, assessed student's ability to comprehend concepts important to prevent HIV, other STDs, and pregnancy (93%) and using interpersonal communication and decision-making skills to avoid or reduce sexual risk behaviors (91%).

Grades 6 - 8. During the past year, about a third of LHEs assessed the skills of students in grades 6 through 8 to perform all seven sexual health skills. Most skills were assessed by just over half of all LHEs.



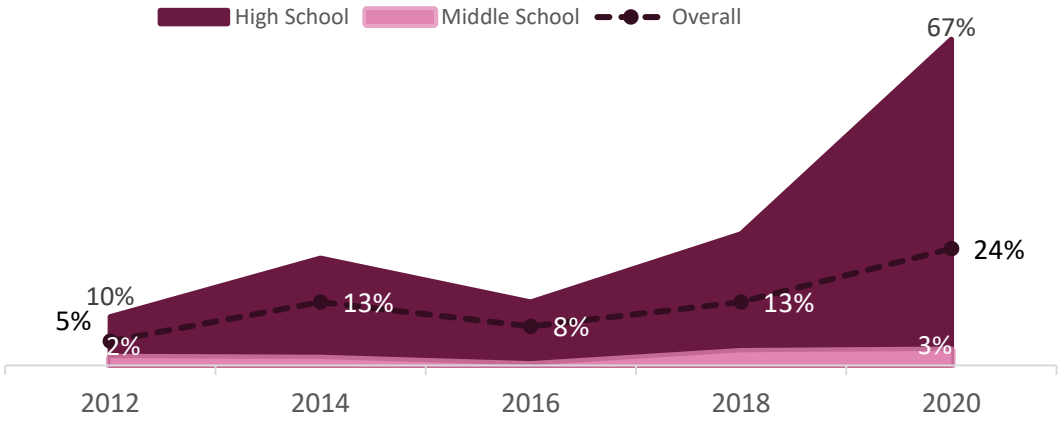
TRENDS IN SEXUAL HEALTH

Sexual health referrals and services. Since 2012, fewer schools have provided referrals for HIV testing, pregnancy testing and prenatal care (56% vs 44%, 58% vs 48%, and 51% vs 44%, respectively); significantly more schools have administered the human papillomavirus (HPV) vaccine (1% vs 4%) and provided condoms to students (5% vs 24%). Since 2014, providing condom-compatible lubricants have doubled (3% vs 6%).

Between 2018 and 2020, referrals for sexual health services remained stable. Schools providing pregnancy testing, prenatal care, and condom-compatible lubricants roughly doubled between 2018 and 2020 (4% to 8% and 2% to 3% and 3% to 6%, respectively). Offering HIV treatment significantly decreased between 2018 and 2020 (3% vs 1%)

Since 2016, the percent of schools providing students with condoms at school has tripled and is five times higher than it was in 2012. Most notable, more than five times as many high schools providing condoms to students in 2020 compared to 2016 (13% vs 67%) and more than doubled between 2018 and 2020 (27% vs 67%). High school student access to condom-compatible lubricants also increased from 4% in 2018 to 20% in 2020.

PROVISION OF CONDOMS ON SCHOOL PROPERTY



Parental consent and notification practices. Parental consent and notification practices for sexual health services and referrals were first asked in 2016. Since that time fewer schools required parental consent before any sexual or reproductive health services were provided (8% vs 3%) with significantly more schools notifying parents about all sexual health services provided (2% vs 3%) or about services provided only upon request (3% vs 6%). For referrals to sexual or reproductive health services, not requiring parental consent or notifying parents significantly increased from 6% in 2016 to 11% in 2020.

Healthy, Safe, and Supportive Environments

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

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

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

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

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

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

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

WHAT WE KNOW:
SAFE & INCLUSIVE SCHOOL ENVIRONMENTS

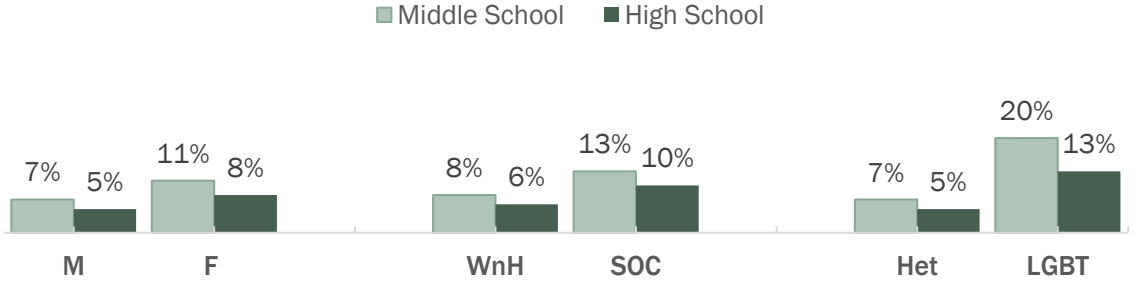
Among Vermont youth, LGBT and students of color have higher prevalence of many risk behaviors such as physical and sexual violence, and bullying, suicide, depression and addiction and are more likely to be threatened and skip school because they feel unsafe compared to heterosexual / cisgender and white,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

Results showing health inequities among Vermont youth by year in school, sex, sexual orientation, race and ethnicity, and geography are available in the YRBS Populations of Interest reports.

Felt Unsafe At or On Their Way to School

During the previous 30 days, 6% of high school and 9% of middle school students skipped school because they felt unsafe at school or on their way to or from school. Female students and students of color are significantly more likely than male students and white, non-Hispanic students to skip school because they felt unsafe during the past month. LGBT students are nearly three times as likely as heterosexual students to report skipping school during the past 30 days because they felt unsafe.

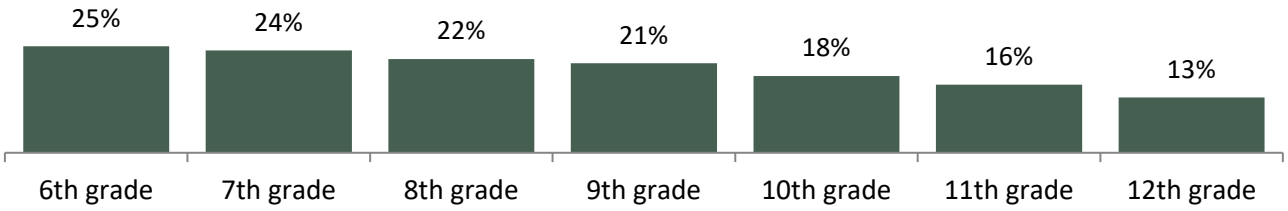
SKIPPED SCHOOL BECAUSE THEY FELT UNSAFE, PAST 30 DAYS



Bullying

During the past 30 days, 17% of high school students and nearly a quarter of middle school students (24%) were bullied. Bullying is more likely to occur among groups, such as LGBTQ youth, transgender youth, socially isolated youth, over- or under-weight, or those who are perceived weak, different, less popular, or have low self-esteem are more likely to experience bullying. [25] Unlike many other risk factors, bullying tends to decrease as students get older.

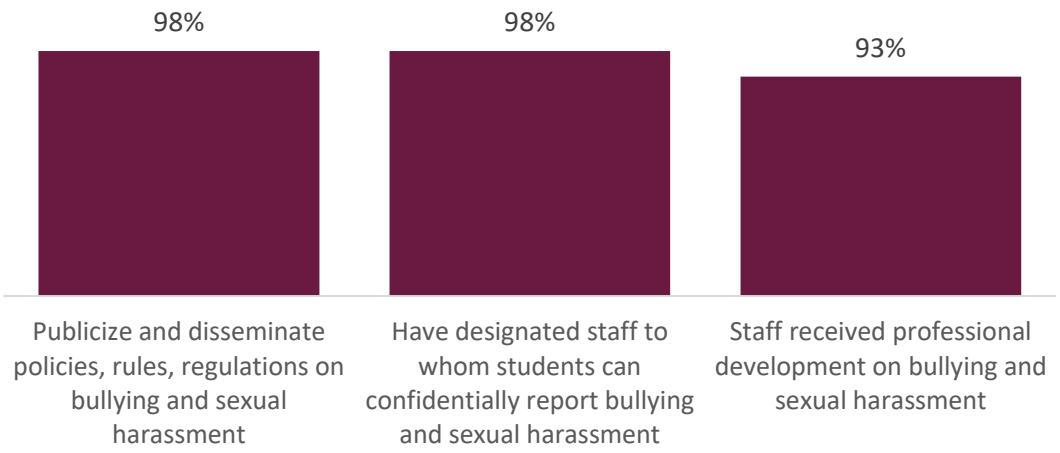
PERCENT OF STUDENTS WHO REPORTED BEING BULLIED DURING THE PAST 30 DAYS



WHAT WE ARE DOING:
SAFE AND SUPPORTIVE SCHOOL ENVIRONMENT

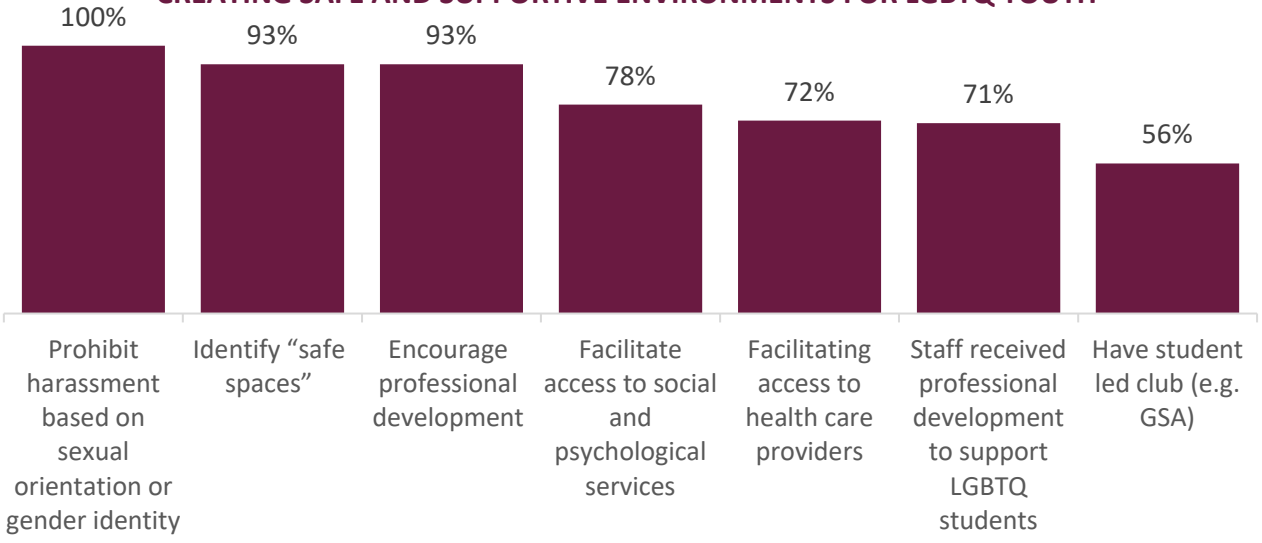
Nearly all schools use electronic, paper, or oral communication to publicize and disseminate policies, rules, or regulations on bullying and sexual harassment, including electronic aggression (98%) and have designated staff to whom students can confidentially report student bullying and sexual harassment (98%). Most (93%) provided professional development to all staff on preventing, identifying, and responding to student bullying and sexual harassment.

