



New Jersey School Boards Association



Task Force on the
Impact of Health and
Wellness on Student
Achievement

2014-2015

**Final Report
August 27, 2015**

New Jersey School Boards Association

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on Student Achievement**

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New Jersey School Boards Association
Serving Local Boards of Education Since 1914

MISSION STATEMENT

The New Jersey School Boards Association, a federation of boards of education, provides training, advocacy and support to advance public education and promote the achievement of all students through effective governance.

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New Jersey School Boards Association

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MEMORANDUM

TO: Donald Webster, Jr., President
Lawrence S. Feinsod, Ed.D., Executive Director

FROM: Patrice Maillet, Director of Business Development
Vincent DeLucia, Director of Training & Professional Development/Educator-in-Residence
Sharon Seyler, Legislative Advocate
Co-chairs, Task Force on the Impact of Health and Wellness on Student Achievement

SUBJECT: Final Report—Task Force on the Impact of Health and Wellness on Student Achievement

DATE: August 27, 2015

We are pleased to submit to you the Final Report of the New Jersey School Boards Association's Task Force on the Impact of Health and Wellness on Student Achievement. The National School Boards Association Board of Directors requested that NJSBA lead this research project to provide information and direction not only to New Jersey's school districts, but for state school boards associations nationwide.

The NJSBA Health and Wellness Task Force began its work in November 2014 and met on a monthly basis to deliberate over research; to consult with professionals in the areas of nutrition, physical fitness, school climate and education; and to identify goals, strategies and best practices. Fifty-six representatives of education and public health organizations participated in the study. The support and expertise of NJSBA staff members were also instrumental in this project.

In all, the task force has recommended 125 actions for consideration by local school districts, the state and federal governments, and the New Jersey School Boards Association. As its core recommendation, the task force calls on all school districts to implement Coordinated School Health programs, as defined by the U.S. Centers for Disease Control.

The report includes a section on research, identified by the Regional Education Laboratory (REL) Mid-Atlantic, a component of the U.S. Department of Education's Institute of Education Sciences, which supports the link between student health and wellness and academic achievement. Also of note is a section on health and wellness success stories in local school districts.

We are confident that the Final Report of the Task Force on the Impact of Health and Wellness on Student Achievement will provide a course of action to promote student health and wellness, healthy school climate and academic success and will serve as a resource for local school districts in New Jersey and throughout the nation.

Executive Summary

The Task Force and Its Work

In 2013, the National School Boards Association Board of Directors requested that the New Jersey School Boards Association (NJSBA) lead a research project on student health and wellness and school climate and how they relate to student achievement. Because of NJSBA's involvement in major studies on special education and school security, both of which encompass topics such as student achievement and school climate, then-President John Bulina agreed to engage the Association in a multi-agency project on health and wellness, including a review of relevant government policy, identification of best practices, and development of recommended action at the federal, state and local levels.

The Task Force was formed in 2014 and completed its work during the first half of 2015 under the leadership of Donald Webster, Jr., NJSBA president, and Lawrence S. Feinsod, Ed.D., executive director.

The charge to the NJSBA Task force on the Impact of Health and Wellness on Student Achievement was to:

- Investigate all areas associated with health and wellness, social-emotional learning, and school/organizational climate as they relate to student achievement;
- Develop recommendations for consideration by local boards of education;
- Produce a white paper, detailing the issue of student health and wellness and its impact on student achievement, identifying best practices, and listing recommendations that state school boards associations can adopt and share with local school districts;
- Produce a user-friendly video on ways in which health and wellness best practices improve student achievement for dissemination to local school boards for sharing with their members and the community.

(See Appendix A for the complete charge to the Task Force.)

The task force met each month at NJSBA headquarters in Trenton from February to June 2015. Members, attending the meetings in person and by telephone, listened to presentations or reviewed materials regarding a wide variety of health and wellness issues facing schools in New Jersey and throughout the country, and discussed potential findings and recommendations. In the process, the Task Force reviewed:

- National and state laws and policies covering child and adolescent health in schools;
- NJSBA policy on the subject;
- The current state of health and wellness in New Jersey schools;
- Recent research on the link between health/wellness and student achievement, and
- Success stories demonstrating the feasibility and value of improving school health and wellness.

Task Force Findings

Based on its deliberations, the Task Force issued a series of findings in the areas of nutrition, physical activity, school climate, and related local school district policy.

Nutrition

- There is firm evidence linking healthy eating and physical activity to academic achievement.
- School breakfast programs are associated with increased academic grades and standardized test scores, reduced absenteeism, and improved cognitive behavior.
- Skipping breakfast is associated with decreased cognitive performance: alertness, attention, memory, processing of complex visual display, and problem-solving.
- Lack of certain foods, such as fruits, vegetables and dairy products, is associated with lower grades.
- Lack of specific nutrients, like vitamins A, B6m and B12 and foliate, iron, zinc and calcium, is associated with lower grades and higher rates of absenteeism and tardiness.
- Hunger due to insufficient food intake is associated with lower grades, absenteeism, repeating a grade, and inability to focus.

Physical Activity

- Physically active students tend to have better grades, school attendance, cognitive performance, and classroom behaviors.
- Higher levels of physical activity and physical fitness levels are associated with improved cognitive performance, including concentration and memory.
- Time spent in physical education classes and recess improves student well-being.
- Brief breaks in classrooms are associated with improved cognitive performance.
- Extracurricular physical activity, such as interscholastic sports, is associated with higher GPAs, lower dropout rates, and fewer disciplinary problems.
- High school students involved in interscholastic athletics would benefit academically if, during their season, they received physical education (PE) credit for their participation in the sports program in lieu of attending gym class. Such [an option](#) would provide them with time for remediation, enrichment and/or homework, which they miss due to after-school practices. [Current regulation](#) does not allow such an alternative.

School Climate

- Comprehensive needs assessments of school climate, including school engagement, school safety, and the school environment, are essential to provide schools with the data needed to pursue strategies that improve school climate.
- The strong and positive relationships that students forge with adults — and observe among adults — in the school setting are critical to developing social competencies that enable them to confront challenges and learn.
- Social and emotional learning is important to enable individuals to learn to understand and manage their emotions and relationships, and to make good decisions. Social-emotional learning can help individuals stop and think before they react, control their response to stress, develop supportive and caring relationships, persist through challenge, seek help, and pay attention to theirs and others' needs and feelings.

- The research of Dr. Maurice Elias of Rutgers University shows that a systemic framework that links academics with service learning, character education and violence prevention has a positive impact on students, including improved attitudes about self, others, and school; positive classroom behavior; higher achievement test scores; and less aggressive behavior and emotional distress.
- Practices that engage students and contribute to social-emotional character development include meaningful, participatory student government; service learning; opportunities for students, staff and the community to provide feedback; open forums for school problem-solving; student input to staff committees; and engagement of students of all backgrounds in leadership and school activities.

Policy

- Improving school health and wellness is a valuable, child-centered means of advancing student achievement.
- The history of school policy on the subject of health and wellness has been one of compliance with federal and state requirements, rather than proactive adoption of policy to drive change.

Task Force Recommendations

Based on its deliberations, the Task Force makes the core recommendation that all school districts implement Coordinated School Health (CSH) programs, as defined and described by the U.S. Centers for Disease Control (CDC). (See <http://www.cdc.gov/healthyyouth/cshp/faq.htm> and <http://www.cdc.gov/healthyyouth/cshp/components.htm>.)

CSH is a systematic approach to improving the health and well-being of all students so they can fully participate and be successful in school. The process involves bringing together school administrators, teachers, other staff, students, families, and community members to assess health needs; set priorities; and plan, implement, and evaluate all health-related activities. CSH typically integrates health promotion efforts across eight interrelated components that already exist to some extent in most schools.

Health Education: Health education provides students with opportunities to acquire the knowledge, attitudes, and skills necessary for making health-promoting decisions, achieving health literacy, adopting health-enhancing behaviors, and promoting the health of others. Comprehensive school health education includes courses of study (curricula) for students in pre-K through grade 12 that address a variety of topics such as alcohol and other drug use and abuse, healthy eating/nutrition, mental and emotional health, personal health and wellness, physical activity, safety and injury prevention, sexual health, tobacco use, and violence prevention. Health education curricula should address the National Health Education Standards (NHES) and incorporate the characteristics of an effective health education curriculum. Health education assists students in living healthier lives. Qualified, trained teachers teach health education.

Physical Education: Physical education is a school-based instructional opportunity for students to gain the necessary skills and knowledge for lifelong participation in physical activity. Physical education is characterized by a planned, sequential K-12 curriculum (course of study) that provides cognitive content and learning experiences in a variety of activity areas. Quality physical education programs assist students in achieving the national standards for K-12 physical education. The outcome of a quality physical education program is a physically educated person who has the knowledge, skills, and confidence to enjoy a lifetime of healthful physical activity. Qualified, trained teachers teach physical education.

Health Services: These services are designed to ensure access and/or referral to primary health care services, to foster appropriate use of primary health care services, to prevent and control communicable disease and other health problems, to provide emergency care for illness or injury, to promote and provide optimum sanitary conditions for a safe school facility and school environment, and to provide educational and counseling opportunities for promoting and maintaining individual, family and community health. Qualified professionals such as physicians, nurses, dentists, health educators, and other allied health personnel provide these services.

Nutrition Services: Schools should provide access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students. School nutrition programs reflect the U.S. Dietary Guidelines for Americans and other criteria to achieve nutrition integrity. The school nutrition services offer students a learning laboratory for classroom nutrition and health education, and serve as a resource for linkages with nutrition-related community services. Qualified child nutrition professionals provide these services.

Counseling, Psychological, and Social Services: These services are provided to improve students' mental, emotional, and social health and include individual and group assessments, interventions, and referrals. Organizational assessment and consultation skills of counselors and psychologists contribute not only to the health of students but also to the health of the school environment. Professionals such as certified school counselors, psychologists, and social workers provide these services.

Healthy and Safe School Environment: A healthy and safe school environment includes the physical and aesthetic surroundings and the psychosocial climate and culture of the school. Factors that influence the physical environment include the school building and the area surrounding it, any biological or chemical agents that are detrimental to health, and physical conditions such as temperature, noise, and lighting. The psychosocial environment includes the physical, emotional, and social conditions that affect the well-being of students and staff.

Health Promotion for Staff: Schools can provide opportunities for school staff members to improve their health status through activities such as health assessments, health education, and health-related fitness activities. These opportunities encourage staff members to pursue a healthy lifestyle that contributes to their improved health status, improved morale, and a greater personal commitment to the school's overall coordinated health program. This personal commitment often transfers into greater commitment to the health of students and creates positive role modeling. Health promotion activities have improved productivity, decreased absenteeism, and reduced health insurance costs.

Family/Community Involvement: An integrated school, parent, and community approach can enhance the health and well-being of students. School health advisory councils, coalitions, and broad-based constituencies for school health can build support for school efforts. Schools actively solicit parent involvement and engage community resources and services to respond more effectively to the health-related needs of students.

In addition to the implementation of CSH programs, the Task Force also recommends (a) school district consideration of a number of practices to support and amplify coordinated school health programs, based upon local circumstances and needs, and (b) action by the state and federal governments and the New Jersey School Boards Association. (These 125 specific recommendations are found on pages 19 through 33 of this report.)

Implementing a Coordinated School Health Program

The Task Force endorses these general strategies to implement a coordinated approach to improve school health policies and programs, as recommended by the U.S. Centers for Disease Control (<http://www.cdc.gov/healthyyouth/cshp/schools.htm>):

1. Secure and maintain administrative support and commitment.
2. Establish a school health council or team.
3. Identify a school health coordinator.
4. Develop a plan.
5. Implement multiple strategies through multiple components.
6. Focus on students.
7. Address priority health-enhancing and health-risk behaviors.
8. Provide professional development for staff.

Resources to Help LEAs Implement or Strengthen Coordinated School Health Programs

Finally, the Task Force identified a large variety of resources to help school districts study, implement, or strengthen coordinated school health programs, including those of the U.S. Centers for Disease Control, other federal agencies, the New Jersey School Boards Association, other national and state organizations, and websites of relevant professional organizations.



Task Force on the Impact of Health and Wellness on Student Achievement

2014-2015

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Definitions of “health and wellness” and “student achievement”

The Task Force defines “health and wellness” as the condition of good physical, mental and emotional health, especially when maintained by an appropriate diet, exercise, and other lifestyle modifications.

The Task Force defines “student achievement” as student academic performance (class grades, standardized tests and graduation rates), education behavior (attendance, dropout rates and behavioral problems), and students’ cognitive skills and attitudes (concentration, memory and mood).

The Task Force agrees with the Centers for Disease Control (CDC) that the academic achievement of America’s youth is strongly linked with their health:

Healthy Students Are Better Learners. Health-related factors such as hunger, physical and emotional abuse, and chronic illness can lead to poor school performance. Health-risk behaviors such as early sexual initiation, violence, unhealthy eating, and physical inactivity are consistently linked to poor grades, test scores, and lower educational attainment. Leading national education organizations recognize the close relationship between health and education, as well as the need to foster health and well-being within the educational environment for all students.

Schools Are the Right Place for a Healthy Start. Scientific reviews have documented that school health programs can have positive effects on academic outcomes, as well as on health-risk behaviors and health outcomes. Similarly, programs that are primarily designed to improve academic achievement are increasingly recognized as important public health interventions. [http://www.cdc.gov/HealthyYouth/health_and_academics/]

Federal and State Laws and Policies Covering Child and Adolescent Health in Schools

The National Association of State Boards of Education State School Health Policy Database (http://www.nasbe.org/healthy_schools/hs/index.php) is an up-to-date, comprehensive database describing national guidelines and state laws and policies on the subject. The database describes national guidelines on the topics of:

Curriculum and Instruction

- Health Education
- Physical Education
- Emotional, Social, and Mental Health Education
- HIV, STD, and Pregnancy Prevention Education
- Nutrition Education
- Alcohol, Tobacco, and Drug Use Education
- Injury and Violence Prevention Education

Staff

- Requirements for Health Educators
- Requirements for Physical Educators
- Requirements for School Nurses
- Requirements for School Counselors
- Requirements for School Psychologists
- Requirements for School Social Workers
- Requirements for Athletic Coaches

Health-Promoting Environment

- Wellness Policies
- School Meals Program
- Competitive Foods in School
- Physical Activity Other Than Physical Education
- Crisis Management/Emergency Response
- Air Quality
- Playground/Facility Safety

Student Services

- Screening for Health Conditions
- Administration of Medications
- Counseling and Mental Health Services
- Immunization

Accommodation

- Staff with HIV
- Students with HIV
- Individual Health Plan for Students

Coordination/ Implementation

Coordinating or Advisory Councils
School Health Program Coordinators

The database also describes New Jersey laws and policies on the topics of:

Curriculum and Instruction

Health Education
Physical Education
Asthma Awareness Education
Emotional, Social, and Mental Health Education
HIV, STD, and Pregnancy Prevention Education
Nutrition Education
Alcohol, Tobacco, and Drug Use Education
Injury and Violence Prevention Education

Staff

Requirements for All Educators Regarding Health Education
Requirements for Health Educators
Requirements for Physical Educators
Requirements for School Nurses
Requirements for Non-Certified Personnel to Administer Medication
Requirements for School Counselors
Requirements for School Psychologists
Requirements for School Social Workers
Requirements for Food Service Personnel
Requirements for Athletic Coaches

Health-Promoting Environment

Wellness Policies
School Meals Program
Competitive Foods in School
Physical Activity Other Than Physical Education
Organized Sports
Safe and Drug-Free Schools
Bullying, Harassment and Hazing
Crisis Management/Emergency Response
Tobacco Use
Air Quality
Pesticide Use
Playground/Facility Safety
Shared Use Agreements

Student Services

Screening for Health Conditions
Administration of Medications
Counseling and Mental Health Services
Immunization

Accommodation

Staff with HIV
Students with HIV
Pregnant or Parenting Students
Individual Health Plan for Students

Coordination/Implementation

Coordinating or Advisory Councils
School Health Program Coordinators
Confidentiality
Limitations on Student Surveys

For current legislation relating to school health and wellness in the New Jersey Legislature and in Congress, see Appendix B.

NJSBA's Research Regarding Health and Wellness

The NJSBA School Security Task Force made these school climate recommendations for local school districts/communities in its final report of October 2014

(<http://www.njsba.org/news/security-task-force/pdfs/final-report.pdf>):

- Local school districts should engage in school climate assessments and develop and implement plans to ensure that students have safe, secure and supportive learning environments that provide meaningful communication and involvement with caring adults on the school staff.
- Not all student groups experience school safety and the school climate in the same manner. To enable students to learn in supportive environments at each grade level, local school boards should adopt policies that recognize the importance of social-emotional learning, character development, restorative practices and community building. In addition, the Task Force recommends that school boards review the information on social-emotional learning, supportive practices, and authoritative disciplinary structures on pages 26 through 30 of this report.
- To build a respectful school climate that enables the advancement of student achievement, local boards of education and school administrators should ensure that the principles of social-emotional learning and character development skill-building are infused into academic instruction in a coordinated manner and that there is a consistent application of discipline.
- Local boards of education should ensure that the School Safety Teams, required by the Anti-Bullying Bill of Rights, are not only reviewing reports of harassment, intimidation and bullying, but are also focusing on practices and processes related to school climate, so as to inform the school boards in their periodic review of HIB (harassment, intimidation and bullying) and related policies.
- To ensure their School Safety Teams have a positive impact on school climate, local boards of education should consider requiring the teams to meet more than the twice-yearly minimum.

The School Security Task Force made these school climate recommendations for state action:

- As recommended by the NJ SAFE task force, the state should form an “interagency working group” comprised of various departments, including education, law and public safety, and health and human services, to address policy and programs on early intervention and mental health services at the community level. A similar state-level approach (the Education-Law Enforcement Working Group) has had a positive impact on local policy and procedures through the state’s Uniform Memorandum of Agreement.
- To clarify the role of the School Safety Teams in improving school climate, the New Jersey State Board of Education should amend administrative code (*N.J.A.C. 6A:16*) to rename these bodies “School Safety/Climate Teams,” as recommended by the state’s Anti-Bullying Task Force.

The Current State of Health and Wellness in New Jersey Schools

Every even-numbered calendar year, the New Jersey Department of Education conducts a survey of middle and high school principals and lead health educators, using questions developed by the CDC. While statewide surveys cannot assess all the ramifications of school health and wellness, the 2014 report provides useful information about these topics:

- *Bullying Prevention and Mental Health:* New Jersey school principals and teachers report a high level of instruction about mental health issues and efforts to improve school climate to prevent bullying. Seventy-nine percent of schools provided health information to parents and families to increase knowledge of preventing school bullying.
- *Health Education:* New Jersey schools offer health education courses that teach a variety of skills to their students. For example, in 2014, 95% of teachers reported a health education curriculum that analyzes the influence of family, peers, culture, media, technology, and other factors on health behavior; while 96% reported a curriculum that guides students to practice health-enhancing behaviors to avoid or reduce risks. Among schools that require a course, 38% require students to repeat the course if they fail it.
- *Nutrition:* School principals report increases in non-fried vegetable offerings, along with reductions in offerings of less healthy food alternatives. Also, 40% of schools report serving locally or regionally grown foods in the cafeteria or classrooms, and 35% report planting fruit or vegetable gardens. On the other hand, from 2012 to 2014, a significant increase (9%) was reported in the number of schools offering cookies, crackers, cakes, pastries, or other baked goods that are not low in fat for purchase at school.
- *Physical Education and Physical Activity:* Physical education is required in all grades in New Jersey, and schools teach skills intended to increase and enhance students' physical activity. A majority of schools also offer sports opportunities to students. In addition, 46% have students participate in physical activity breaks within the classroom during the school day. Families were offered information to increase knowledge of physical activity in 58% of schools.
- *Professional Development:* The most frequent types of professional development received in the two years before the 2014 survey were as follows: violence prevention (82%), suicide prevention (66%), using interactive teaching methods (64%), classroom management techniques (62%), and physical activity and fitness (63%). The most commonly requested professional development opportunities were the following: suicide prevention (85%), emotional and mental health (84%), alcohol-use or other drug-use prevention (83%), human sexuality (83%), and violence prevention (82%).
- *School Organization to Guide Health Policy:* Nearly all schools (92%) have someone who oversees or coordinates school health and safety programs and activities, but fewer have a school health team that offers guidance on development of policies or coordination of activities on health topics (64%). Schools reported an increase in the use of the School Health Index or other self-assessment tools to assess school policies, activities, and programs.

- *Sexual Health:* Nearly all lead health teachers in high schools report addressing HIV, STD, and pregnancy prevention topics with their students, with 100% teaching the following: health consequences of HIV, other STDs, and how they are transmitted; health consequences of pregnancy; the benefits of being sexually abstinent; how to access valid and reliable health information; the efficacy of condoms; and the importance of using condoms consistently and correctly. A majority of middle school lead health teachers addressed these topics, as well, with the exception of condom information.
- *Tobacco Prevention:* The vast majority of lead health teachers teach students various tobacco use prevention topics, such as identifying short- and long-term health consequences of tobacco use (96%) and identifying tobacco products and the harmful substances they contain (95%). Almost all schools have adopted a policy prohibiting tobacco use (95%); and a smaller proportion (62%) have policies prohibiting use among students, staff, and visitors in school buildings, at school functions, in school vehicles, on school grounds, and at off-site school events for 24 hours a day and seven days a week.

Task Force Findings

The Link Between Health/Wellness and Student Achievement

A literature search performed for the Task Force by the Regional Education Laboratory (REL) Mid-Atlantic, a component of the U.S. Department of Education's Institute of Education Sciences, suggests that there is a high level of scholarly support for the link between health and wellness and student achievement (see Appendix C). Results such as these have led the U.S. Centers for Disease Control to conclude that "academic success of America's youth is strongly linked with their overall health and that scientific reviews have documented that school health programs can have positive impacts on educational outcomes." (See <http://www.cdc.gov/healthyyouth/cshp/faq.htm>; for additional discussion of the link, see http://www.cdc.gov/healthyyouth/health_and_academics/index.htm).

Based on its review of the evidence, the Task Force believes there is firm evidence linking healthy eating and physical activity to academic achievement. Regarding dietary behaviors and academic achievement, the Task Force believes that:

- School breakfast programs are associated with increased academic grades and standardized test scores, reduced absenteeism, and improved cognitive behavior;
- Skipping breakfast is associated with decreased cognitive performance: alertness, attention, memory, processing of complex visual display, and problem-solving;
- Lack of certain foods, like fruits, vegetables or dairy products, is associated with lower grades among students;
- Lack of specific nutrients, such as vitamins A, B6m and B12, foliate, iron zinc and calcium, is associated with lower grades and higher rates of absenteeism and tardiness, and
- Hunger due to insufficient food intake is associated with lower grades, absenteeism, repeating a grade, and inability to focus.

Regarding physical activity and academic achievement, the Task Force believes that:

- Physically active students tend to have better grades, school attendance, cognitive performance, and classroom behaviors;
- Higher levels of physical activity and physical fitness levels are associated with improved cognitive performance, including concentration and memory;
- Time spent in physical education classes and recess improves student well-being;
- Brief breaks in classrooms are associated with improved cognitive performance;
- Extracurricular physical activity, such as interscholastic sports, is associated with higher GPAs, lower dropout rates, and fewer disciplinary problems; and
- Middle school and high school students involved in interscholastic athletics would benefit academically if, during their season, they received physical education (PE) credit for their participation in the sports program in lieu of attending gym class. Such an option would provide them with time for remediation, enrichment and/or homework, which they miss due to after-school practices.

Other Health and Wellness Topics

The Task Force agrees with the October 2014 report of NJSBA's School Security Task Force, which emphasized the importance of a healthy school climate in reducing the chance of violent incidents in the school.

The Task Force also believes that:

- Improving school health and wellness is a valuable, child-centered means of improving student achievement.
- The history of school policy on the subject of health and wellness has been one of compliance with federal and state requirements, rather than proactive adoption of policy to drive change.
- Comprehensive needs assessments of school climate, including school engagement, school safety, and the school environment, are essential to provide schools with the data needed to pursue strategies that improve school climate.
- The strong and positive relationships that students forge with adults — and observe among adults — in the school setting are critical to developing social competencies that enable them to confront challenges and learn.
- Social and emotional learning is important to enable individuals to learn to understand and manage their emotions and relationships, and to make good decisions. Social-emotional learning can help individuals stop and think before they react, control their response to stress, develop supportive and caring relationships, persist through challenge, seek help, and pay attention to theirs and others' needs and feelings.
- The research of Dr. Maurice Elias of Rutgers University shows that a systemic framework that links academics with service learning, character education and violence prevention has a positive impact on students, including improved attitudes about self, others, and school; positive classroom behavior; higher achievement test scores; and less aggressive behavior and emotional distress.
- Practices that engage students and contribute to social-emotional character development include meaningful, participatory student government; service learning; opportunities for students, staff and the community to provide feedback; open forums for school problem-solving; student input to staff committees; and engagement of students of all backgrounds in leadership and school activities.

Finally, the Task Force has identified hundreds of New Jersey and national success stories demonstrating the feasibility and value of improving school health and wellness. Some examples are provided in Appendix D. Many more may be found in the CDC publication, *Putting Local School Wellness Policies into Action: Stories from School Districts and Schools*, at http://www.cdc.gov/healthyyouth/npao/pdf/251553_SchoolWellnessInAction_Final_508_Ready_508tagged.pdf and on the CDC website at <http://www.cdc.gov/healthyyouth/stories/index.htm>.

These success stories show that many districts and schools have already implemented programs to improve health and wellness and are reaping the benefits. In the following pages, this report makes specific recommendations about such programs and describes numerous resources to help all districts and schools plan and implement programs of their own.

Task Force Recommendations

Core Recommendation

The Task Force's core recommendation is that all school districts implement Coordinated School Health (CSH) programs, as defined and described by the U.S. Centers for Disease Control (CDC) (see <http://www.cdc.gov/healthyyouth/cshp/faq.htm> and <http://www.cdc.gov/healthyyouth/cshp/components.htm>).

CSH is a systematic approach to improving the health and well-being of all students so they can fully participate and be successful in school. The process involves bringing together school administrators, teachers, other staff, students, families, and community members to assess health needs; set priorities; and plan, implement, and evaluate all health-related activities. CSH typically integrates health promotion efforts across eight interrelated components that already exist to some extent in most schools.

Health Education: Health education provides students with opportunities to acquire the knowledge, attitudes, and skills necessary for making health-promoting decisions, achieving health literacy, adopting health-enhancing behaviors, and promoting the health of others. Comprehensive school health education includes courses of study (curricula) for students in pre-K through grade 12 that address a variety of topics such as alcohol and other drug use and abuse, healthy eating/nutrition, mental and emotional health, personal health and wellness, physical activity, safety and injury prevention, sexual health, tobacco use, and violence prevention. Health education curricula should address the National Health Education Standards (NHES) and incorporate the characteristics of an effective health education curriculum. Health education assists students in living healthier lives. Qualified, trained teachers teach health education.

Physical Education: Physical education is a school-based instructional opportunity for students to gain the necessary skills and knowledge for lifelong participation in physical activity. Physical education is characterized by a planned, sequential K-12 curriculum (course of study) that provides cognitive content and learning experiences in a variety of activity areas. Quality physical education programs assist students in achieving national and state standards for K-12 physical education. The outcome of a quality physical education program is a physically educated person who has the knowledge, skills, and confidence to enjoy a lifetime of healthful physical activity. Qualified, trained teachers teach physical education.

Health Services: These services are designed to ensure access or referral to primary health care services or both, foster appropriate use of primary health care services, prevent and control communicable disease and other health problems, provide emergency care for illness or injury, promote and provide optimum sanitary conditions for a safe school facility and school environment, and provide educational and counseling opportunities for promoting and maintaining

individual, family, and community health. Qualified professionals such as physicians, nurses, dentists, health educators, and other allied health personnel provide these services.