BULLYING AND SEXUAL HARASSMENT



All schools (100%) prohibit harassment based on a student's perceived or actual sexual orientation or gender identity. Four in ten (41%) implement practices related to creating safe and supportive environments for lesbian, gay, bisexual, transgender, and questioning youth. Differences by school type are shown in Appendix A.

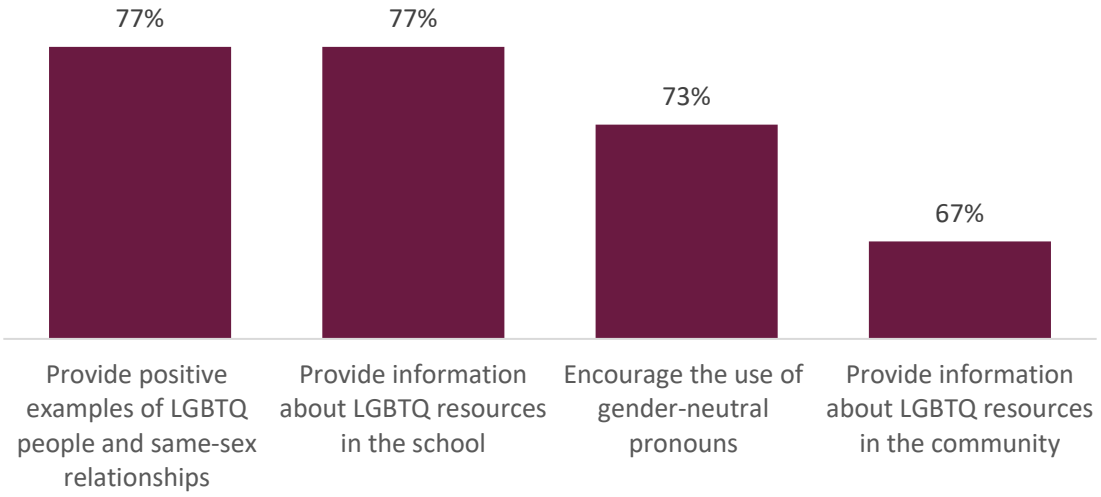
CREATING SAFE AND SUPPORTIVE ENVIRONMENTS FOR LGBTQ YOUTH



WHAT WE ARE DOING:
SAFE AND SUPPORTIVE ENVIRONMENTS THROUGH HEALTH EDUCATION

While teaching sexual health education, 89% of LHEs encouraged students to respect others' sexual and gender identities. While teaching sexual health education roughly three-quarters of LHEs encourage the use of gender-neutral pronouns such as "they/them" to recognize gender diversity among students (73%), provide positive examples of LGBTQ people and same-sex relationships (77%), and provide students with information about LGBTQ resources (77%) and within the community (67%). Differences by school type are shown in Appendix A.

CREATING SAFE AND SUPPORTIVE ENVIRONMENTS FOR LGBTQ YOUTH IN HEALTH EDUCTION

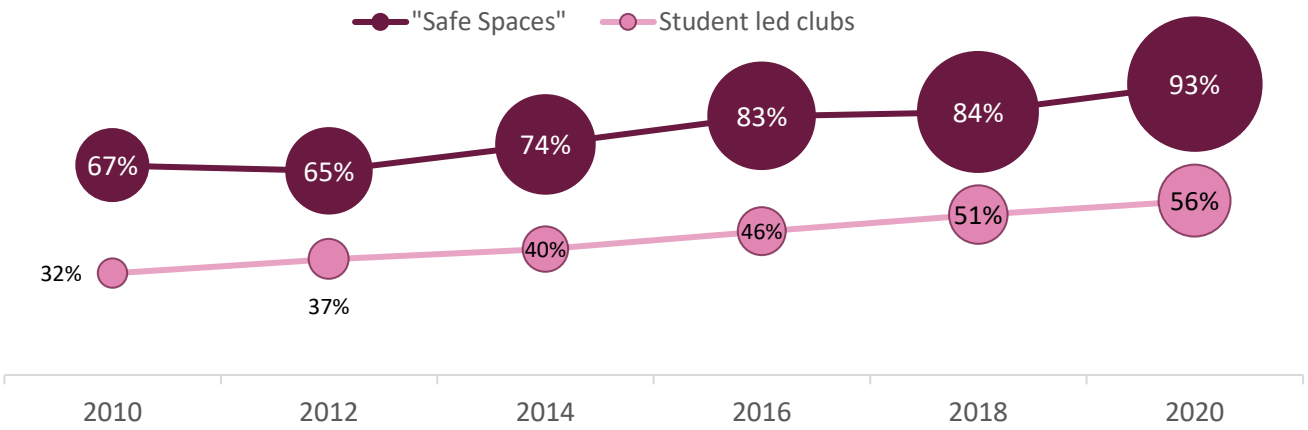


SAFE AND SUPPORTIVE SCHOOL ENVIRONMENT TRENDS

Trends Creating Safe and Supportive Environments. Over the past decade, activities related to creating safe and supportive environments for LGTBQ youth have significantly increased from 19% in 2010 to 41% in 2020.

In 2020, more than half of all schools (56%) had a student-led club that aims to create a safe, welcoming, and accepting school environment for all youth regardless of sexual orientation or gender identity compared to a third of schools (32%) a decade ago. Identifying "safe spaces" where LGBTQ student can receive support from administrators, teachers, or other staff has significantly increased from 67% in 2010 and from 84% in 2018.

HAVING A STUDENT-LED CLUB TO CREATE SAFE, WELCOMING, AND ACCEPTING SCHOOL ENVIRONMENTS AND SCHOOLS THAT IDENTIFY "SAFE SPACES" FOR LGBTQ YOUTH HAS SIGNIFICANTLY INCREASED OVER THE PAST DECADE



Since 2010 and between 2018 and 2020, access has increased for LGBT youth connect with providers not on school property who have experience in providing health services (54% vs 67% vs 72%, respectively) and social and psychological services (62% vs 67% vs 78%).

The percent of schools in which all staff received professional development on preventing, identifying, and responding to student bullying and sexual harassment significantly increased from 2014 (90%) and between 2018 and 2020 (88% vs 93%). Encouraging staff to attend professional development on safe and supportive school environments for all students, regardless of sexual orientation or gender identity also significantly increased from 2010 (80%) and between 2018 and 2020 (88% vs 93%).

Trends Creating Safe and Supportive Environments through Health Education. The percent of schools that provide curricula or supplemental materials that include HIV, STD, or pregnancy prevention information that is relevant for LGBTQ youth has significantly increased since 2010 (43%) and between 2018 and 2020 (65% vs 72%).

In addition, the percent of schools that provide curricula or supplementary materials that include HIV, STD, or pregnancy information that is relevant to LGBTQ youth has significantly increased from 43% in 2010 to 65% in 2018 to 72% in 2020.

WHAT WE KNOW:
STUDENT, FAMILY & COMMUNITY ENGAGEMENT

School and Community Engagement – Extracurricular participation

During a typical week, a quarter of high school students (24%) spend ten hours or more participating in extracurricular activities such as sports, band, drama, or clubs run by the school or the community. A third (34%) did not participate in any activities.

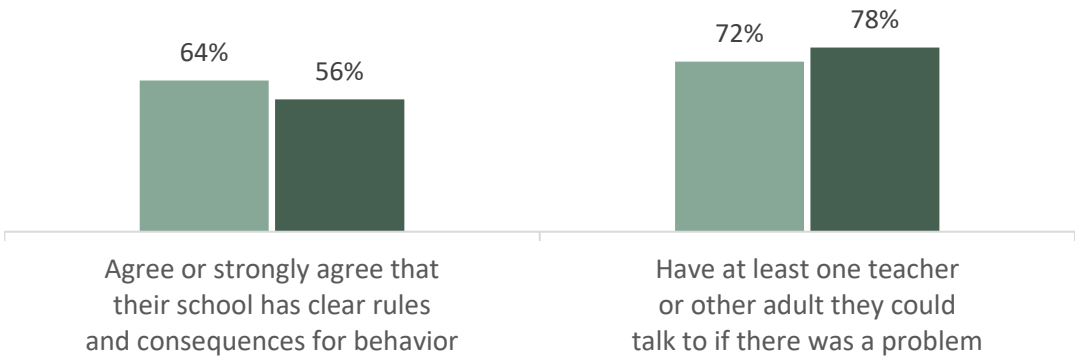
Seven in ten middle school students participated on at least one sport team during the past year (72%). Nearly a third participated on three or more teams (31%).

School Connectedness

Two-thirds of middle school students (64%) and just over half of all high school students (56%) agree or strongly agree that their school has clear rules and consequences for behavior. Nearly two in ten middle school students (18%) and a quarter of high school students (24%) do not believe (strongly disagree or disagree) their school has clear rules and consequences for behaviors

Roughly three quarters of middle school (72%) and high school (78%) students have at least one teacher or other adult in their school that they can talk to if they have a problem. One in seven middle school (15%) and 11% of high school students were not sure or do not have someone they could talk to if they had a problem.

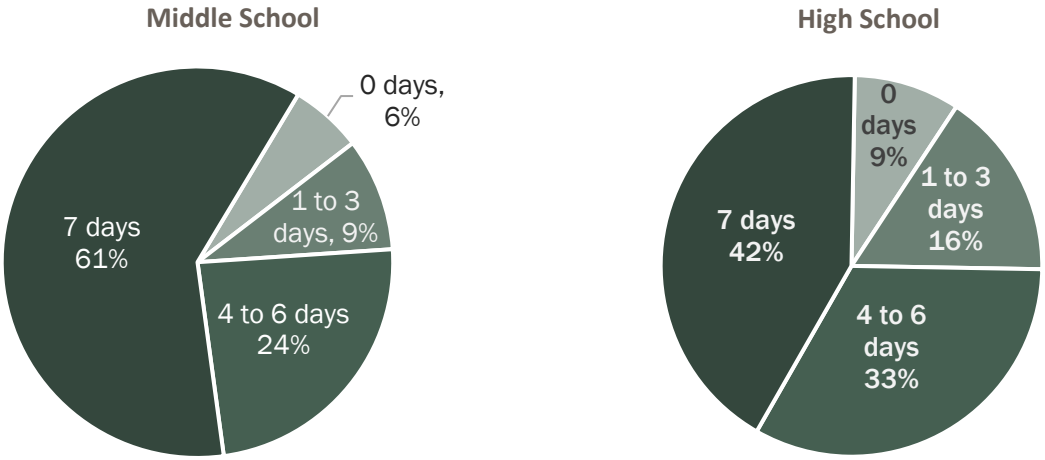
CLEAR RULES FOR BEHAVIOR & TRUSTED ADULTS AT SCHOOL



Family Engagement

Three quarters of high school students (75%) and 85% of middle school students ate dinner at home with at least one of their parents on four or more days during the previous week. Less than ten percent did not eat dinner with their parents during the past week.