Nutrition Services: Schools should provide access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students. School nutrition programs reflect the U.S. Dietary Guidelines for Americans and other criteria to achieve nutrition integrity. The school nutrition services offer students a learning laboratory for classroom nutrition and health education, and serve as a resource for linkages with nutrition-related community services. Qualified child nutrition professionals provide these services.

Counseling, Psychological, and Social Services: These services are provided to improve students' mental, emotional, and social health and include individual and group assessments, interventions, and referrals. Organizational assessment and consultation skills of counselors and psychologists contribute not only to the health of students but also to the health of the school environment. Professionals such as certified school counselors, psychologists, and social workers provide these services.

Healthy and Safe School Environment: A healthy and safe school environment includes the physical and aesthetic surroundings and the psychosocial climate and culture of the school. Factors that influence the physical environment include the school building and the area surrounding it, any biological or chemical agents that are detrimental to health, and physical conditions such as temperature, noise, and lighting. The psychosocial environment includes the physical, emotional, and social conditions that affect the well-being of students and staff.

Health Promotion for Staff: Schools can provide opportunities for school staff members to improve their health status through activities such as health assessments, health education, and health-related fitness activities. These opportunities encourage staff members to pursue a healthy lifestyle that contributes to their improved health status, improved morale, and a greater personal commitment to the school's overall coordinated health program. This personal commitment often transfers into greater commitment to the health of students and creates positive role modeling. Health promotion activities have improved productivity, decreased absenteeism, and reduced health insurance costs.

Family/Community Involvement: An integrated school, parent, and community approach can enhance the health and well-being of students. School health advisory councils, coalitions, and broadly based constituencies for school health can build support for school health program efforts. Schools actively solicit parent involvement and engage community resources and services to respond more effectively to the health-related needs of students.

Suggested Practices for School Districts/Action by N.J., U.S. and the NJSBA

The Task Force also recommends that school districts consider practices designed to support and amplify the core commendation, based on local circumstances and needs. It also calls for action by the state and federal governments and the New Jersey School Boards Association.

Health Education

- 1.** School districts should offer comprehensive school health education as part of a planned, ongoing, systematic, sequential, and standards-based program.
- 2.** School districts should ensure that comprehensive school health education curriculum, instruction, and assessment are aligned.
- 3.** School districts should ensure that comprehensive school health education is taught by certified, highly qualified, effective teachers.
- 4.** School districts should have guidelines for development, review, and adoption of comprehensive school health curriculum.
- 5.** School districts should ensure that nutrition education is part of comprehensive school health education and is also included in other classroom content areas such as math, science, language arts, social sciences, and family and consumer sciences.
- 6.** School districts should assess all nutrition education lessons and materials for accuracy, completeness, balance, and consistency with state and district educational goals and curriculum standards.
- 7.** School districts should allocate sufficient time and resources for effective school health instruction.
- 8.** School districts should ensure that comprehensive health education offers multidisciplinary, multicultural perspectives and provides learning opportunities for multiple learning styles.
- 9.** School districts should provide ongoing, timely professional development related to school health issues — including healthy food options for breakfast, lunch, snacks, and consumption at school-sponsored events — for teachers, support staff program administrators, and school health and mental health providers.
- 10.** School districts should conduct regular evaluation of their comprehensive school health education programs.
- 11.** School districts should base nutrition education on current science, research, national guidelines, and national and state standards.
- 12.** School districts should ensure that their nutrition education program links with school meal programs, other school foods, and nutrition-related community services that occur outside the classroom or that link classroom nutrition education to the larger school community, such as school gardens, cafeteria-based nutrition education, and after-school programs.
- 13.** School districts should ensure that their instructional staffs collaborate with agencies and groups conducting nutrition education in the community, in order to send consistent messages to students and their families.

14. School districts should conduct nutrition education activities and promotions that involve parents, students, and the community.
15. School districts should attempt to influence home food consumption.
16. School districts should build awareness among teachers, food service staff, coaches, nurses, bus drivers and other school staff members about the importance of nutrition, physical activity, and body-size acceptance to academic success and lifelong wellness.
17. School districts should seek to expand participation in breakfast programs.
18. School districts should control the quality of food available in kiosks and vending machines.
19. School districts should incorporate health education standards, including nutrition standards, in all school programs including academic, social/emotional, and student management programs.

Physical Education

1. School districts should ensure that physical education is sequential and based on state standards.
2. School districts should establish specific durations of physical education (health, safety and physical education) per week and per day—i.e., 150 minutes in total per week, and 30 minutes of any one of the three per day. The program should apply to the entire school year for all students in Grades PreK-1, 2-4, 5-8 and 9-12, including students with disabilities, with special health-care needs, and in alternative educational settings.
3. School districts should ensure that certified, highly-qualified physical education teachers teach all physical education.
4. School districts should ensure that all students in grades PK-5 have at least 20 minutes a day of supervised recess, preferably outdoors and involving moderate to vigorous physical activity.
5. School districts should schedule lunch after recess where class schedules permit.
6. School districts should ensure that all schools offer extracurricular physical activity programs, such as physical activity clubs or intramural programs.
7. School districts should provide that high school athletes receive PE credit during their season in lieu of attending gym class, in order to provide them with time for remediation, enrichment, or homework that they miss due to after-school practices.
8. School districts should ensure that staff do not use physical activity or exercise (e.g., running laps and doing pushups) or withhold opportunities for physical activity (e.g., recess and physical education) as punishment.
9. School districts should provide students with opportunities for physical activity in addition to physical education.
10. School districts should consider how physical education is impacted when considering or implementing block scheduling.

Health Services

1. School districts should employ highly qualified health services professionals.
2. School districts should ensure that school nurses adhere to the scope and standards of professional school nurse practice.
3. School districts should base health policies and procedures on evidence-based practices and standards.
4. School districts should coordinate health services with other health and wellness programs, services, and recommendations.
5. School districts should connect school health services with existing curriculum that addresses the health and well-being of students and staff.
6. School districts should ensure that nursing services are available for all students.
7. School districts should ensure that school nurses and other health professionals receive professional development.
8. School districts should ensure that school health services providers promote collaboration within the school community and with outside community members, including families.
9. School districts, especially those serving minority populations and other groups that have historically experienced health care access disparities, should consider the feasibility of establishing school-based youth services programs.

Nutrition Services

1. School districts should ensure that school meals offer varied and nutritious food choices that are consistent with USDA nutrition standards and Dietary Guidelines for Americans.
2. School districts should ensure that menu choices are appealing to children.
3. School districts should seek to ensure that all children have breakfast, either at home or at school, in order to meet their nutritional needs and enhance their ability to learn.
4. School districts should ensure that modified meals are available for students with appropriate medical documentation of food allergies or other special dietary needs.
5. School districts should ensure that school meals are served in clean and pleasant settings.
6. School districts should provide appropriate meal times and adequate time for students to eat (at least 10 minutes for breakfast and 20 minutes for lunch, after sitting down to eat), with the understanding that too little time leads to unfinished meals, while too much time leads to poor behavior choices.
7. School districts should make every effort to eliminate social stigma attached to, and prevent overt identification of, students who are eligible for free and reduced price school meals through such means as technologies that enable all students to have monies on account for school meals and to use ATM-like cards when paying.

8. School districts should ensure that schools in which more than 50 percent of students are eligible for free or reduced-price school meals sponsor Summer Food Service Programs for at least six weeks between the last day of the academic school year and the first day of the following school year, and preferably throughout the entire summer vacation.
9. School districts should aim to make school food service programs financially self-supporting.
10. School districts should ensure that qualified nutrition professionals administer school meal programs.
11. School districts should ensure that all food service personnel have adequate pre-service training in food service operations and regularly participate in professional development activities that address requirements for child nutrition programs, menu planning and preparation, food safety, strategies for promoting healthy eating behaviors, harassment/intimidation/bullying, child abuse/neglect, and related topics.
12. School districts should ensure that all foods made available at school comply with state and local food safety and sanitation regulations.
13. Based on their students' nutritional needs and the availability of food programs in the community, school districts should consider providing food when school is not in session, including after-school, weekends, vacations during the school year, and the summer.
14. School districts should not use foods or beverages as rewards for academic performance or good behavior, unless this practice is allowed by a student's individualized education plan (IEP), and should not withhold food or beverages as a punishment.
15. School districts should discourage students from sharing food or beverages during meal or snack times to avoid problems with allergies and dietary restrictions.
16. The New Jersey School Boards Association should develop guidelines for local district RFPs for food services.

Counseling, Psychological, and Social Services

1. School districts should seek to eliminate stigma related to mental health disorders through district policy reviews, professional development for all staff, and parent training.
2. School districts should develop protocols, policies and procedures to obtain parental consent for children to participate in clinical assessment and treatment services.
3. School districts should provide early and ongoing screening for existing and emerging conditions that affect social-emotional development, behavior, and psychological functioning.
4. School districts should develop proactive linkages to local community services that provide supports for target conditions, such as faith groups, community service organizations, and youth sports and arts programs.
5. School districts should collaborate with local community providers to develop and increase their capacity to provide appropriate services for young people whose economic circumstances may be a barrier to accessing best-practice services.

6. School districts should strengthen their capacity to provide crisis intervention and brief treatment services.
7. School districts should ensure that all staff are informed about normative development, common stressors that may interfere with learning and behavioral health (e.g., bereavement, parental divorce), atypical emotional responses, classroom-based interventions that improve school climate, systems-based interventions that improve quality of life in school settings, and mechanisms for referring students for more extensive behavioral health services.
8. School districts should seek to strengthen parent-school linkages related to behavioral health needs of children and adolescents.
9. School districts should seek to reduce child and adolescent risk behaviors, including tobacco use, unsafe sexual behaviors, drug and alcohol use, and suicide.
10. The State of New Jersey should form an “interagency working group,” including the departments of education, law and public safety, and health and human services, to address policy and programs on early intervention and mental health services at the community level. (This recommendation reiterates a recommendation of the NJSBA School Security Task Force in October 2014.)
11. To clarify the role of the School Safety Teams in improving school climate, the New Jersey State Board of Education should amend administrative code (*N.J.A.C. 6A:16*) to rename these bodies “School Safety/Climate Teams,” as recommended by the state’s Anti-Bullying Task Force. (This recommendation reiterates a recommendation of the NJSBA School Security Task Force in October 2014.)

A Healthy and Safe School Environment

1. School districts should provide physical and social environments that are safe and supportive, promulgate district expectations of healthy behaviors, and implement policies that promote health and safety and reduce risk of disease.

Physical Environment

2. School districts should work to prevent exposure to both indoor and outdoor allergens through comprehensive air quality and pesticide programs within the framework of existing codes and standards.
3. School districts should form active cross-organizational safety committees, including parents, students and community members, and charge them to ensure that programs and policies comply with workplace and public facilities safety rules and regulations, and that maintenance and repair policies are in place.
4. School districts should ensure that facilities comply with requirements of the Americans with Disabilities Act (ADA).
5. School districts should formalize operating, maintenance and capital replacement policies and practices that all staff and administration support and follow.
6. School districts should ensure that transportation is an essential service that is managed in accordance with all state and federal regulations and guidelines.

7. School districts should permit school spaces and facilities to be used by students, staff and community members before, during and after the school day, on weekends, and during school vacations.
8. School districts should provide professional development on comprehensive approaches to physical activity in schools.
9. School districts should encourage municipal governments to establish bikeways and safe routes to school as part of their master plans and promote bike-to-school programs by installing bike racks and promoting safe routes.
10. School districts should provide adequate and safe playground facilities, such as those described in standards promulgated by the National Program for Playground Safety.
11. School Districts should evaluate how their facilities impact student and staff health and ensure that facilities meet health standards.
12. School districts should regularly review and seek to improve all policies that relate to facilities, maintenance, and buildings and grounds.
13. School districts should involve building and grounds and maintenance personnel in all aspects of ensuring that the physical environment meets all health and safety standards.
14. School districts should use state-required updates to their Long Range Facility Plan as opportunities to ensure that health and wellness needs are met in an effective, consistent, and financially prudent manner.
15. School districts should ensure that school health and wellness planning includes consultation with professionals in the areas of sustainability, architecture, engineering and information technology, as well as with construction and fire code officials.
16. School districts should routinely evaluate and review the condition of their buildings and identify maintenance issues in need of attention.

Social/Emotional Environment/School Climate

17. School districts should establish personnel and systems-based programs to improve school climate, including standing committees in each school responsible for school climate improvement.
18. In view of research indicating that children make healthier decisions when they have at least one adult who acts as a resource or mentor, school districts should create opportunities for students to feel attached to at least one caring, responsible adult at school.
19. School districts should clearly articulate and fairly manage anti-bullying policies and procedures, including consistent follow-through.
20. School districts should provide visible, vocal and consistent leadership for respectful behavior.
21. School districts should ensure that all staff adhere to state and national professional codes of conduct.

22. School districts should consider providing conflict resolution training for all students and staff.
23. School districts should ensure that all staff receive significant professional development in violence prevention—including conflict resolution, peer mediation, bullying prevention, school climate improvement, social-emotional learning, and character education.
24. School districts should ensure that professional development in bullying prevention includes recognizing acts of name-calling, teasing, exclusion, taunting, threatening, harassment, and other bullying behaviors, and intervening immediately when they occur.
25. School districts should conduct detailed school climate assessments, including anonymous input by staff, students and parents, and create a site-based improvement plan based on assessment findings.
26. School districts should include provisions for a healthy emotional environment in their mission statements.
27. School districts should provide adequate, appropriate supervision in all areas of the school.
28. School districts should adopt policies that recognize the importance of social-emotional learning, character development, restorative practices, and community building. (This recommendation reiterates a recommendation of the NJSBA School Security Task Force in October 2014.)
29. School districts should ensure that the principles of social-emotional learning and character development skill-building are infused into academic instruction in a coordinated manner and that there is a consistent application of discipline. (This recommendation reiterates a recommendation of the NJSBA School Security Task Force in October 2014.)
30. School districts should ensure that School Safety Teams, required by the Anti-Bullying Bill of Rights, not only review reports of harassment, intimidation, and bullying, but also proactively focus on practices and processes related to school climate, so as to inform school boards in their periodic review of policies related to harassment, intimidation, and bullying. (This recommendation reiterates a recommendation of the NJSBA School Security Task Force in October 2014.)

Health Promotion for Staff

1. School districts should disseminate information, build awareness, provide health education, and support health-promoting activities that focus on skill development and lifestyle behavior change for staff members.
2. School districts should provide staff with access to facilities that meet staff wellness needs and interests.
3. School districts should ensure that nutrition standards apply to all foods and beverages, including those in vending machines available to staff members.

4. School districts should prohibit all use of tobacco by students, staff members, and visitors on school grounds.
5. School districts should integrate staff wellness programs into district and school culture and structure.
6. School districts should link staff wellness programs to related programs, such as employee assistance programs, emergency care, and programs that help employees balance work and family life.
7. School districts should offer worksite screening programs linked to medical care to ensure follow-up and appropriate treatment, as necessary.
8. School districts should conduct ongoing evaluation to promote improvement in the effectiveness and efficiency of the staff wellness program.
9. School districts should encourage staff members to model healthy eating and physical activity behaviors.

Family/Community Involvement

1. School districts should form community health and wellness task forces representing all stakeholders (professional and support staff, parents, local governing bodies, health agencies, emergency responders, law enforcement, businesses, faith-based organizations, and community members) as a means of promoting health and wellness to the entire community.
2. School districts should communicate and form partnerships with local departments of health and other stakeholders to support connections among healthy eating, physical activity, and academic achievement.
3. School districts should form public private partnerships/shared services to advocate for and provide health and wellness services.
4. School districts should encourage local governing bodies and health departments to develop community health improvement plans including such topics as safe ways to school, bike paths, crossing guards, and wellness of municipal employees.
5. School districts should facilitate school and family access to resources from community businesses, social service agencies, and other groups, and encourage schools to serve as resources to the community.
6. School districts should promote ongoing, meaningful and effective communication among schools, families and the community about school programs and student progress, including parent academies to educate parents about child development, good parenting, and health issues.
7. School districts should provide appropriate training and involve families and community members in instructional and support areas both in and out of the school.
8. School districts should involve families in learning activities at home and in the community, including interactive homework and other curriculum-linked enrichment activities.

9. School districts should provide opportunities and support for students, families of students and community members, including senior citizens, to participate in school programs, decisions, governance, and advocacy.

Policy/Administrative Issues

1. School districts should create a health and wellness team and provide it with administrative support and appropriate professional development.
2. School districts should study the Center for Disease Control's Coordinated School Health program and implement components appropriate to their needs and circumstances.
3. School districts should establish, implement and monitor school wellness policies that define administrators' responsibilities, promote healthy school nutrition environments, and support a comprehensive approach to physical activity.
4. School districts should make wellness policies part of their district strategic plan.
5. School districts should ensure ongoing, periodic review of their school health and wellness policies and plans.
6. School districts should ensure that all adopted curricula are aligned with health and wellness practices.
7. School districts should work to secure buy-in from all school personnel and attempt to identify champions in each school.
8. School districts should collect data on health and educational behaviors and outcomes to assess the benefits of school health policies and practices.
9. School districts should celebrate successes resulting from wellness policies.
10. School districts should engage in school climate assessments and develop and implement plans to ensure that students have safe, secure and supportive learning environments that provide meaningful communication and involvement with caring adults among school staff. (This recommendation reiterates a recommendation of the NJSBA School Security Task Force in October 2014.)
11. School climate assessments should include social/emotional learning, wellness and safety and, where appropriate, utilize already existing assessment instruments, such as that developed by the United Way of Northern New Jersey's School Culture and Climate Initiative.
12. New Jersey School Boards Association professional development and mandated training for board members should include information about the relationship between health/wellness and student achievement.

Implementing a Coordinated School Health Program

The Task Force endorses these general strategies to implement a coordinated approach to improve school health policies and programs, as recommended by the Centers for Disease Control (CDC) (<http://www.cdc.gov/healthyyouth/cshp/schools.htm>):

1. Secure and maintain administrative support and commitment.

The superintendent's support at the district level and the principal's support at the school level are essential for implementing and maintaining a coordinated and systematic approach to school health. School administrators can support a coordinated approach to school health by:

- incorporating health in the district's or school's vision and mission statements, including health goals in the school's improvement plan
- appointing someone to oversee school health
- allocating resources
- modeling healthy behaviors
- regularly communicating the importance of wellness to students, staff, and parents

2. Establish a school health council or team.

An effective school health system uses a team approach to guide programming and facilitate collaboration between the school and the community. At the district level, this group is typically called a school health council, and at the school level, it is typically called a school health team.

Ideally, the district school health council includes at least one representative from each of the eight components, and school administrators, parents, students, and community representatives involved in the health and well-being of students, such as a representative from the local health department and the school district's medical consultant.

School health teams generally include a site administrator, an identified school health leader, teachers and other staff representing the components, parents, students, and community representatives when appropriate.

3. Identify a school health coordinator.

A full-time or part-time school health coordinator is a critical factor for the successful implementation of a coordinated approach to school health. The school health coordinator helps maintain active school health councils and facilitate health programming in the district and school and between the school and community. The coordinator organizes the eight components of school health and facilitates actions to achieve a successful, coordinated school health system, including policies, programs, activities, and resources.

4. Develop a plan.

A school health council or team should use a program planning process to achieve health promotion goals. The process, which should involve all stakeholders, includes:

- defining priorities based on the students' unique health needs
- determining what resources are available
- developing an action plan based on realistic goals and measurable objectives
- establishing a timeline for implementation
- evaluating whether the goals and objectives are met

Ideally, this plan would be incorporated into a school's overall improvement plan to link health with learning outcomes. CDC has developed an assessment and planning resource, the School Health Index (<http://www.cdc.gov/healthyyouth/shi/index.htm>), to help schools analyze the strengths and weaknesses of their school health policies, programs, and services, and plan for improvement.

5. Implement multiple strategies through multiple components.

Each school health component employs a unique set of strategies. These strategies include classroom instruction, policies and procedures, environmental change, health, counseling and nutrition services, parent and community involvement, and social support. However, no single strategy or single component will achieve all the desired health outcomes for all students. Therefore, it is necessary to implement all of the components so the full range of strategies becomes available to systematically address health behaviors and improve student learning.

6. Focus on students.

The focus of coordinated school health should be on meeting the education and health needs of students as well as providing opportunities for students to be meaningfully involved in the school and the community. School health efforts should give young people the chance to exercise leadership, build skills, form relationships with caring adults, and contribute to their school and community. Students can promote a healthy and safe school and community through peer education, peer advocacy, cross-age mentoring, service learning, and participation on school health teams advisory committees, councils, and boards that address health, education, and youth issues. Protective factors that are health enhancing in schools include:

- a supportive and nurturing environment that fosters respect, connectedness, and meaningful involvement
- adults modeling positive social interactions and having the same expectations of students
- group norms that value a healthy lifestyle

7. Address priority health-enhancing and health-risk behaviors.

Schools can implement policies and programs to help students avoid or reduce health risk behaviors that contribute to the leading causes of death and disability among young people as well as among adults. In the United States, six categories of priority health-risk behaviors are related to the leading causes of death and disability: behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and STDs, including HIV infection; unhealthy eating; and physical inactivity.

Schools can assess health-risk behaviors among young people, along with general health status and health problems, such as obesity and asthma, through formal surveys such as the Youth Risk Behavior Survey (<http://www.cdc.gov/healthyyouth/data/yrbs/index.htm>).

Programs that reduce these risk behaviors and promote protective factors have been identified through research and, when appropriate, can be incorporated into school programming (see Registries of Effective Programs at <http://www.cdc.gov/healthyyouth/AdolescentHealth/registries.htm>). CDC has developed guidelines (<http://www.cdc.gov/healthyyouth/npao/strategies.htm>) to help schools promote physical activity and healthy eating and build a systematic and coordinated approach to school health.

8. Provide professional development for staff.

Continuing education is essential for teachers, administrators and other school employees committed to improving the health, academic success, and well-being of students. All school employees need to stay current in their skills and knowledge. Professional development provides opportunities for school employees to identify areas for improvement, learn about and use proven practices, solve problems, develop skills, and reflect on and practice new strategies. In districts and schools promoting a coordinated school health approach, professional development should focus on the development of leadership, communication, and collaboration skills. CDC recommends six key professional development practices. There are numerous resources available to help school districts at any stage of development of their coordinated school health programs.

Resources to Help LEAs Implement or Strengthen Coordinated School Health Programs

The Task Force identified a large variety of resources to help LEAs study, implement, or strengthen coordinated school health programs.

U.S. Centers for Disease Control (CDC)

- The “School Health Index (SHI): Self-Assessment & Planning Guide 2014” is a confidential online self-assessment and planning tool that schools can use to improve their health and safety policies and programs. The SHI was developed by CDC in partnership with school administrators and staff, school health experts, parents, and national nongovernmental health and education agencies to:
 - Enable schools to identify strengths and weaknesses of health and safety policies and programs
 - Enable schools to develop an action plan for improving student health, which can be incorporated into the School Improvement Plan
 - Engage teachers, parents, students and the community in promoting health-enhancing behaviors and better healthSee <http://www.cdc.gov/healthyyouth/shi/index.htm>
- The “Health Education Curriculum Analysis Tool” (HECAT) helps school districts, schools and others conduct a clear, complete and consistent analysis of health education curricula based on the National Health Education Standards and CDC’s Characteristics of an Effective Health Education Curriculum. HECAT results can help schools select or develop appropriate and effective health education curricula and improve the delivery of health education. The HECAT can be customized to meet local community needs and conform to the curriculum requirements of the state or school district. See <http://www.cdc.gov/healthyyouth/HECAT/index.htm>
- The “Physical Education Curriculum Analysis Tool” (PECAT) is a self-assessment and planning guide designed to help school districts and schools conduct clear, complete and consistent analyses of physical education curricula, based upon national physical education standards. Specifically, the PECAT:
 - Assesses how closely physical education curricula align with national standards for high quality physical education programs
 - Analyzes content and student assessment components of a curriculum that correspond to national standards for physical education for four grade levels: K–2, 3–5, 6–8, and 9–12
 - Helps school districts or individual schools identify changes needed in locally developed curriculaPECAT results can be used by school districts to enhance existing physical education curricula, develop curricula or select published curricula that will deliver high quality physical education to students. See <http://www.cdc.gov/healthyyouth/PECAT/index.htm>
- The publication, *Parent Engagement: Strategies for Involving Parents in School Health*, defines and describes parent engagement and identifies specific strategies and actions that

schools can take to increase parent engagement in school health promotion activities. The publication is intended for school administrators, teachers, support staff, parents, and others interested in promoting parent engagement. See

http://www.cdc.gov/healthyyouth/protective/pdf/parent_engagement_strategies.pdf

- “Improving Academic Achievement through Healthy Eating and Physical Activity” is a PowerPoint Presentation, with speaker notes, to help engage stakeholders in supporting healthy school environments. See http://www.cdc.gov/healthyyouth/health_and_academics/index.htm
- CDC’s “Program Evaluation” page includes information on selecting an evaluation consultant, gaining consensus among stakeholders, developing evaluation questions, choosing indicators for school health programs, evaluation planning, data collection methods, and data analysis. See <http://www.cdc.gov/healthyyouth/evaluation/index.htm>
- CDC’s “Health and Academics” page provides links to resources indicating that the academic achievement of America’s youth is strongly connected with their health; that school health programs can have positive effects on academic outcomes, as well as health-risk behaviors and health outcomes; and that schools play a critical role in promoting the health and safety of young people and helping them establish lifelong healthy behaviors. See http://www.cdc.gov/healthyyouth/health_and_academics/index.htm
- The CDC and the Bridging the Gap research program have collaborated to produce this series of briefs:
 - Local School Wellness Policies: Where Do They Stand and What Can You Do? — http://www.bridgingthegapresearch.org/_asset/xj5fdy/Local_School_Wellness_Policies_Oct_2014.pdf
 - Supporting Quality Physical Education and Physical Activity in Schools — http://www.bridgingthegapresearch.org/_asset/g49jib/Quality_PhysEd_PhysActivity_Oct_2014.pdf
 - Supporting Recess in Elementary Schools — http://www.bridgingthegapresearch.org/_asset/1d74y4/Supporting_Recess_Elementary_Schools_Oct_2014.pdf
 - Creating Supportive School Nutrition Environments — http://www.bridgingthegapresearch.org/_asset/2yk39p/Creating_Supportive_School_Nutrition_Environments_Oct_2014.pdf
 - Improving Access to Drinking Water in Schools — http://www.bridgingthegapresearch.org/_asset/p5yzxu/Improving_Access_Drinking_Water_Oct_2014.pdf
 - Marketing and Promotion of Foods and Beverages at School — http://www.bridgingthegapresearch.org/_asset/0jyl79/MarketingPromotion_FoodsBeverages_Schools_Oct_2014.pdf
 - Addressing Weight Status Measurement in Schools — http://www.bridgingthegapresearch.org/_asset/srnnhy/Addressing_Weight_Status_Measurement_Oct_2014.pdf

- The CDC offers these suggestions for obtaining technical assistance in planning and implementing a coordinated approach to school health:
 - Check with state education and health agencies to see if they offer any grants or technical assistance.
 - Join a state or national listserv such as the Comprehensive Health Education Network (CHEN), administered by the American School Health Association, to stay abreast of new developments and learn about national, state, or regional trainings.
 - Join a professional organization devoted to comprehensive school health so you can network with other school health coordinators. For example, the [American School Health Association](#) has a Section specifically for school health coordinators.