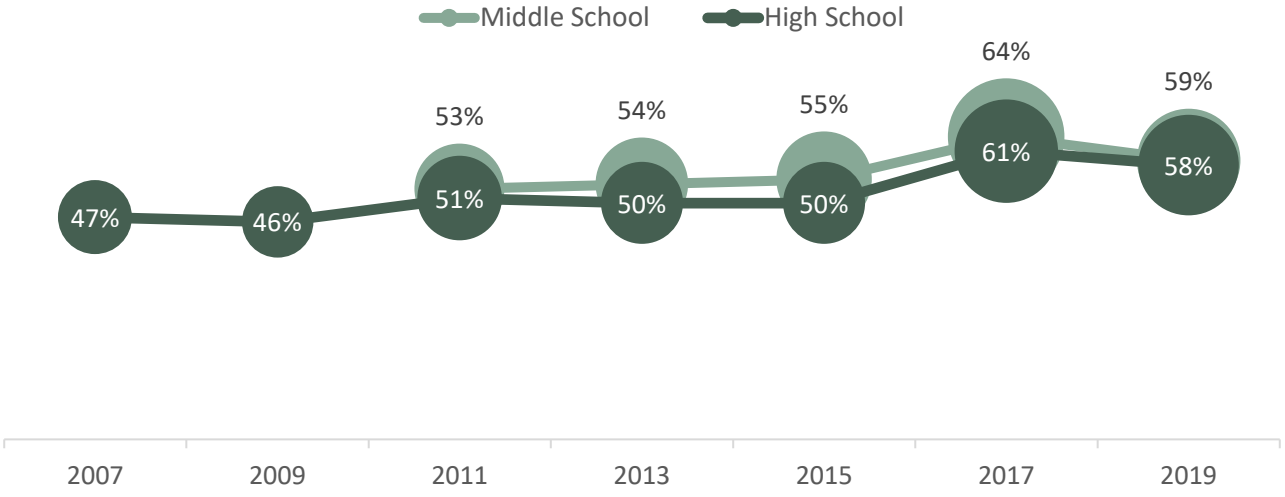
ATE DINNER AT HOME WITH PARENTS, PAST WEEK



Community Connectedness

About six in ten middle (59%) and high school students (58%) agree or strongly agree that they matter to people in their community. Feeling like one matters to the people in their community has significantly increased over the past decade but decreased between 2017 and 2019.

FEEL LIKE THEY MATTER BY PEOPLE IN THEIR COMMUNITY

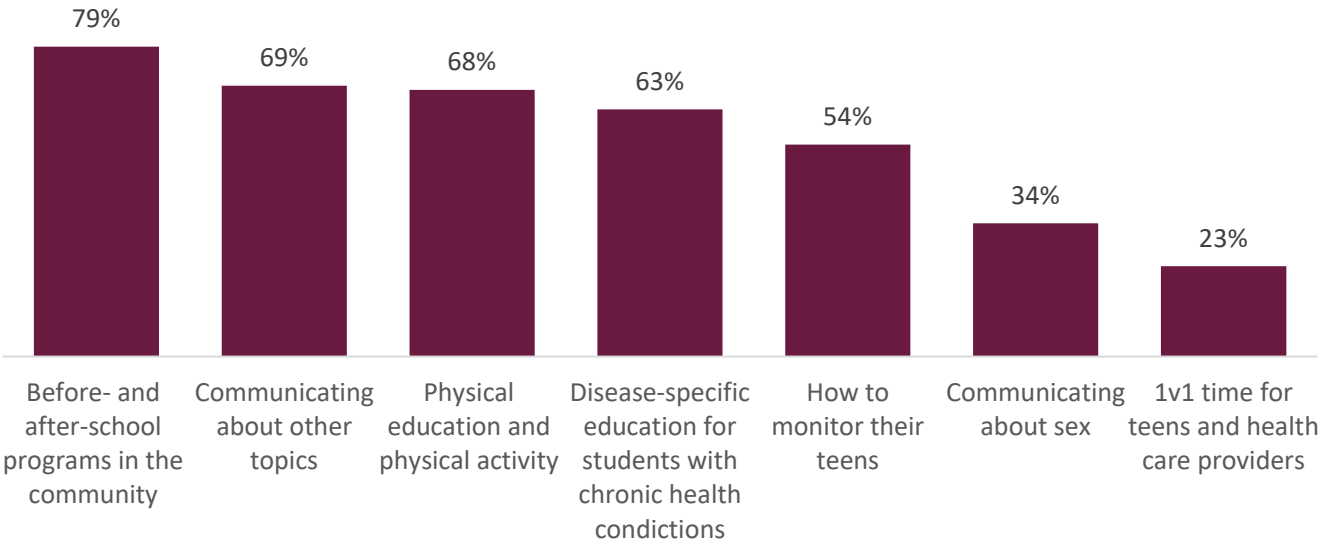


WHAT WE ARE DOING:
ENGAGING STUDENTS, SCHOOLS, FAMILIES, AND COMMUNITIES

Working with Parents and Families

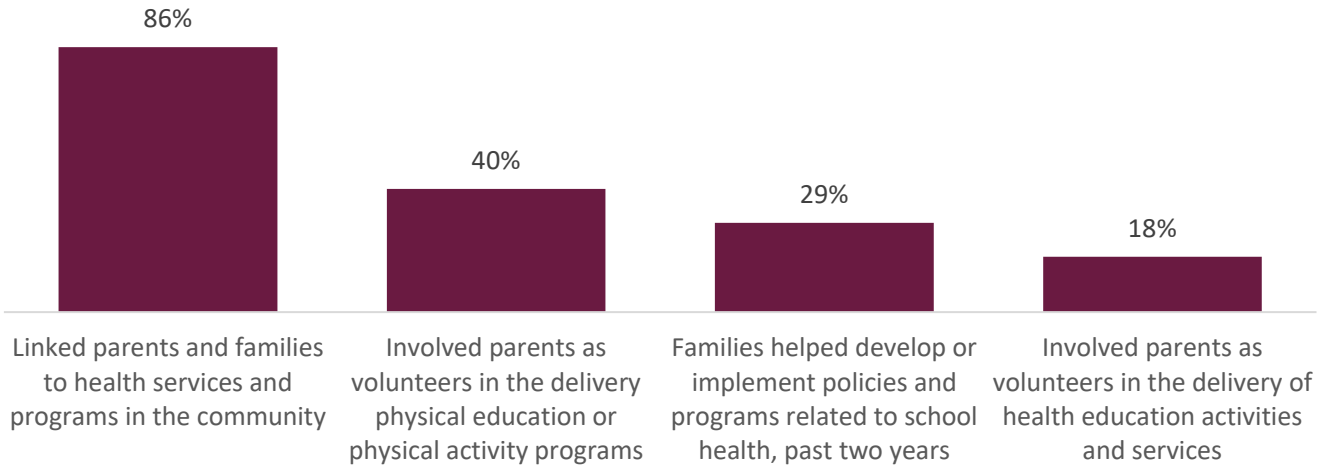
During the past year, schools provided parents with information to help support parent-adolescent communication and development. Types of information provided to parents and families are shown below.

INFORMATION PROVIDED TO PARENTS AND FAMILIES



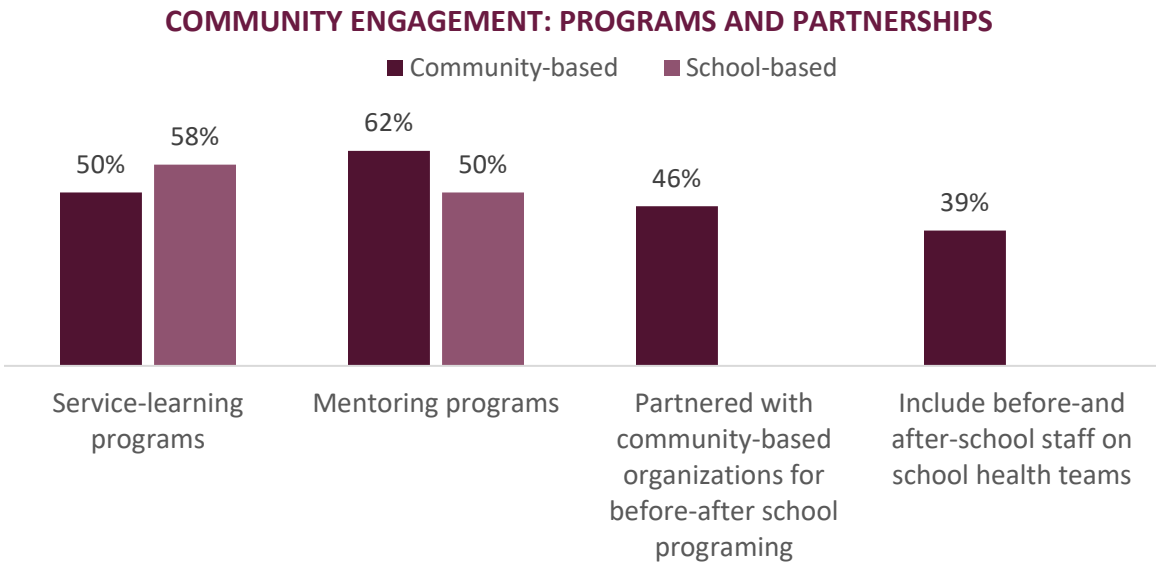
In addition, 86% of schools linked parents and families to health services and programs in the community; less than half involve parents and families in the development and delivery of services and activities. Differences in family engagement by school type are shown in Appendix A.