- The CDC also provides assistance concerning funding for coordinated school health programs, pointing out that competitive funding is available from several federal agencies and some state and local agencies. CDC provides competitive funding for state health and education departments so they can work together to help build the capacity of school districts to implement a coordinated approach to school health. All states and territories that meet certain criteria can apply for funding from CDC every five years. CDC also provides competitive funding for national nongovernmental organizations (NGOs) to build the capacity of schools to address specified health-risk behaviors and conditions. All NGOs that meet certain criteria can apply for funding from CDC every five years. Finally, some states provide grants to help schools use CDC's School Health Index or similar tools to assess the comprehensive school health components and develop a plan for improvement or implementation. The CDC announces new funding opportunities at <http://www.cdc.gov/healthyyouth/FOA/index.htm>.

Other Federal Agencies

- The U.S. Department of Agriculture provides funding for school meal programs, including the school lunch and breakfast programs and the fresh fruit and vegetable program. In 2015-2016, the fresh fruit and vegetable program has allocated \$4.1 million for New Jersey to provide improved nutritional opportunities to 76,400 students in 151 schools. See <http://www.fns.usda.gov/>.

- The Office of Safe and Drug-Free Schools, U.S. Department of Education, offers grants for physical education programs, elementary and secondary school counseling programs, integration of schools and mental health systems, drug and violence prevention, safe schools/healthy students, and character and civic education. See <http://www2.ed.gov/about/offices/list/osdfs/programs.html>

- The National Center on Safe Supportive Learning Environments, coordinated by the U.S. Department of Education, provides a collection of school climate surveys and other tools to measure school culture. See <http://safesupportivelearning.ed.gov/topic-research/school-climate-measurement/school-climate-survey-compedium>

- The U.S. Environmental Protection Agency provides resources for sun safety and school chemical cleanup campaigns. See <http://www.epa.gov/>

- The Safe Routes to School Program of the U.S. Department of Transportation helps states improve the ability of primary and middle school students to walk and bicycle to school safely. See http://www.fhwa.dot.gov/environment/safe_routes_to_school/
- The Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services, provides resources and funding information for school-based health centers, often operated as partnerships between a school and a community health organization, such as a community health center, hospital, or local health department. The specific services such centers provide — such as treating students for acute illnesses, treating for chronic conditions, or screening for dental, vision and hearing problems — vary based on community needs and resources as determined by the partners. All emphasize prevention, early intervention, and risk reduction and counsel students on healthy habits and how to prevent injury, violence, and other threats. The New Jersey Department of Education reports that there are currently 90 school-based youth services programs operating in 67 New Jersey high schools, 18 middle schools and 5 elementary schools. See <http://www.hrsa.gov/ourstories/schoolhealthcenters/> and <http://www.state.nj.us/dcf/families/school/>
- The Safe Schools/Healthy Students, Substance Abuse and Mental Health Services Administration offers initiatives to prevent violence and substance abuse among youth in schools and communities. See <http://www.sshs.samhsa.gov/>
- The Children’s Health Insurance Program, Centers for Medicare and Medicaid Services, allows school-based or school-linked health centers in some states to bill Medicaid/Children’s Health Insurance Program for reimbursement of medical services provided to eligible students. See <http://www.medicaid.gov/index.html>

New Jersey School Boards Association

- The NJSBA Grants Support Program—<http://www.njsba.org/services/grants-office.php>—offers assistance to New Jersey school districts, charter schools, and affiliated local education foundations. The program provides grants information, customized funder research, and consultation to assist districts in developing project ideas, obtaining funding for new projects, and expanding initiatives already in progress. For more information about the program, see Appendix E.
- The NJSBA Policy Service operates a clearinghouse of sample policies for reference by boards of education, including polices related to many of the recommendations in this report. See www.njsba.org/policy. For sample policy on the topic of Health, see Appendix F; Wellness and Nutrition, see Appendix G; Drugs, Alcohol, Steroids, Tobacco, see Appendix H; Health Examinations and Immunizations, see Appendix I; and Administering Medication, see Appendix J.

Other National and State Organizations

- An American Cancer Society publication, *Promoting Healthy Youth, Schools, and Communities: A Guide to Community-School Health Councils*, presents a five-step approach to planning, conducting, and evaluating a community-school health advisory council: (1) convening an advisory council (learning about councils, obtaining support from the district, identifying potential members, organizing and conducting the first meeting, and following up); (2) creating a vision and building ownership; (3) developing an action plan; (4) taking action and getting results (designing a structure for the council's work, creating a plan for marketing the council's efforts, and handling conflict); and (5) maintaining momentum—e.g., evaluating the council's efforts, holding an annual renewal meeting, revitalizing council membership, expanding school health improvement efforts, and considering conducting a needs assessment.
(<http://www.cancer.org/acs/groups/content/@nho/documents/document/guidetocommunityschoolhealthcou.pdf>)
- An American School Health Association publication, *What School Administrators Can Do to Enhance Student Learning by Supporting a Coordinated Approach to Health (2010)*, proposes concrete actions that district and building administrators can take to adopt and support coordinated approaches to enhance learning and health. See <http://www.ode.state.or.us/teachlearn/subjects/health/administratorscoordinatedapproachsupport.pdf>. For other resources of the American School Health Association, see <http://www.ashaweb.org/resources/>.
- The Center for Green Schools works directly with teachers, students, administrators, elected officials and communities to create programs, resources and partnerships that transform schools into healthy learning environments. It is dedicated to transforming all schools into sustainable and healthy places to live, learn, work and play. Its website offers videos, print resources, and web trainings. See <http://www.centerforgreenschools.org/our-story.aspx>.
- The Center for Supportive Schools provides training and programs to engage students in learning and enable them to develop positive social, emotional and health behaviors. See <http://supportiveschools.org>.
- A Connecticut State Department of Education publication, *Guidelines for a Coordinated Approach to School Health: Addressing the Physical, Social and Emotional Health Needs of the School Community*, seeks to help communities develop and strengthen practices, activities and curriculum that promote the health of students and reduce the negative impact of health problems on academic performance. It contains recommendations for local policies, which school districts may choose to use as written or adapt to address local needs and reflect community priorities. See http://www.sde.ct.gov/sde/LIB/sde/PDF/deps/student/Guidelines_CSH.pdf .
- A National Association of County and City Health Officials publication, *Building Healthier Communities: Local Nutrition and Physical Activity Programs*, describes 16 local public health programs addressing policy and environmental changes through nutrition and physical activity programs. It includes details about the planning,

partnerships, and integration that were essential to success and highlights how the programs addressed disparities in their communities. See <http://eweb.naccho.org/eweb/DynamicPage.aspx?webcode=NACCHOPubResults&Site=naccho>.

- A National Association of State Boards of Education publication, *How Schools Work and How to Work with Schools: A Primer for Professionals Who Serve Children and Youth*, is intended to help people from different backgrounds, occupations and training to work with school staff to improve the health, safety, and well-being of children and youth. See http://www.cdc.gov/healthyyouth/cshp/pdf/nasbe_howschoolswork.pdf.
- The National Program for Playground Safety (NPPS) employs research-based advocacy and training to empower communities to create safe, inclusive and high-quality play areas for children. Its goals are to raise community awareness of children's outdoor play areas; to advocate at the local, state, and national levels for safe, inclusive, high-quality play areas for children; and to educate professionals who are involved with children's play areas. NPPS's website includes state regulations and standards/guidelines of the Americans with Disabilities Act, the American Society for Testing and Materials, and U.S. Consumer Product Safety Commission. See <http://www.playgroundsafety.org/standards>.
- The National School Climate Center offers a "Comprehensive School Climate Inventory," which provides an in-depth profile of strengths and needs to help schools integrate social and emotional learning with academic instruction. See <http://www.schoolclimate.org/climate/>.
- A National Training and Development Consortium for School Health's publication, *Building Competencies for Managers and Staff of Coordinated School Health Programs*, identifies nine school health program professional responsibilities and includes a competency self-assessment tool. See <http://www.cdc.gov/healthyyouth/cshp/pdf/competency.doc>.
- The New Jersey Department of Education's School Climate Survey, developed in collaboration with the Bloustein Center for Survey Research at Rutgers, provides a variety of tools "to collect and analyze objective information from diverse school populations (i.e., students, staff and parents) for reinforcing positive conditions for learning and addressing vulnerabilities in local learning conditions." See <http://www.state.nj.us/education/students/safety/behavior/njscs/>.
- The New Jersey Statewide Parent Advocacy Network, through its Coordinated School Health Initiatives, provides School Health Specialists, who work with school Health Committees, resources to assess the school's health plan and to help schools create and implement an individualized School Health Improvement Plan. See <http://www.spanadvocacy.org/content/coordinated-school-health-initiatives>.
- The Rudd Center for Food Policy & Obesity at the University of Connecticut offers a Schools, Families, and Communities Program that supports community and grassroots

efforts by aiding parents, teachers, and administrators nationally who want to change the school environment. See <http://www.uconnruddcenter.org/schools-families-communities>.

- Rutgers University's NJ Safe Routes to School Resource Center helps communities find solutions to create safer walking and bicycling environments for children. See <http://www.saferoutesnj.org/>.
- The Search Institute has identified a framework of 40 developmental assets, or building blocks of healthy development, that help children and youth grow up healthy, caring, and responsible. Search Institute surveys of more than 4 million children and youth have consistently demonstrated that the more developmental assets young people acquire, the better their chances of succeeding in school and becoming happy, healthy and contributing members of their communities and society. The Institute also suggests means of building those assets, such as reading to children, minimizing television viewing, and participating in organized youth group/sports/arts activities. See <http://www.search-institute.org/research/developmental-assets>.
- The Sustainable Jersey for Schools certification program, which has more than 279 participating schools, offers programs and funding opportunities to improve health and wellness and sustain the environment. See <http://www.sustainablejersey.com/about/sustainable-jersey-for-schools/>.
- United Way of Northern New Jersey, in partnership with the College of Saint Elizabeth Center for Human and Social Development, offers a School Culture and Climate Initiative, a data-driven process to help schools improve their culture and climate. See http://www.unitedwaynj.org/ourwork/ed_youthempowerhowwehelp_scci.php.

Websites of Relevant Professional Organizations

- American Dietetic Association — <http://www.eatright.org/>
- American School Counselor Association — <http://www.schoolcounselor.org/>
- American School Health Association — <http://www.ashaweb.org/>
- National Association of School Nurses — <http://www.nasn.org/>
- National Association of School Psychologists — <http://www.nasponline.org/>
- School Nutrition Association — <http://www.schoolnutrition.org/>
- School Social Work Association of America — <http://www.sswaa.org/>

APPENDIX A: Charge to the Task Force on the Impact of Health and Wellness on Student Achievement

Charge: By June 2015, the Task Force on the Impact of Health and Wellness on Student Achievement (HWSA) of the New Jersey School Boards Association will determine the ways in which health and wellness policies, practices, and processes impact student achievement, and will develop recommendations for consideration by local Boards of Education. From that list, Boards of Education would select those recommendations they choose to implement, based on local district needs.

The HWSA task force will investigate all areas associated with health & wellness, social emotional learning (SEL), and school/organizational climate as they relate to student achievement.

Background: Significant research supports the idea that healthy students are more successful students. In other words, health and wellness is among the important factors, along with school/organizational climate, community schools, and social-emotional learning, that impact student achievement.

This linkage has been cited by several organizations. For example, the “Let's Move! Active Schools Campaign” (<http://www.letsmove.gov/active-schools>) says that regular physical activity helps students succeed in school. The Centers for Disease Control found a negative association (http://www.cdc.gov/healthyyouth/health_and_academics/data.htm) between health-risk behaviors and high school students' academic success, after controlling for sex, race/ethnicity and grade level.

Yet, neither the NJSBA nor its sister organizations have a formal resource to guide school board members and educators to develop healthy school climates, giving consideration to both health and wellness and social emotional learning. This effort, by the HWSA task force, seeks to provide a roadmap for local school boards to follow, and share with local partners, on the journey toward advancing health and wellness and, in turn, student achievement.

What: The subjects to be researched include all areas of the educational system that affect children and their health and wellness, and thus may impact achievement. These include, but may not be limited to:

- Curriculum, and what children are learning in schools.
- Local school district policies that govern individual schools.
- Federal and state guidelines.
- Pending legislation on the federal and state levels.
- Human resources and personnel requirements for schools.
- Food and nutrition guidelines.
- Physical education programs and requirements.
- Before- and after- school programs, what is provided and what is possible.
- School gardens and environmental/outdoor education.
- Sustainability and “green” efforts and practices in schools.
- School facilities, classroom design and layout, and other physical plant issues.

- Mental health and its impact on student health and wellness.
- Community life and organizations.
- Parental involvement, including the National PTA.
- The role of the faith-based community on student health and wellness.

Who: Representation shall be sought from all facets of school and community life that impact children, including, but not limited to, the following stakeholders:

- National School Boards Association Board of Directors.
- National School Boards Association Executive Leadership.
- National School Boards Association staff.
- National School Boards Association advocacy, governmental relations, policy and business development representatives.
- State School Board Associations
- National representatives of the faith-based community.
- National corporate leaders.
- Representatives of the small-business community.
- The National PTA and/or other family/community organizations.
- National teacher associations or teacher representatives.
- National principals' and supervisors' associations or representatives.
- National superintendents' association or representatives.
- Social services and volunteer organizations, such as those advocating the prevention of child abuse.
- School health services professionals.
- Nutrition services counseling professionals.
- Youth-based organizations, such as the YMCA.
- Let's Move! National health and wellness campaign.
- National and state government representatives.
- Law enforcement representatives.
- U.S. Department of Education.
- U.S. Department of Health.
- U.S. Department of Agriculture.

How: Create a force that shall meet regularly over a six-month period to identify and research a comprehensive list of areas in which student health and wellness impact student achievement, and recommend ways to affect and improve them.

Suggested steps include:

- Conduct surveys on student health and wellness practices that may affect student achievement, and consult with experts in related areas.
- Review current developments and latest research governing student health and wellness, and how it impacts achievement.
- Identify best practices and changes in statute and regulation that would promote positive changes in student health and wellness and which, in turn, would impact student achievement.

- Determine the financial impact of possible changes, and identify possible funding sources.
- Review relevant NJSBA policies.

Outcome: Produce a white paper to share with all local school boards, detailing the issue of student health and wellness, and its impact on student achievement. The report will identify best practices and list recommendations that state school boards associations could adopt and share with local school districts. Ideally, school districts would select for implementation those recommendations that best fit their local needs.

Also, produce a user-friendly video on ways in which health and wellness best practices improve student achievement, and disseminate the video to local school boards for sharing with the community.

APPENDIX B: Examples of Current Legislation Relating to School Health in the New Jersey Legislature and in the U.S. Congress

New Jersey Legislature

Bills A1931 and S1147, sponsored by Assemblyman Herb Conaway, Senators Loretta Weinberg and Joe Vitale, significantly restrict access to religious exemptions from immunizations.

Bill A3889, sponsored by Assemblywoman Pamela Lampitt, establishes a school breakfast kiosk pilot program to ensure students have greater accessibility to breakfast items in school. A school district seeking to participate in the two-year pilot program shall submit to the Department of Agriculture a plan outlining how the school will make food available on a cart, cubicle, or kiosk on the way into the school or to a classroom, dining room, or other designated area. The plan shall also outline food choices, including how they will be consistent with federal guidelines, pricing, and packaging requirements, as well as location, support, and disposal needs. Within 180 days after completion of the pilot program, the Department of Agriculture shall prepare and issue a report to the governor and the legislature on the impact of the pilot program on students, including the percentage of low income students receiving breakfast services under the program.

Bill A4030, sponsored by Assembly Representatives Gary Schaer and Valerie Vainieri Huttel, requires the Department of Agriculture, in consultation with the Department of Education, to develop and administer an incentive fund that will provide a 10-cent per breakfast supplement to the existing federal reimbursement to school districts that participate in the federal school breakfast program.

Bill A4207, sponsored by Assembly Representatives Pamela Lampitt and Patrick J. Diegnan, Jr., stipulates that a student enrolled in a school district who sustains a concussion must receive an evaluation by a physician trained in the evaluation and management of concussions and written clearance from the physician to return to school.

Bill S1147, sponsored by Assemblywoman Nancy F. Muñoz, limits the exceptions from state-mandated immunizations. "Vaccinations are effective and have a proven history of preventing serious childhood diseases," said Muñoz, "Too many children aren't being vaccinated, causing the return of some diseases such as the recent measles outbreak. Some parents may have a valid medical or religious reason for not vaccinating their child. This measure respects that decision while protecting the public." The bill permits an exemption from immunizations in either of the following: a written statement to the school by a licensed physician with the reason why the vaccine is medically unnecessary; or a statement by the student or parent explaining that a vaccine conflicts with their religious practices.

Bill S1594, sponsored by Senator Shirley K. Turner, requires that a public school district must provide a daily recess period of at least 20 minutes for students in grades kindergarten through 5. The recess period is to be held outdoors, if feasible. The bill also provides that recess will not be permitted to be used to meet the current statutory requirements regarding the provision of health, safety, and physical education courses in public schools, which are set forth in State law at N.J.S.18A:35-5.

United States Congress

Child Nutrition Bills Introduced in the 114th Congress

S.418, “Promoting Health as Youth Skills in Classrooms and Life Act,” sponsored by Sen. Tom Udall (NM), amends the Elementary and Secondary Education Act of 1965 to include health education and physical education in the definition of "core academic subjects."

S.540, “School Food Modernization Act,” sponsored by Sen. Susan M. Collins (ME), amends the Richard B. Russell National School Lunch Act to direct the Department of Agriculture to issue loan guarantees to local educational agencies or school food authorities administering or operating a school lunch program, tribal organizations, or consortia of such entities to finance the construction, remodeling, or expansion of infrastructure or the purchase of durable equipment that will facilitate their provision of healthy meals through the school lunch program.

S.569, “Farm to School Act of 2015,” sponsored by Sen Patrick J. Leahy (VT), reauthorizes the farm-to-school program, among other provisions.

S.613, “Summer Meals Act of 2015,” sponsored by Sen. Kirsten E. Gillibrand (NY), amends the Richard B. Russell National School Lunch Act to improve the efficiency of summer meals.

H.R.881, “Bringing Awareness and Knowledge to Exempt Schools Against Legislative Encroachment Act, sponsored by Rep. Ted Poe (TX-2), prohibits the Secretary of Agriculture from applying the rule entitled "National School Lunch Program and School Breakfast Program: Nutrition Standards for All Foods Sold in School as Required by the Healthy, Hunger-Free Kids Act of 2010" to food sold as a fundraiser that takes place on the grounds of a school and prohibits limiting the number of such fundraisers by state agencies or the Secretary.

H.R.1061, “Farm to School Act of 2015,” sponsored by Rep. Jeff Fortenberry (NE-1), reauthorizes the farm-to-school program, among other provisions.

H.R.1363, “No Hungry Kids Act,” sponsored by Rep. Steve King (IA-4), nullifies the rule published by the Department of Agriculture on January 26, 2012, establishing nutrition standards for the school lunch and breakfast programs.

H.R.1411, “ENRICH Act,” sponsored by Rep. Tim Ryan (OH-13), requires the Health Resources and Services Administration to establish a program of three-year competitive grants to accredited medical schools for the development or expansion of an integrated nutrition and physical activity curriculum.

H.R.1504, “Reducing Federal Mandates on School Lunch Act,” sponsored by Rep. Kristi Noem (SD), prohibits the Department of Agriculture from enforcing maximum limits on calories, grains or meat/meat alternates; blocks implementation of Target 2 and Final Target sodium limits; and restores the 2012 requirement that half of all grains offered with school meals be whole grain rich. In addition, the bill would prohibit the USDA from enforcing new school meal and Smart Snacks standards and Paid Lunch Equity mandates for any school food authority that certifies that complying with the new rules would increase costs.

H.R.1519, “Recognizing Achievement in Classified School Employees Act,” sponsored by Rep. Dina Titus (NV-1), directs the Secretary of Education to award National Classified School Employee of the Year Awards to classified public school employees within certain occupational specialties who provide exemplary service to students in prekindergarten through higher education.

H.R.1687, “Sugar Sweetened Beverages Tax (SWEET) Act,” sponsored by Rep. Rosa DeLauro (CT-3), amends the Internal Revenue Code of 1986 to impose an excise tax on sugar-sweetened beverages, to dedicate the revenues from such tax to the prevention, treatment, and research of diet-related health conditions in priority populations, and for other purposes.

H.R.1728, “Summer Meals Act of 2015,” sponsored by Rep. Don Young, (AK), amends the Richard B. Russell National School Lunch Act to improve the efficiency of summer meals.

H.R.2152, “Safe Chicken and Meat for Children Act,” sponsored by Rep. Rosa DeLauro (CT), prevents Chinese meat and chicken from being used in federal nutrition programs including school lunch, breakfast, Child and Adult Care Food and Summer Food Service Programs.

H.R.2407, “School Milk Nutrition Act of 2015,” sponsored by Rep. G.T. Thompson (PA), aims to increase dairy consumption in schools by reaffirming the requirement that milk is offered with each school meal. The legislation would allow schools to serve low-fat, one percent flavored milk along with the fat-free skim flavored milk already permitted under current regulations. In addition, the bill would urge USDA to address the needs of lactose-intolerant students by offering lactose-free milk.

H.R.2508, “Healthy School Meals Flexibility Act,” sponsored by Sen. John Hoeven (ND), amends the Richard B. Russell National School Lunch Act to prohibit further reductions in sodium levels and to reinstate the grain-rich requirements applicable to the national school lunch and breakfast programs.

H.R.2627, “Salad Bars in Schools Expansion Act,” sponsored by Rep. Tim Ryan (OH), directs the USDA to create a plan to promote salad bars, including a new five-year grant program and more training and technical assistance for schools.

H.R.2660, “Wise Investment (WIC) in our Children Act,” sponsored by Rep. Rosa DeLauro (CT), amends the Child Nutrition Act of 1966 to increase the age of eligibility for children (to age 6) to receive benefits under the special supplemental nutrition program for women, infants and children. The bill is proposed in response to some children experiencing a nutritional gap of almost 12 months, in which time their nutrition is neither supported by WIC nor by school meals.

Proceedings of House Subcommittee Hearing on Federal Child Nutrition Programs

On May 19, 2015, the House Subcommittee on Early Childhood, Elementary and Secondary Education held a hearing on “Addressing Waste, Fraud, and Abuse in Federal Child Nutrition Programs,” with regard to H.R.5, the ESEA Reauthorization, Student Success Act. Prior to the hearing, the National School Boards Association submitted a letter to Chairman Todd Rokita (IN) discussing the impact of multiple new requirements on school districts' ability to step up

program integrity measures and stressing that flexibility and sufficient federal resources are essential for school districts to successfully provide both healthy meals and an excellent education to all students.

During the hearing, the witnesses were asked such questions as:

- Why are programs for poor people often the subject of waste, fraud and abuse, but not other federal expenditures?
- What are the returns on investment (ROI) for child nutrition programs?
- When do the costs of program integrity (income verification and enforcement) outweigh the benefits, and undermine the goal of serving healthy meals to hungry kids?

The witnesses made the following points:

- School Food Authorities are required to verify just 3 percent of applications for free and reduced price meals, yet according to the U.S. Department of Agriculture (USDA) Inspector General, fraud is not a significant factor in school meal programs.
- School districts were overwhelmed by new guidance and regulations after the 2010 reauthorization, which led to compliance errors.
- The USDA is aware that its role in program integrity needs to be strengthened and is taking steps to improve.

APPENDIX C: Representative Articles Suggesting Links between Health/Wellness and Student Achievement

These articles, presented in reverse chronological order, were identified in a March 2015 literature search conducted by the Regional Education Laboratory Mid-Atlantic, a component of the U.S. Department of Education's Institute of Education Science. Abstracts and executive summaries are copied directly from the reports.

The Relationship between Mental Health, Acculturative Stress, and Academic Performance in a Latino Middle School Sample

Albeg, Loren J.; Castro-Olivo, Sara M.

Contemporary School Psychology, v18 n3 p178-186 Sep 2014 —

<http://link.springer.com/article/10.1007%2Fs40688-014-0010-1>

This study evaluated the relationship between acculturative stress, symptoms of internalizing mental health problems, and academic performance in a sample of 94 Latino middle school students. Students reported on symptoms indicative of depression and anxiety related problems and acculturative stress. Teachers reported on students' academic behavior and performance. Acculturative stress and symptoms of internalizing mental health problems were found to have a significant inverse association with students' academic performance. Implications for the development of culturally responsive interventions that address mental health problems and acculturative stress are discussed. [emphasis added]

Health and Academic Achievement: Cumulative Effects of Health Assets on Standardized Test Scores among Urban Youth in the United States

Ickovics, Jeannette R.; Carroll-Scott, Amy; Peters, Susan M.; Schwartz, Marlene; Gilstad-Hayden, Kathryn; McCaslin, Catherine

Journal of School Health, v84 n1 p40-48 Jan 2014 —

<http://onlinelibrary.wiley.com/doi/10.1111/josh.12117/abstract;jsessionid=3564E38A60173F66A811197213CB217E.f01t04>

... Study objectives are to (1) document associations between health assets and academic achievement, and (2) examine cumulative effects of these assets on academic achievement. Methods: Participants include 940 students (grades 5 and 6) from 12 schools randomly selected from an urban district. Data include physical assessments, fitness testing, surveys, and district records. Fourteen health indicators were gathered including physical health (e.g., body mass index [BMI]), health behaviors (e.g., meeting recommendations for fruit/vegetable consumption), family environment (e.g., family meals), and psychological well-being (e.g., sleep quality). Data were collected 3-6 months prior to standardized testing. Results: On average, students reported 7.1 health assets out of 14. Those with more health assets were more likely to be at goal for standardized tests (reading/writing/mathematics), and students with the most health assets were 2.2 times more likely to achieve goal compared with students with the fewest health assets (both p<0.001). Conclusions: Schools that utilize nontraditional instructional strategies to improve student health may also improve academic achievement, closing equity gaps in both health and academic achievement. [emphasis added]

The Association of Self-Reported Sleep, Weight Status, and Academic Performance in Fifth-Grade Students

Stroebele, Nanette; McNally, Janise; Plog, Amy; Siegfried, Scott; Hill, James O.

Journal of School Health, v83 n2 p77-84 Feb 2013 —

<http://onlinelibrary.wiley.com/doi/10.1111/josh.12001/abstract>

.... Fifth-grade students completed an online school-administered health survey with questions regarding their eating behavior, physical activity, academic performance, and sleep patterns.