FAMILY ENGAGMENT

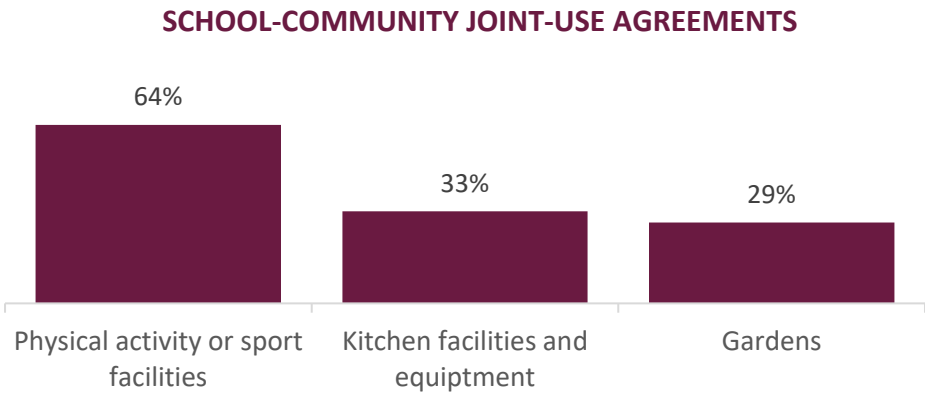


Engaging Communities

More than eight in ten schools (84%) participate in service-learning and mentoring programs. Specifically, about half of all schools implement school-based mentoring programs in which family or community members serve as role models to students or mentor students (50%), connect students to community-based service-learning programs (50%) and partnered with community-based organizations to provide students with before- or after-school programming (46%). Slightly more implement school-based service-learning programs (58%) and connect students to community-based mentoring programs (62%). About half (46%) partnered with community-based organizations (e.g., Boys & Girls Clubs, YMCA, 4H Clubs) to provide students with before-or after-school programming. About four in ten schools (39%) encouraged before- or after-school program staff or leaders to participate in school health council, committee, or team meetings.



In addition, nearly two-thirds of schools have joint use agreements for shared use of school or community sport or physical activity facilities (64%), a third (33%) have joint use agreements for shared use of kitchen facilities and equipment. Three in ten schools (29%) have joint use agreements for shared use of school or community gardens.

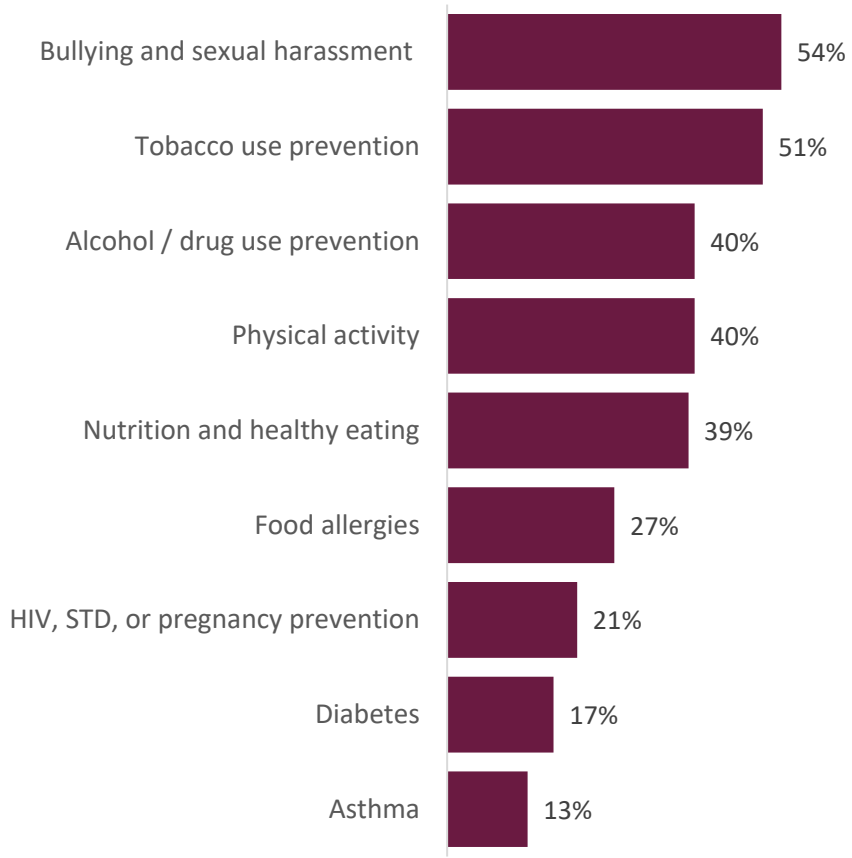


WHAT WE ARE DOING:
ENGAGING SCHOOLS, FAMILIES, AND COMMUNITIES IN HEALTH EDUCATION

Increasing Parent and Family Knowledge on Health-Related Topics

More than half of all LHEs (52%) gave students in health education homework assignments or activities to do at home with their parents during the past year. In addition, LHEs provide parents and families with content specific information to increase their knowledge on various health-related topics. See Appendix A for information by school type.

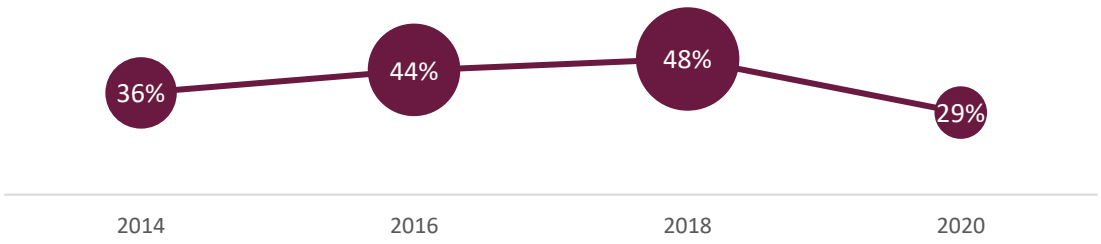
HEALTH RELATED INFORMATION PROVIDED TO PARENTS AND FAMILIES



TRENDS IN FAMILY AND COMMUNITY INVOLVEMENT

Trends in school policies and practices to increase family and community engagement. Strategies used to engage families and communities were first asked in 2014. Since 2014 and between 2018 and 2020, the percent of schools in which families help develop or implement policies and programs related to school health during the previous two years (36% vs 48% vs 29%) and who involved parents as school volunteers in the delivery of health education activities and services significantly decreased (33% vs 28% vs 18%). Between 2018 and 2020 fewer schools also provided parents and families with information about how to monitor their teen (63% vs 54%) and disease specific information for students with chronic health conditions (68% vs 63%).

HAVING PARENTS AND FAMILIES HELP DEVELOP OR IMPLEMENT POLICIES AND PROGRAMS RELATED TO HEALTH HAS SIGNFICANTLY DECREASED SINCE 2014



Trends to increase family and parental involvement in health education. In 2020, fewer LHEs (52%) provided students with homework to complete with their parents during the current school year compared to those in 2018 (59%) and 2014 (70%). Between 2018 and 2020 fewer LHEs provided parents and families with information about HIV, STD, or pregnancy prevention (29% vs 21%), nutrition and healthy eating (48% vs 39%), asthma (22% vs 13%), food allergies (37% vs 27%) and preventing student bullying and sexual harassment (74% vs 54%).

Vermont School Health Profiles: 2020 Report

Appendix A: Results by School Type

Table of Contents

Principal Survey

1. Percentage of schools that ever used the School Health Index or other self-assessment tool to assess school policies, activities, and programs in the following areas:	Overall %	MS %	JR/SR %	HS %
School Health Index to assess physical education and physical activity	64	59	83	58
School Health Index to assess nutrition	55	53	69	45
School Health Index to assess tobacco-use prevention	64	58	76	67
School Health Index to assess alcohol- and other drug-use prevention	62	56	72	67
School Health Index to assess chronic health conditions (e.g., asthma, food allergies)	36	36	47	26
School Health Index to assess unintentional injury and violence prevention	44	37	65	38
School Health Index to assess sexual health, including HIV, other STD, and pregnancy prevention	50	45	68	45

2. Percentage of schools with a School Improvement Plan that includes health-related objectives on the following topics:	Overall %	MS %	JR/SR %	HS %
SIP includes health education	29	27	30	33
SIP includes physical education	24	27	19	25
SIP includes physical activity	27	27	22	33
SIP includes school meal programs	21	21	19	25
SIP includes foods and beverages available at school outside the school meal programs	17	17	11	21
SIP includes health services	32	30	26	42
SIP includes counseling, psychological, and social services	63	54	71	76
SIP includes physical environment	40	41	34	43
SIP includes social and emotional climate	79	82	78	75
SIP includes family engagement	64	64	63	67
SIP includes community involvement	62	61	63	62
SIP includes employee wellness	37	36	30	45

3. Percentage of schools that reviewed health and safety data as part of school's improvement planning process.	Overall %	MS %	JR/SR %	HS %
Reviewed health and safety data	81	72	93	91

4. Percentage of schools that did the following activities during the past year:	Overall %	MS %	JR/SR %	HS %
Reviewed your district's local wellness policy	86	86	86	87
Helped revise your district's local wellness policy	59	53	61	74
Communicated to school staff about your district's local wellness policy	72	71	76	71
Communicated to parents and families about your district's local wellness policy	54	55	45	59
Communicated to students about your district's local wellness policy	47	46	46	50
Measured your school's compliance with your district's local wellness policy	46	48	39	50
Developed an action plan that describes steps to meet requirements of your district's local wellness policy	33	33	18	50

5. Percentage of schools that currently have someone who oversees or coordinates school health and safety programs and activities.	Overall %	MS %	JR/SR %	HS %
Someone oversees school health/safety programs	87	86	83	96

6. Percentage of schools that have one or more than one group (e.g., school health council, committee, team) that offers guidance on the development of policies or coordinates activities on health topics.	Overall %	MS %	JR/SR %	HS %
Group that offers guidance on health topics	73	67	72	88

7. Percentage of schools that have a school health council, committee, or team that did the following activities during the past year:	Overall %	MS %	JR/SR %	HS %
Council identified student health needs	80	79	80	81
Council recommended new/revised health and safety policies	77	70	76	90
Council sought funding to support health and safety priorities	77	74	81	80
Council communicated importance of health and safety policies	87	83	95	90
Council reviewed health-related curricula	81	79	81	85

8. Percentage of schools that have taken any of the following actions related to before- or after-school programs:	Overall %	MS %	JR/SR %	HS %
Included before or after-school settings as part of SIP	37	38	35	37
Encouraged before- or after-school program staff to participate in meetings	39	38	36	45
Partnered with community-based organizations	46	55	27	43

9. Percentage of schools that have a student-led club that aims to create a safe, welcoming, and accepting school environment for all youth, regardless of sexual orientation or gender identity.	Overall %	MS %	JR/SR %	HS %
Have a gay/straight alliance	56	36	69	92

10. Percentage of schools that engage in the following practices related to lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth:	Overall %	MS %	JR/SR %	HS %
Safe spaces for LGBTQ youth	93	90	93	100
Prohibit harassment	100	100	100	100
Encourage staff professional development on safe environment	93	93	97	91
Health services for LGBTQ youth	72	61	80	91
Social and psychological services for LGBTQ youth	78	71	79	96