Differences in health behaviors were examined by sex, self-reported weight status, and sufficient (greater than or equal to 9 hours) versus insufficient sleep. Logistic regression was used to determine the relationship between academic performance and the health behaviors. Results: One third of the sample did not get the recommended amount of physical activity and more than half of the students watched television greater than or equal to 2 hours/day. Self-reported overweight status was related to lower self-reported academic performance, fewer lunch and breakfast occasions, less physical activity, not meeting the recommendations for vegetable and soda consumption as well as hours of television watching. Sufficient sleep (greater than or equal to 9 hours/night) was associated with better grades, meeting the recommended hours of daily television watching and video game playing, being more physically active and increased breakfast and lunch frequency. Percentage of serving free/reduced lunch, soda consumption, breakfast frequency, amount of physical activity, and television watching were associated with academic performance. Conclusion: More positive health behaviors generally were associated with better academic performance. Promoting healthy behaviors in schools might improve not only students' health [but] academic performance as well. [emphasis added]

The Relationship among Aerobic Capacity, Body Composition, and Academic Achievement of Fourth and Fifth Grade Hispanic Students

Santiago, Jose A.; Roper, Emily A.; Disch, James G.; Morales, Julio

Physical Educator, v70 n1 89-105 2013 — <http://js.sagamorepub.com/pe/article/view/2938>

.... The purpose of the study was to examine the relationship of aerobic capacity and body composition with academic achievement in Hispanic elementary school children. Participants in the study were 155 Hispanic school children (84 boys and 71 girls), aged 9 to 13, in the fourth and fifth grade at an urban elementary school in southeast Texas. Health-related fitness measures included aerobic capacity, body mass index, and percent body fat. Academic achievement variables included reading and math final percentage grades. Correlations and stepwise multiple regression analyses were performed to analyze the relationship between the variables. Analyses were conducted on the whole sample and by gender. Pearson correlations revealed a significant positive relationship ($r = 0.26$, $p = 0.022$) between aerobic capacity and math performance for girls. Stepwise multiple linear regression analysis also revealed that aerobic capacity was a significant predictor of math performance in girls.... These findings suggest that aerobic capacity positively effects math performance in fourth and fifth grade Hispanic elementary school girls. [emphasis added]

The Effects of Breakfast on Behavior and Academic Performance In Children and Adolescents

Katie Adolphus, Clare L. Lawton, and Louise Dye

Frontiers in Human Neuroscience 2013; 7: 425 —

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3737458/>

.... The literature was searched for articles published between 1950–2013 indexed in Ovid MEDLINE, Pubmed, Web of Science, the Cochrane Library, EMBASE databases, and PsychINFO. Thirty-six articles examining the effects of breakfast on in-class behavior and academic performance in children and adolescents were included. The effects of breakfast in different populations were considered, including undernourished or well-nourished children and adolescents from differing socio-economic status (SES) backgrounds. The habitual and acute effects of breakfast and the effects of school breakfast programs (SBPs) were considered. The evidence indicated a mainly positive effect of breakfast on on-task behavior in the classroom. There was suggestive evidence that habitual breakfast (frequency and quality) and SBPs have a positive effect on children's academic performance

with clearest effects on mathematic and arithmetic grades in undernourished children. Increased frequency of habitual breakfast was consistently positively associated with academic performance. Some evidence suggested that quality of habitual breakfast, in terms of providing a greater variety of food groups and adequate energy, was positively related to school performance. However, these associations can be attributed, in part, to confounders such as SES and to methodological weaknesses such as the subjective nature of the observations of behavior in class. [emphasis added]

**Associations of Physical Fitness and Academic Performance among Schoolchildren
Van Dusen, Duncan P.; Kelder, Steven H.; Kohl, Harold W., III; Ranjit, Nalini; Perry,
Cheryl L.**

Journal of School Health, v81 n12 p733-740 Dec 2011 —

<http://onlinelibrary.wiley.com/doi/10.1111/j.1746-1561.2011.00652.x/abstract>

.... Methods: Analyses were based on a convenience sample of 254,743 individually matched standardized academic (TAKS[™]) and fitness (FITNESSGRAM[R]) test records of students, grades 3-11, collected by 13 Texas school districts. We categorized fitness results in quintiles by age and gender and used mixed effects regression models to compare the academic performance of the top and bottom fitness groups for each test. Results: All fitness variables except body mass index (BMI) showed significant, positive associations with academic performance after adjustment for socio-demographic covariates, with standardized mean difference effect sizes ranging from 0.07 to 0.34. Cardiovascular fitness showed the largest interquintile difference in TAKS score (32-75 points), followed by curl-ups. Additional adjustment for BMI and curl-ups showed dose-response associations between cardiovascular fitness and academic scores (p less than 0.001 for both genders and outcomes). Analysis of BMI demonstrated limited, nonlinear association with academic performance after socio-demographic and fitness adjustments. Conclusions: Fitness was strongly and significantly related to academic performance. Cardiovascular fitness showed a dose-response association with academic performance independent of other socio-demographic and fitness variables. The association appears to peak in late middle to early high school. We recommend that policymakers consider physical education (PE) mandates in middle high school, school administrators consider increasing PE time, and PE practitioners emphasize cardiovascular fitness. [emphasis added]

Healthier Students Are Better Learners: A Missing Link in School Reforms to Close the Achievement Gap

Basch, Charles E.

Journal of School Health, v81 n10 p593-598 Oct 2011 —

<http://onlinelibrary.wiley.com/doi/10.1111/j.1746-1561.2011.00632.x/abstract>

.... Methods: Literature was reviewed and synthesized to identify health problems affecting school-aged youth that are highly prevalent, disproportionately affect urban minority youth, directly and indirectly causally affect academic achievement, and can be feasibly and effectively addressed through school health programs and services. Results: Based on these criteria, 7 educationally relevant health disparities were selected as strategic priorities to help close the achievement gap: (1) vision, (2) asthma, (3) teen pregnancy, (4) aggression and violence, (5) physical activity, (6) breakfast, and (7) inattention and hyperactivity. Research clearly shows that these health problems influence students' motivation and ability to learn. Disparities among urban minority youth are outlined, along with the causal pathways through which each adversely affects academic achievement, including sensory perceptions, cognition, school connectedness, absenteeism, and dropping out. Evidence-based approaches that schools can implement to address these problems are presented. These health problems and the causal pathways they influence have interactive and a

synergistic effect, which is why they must be addressed collectively using a coordinated approach. Conclusions: No matter how well teachers are prepared to teach, no matter what accountability measures are put in place, no matter what governing structures are established for schools, educational progress will be profoundly limited if students are not motivated and able to learn. Particular health problems play a major role in limiting the motivation and ability to learn of urban minority youth. This is why reducing these disparities through a coordinated approach warrants validation as a cohesive school improvement initiative to close the achievement gap. Local, state, and national policies for implementing this recommendation are suggested. [emphasis added]

The Association between School Based Physical Activity, Including Physical Education, and Academic Performance

Centers for Disease Control and Prevention.

Atlanta, GA: U.S. Department of Health and Human Services; 2010 —

http://www.cdc.gov/healthyyouth/health_and_academics/pdf/pa-pe_paper.pdf

For this review, relevant research articles and reports were identified through a search of nine electronic databases, using both physical activity and academic-related search terms. The search yielded a total of 406 articles that were examined to determine their match with the inclusion criteria. Forty-three articles (reporting a total of 50 unique studies) met the inclusion criteria and were read, abstracted, and coded for this synthesis. Across all 50 studies (reported in 43 articles), there were a total of 251 associations between physical activity and academic performance, representing measures of academic achievement, academic behavior, and cognitive skills and attitudes. Measures of cognitive skills and attitudes were used most frequently (112 of the 251 associations tested). Of all the associations examined, slightly more than half (50.5%) were positive, 48% were not significant, and only 1.5% were negative. Examination of the findings by each physical activity context [School-Based Physical Education Studies, Recess Studies, Classroom Physical Activity Studies, and Extracurricular Physical Activity Studies] provided insights regarding specific relationships. [emphasis added]

Research Review: School-based Health Interventions and Academic Achievement

Julia Dilley

Washington State Board of Health, September 2009 —

<http://sboh.wa.gov/Portals/7/Doc/HealthDisparities/HealthAndAA.pdf>

Health and Education Are Linked. For students in middle and high school, health risks and academic risks affect each other. Students who do poorly in school may have more health risks, which adversely affect their achievement and in turn contribute to health risks. Data from the Healthy Youth Survey in Washington State provide a new way of looking at the relationship between health risk and academic achievement. The report examines 13 key physical and mental health risk factors and analyzes the relationship between these specific health factors and the grades students report getting in school. Every Health Risk Can Affect Academic Success. The more health risks students have, the less likely they will succeed in school or graduate on time. Each health risk that can be removed has the potential to positively influence academic behaviors. Improvement of even a single health factor may help improve academic achievement. . . . The findings of this report suggest that implementing proven school-based health interventions is an opportunity to improve students' academic achievement, well-being, and quality of life. [emphasis added]

A Correlational Study of the Relationship between a Coordinated School Health Program and School Achievement: A Case for School Health

Vinciullo, Frances M.; Bradley, Beverly J.

Journal of School Nursing, v25 n6 p453-465 2009 —

<http://jsn.sagepub.com/content/25/6/453>

The study was conducted to determine whether there is a relationship between the Coordinated School Health Program (CSHP) and student academic performance. Data were collected from schools and the community for three reports for 50 states and the District of Columbia (DC). The School Health Policies and Programs Survey (SHPPS), the National Assessment of Educational Progress (NAEP), and the U.S. Census 2000 Profile were used to study the relationships among three parameters: (a) The intervention called a CSHP; (b) Student achievement; and (c) Rate of poverty in each state. A stepwise regression analysis was conducted, controlling for poverty using state-level data. Components of a CSHP had statistically significant relationships with academic achievement. Students in states with policies promoting students' health demonstrated higher academic scores and higher rates of high school completion. [emphasis added]

Pilot Study: EatFit Impacts Sixth Graders' Academic Performance on Achievement of Mathematics and English Education Standards

Shilts, Mical Kay; Lamp, Cathi; Horowitz, Marcel; Townsend, Marilyn S.

Journal of Nutrition Education and Behavior, v41 n2 p127-131 Mar-Apr 2009 —

[http://www.jneb.org/article/S1499-4046\(08\)00692-1/abstract](http://www.jneb.org/article/S1499-4046(08)00692-1/abstract)

Objective: Investigate the impact of a nutrition education program on student academic performance as measured by achievement of education standards. Design: Quasi-experimental crossover-controlled study. Setting: California Central Valley suburban elementary school (58% qualified for free or reduced-priced lunch). Participants: All sixth-grade students (n = 84) in the elementary school clustered in 3 classrooms. Intervention: 9-lesson intervention with an emphasis on guided goal setting and driven by the Social Cognitive Theory. Main Outcome Measure: Multiple-choice survey assessing 5 education standards for sixth-grade mathematics and English at 3 time points: baseline (T1), 5 weeks (T2), and 10 weeks (T3). Analysis: Repeated measures, paired t test, and analysis of covariance. Results: Changes in total scores were statistically different (P less than 0.05), with treatment scores (T3 - T2) generating more gains. The change scores for 1 English (P less than 0.01) and 2 mathematics standards (P less than 0.05; P less than 0.001) were statistically greater for the treatment period (T3 - T2) compared to the control period (T2 - T1). Conclusion and Implications: Using standardized tests, results of this pilot study suggest that "EatFit" can improve academic performance measured by achievement of specific mathematics and English education standards. Nutrition educators can show school administrators and wellness committee members that this program can positively impact academic performance, concomitant to its primary objective of promoting healthful eating and physical activity. [emphasis added]

Linking the Organizational Health of Middle Grades Schools to Student Achievement

Roney, Kathleen; Coleman, Howard; Schlichting, Kathleen A.

NASSP Bulletin, v91 n4 p289-321 2007 — <http://bul.sagepub.com/content/91/4/289>

The purpose of this study was to examine the relationship between student reading achievement and the organizational health of five middle grades schools in North Carolina. The theoretical framework was based upon Hoy and Feldman's definition of organizational health, which links

healthy school climates to improved learning environments and increased student achievement. A mixed-methods sequential research design was used. Data analysis revealed a moderately positive relationship among the five schools' overall Organizational Health Inventory for Middle Schools index scores and student reading scores. [emphasis added]

Bridging Student Health Risks and Academic Achievement through Comprehensive School Health Programs.

Symons, Cynthia Wolford; Cinelli, Bethann; James, Tammy C.; Groff, Patti

Journal of School Health, v67 n6 p220-27 Aug 1997 — <https://www.questia.com/read/1G1-19781771/bridging-student-health-risks-and-academic-achievement>

Research confirms a direct link between student health risk behavior and education outcomes, education behaviors, and student attitudes. This article discusses barriers to comprehensive school health programming; summarizes relevant information concerning several health-risk behaviors (intentional injuries, diet, physical activity, sexual-risk behaviors, and substance abuse); and presents research and advocacy recommendations. [emphasis added]

APPENDIX D: LEA Health and Wellness Success Stories

West New York, New Jersey

Source: District staff communication to Task Force

In 2005, the assistant superintendent of West New York's schools, Rosemary Donnelly was approached by a contact from the American Heart Association (AHA) about joining a new wellness initiative. The group was being spearheaded by the AHA, the Clinton Foundation and the Robert Wood Johnson Foundation. This group was the Alliance for a Healthier Generation (Alliance), whose mission was to stem the rise of childhood obesity in our nation. Ms. Donnelly reached out to members of her district's staff and asked if they would like to get involved. This discussion led to a gentle revolution in this one-square-mile urban school district.

West New York schools used the tools provided by the Alliance to start Wellness teams in all schools and appointed co-chairs of a district wellness team. The district provided a small stipend to each member of the teams to show that they valued the concepts that were being implemented. In the first year of the project, the district set lofty goals, planned to make big changes, and accomplished close to nothing. This led to a rethinking of the approach that was being taken.

In year two, the committee was reconstructed, tapping into staff members who had different backgrounds and diverse passions for different facets of wellness. A meeting was held, goals were set, and people were empowered to reach those goals by following their personal passions and sharing them with students and their peers.

From years two to five the results were remarkable. By setting goals and allowing those goals to be reached in ways that each member saw fit, the district's successes grew exponentially and organically. To quote one of the co-chairs "When the district stopped focusing on cookies and started to focus on culture, that's when things started to change." The wellness teams and the Alliance made sure to celebrate and recognize little successes to begin with and used these to build momentum for the program and the larger successes that were to come.

The district went on to have the first school in the nation to reach gold status with the Alliance for a Healthier Generation, and every school in the district was recognized at some level by the organization. The district saw a complete change in the way students were taught about wellness. Wellness had snuck its way into every part of the day, fitness breaks in classrooms, label-reading lessons in science class, art projects that asked students to draw what wellness meant to them, and after-school fitness classes for staff and students.

The district was featured on the Rachael Ray television show and a number of news programs. A national broadcast news segment described the district's recognition that a healthy student is a student who is better prepared to learn and grow up to be a productive and healthy adult. In 2012, when President Clinton visited one of the elementary schools to celebrate the program, he said, "this isn't just here for you to see today; if you came back here tomorrow or next month, you would see the same things happening in these schools, this is in their DNA now, this is their culture."