11. Percentage of schools in which all staff received professional development on preventing, identifying, and responding to student bullying and sexual harassment, including electronic aggression, during the past year.	Overall %	MS %	JR/SR %	HS %
Professional development preventing bullying/harassment	93	93	97	91

12. Percentage of schools that have a designated staff member to whom students can confidentially report student bullying and sexual harassment, including electronic aggression.	Overall %	MS %	JR/SR %	HS %
Confidential report bullying/harassment	98	97	100	100

13. Percentage of schools that use electronic, paper, or oral communication to publicize and disseminate policies, rules, or regulations on bullying and sexual harassment, including electronic aggression.	Overall %	MS %	JR/SR %	HS %
Publicize bullying/harassment rules	98	99	93	100

14. Percentage of schools that taught a required physical education course in each of the following grades:	Overall %	MS %	JR/SR %	HS %
PE taught in grade 6	100	100	100	.
PE taught in grade 7	100	100	100	.
PE taught in grade 8	98	100	93	.
PE taught in grade 9	95	.	90	100
PE taught in grade 10	83	.	82	84
PE taught in grade 11	50	.	43	57
PE taught in grade 12	46	.	43	50

15. Percentage of schools in which physical education teachers or specialists received professional development on physical education or physical activity during the past year.	Overall %	MS %	JR/SR %	HS %
Professional development on PE	99	99	100	100

16. Percentage of schools that engage in the following physical education practices:	Overall %	MS %	JR/SR %	HS %
Provide PE teachers with written PE curriculum	73	70	76	79
Require PE teachers to follow written PE curriculum	76	68	76	96
Allow waivers/exemptions/substitutions for PE requirements	44	22	65	80
Allow teachers to exclude students from PE as punishment	2	1	3	4
Require PE teachers to be certified/licensed/endorsed	99	100	100	96
Limit PE class sizes	68	73	52	71
Dedicated budget for PE materials	96	93	100	100
Provide adapted PE	84	81	94	80
Include students with disabilities in regular PE	100	100	100	100

17. Percentage of schools in which students participate in physical activity in classrooms during the school day outside of physical education.	Overall %	MS %	JR/SR %	HS %
Physical activity in class	88	96	84	71

18. Percentage of schools that offer opportunities for all students to be physically active during the school day, such as recess, lunchtime intramural activities, or physical activity clubs.	Overall %	MS %	JR/SR %	HS %
Physical activity during the school day	85	97	67	69

Offer opportunities for all students to be physically active during the school day, such as recess, lunchtime intramural activities, or physical activity clubs OR during class.	Overall %	MS %	JR/SR %	HS %
Offer all opportunities to be active	96	100	94	87

19. Percentage of schools that offer interscholastic sports to students.	Overall %	MS %	JR/SR %	HS %
Offer interscholastic sports	88	87	90	87

20. Percentage of schools that offer opportunities for students to participate in physical activity through organized physical activities or access to facilities or equipment for physical activity during the following times:	Overall %	MS %	JR/SR %	HS %
Physical activity before school	53	50	46	70
Physical activity after school	91	90	90	96
Provide opportunities before OR after school	94	93	97	96

21. Percentage of schools that have a joint use agreement for shared use of the following school or community facilities:	Overall %	MS %	JR/SR %	HS %
Joint use agreement of physical activity or sports facilities	64	64	58	71
Joint use agreement of kitchen facilities and equipment	33	43	13	27
Joint use agreement of gardens	29	38	16	21

22. Percentage of schools that have a written plan for providing opportunities for students to be physically active before, during, and after school.	Overall %	MS %	JR/SR %	HS %
Comprehensive School Physical Activity Program: Plan	12	18	0	9

CSPAP: Comprehensive School Physical Activity Plan	Overall %	MS %	JR/SR %	HS %
Have an established, implemented and/or evaluated a CSPAP	79	92	64	65
Have key CSPAP elements in place including required physical education and related practices, recess or classroom physical activity, physical activity before or after school	80	92	64	65
Have at least one process or supporting elements of CSPAP including a written plan for implementing CSPAP, professional development for PE teachers, family engagement around CSPAP, joint use agreement for facilities, or assessment of opportunities for student physical activity.	100	100	100	100

23. Percentage of schools that have assessed opportunities available to students to be physically active before, during, or after school.	Overall %	MS %	JR/SR %	HS %
Assess opportunities for students to be active	52	56	41	55

24. Percentage of schools that have adopted a policy prohibiting tobacco use.	Overall %	MS %	JR/SR %	HS %
Policy prohibiting tobacco use	100	100	100	100

25a. Percentage of schools that have a tobacco-use prevention policy that specifically prohibits the use of each type of tobacco during any school-related activity for students:	Overall %	MS %	JR/SR %	HS %
Prohibit use of cigarettes for students	99	99	100	100
Prohibit use of smokeless tobacco for students	99	99	100	100
Prohibit use of cigars for students	95	97	90	96
Prohibit use of pipes for students	95	97	90	96
Prohibit use of electronic vapor products for students	96	94	97	100

25b. Percentage of schools that have a tobacco-use prevention policy that specifically prohibits the use of each type of tobacco during any school-related activity for the following faculty/staff:	Overall %	MS %	JR/SR %	HS %
Prohibit use of cigarettes for faculty/staff	98	97	100	96
Prohibit use of smokeless tobacco for faculty/staff	97	96	100	96
Prohibit use of cigars for faculty/staff	95	96	90	96
Prohibit use of pipes for faculty/staff	95	96	90	96
Prohibit use of electronic vapor products for faculty/staff	95	93	97	100

25c. Percentage of schools that have a tobacco-use prevention policy that specifically prohibits the use of each type of tobacco during any school-related activity for visitors:	Overall %	MS %	JR/SR %	HS %
Prohibit use of cigarettes for visitors	98	97	100	96
Prohibit use of smokeless tobacco for visitors	96	94	100	96
Prohibit use of cigars for visitors	95	96	90	96
Prohibit use of pipes for visitors	95	96	90	96
Prohibit use of electronic vapor products for visitors	95	93	97	100

26a. Percentage of schools that have a tobacco-use prevention policy that specifically prohibits tobacco use during each of the following times for students:	Overall %	MS %	JR/SR %	HS %
Prohibit tobacco use during school hours for students	99	100	97	100
Prohibit tobacco use during non-school hours for students	96	96	93	100

26b. Percentage of schools that have a tobacco-use prevention policy that specifically prohibits tobacco use during each of the following times for faculty/staff:	Overall %	MS %	JR/SR %	HS %
Prohibit tobacco use during school hours for faculty/staff	97	97	97	96
Prohibit tobacco use during non-school hours for faculty/staff	90	88	90	96

26c. Percentage of schools that have a tobacco-use prevention policy that specifically prohibits tobacco use during each of the following times for visitors:	Overall %	MS %	JR/SR %	HS %
Prohibit tobacco use during school hours for visitors	98	99	97	96
Prohibit tobacco use during non-school hours for visitors	90	88	90	96

27a. Percentage of schools that have a tobacco-use prevention policy that specifically prohibits tobacco use in each of the following locations for the following groups of people:	Overall %	MS %	JR/SR %	HS %
Prohibit tobacco use in school buildings for students	100	100	100	100
Prohibit tobacco use outside on school grounds for students	100	100	100	100
Prohibit tobacco use on school buses for students	100	100	100	100
Prohibit tobacco use at off-campus, school-sponsored events for students	95	97	90	96

27b. Percentage of schools that have a tobacco-use prevention policy that specifically prohibits tobacco use in each of the following locations for faculty/staff:	Overall %	MS %	JR/SR %	HS %
Prohibit tobacco use in school buildings for faculty/staff	99	99	100	100
Prohibit tobacco use outside on school grounds for faculty/staff	99	99	100	100
Prohibit tobacco use on school buses for faculty/staff	98	99	100	96
Prohibit tobacco use at off-campus, school-sponsored events for faculty/staff	92	93	87	96

27c. Percentage of schools that have a tobacco-use prevention policy that specifically prohibits tobacco use in each of the following locations for visitors	Overall %	MS %	JR/SR %	HS %
Prohibit tobacco use in school buildings for visitors	99	99	100	100
Prohibit tobacco use outside on school grounds for visitors	99	99	100	100
Prohibit tobacco use on school buses for visitors	98	97	100	96
Prohibit tobacco use at off-campus, school-sponsored events for visitors	84	83	80	92

27. Percentage of schools that have a “tobacco-free environment”:	Overall %	MS %	JR/SR %	HS %
Tobacco-free school environment	77	72	77	92
Tobacco-free environment includes electronic vapor products	75	67	76	92

28. Percentage of schools that never, rarely, sometimes, or always or almost always offer fruits or non-fried vegetables at school celebrations when foods or beverages are offered.	Overall %	MS %	JR/SR %	HS %
Food or beverages are not offered at school celebrations	3	3	0	8
Never	0	0	0	0
Rarely	5	4	7	4
Sometimes	40	36	48	42
Always or almost always	52	57	45	46

29. Percentage of schools in which students can purchase snack foods or beverages from one or more vending machines at the school or at a school store, canteen, or snack bar.	Overall %	MS %	JR/SR %	HS %
Purchase from vending machines	42	21	55	84

30. Percentage of schools in which students can purchase the following snack foods or beverages from vending machines or at the school store, canteen, or snack bar:	Overall %	MS %	JR/SR %	HS %
Students can purchase chocolate candy at school	2	1	3	4
Students can purchase other kinds of candy at school	3	3	3	4
Students can purchase salty snacks not low in fat at school	12	7	15	22
Students can purchase low sodium snacks at school	26	14	32	53
Students can purchase not low in fat cookies or other baked goods at school	15	7	21	30
Students can purchase not low in fat ice cream at school	12	7	18	18
Students can purchase 2% or whole milk at school	22	14	24	39
Students can purchase nonfat or 1% milk at school	30	15	38	61
Students can purchase water ices that do not contain juice at school	7	3	10	13
Students can purchase soda pop or fruit drinks that are not 100% juice at school	6	4	7	9
Students can purchase sports drinks at school	17	4	32	36
Students can purchase energy drinks at school	0	0	0	0
Students can purchase plain water, with or without carbonation at school	37	16	57	79
Students can purchase calorie-free, flavored water, with or without carbonation at school	24	8	31	61
Students can purchase 100% fruit/vegetable juice at school	28	16	35	57
Students can purchase caffeinated foods/beverages at school	19	4	25	53
Students can purchase fruits at school	31	17	38	61
Students can purchase non-fried vegetables at school	21	7	25	56

30n. Percentage of schools that do not chocolate or other candy, salty snacks that are not low in fat, bakes goods that are not low in fat, soda or sugar-sweetened beverages, and sports drinks.	Overall %	MS %	JR/SR %	HS %
Do not sell less healthy foods and beverages	75	90	65	43

31. Percentage of schools that have done any of the following activities during the current school year:	Overall %	MS %	JR/SR %	HS %
Priced foods and beverages based on nutritious value	14	14	10	18
Collected suggestions on nutritious food preferences	58	59	55	62
Provided information on nutrition and caloric content of foods	58	56	54	66
Conducted taste tests to determine food preferences for nutritious items	53	60	31	57
Served locally grown foods in cafeteria or classrooms	91	94	93	78
Planted a school food or vegetable garden	70	76	58	65
Placed fruits and vegetables near cafeteria cashier	92	88	97	96
Used attractive displays for fruits and vegetables in cafeteria	89	87	90	96
Offered self-serve salad bar to students	90	88	90	96
Encouraged students to drink plain water	92	96	96	79
Prohibited school staff from giving students food or food coupons as a reward	41	43	35	40
Prohibited selling less nutritious foods and beverages for fundraising	38	42	36	30

32. Percentage of schools that prohibit advertisements for candy, fast food restaurants, or soft drinks in the following locations:	Overall %	MS %	JR/SR %	HS %
Prohibit advertising in school buildings	85	90	76	79
Prohibit advertising on school grounds	82	90	72	70
Prohibit advertising on school buses	85	90	76	79
Prohibit advertising in school publications	82	88	69	79
Prohibit advertising in curricula or other educational materials	76	80	70	74

33. Percentage of schools that permit students to have a drinking water bottle with them during the school day.	Overall %	MS %	JR/SR %	HS %
Water bottle permitted in all or in certain locations	100	100	100	100

34. Percentage of schools that offer a free source of drinking water in the following locations:	Overall %	MS %	JR/SR %	HS %
Drinking water in cafeteria during breakfast	92	94	86	92
Drinking water in cafeteria during lunch	93	97	85	92
Drinking water in gymnasium	97	97	93	100
Drinking water in outdoor physical activity facilities	63	52	74	79
Drinking water in school hallways	100	100	100	100

35. Percentage of schools that have a full-time registered nurse who provides health services to students.	Overall %	MS %	JR/SR %	HS %
Full-time nurse at school	77	65	87	100

36. Percentage of schools that have a part-time registered nurse who provides health services to students.	Overall %	MS %	JR/SR %	HS %
Part-time nurse at school	30	37	17	26

37. Percentage of schools that have a school-based health center that offers health services to students.	Overall %	MS %	JR/SR %	HS %
School-based health center	26	20	31	39

38. Percentage of schools that provide the following services to students:	Overall %	MS %	JR/SR %	HS %
Provide HIV testing	1	0	3	0
Provide HIV treatment	1	0	3	0
Provide STD testing	2	0	3	4
Provide STD treatment	2	0	3	4
Provide pregnancy testing	8	0	24	14
Provide condoms	24	3	57	67
Provide condom-compatible lubricants	6	0	11	20
Provide contraceptives other than condoms	1	0	3	0
Provide prenatal care	3	0	10	5
Provide HPV vaccine administration	4	1	14	0
Provide assessment for alcohol or other drug use, abuse, or dependency	49	32	77	65
Provide daily medication administration for students with chronic health conditions	96	96	100	91
Provide stock rescue or 'as needed' medication for any student experiencing a health emergency	91	93	96	82
Provide case management for students with chronic health conditions	89	87	93	91

39. Percentage of schools that provide students with referrals to any organizations or health care professionals not on school property for the following services:	Overall %	MS %	JR/SR %	HS %
Referral for HIV testing	44	28	64	71
Referral for HIV treatment	49	33	67	76
Referral for nPEP	45	31	59	67
Referral for PrEP	44	30	59	65
Referral for STD testing	47	30	70	77
Referral for STD treatment	47	30	71	71
Referral for pregnancy testing	48	31	70	77
Referral for provision of condoms	43	26	71	61
Referral for provision of condom-compatible lubricants	39	24	59	65
Referral for provision of contraceptives other than condoms	47	28	74	77
Referral for prenatal care	44	24	71	77
Referral for HPV vaccine administration	51	33	70	81
Referral for alcohol or other drug abuse treatment	71	56	90	95

40. Percentage of schools that have a protocol that ensures students with a chronic condition that may require daily or emergency management (e.g., asthma, diabetes, food allergies) are enrolled in private, state, or federally funded insurance programs if eligible.	Overall %	MS %	JR/SR %	HS %
Protocol for insurance programs	74	70	80	78

41. Percentage of schools that routinely use school records to identify and track students with a current diagnosis of the following chronic conditions:	Overall %	MS %	JR/SR %	HS %
Track students with asthma	98	100	100	90
Track students with food allergies	98	100	100	90
Track students with diabetes	95	94	100	90
Track students with epilepsy or seizure disorder	93	93	97	90
Track students with obesity	35	41	31	20
Track students with hypertension/high blood pressure	60	57	76	52
Track students with oral health condition	68	73	79	42

42. Percentage of schools that provide referrals to any organizations or health care professionals not on school property for students diagnosed with or suspected to have the following chronic conditions:	Overall %	MS %	JR/SR %	HS %
Refer students with asthma	77	73	86	76
Refer students with food allergies	73	69	86	72
Refer students with diabetes	72	65	83	76
Refer students with epilepsy or seizure disorder	71	67	80	72
Refer students with obesity	60	51	72	72
Refer students with hypertension/high blood pressure	68	61	83	72
Refer students with oral health condition	78	77	83	72

43. Percentage of schools with practices regarding parental consent and notification when sexual or reproductive health services are provided.	Overall %	MS %	JR/SR %	HS %
School does not provide any sexual or reproductive health services	73	89	39	40
Parental consent is required before any sexual or reproductive health services are provided	3	5	0	0
Parents are provided with information about services provided only upon request	6	2	6	26
Parents may be notified depending on the service provided	10	3	25	26
Parents are notified about all services provided	3	2	6	9
Parents are not notified about any services provided	4	0	25	0

44. Percentage of schools with practices regarding parental consent and notification when sexual or reproductive health services are referred.	Overall %	MS %	JR/SR %	HS %
School does not refer any sexual or reproductive health services	45	63	20	17
Parental consent is required before any sexual or reproductive health services are referred	15	21	4	11
Parents are provided with information about services referrals only upon request	7	3	8	18
Parents may be notified depending on the referral provided	19	8	34	36
Parents are notified about all referrals provided	3	2	4	5
Parents are not notified about any referrals provided	11	3	30	12

45. Percentage of schools in which any staff received professional development on each of the following topics during the past two years:	Overall %	MS %	JR/SR %	HS %
Received professional development related to connecting students to sexual health services in all areas shown below.	**25**	**20**	**28**	**36**
Any staff prof dev on basic sexual health overview	53	46	62	64
Any staff prof dev on sexual health services that adolescents should receive	50	43	61	60
Any staff prof dev on laws/policies for sexual health services	47	37	59	64
Any staff prof dev on maintaining student confidentiality for sexual health services	58	46	73	78
Any staff prof dev on creating/using student referral guide for sexual health services	28	21	31	46
Any staff prof dev on making successful referrals to sexual health services	35	25	44	55
Any staff prof dev on best practices for sexual health services provision	39	30	50	55
Any staff prof dev on LGBTQ-inclusive services	49	34	63	74

46. Percentage of schools that have done any of the following activities during the current school year:	Overall %	MS %	JR/SR %	HS %
Support parent-adolescent communication about sex	34	26	31	61
Support parent-adolescent communication about topics other than sex	69	70	62	75
Provide how to monitor their teen information	54	54	50	57
Support one-on-one time between adolescents and their health care providers	23	22	18	31
Provide PE and physical activity program information	68	67	66	75
Involve parents as volunteers in health education activities	18	17	17	22
Involve parents as volunteers in PE/physical activity programs	40	46	37	25
Link parents to health services and programs in the community	86	86	82	92
Provide disease-specific education for parents and families of students with chronic health conditions	63	60	55	81
Provide information about before- or after-school programs in the community	79	80	83	74

47. Percentage of schools that currently implement any of the following school-based positive youth development programs:	Overall %	MS %	JR/SR %	HS %
School-based service-learning programs	58	42	71	87
School-based mentoring programs	50	49	48	58

48. Percentage of schools that currently connect students to any of the following community-based positive youth development programs:	Overall %	MS %	JR/SR %	HS %
Community-based service-learning programs	50	36	55	82
Community-based mentoring programs	62	61	69	56

49. Percentage of schools in which students' families helped develop or implement policies and programs related to school health during the past two years.	Overall %	MS %	JR/SR %	HS %
Families help develop school health policies	29	26	32	35

State-Added Questions: Principal Survey

School district or supervisory union Whole School, Whole Community, Whole Child (WSCC) team participation.	Overall %	MS %	JR/SR %	HS %
There is a team with representatives from our school and it meets at least 4x/year	46	48	35	56
There is a team with representatives from our school but it meets less then 4x/year	16	15	20	13
Our SU/SD has a team but our school is not represented	1	0	3	0
Our SU/SD does not have a WSCC team	9	12	7	4
Not sure	28	26	35	26

Have a cooperative or formal agreement with an outside agency to provide assessments and treatment services for the following issues:	Overall %	MS %	JR/SR %	HS %
Drug and/or alcohol problems	47	42	51	56
Mental health issues	71	68	83	68

Percent of schools who served more than half of grains as whole grains, used recipes that were low in sodium, and offered only fat-free or low-fat milk as part of the School Meal Program, during the past two years.	Overall %	MS %	JR/SR %	HS %
School Meal Program used recipes that were low in sodium, and offered only fat-free or low-fat milk and used whole grains serves at least	92	88	97	95

During next two years, school will make changes to the School Meal Program by decreasing the amount of whole grains served, serve items or use recipes that are not low in sodium, or offer 2% or whole mile (plain or flavored).	Overall %	MS %	JR/SR %	HS %
Yes	14	17	14	5
No	36	36	48	22
Not sure	50	46	38	73

Percent of schools that have a concussion management plan that includes the following components:	Overall %	MS %	JR/SR %	HS %
A concussion management plan	89	84	93	96
A system for notifying parents within 24 hours of a student sustaining a concussion	94	90	100	100
A system to track concussions among students	83	75	87	100
Return to play protocols for students who have sustained a concussion	89	81	97	100
Return to learn protocols for students who have sustained a concussion	83	71	97	100
Provide written information or concussion education materials to parents and students every year	83	74	90	100
Provide professional development or written information about concussions for all teachers	57	51	55	75
Require coaches to complete a concussion education training program at least every two years	90	85	93	100

Lead Health Educator Survey

1. Percentage of schools in which students take the following number of required health education courses in grades 6 through 12:	Overall %	MS %	JR/SR %	HS %
0 courses	9	15	4	0
1 course	24	13	22	57
2 courses	24	22	25	29
3 courses	25	32	26	5
4 or more courses	18	18	22	10

2. Percentage of schools that taught a required health education course in each of the following grades:	Overall %	MS %	JR/SR %	HS %
Health education required in grade 6	89	93	70	.
Health education required in grade 7	90	98	71	.
Health education required in grade 8	88	96	71	.
Health education required in grade 9	77	.	81	74
Health education required in grade 10	69	.	61	79
Health education required in grade 11	34	.	34	33
Health education required in grade 12	37	.	34	42

3. Percentage of schools that require students who fail a required health education course to repeat it.	Overall %	MS %	JR/SR %	HS %
Required to repeat failed Health education course	49	8	88	95

4. Percentage of schools in which those who teach health education are provided with each of the following materials:	Overall %	MS %	JR/SR %	HS %
Provided goals for health education	72	67	73	84
Provided chart health education	51	53	51	47
Provided plans for assessing student performance in health education	56	50	62	63
Provided written health education curriculum	43	48	34	42

5. Percentage of schools in which the health education curriculum addresses each of the following skills:	Overall %	MS %	JR/SR %	HS %
Comprehending concepts	91	83	100	100
Analyzing the influence of family and other factors on health behaviors	91	83	100	100
Accessing valid information to enhance health	87	78	100	96
Interpersonal communication skills to enhance health	89	80	100	100
Decision-making skills to enhance health	94	88	100	100
Goal-setting skills to enhance health	88	78	100	100
Health-enhancing behaviors	92	86	96	100
Advocating for health	85	78	93	96

6. Percentage of schools in which those who teach sexual health education are provided with each of the following materials:	Overall %	MS %	JR/SR %	HS %
Sex ed materials - approved health education scope and sequence	59	56	67	57
Sex ed materials - written health education curriculum	56	58	56	52
Sex ed materials - teacher pacing guides	35	45	23	24
Sex ed materials - teaching resources	67	64	72	67
Sex ed materials - engage students in learning strategies	68	64	76	70
Sex ed materials - assess student knowledge and skills methods	60	58	68	57

7. Percentage of schools that provide curricula or supplementary materials that include HIV, STD, or pregnancy prevention information that is relevant to lesbian, gay, bisexual, transgender, and questioning youth.	Overall %	MS %	JR/SR %	HS %
Curricula for LTBTQ youth	72	63	82	86

8. Percentage of schools in which health education instruction is required for students in any of grades 6 through 12.	Overall %	MS %	JR/SR %	HS %
Health Education required for any of grades 6-12	91	86	96	100

9. Percentage of schools in which teachers tried to increase student knowledge on each of the following topics in a required course in any of grades 6 through 12 during the current school year:	Overall %	MS %	JR/SR %	HS %
Taught alcohol/other drug-use prevention	95	92	100	100
Taught asthma	34	35	38	27
Taught chronic disease prevention	79	70	92	86
Taught emotional and mental health	93	87	100	100
Taught epilepsy or seizure disorder	20	17	32	14
Taught food allergies	52	53	45	57
Taught foodborne illness prevention	52	54	44	55
Taught HIV prevention	87	76	100	100
Taught human sexuality	93	87	100	100
Taught infectious disease prevention	74	72	85	64
Taught injury prevention and safety	83	79	96	82
Taught nutrition and dietary behavior	95	93	100	96
Taught physical activity and fitness	97	97	100	96
Taught pregnancy prevention	87	75	100	100
Taught STD prevention	89	79	100	100
Taught suicide prevention	82	73	86	100
Taught tobacco-use prevention	95	90	100	100
Taught violence prevention	90	85	96	95

10. Percentage of schools in which teachers taught each of the following tobacco-use prevention topics in a required course for students in any of grades 6 through 12 during the current school year:	Overall %	MS %	JR/SR %	HS %
Taught all 19 tobacco topics listed below	**36**	**38**	**34**	**33**
Taught tobacco products and harmful substances	87	82	92	95
Taught health consequences of tobacco product use	89	82	96	100
Taught consequences of tobacco product use	85	78	96	95
Taught addictive nature of nicotine	89	82	96	100
Taught effects of nicotine on the adolescent brain	85	79	88	100
Taught effects of tobacco product use on athletic performance	80	76	84	86
Taught effects of second-hand smoke	84	74	96	95
Taught social influences on tobacco product use	84	79	92	91
Taught tobacco product use reasons	86	79	96	96
Taught assessments of number of peers use tobacco products	67	61	65	86
Taught interpersonal communication skills to avoid tobacco product use	81	74	96	82
Taught goal-setting skills to avoid tobacco product use	73	68	84	73
Taught information on tobacco-use prevention and cessation	71	68	69	82
Taught supporting others who want to quit using tobacco products	68	64	69	77
Taught harmful effects of tobacco product use on fetal development	64	51	88	73
Taught relationship between tobacco products and alcohol or other drugs	78	69	92	86
Taught treatment of tobacco product addiction	75	66	84	86
Taught policies and laws for tobacco products sale	77	71	84	86
Taught benefits of tobacco product cessation programs	59	52	66	68

11: Percentage of schools in which teachers taught about the following tobacco products in a required course for students in any of grades 6 through 12 during the current school year:	Overall %	MS %	JR/SR %	HS %
Taught about cigarettes	88	85	92	91
Taught about smokeless tobacco	81	77	92	82
Taught about cigars	62	61	64	64
Taught about pipes	55	53	53	64
Taught about electronic vapor products	90	85	92	100

12. Percentage of schools in which teachers taught each of the following alcohol- and other drug-use prevention topics in a required course for students in any of grades 6 through 12 during the current school year:	Overall %	MS %	JR/SR %	HS %
Taught about proper medicine use and abuse	80	71	84	100
Taught about harmful effects of using alcohol/drug use	90	83	96	100
Taught about situations that lead to alcohol/drug use	89	82	96	100
Taught about alcohol/drug use as unhealthy way to manage weight	52	48	57	55
Taught about reasons for alcohol/drug use	87	79	96	100
Taught interpersonal communication skills to avoid alcohol/drug use	88	82	96	95
Taught supporting others who want to quit using alcohol/drugs	72	63	84	82
Taught social influences on alcohol/drug use	85	77	92	100
Taught persuading others to be alcohol/drug free	77	70	84	86

13. Percentage of schools in which teachers taught each of the following sexual health topics in a required course in any of grades 6, 7, or 8 during the current school year:	Overall %	MS %	JR/SR %	HS %
Taught all 22 MS HIV topics listed below	**25**	**31**	**10**	**.**
MS taught HIV and STD transmission	65	68	59	.
MS taught HIV/STD health consequences	64	70	50	.
MS taught sex abstinence benefits	69	71	62	.
MS taught accessing HIV/STD information	61	70	38	.
MS taught family influences on sexual risk behaviors	66	70	57	.
MS taught communication skills for HIV/STD risk reduction	55	62	38	.
MS taught goal-setting skills for HIV/STD risk reduction	55	62	38	.
MS taught influencing others to avoid sexual risk behaviors	55	60	42	.
MS taught efficacy of condoms	50	59	29	.
MS taught importance of condoms	49	59	24	.
MS taught how to obtain condoms	43	53	19	.
MS taught correct use of condom	39	49	14	.
MS taught other contraception methods	48	59	19	.
MS taught importance of using condom and another contraception	49	60	20	.
MS taught healthy relationships	71	74	67	.
MS taught limiting sex partners	54	59	43	.
MS taught preventive care	53	62	28	.
MS taught sexual consent	61	68	43	.
MS taught recognizing sexual victimization	52	54	47	.
MS taught sexual diversity	61	65	52	.
MS taught effect of gender roles and stereotypes	49	52	42	.
MS taught relationship between alcohol and other drug use and sexual risk behaviors	67	72	57	.

14. Percentage of schools in which teachers assess the ability of students to do each of the following in a required course for students in any of grades 6, 7, or 8 during the current school year:	Overall %	MS %	JR/SR %	HS %
MS assessed student comprehension	55	58	47	.
MS assessed student ability to analyze family influence on sexual risk behaviors	53	55	47	.
MS assessed student ability to access HIV/STD information	52	58	38	.
MS assessed student interpersonal communication skills	59	65	42	.
MS assessed student decision-making skills for HIV/STD prevention	53	59	38	.
MS assessed student goal-setting ability	55	54	57	.
MS assessed student influence on sexual risk behaviors	48	52	38	.

13. Percentage of schools in which teachers taught each of the following sexual health topics in a required course in any of grades 9, 10, 11, or 12 during the current school year:	Overall %	MS %	JR/SR %	HS %
Taught all 22 HS HIV topics listed below	**52**	**.**	**54**	**50**
HS taught HIV and STD transmission	93	.	88	100
HS taught HIV/STD health consequences	93	.	88	100
HS taught sex abstinence benefits	93	.	87	100
HS taught accessing HIV/STD information	89	.	87	90
HS taught family influences on sexual risk behaviors	87	.	79	95
HS taught communication skills for HIV/STD risk reduction	87	.	79	95
HS taught goal-setting skills for HIV/STD risk reduction	82	.	79	86
HS taught influencing others to avoid sexual risk behaviors	87	.	79	95
HS taught efficacy of condoms	91	.	87	95
HS taught importance of condoms	93	.	87	100
HS taught how to obtain condoms	89	.	83	95
HS taught correct use of condom	91	.	87	95
HS taught other contraception methods	93	.	87	100
HS taught importance of using condom and another contraception	93	.	87	100
HS taught healthy relationships	89	.	83	95
HS taught limiting sex partners	91	.	87	95
HS taught preventive care	91	.	83	100
HS taught sexual consent	93	.	87	100
HS taught recognizing sexual victimization	91	.	87	95
HS taught sexual diversity	84	.	79	91
HS taught effect of gender roles and stereotypes	78	.	71	86
HS taught relationship between alcohol and other drug use and sexual risk behaviors	93	.	87	100

14. Percentage of schools in which teachers assess the ability of students to do each of the following in a required course for students in any of grades 9, 10, 11, or 12 during the current school year:	Overall %	MS %	JR/SR %	HS %
HS assessed student comprehension	93	.	87	100
HS assessed student ability to analyze family influence on sexual risk behaviors	80	.	79	81
HS assessed student ability to access HIV/STD information	89	.	79	100
HS assessed student interpersonal communication skills	91	.	87	95
HS assessed student decision-making skills for HIV/STD prevention	84	.	83	86
HS assessed student goal-setting ability	78	.	79	76
HS assessed student influence on sexual risk behaviors	73	.	79	67

15. Percentage of schools in which teachers provided students with the opportunity to practice the following skills in a required course for students in any of grades 6 through 12 during the current school year:	Overall %	MS %	JR/SR %	HS %
Students can practice skills	72	62	89	76
Students can practice analyzing influence of family/media/culture	70	62	77	81
Students can practice accessing information	75	64	85	95

16. Percentage of schools in which teachers implemented the following inclusive practices when providing sexual health education in a required course for students in grades 6 through 12 during the current school year:	Overall %	MS %	JR/SR %	HS %
Inclusive practices - encouraged gender-neutral pronouns	73	66	73	90
Inclusive practices - provided positive examples of LGBTQ people	77	68	93	80
Inclusive practices - encouraged respect of sexual and gender identities	89	85	89	100
Inclusive practices - provided information about LGBTQ resources within school	77	68	77	95
Inclusive practices - identified LGBTQ resources available outside of school	67	58	70	85

17. Percentage of schools in which teachers taught each of the following nutrition and dietary behavior topics in a required course for students in any of grades 6 through 12 during the current school year:	Overall %	MS %	JR/SR %	HS %
Taught all 22 nutrition topics listed below	**23**	**22**	**23**	**27**
Taught benefits of healthy eating	92	88	96	96
Taught benefits of drinking plenty of water	90	86	93	96
Taught benefits of eating breakfast every day	88	85	89	96
Taught food guidance using current Dietary Guidelines for Americans	83	81	77	96
Taught using food labels	83	75	93	96
Taught differentiating nutritious/non-nutritious beverages	86	83	93	86
Taught balancing food intake and physical activity	90	86	96	91
Taught eating more fruits, vegetables, whole grain products	92	89	93	96
Taught choosing low solid fat foods	79	71	85	96
Taught choosing low added sugar foods	85	78	93	96
Taught choosing low sodium foods	70	63	81	77
Taught eating high calcium foods	70	64	77	77
Taught eating high iron foods	63	56	69	77
Taught food safety	64	66	59	64
Taught preparing healthy meals	74	71	74	82
Taught unhealthy weight control practice risks	76	63	93	91
Taught accepting body size differences	77	68	89	86
Taught eating disorder signs, symptoms, treatment	68	58	81	82
Taught diet and chronic disease relationship	75	67	85	82
Taught body mass index (BMI)	43	34	56	52
Taught influence of the media on dietary behaviors	74	60	93	86
Taught food production	57	57	55	59

18. Percentage of schools in which teachers taught each of the following physical activity topics in a required course for students in any of grades 6 through 12 during the current school year:	Overall %	MS %	JR/SR %	HS %
Taught all 13 physical activity topics listed below	**45**	**34**	**69**	**46**
Taught physical activity benefits	92	90	96	91
Taught mental and social benefits of physical activity	93	90	96	96
Taught health-related fitness	92	91	92	96
Taught phases of a workout	85	79	92	91
Taught muscle- and bone-strengthening physical activity	82	78	84	91
Taught decreasing sedentary activities	87	83	88	96
Taught preventing injury during physical activity	89	86	92	91
Taught weather-related safety	65	60	85	55
Taught dangers of performance-enhancing drugs	67	56	85	73
Taught increasing daily physical activity	91	88	96	96
Taught incorporating physical activity into daily life	89	84	93	96
Taught using safety equipment	77	74	85	77
Taught drinking water benefits	89	86	92	91

19. Percentage of schools in which health education staff worked with the following groups on health education activities during the current school year:	Overall %	MS %	JR/SR %	HS %
Staff worked with physical education staff	79	82	72	79
Staff worked with health services staff	74	72	86	63
Staff worked with mental health or social services staff	76	74	78	79
Staff worked with nutrition or food service staff	39	46	14	47
Staff worked with school health council	52	47	55	63

20. Percentage of schools that provided parents and families with health information designed to increase parent and family knowledge of the following topics during the current school year.	Overall %	MS %	JR/SR %	HS %
Provide parents with HIV/other STD/pregnancy prevention information	21	20	22	24
Provide parents with tobacco-use prevention information	51	45	56	62
Provide parents with alcohol- or other drug-use prevention information	40	37	44	46
Provide parents with physical activity information	40	43	48	23
Provide parents with nutrition and healthy eating information	39	40	44	32
Provide parents with asthma information	13	12	14	14
Provide parents with food allergies information	27	28	29	23
Provide parents with diabetes information	17	10	31	18
Provide parents with bullying and sexual harassment information	54	55	55	50

21. Percentage of schools in which teachers have given students health education homework assignments or activities to do at home with their parents during the current school year.	Overall %	MS %	JR/SR %	HS %
Homework to do with parents	52	45	63	59

22: Percentage of schools in which the lead health education teacher received professional development (e.g., workshops, conferences, continuing education, any other kind of in-service) on each of the following topics during the past two years:	Overall %	MS %	JR/SR %	HS %
Received professional development on alcohol- or other drug-use prevention	59	52	68	64
Received professional development on asthma	20	19	30	9
Received professional development on chronic disease prevention	28	30	28	23
Received professional development on emotional and mental health	78	75	83	77
Received professional development on epilepsy or seizure disorder	20	19	22	23
Received professional development on food allergies	27	25	40	18
Received professional development on foodborne illness prevention	14	8	21	18
Received professional development on HIV prevention	32	23	43	41
Received professional development on human sexuality	59	53	61	73
Received professional development on infectious disease prevention	30	28	36	32
Received professional development on injury prevention and safety	38	43	28	36
Received professional development on nutrition and dietary behavior	42	40	46	41
Received professional development on physical activity and fitness	54	54	46	64
Received professional development on pregnancy prevention	30	19	43	45
Received professional development on STD prevention	37	27	50	45
Received professional development on suicide prevention	50	49	57	45
Received professional development on tobacco-use prevention	50	47	56	55
Received professional development on violence prevention	52	49	54	59

23: Percentage of schools in which the lead health education teacher received professional development (e.g., workshops, conferences, continuing education, any other kind of in-service) on each of the following topics during the past two years:	Overall %	MS %	JR/SR %	HS %
Received professional development on teaching students with disabilities	53	54	46	59
Received professional development on teaching students of various cultural backgrounds	51	52	46	55
Received professional development on teaching students with limited English proficiency	13	13	4	23
Received professional development on supporting LGBTQ students	77	73	86	77
Received professional development on interactive teaching methods	56	51	68	55
Received professional development on encouraging family or community involvement	38	40	40	32
Received professional development on teaching skills for behavior change	59	56	76	45
Received professional development on classroom management techniques	63	60	72	59
Received professional development on assessing students in health education	43	37	46	55

24: Percentage of schools in which the lead health education teacher received professional development on each of the following topics related to teaching sexual health education during the past two years:	Overall %	MS %	JR/SR %	HS %
Received professional development on aligning lessons with district sexual health education	37	36	33	46
Received professional development on creating safe learning environment	45	42	59	36
Received professional development on connecting students to on-site sexual health services	30	24	37	41
Received professional development on effective instructional strategies	45	42	49	50
Received professional development on building student skills in HIV/other STD/pregnancy prevention	38	36	41	41
Received professional development on assessing student knowledge in sexual health education	38	32	49	41
Received professional development on current sexual health education policies	21	19	26	23
Received professional development on identifying modifications to curriculum	36	32	41	41
Received professional development on engaging parents	19	22	22	9

25: Percentage of schools in which the lead health education teacher would like to receive professional development on each of the following topics:	Overall %	MS %	JR/SR %	HS %
Like professional development on alcohol- or other drug-use prevention	67	70	67	59
Like professional development on asthma	38	40	42	27
Like professional development on chronic disease prevention	49	50	53	41
Like professional development on emotional and mental health	83	80	82	91
Like professional development on epilepsy or seizure disorder	45	46	53	32
Like professional development on food allergies	43	40	49	41
Like professional development on foodborne illness prevention	41	40	46	36
Like professional development on HIV prevention	58	58	71	41
Like professional development on human sexuality	74	73	82	68
Like professional development on infectious disease prevention	47	49	57	32
Like professional development on injury prevention and safety	46	49	57	23
Like professional development on nutrition and dietary behavior	67	67	75	55
Like professional development on physical activity and fitness	49	53	49	36
Like professional development on pregnancy prevention	56	53	71	46
Like professional development on STD prevention	56	53	71	46
Like professional development on suicide prevention	71	70	75	68
Like professional development on tobacco-use prevention	62	65	60	55
Like professional development on violence prevention	73	78	67	68

26: Percentage of schools in which the lead health education teacher would like to receive professional development on each of the following topics:	Overall %	MS %	JR/SR %	HS %
Like professional development on teaching students with disabilities	68	66	74	68
Like professional development on teaching students of various cultural backgrounds	64	66	60	64
Like professional development on teaching students with limited English proficiency	49	47	57	45
Like professional development on supporting LGBTQ students	74	74	71	77
Like professional development on interactive teaching methods	73	72	66	82
Like professional development on encouraging family or community involvement	71	68	75	77
Like professional development on teaching skills for behavior change	73	69	75	82
Like professional development on classroom management techniques	60	69	53	43
Like professional development on assessing students in health education	78	76	86	73

27: Percentage of schools in which the lead health education teacher would like to receive professional development on each of the following topics related to teaching sexual health education:	Overall %	MS %	JR/SR %	HS %
Like professional development on aligning lessons with district sexual health education	64	68	59	59
Like professional development on creating safe learning environment	60	63	59	55
Like professional development on connecting students to on-site sexual health services	64	64	66	59
Like professional development on effective instructional strategies	71	67	77	73
Like professional development on building student skills in HIV prevention	63	60	70	64
Like professional development on assessing student knowledge in sexual health education	71	65	81	71
Like professional development on current sexual health education policies	59	64	59	45
Like professional development on identifying modifications to curriculum	71	68	81	68
Like professional development. on engaging parents in sexual health education	73	69	85	68

28. Percentage of schools in which the major emphasis of the lead health education teacher's professional preparation was on the following:	Overall %	MS %	JR/SR %	HS %
Health Education or Health Education /Physical Education combined	45	39	45	59
Physical Education or kinesiology	24	26	22	18
Home economics or other	8	5	10	14
Nursing or counseling	19	26	19	0
Public health or other	4	2	4	9

29. Percentage of schools in which the lead health education teacher is certified, licensed, or endorsed by the state to teach health education in middle school or high school.	Overall %	MS %	JR/SR %	HS %
Certified by state to teach	77	64	89	100

30: Percentage of schools in which the lead health education teacher had the following number of years of experience teaching health education courses or topics:	Overall %	MS %	JR/SR %	HS %
1 year	13	17	10	5
2 to 5 years	23	22	37	9
6 to 9 years	15	17	8	18
10 to 14 years	15	20	11	5
15 years or more	35	25	34	64

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Visit:

Vermont Department of Health: School Health Profiles
http://www.healthvermont.gov/stats/surveys

Centers for Disease Control and Prevention (CDC):
Division of Adolescent and School Health (DASH)
https://www.cdc.gov/healthyyouth/data/profiles/index.htm

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