South-Orange Maplewood, New Jersey

Source: District staff communication to Task Force

The district reports these accomplishments:

- it is the only two-time New Jersey recipient of the Carol M. White Physical Education for Progress Award (PEP Grant), in 2009 and 2013, with award funding totaling \$2.74 million
- its Department of Health and Physical Education has been nationally recognized as a model for school wellness by the Society for Health and Physical Educators
- it has implemented the Coordinated Approach To Child Health (CATCH) program in five elementary schools
- it has implemented the SPARK PE curriculum K-12 to develop articulation between all schools and grade levels.
- it has a staff wellness initiative that has teachers wearing pedometers and participating in Zumba and Spin classes exclusively for district staff
- it has shifted the focus of its physical education program from team sports and games to concept-based physical education in middle school (invasion, fitness and net/wall games) and a fitness-focus in high school (Spin, Interactive Cardio, Advanced Fitness, and other lifetime activity pursuits such as golf, table tennis, badminton, and Project Adventure)
- it has installed climbing walls at the elementary schools and school gardens at three elementary schools
- its PE Supervisor was the National PE Supervisor of the Year in 2013

Long Branch, New Jersey

Source: District staff communication to Task Force

The district “made the decision to take control of our future.” Transformed its approach to healthcare, and is on track to save approximately \$4,000,000 in health care costs. Working with Integrity Health, the district established an on-site primary care health facility called “Partnership Health Center Long Branch” (PHCLB). At the Center, employees, who choose to participate, and their dependents, receive care without co-pays; lab work, X-rays, and most prescriptions are included at no cost. The doctor in residence coordinates all aspects of each patient’s care, working with other doctors to ensure outside procedures align with the member’s overall health plan. In effect, the Center serves as the hub of a care coordination wheel.

Over time, employees visit the PHCLB more often (instead of expensive emergency rooms); receive better health care; and ultimately achieve better health. To date, utilization rates are well ahead of projections – more than 2,500 visits so far. As a result, members are saving time and a substantial amount of out-of-pocket expense. Next year, a member with family coverage can save over \$500 in chapter 78 contributions, plus \$10 every visit to the Center.

School Union #106, Maine

Source: CDC — http://www.cdc.gov/healthyouth/mih/stories/school_union106.htm

All six schools in the union have removed from their machines soft drinks and snacks that do not meet the definition of a healthy food. More healthful options have been added, including water, 100% fruit juices, breakfast bars, baked chips, and low-fat crackers. Since making the change, the high school student council has reported an increase in revenue from some machines and no

change in revenue from the other machines. Food service programs now serve low-sugar, whole-grain breakfast cereals instead of high-sugar cereals. Whole-wheat bread has replaced white bread. A major soft drink company agreed to remove all soft drinks and all associated labeling from all state schools. Soft drink machines are being replaced with water and juice machines.

Charlotte-Mecklenburg County, North Carolina

Source: CDC — http://www.cdc.gov/healthyouth/stories/pdf/2008/success_08_charlotte.pdf

Since 2004, the district’s Asthma Education Program (AEP), a collaborative effort between the County Health Department and the district, has:

- Increased the identification of students with asthma.
- Offered the American Lung Association’s Open Airways for Schools curriculum to all students with asthma in grades 3–5, and developed asthma education curricula for grades 4–6 and 9.
- Assisted more than 700 students through the AEP respiratory care program.
- Worked with community physician practices to develop a universal asthma action plan and an asthma education program for parents of students with asthma.
- Developed district-wide asthma-friendly policies and guidelines.
- Partnered with Chris Draft, a National Football League player with asthma, to launch a local asthma awareness campaign.

San Diego, California

Source CDC — http://www.cdc.gov/healthyouth/stories/pdf/2012/success_12_sandiego.pdf

To ensure that schools are safe places for all students and staff, the district convened the Safe Schools Task Force to look at existing policies and procedures that address bullying, harassment, and intimidation. The task force brought together administrators, teachers, community members, and agency staff, with special outreach to the LGBT community. The Task Force —

- Developed a district-wide Bullying, Harassment and Intimidation Prohibition Policy (unanimously adopted ... in April 2011) that complies with federal and state laws and extensively delineates the types of protections addressed (including race, religion, creed, color, marital status, parental status, veteran status, sex, sexual orientation, gender expression or identity, ancestry, national origin, ethnic group identification, age, and mental or physical disability).
- Developed a procedure addressing bullying, harassment, and intimidation that outlines reporting duties for staff and students, lists training requirements for all staff, and includes an investigative reporting form.
- Established sub-committees to focus on staff development, curriculum, and communication regarding the new policy and procedure.
- Encouraged school sites to create “Safe Spaces” specifically for LGBT students. The superintendent was a vocal supporter of the new policy and procedure and spoke publicly on the importance of safe schools.

During the 2011–2012 school year:

- All cabinet-level staff attended training on LGBT issues.
- 75% of district high schools had active gay-straight alliances (GSAs).

- All middle/high school sites received Safe Space Kits from the Gay, Lesbian, and Straight Education Network (GLSEN)—designed to help educators create safe spaces for LGBT youth in schools.
- The district formed new partnerships with three agencies that serve LGBT youth—the San Diego LGBT Center, and local chapters of GLSEN and GSA Network.
- The first-ever GSA at a middle school was started.
- The district incorporated LGBT information into four district training events.

Gadsden County, Florida

Source CDC — http://www.cdc.gov/healthyyouth/stories/pdf/ss_booklet_07.pdf

Beginning in 2005, the CDC-funded state Coordinated School Health Program (CSHP) provided resources and technical assistance to Gadsden County, Florida, to implement a districtwide CSHP. Gadsden County suffers disproportionately from health disparities and academic challenges. To begin the project, the school district formed a planning and advisory committee, Gadsden County Wellness Approach to Community Health (G-WATCH). Next, every participating school was required to complete CDC’s School Health Index (SHI) to identify its individual needs. G-WATCH used the results of the SHI assessments to develop a coordinated school health strategic plan that included 45 goals and emphasized nutrition education and physical activity. The state CSHP gave each of the participating schools \$2,000 yearly to maintain a Healthy School Team to implement activities consistent with the district strategic plan.

Program Impact: After 2 years of implementation, G-WATCH accomplishments include:

- Adopting a district policy that encourages physical fitness and discourages employing or withholding physical activity as punishment.
- Passing a district policy for a daily 15-minute recess for students in grades pre-K–5.
- Prohibiting sales of carbonated beverages during meal periods.
- Implementing meal schedules that comply with the Florida guideline of a 20-minute seated eating time.

For many additional success stories, see the CDC publication *Putting Local School Wellness Policies into Action: Stories from School Districts and Schools* — http://www.cdc.gov/healthyyouth/npao/pdf/251553_SchoolWellnessInAction_Final_508_Ready_508tagged.pdf — and the CDC website — <http://www.cdc.gov/healthyyouth/stories/index.htm>.

APPENDIX E: Grants Development Support for New Jersey Schools

The New Jersey School Boards Association Grants Support Program provides school districts, charter schools, and affiliated local educational foundations with grants information, customized funder research, and consultation to develop project ideas, obtain funding for new projects, and even expand initiatives already in progress. The program employs the services of Grants Office, a national grants development services firm with a 15-year track record of helping schools find and secure funding.

The Grant Support Program provides assistance at all levels of grant development:

Services Included in NJSBA Membership

- Real-time access to a searchable database of current federal, state, and foundation grant opportunities provided
- Email alerts of new opportunities and pending deadlines
- Training on grant seeking and education-friendly grant programs

Discounted Premium Grant Services

- Tier 1 - Custom funder identification by project
- Tier 2 - Unlimited access to grant research and consultation, including research about grants for projects across the district, pre-submission review of grants prepared by the district, and phone and in-person consultation

Proposal Development Services

Additional information may be found at www.njsba.org/services/grants-office.php or by contacting the Grants Office by phone at (800) 473-5608 or by email at info@grantsoffice.com.

APPENDIX F: Sample LEA Policy: Health

THE DISTRICT BOARD OF EDUCATION FILE CODE: 5141

The district, New Jersey X Monitored
 X Mandated Policy
 X Other Reasons

HEALTH

The board of education believes that good health is vital to successful learning. In order to help district pupils achieve and maintain good health, the board directs the chief school administrator to develop pupil health services that employ professional personnel and interact with both parents/guardians and community health agencies. The program shall include but not be limited to:

- A. Employment of a medical inspector to perform those duties required by law, and to advise the chief school administrator on all matters affecting the health of pupils;
- B. Employment of at least one certified school nurse to assist with physical examinations; conduct biennial scoliosis screening; conduct an audiometric screening; maintain pupil health records; observe and recommend to the principal the exclusion of pupils who show evidence of communicable disease or who have not submitted acceptable evidence of immunizations; instruct teachers on communicable diseases and other health concerns; train and supervise the emergency administration of epinephrine for school staff who have been designated as delegates; supervise other nursing tasks; provide appropriate response to Do Not Resuscitate (DNR) orders; maintain valid, current Cardiopulmonary Resuscitation (CPR) certification; review and summarize health and medical information for the Child Study Team; write and update annually the accommodation plan under Section 504 for any student who requires one;
- C. Provision of proper and adequate facilities, equipment and supplies for professional health personnel and other staff;
- D. Establishment of a system of pupil health records in compliance with state law;
- E. Implement the Core Curriculum Content Standards in physical education, health, family life, safety, and use of drugs, alcohol, tobacco and anabolic steroids; recommendations for appropriate equipment and supplies to teach such courses;
- F. Development of rules and procedures to foster good pupil health, and periodic dissemination of these rules and procedures to the staff;

- G. Development of a program to provide safe drinking water and otherwise to maintain the buildings, grounds, facilities and equipment of the district in sanitary condition in accordance with law;
- H. Development and enforcement of an eye protection program as required by statute and administrative code;
- I. A regular report to the board on progress and accomplishments in the field of pupil health;
- J. Health services to staff that support pupil health;
- K. Provision of emergency services for injury and sudden illness;
- L. Provision for required physical examinations including an examination to certify that a pupil returning to school after suffering a contagious/infectious condition or illness is no longer a threat to the health of others;
- M. Development of all regulations and procedures necessary for evaluation of pupils suspected of being under the influence of drugs/alcohol, tobacco or anabolic steroids;
- N. Encouragement of correction of defects through fully informing pupils and parents/guardians concerning the findings of health examinations for scoliosis;
- O. Preparation for the potential disruption of a pandemic flu outbreak, such as avian flu, by filling out a school preparedness checklist available from www.pandemicflu.gov or NJSBA, with periodic reports to the school board on steps the district has already taken, as well as additional steps that need to be taken, to prepare for a flu pandemic.

Annual Nursing Plan

The chief school administrator (or his/her designee) in conjunction with the school physician and the certified school nurse shall develop an annual Nursing Services Plan that details the provision of nursing services based upon the needs of the students in this school district. The Nursing Services Plan shall be adopted annually at a regular meeting and submitted to the Executive County Superintendent of education for review and approval. The Nursing Services Plan shall include:

- A. A description of the basic nursing services provided all students;
- B. A summary of specific medical needs of individual students and the services required to address the needs;
- C. A description of how nursing services will be provided in an emergency;
- D. Detailed nursing assignments for all school buildings;

E. The nursing services and additional medical services provided to nonpublic schools.

Students with Diabetes

As used in this policy, an “individualized health care plan” means a document setting out the health services needed by the student at school, and an “individualized emergency health care plan” outlines a set of procedural guidelines that provide specific directions about what to do in a particular emergency situation. Both are to be developed by the school nurse, in consultation with the parent or guardian of a student with diabetes and other medical professionals who may be providing diabetes care to the student, and signed by the parent or guardian.

The board believes that diabetes is a serious chronic disease that impairs the body’s ability to use food, and must be managed 24 hours a day in order to avoid the potentially life-threatening short-term consequences of blood sugar levels that are either too high or too low. In order to manage their disease, students with diabetes must have access to the means to balance food, medications, and physical activity level while at school and at school-related activities.

Accordingly, a parent or guardian of a student with diabetes shall inform the school nurse, who shall develop an individualized health care plan and an individualized emergency health care plan for the student. Further, the parent or guardian must annually provide to the board of education written authorization for the provision of diabetes care as outlined in the plans, including authorization for the emergency administration of glucagon.

Both plans shall be updated by the school nurse prior to the beginning of each school year and as necessary if there is a change in the student’s health status. The plans may include elements specified in N.J.S.A. 18A:40-12.13 including, but not limited to:

- A. The symptoms of hypoglycemia for that particular student and the recommended treatment;
- B. The symptoms of hyperglycemia for that particular student and the recommended treatment;
- C. The frequency of blood glucose testing;
- D. Written orders from the student’s physician or advanced practice nurse outlining the dosage and indications for insulin administration and the administration of glucagon, if needed;
- E. Times of meals and snacks and indications for additional snacks for exercise;
- F. Full participation in exercise and sports, and any contraindications to exercise, or accommodations that must be made for that particular student;
- G. Accommodations for school trips, after-school activities, class parties, and other school-related activities;

- H. Education of all school personnel who may come in contact with the student about diabetes, how to recognize and treat hypoglycemia, how to recognize hyperglycemia, and when to call for assistance;
- I. Medical and treatment issues that may affect the educational process of the student with diabetes; and
- J. How to maintain communications with the student, the student's parent or guardian and healthcare team, the school nurse, and the educational staff.

The school nurse assigned to a particular school shall coordinate the provision of diabetes care at that school and ensure that appropriate staff are trained in the care of these students, including staff working with school-sponsored programs outside of the regular school day. The school nurse shall also ensure that each school bus driver that transports a student with diabetes is provided notice of the student's condition, how to treat hypoglycemia, and emergency/parent contact information. A reference sheet identifying signs and symptoms of hypoglycemia shall be posted in plain view within school buildings.

The school nurse shall have the primary responsibility for the emergency administration of glucagon to a student with diabetes who is experiencing severe hypoglycemia. The school nurse shall designate, in consultation with the board of education, additional employees of the school district who volunteer to administer glucagon to a student with diabetes who is experiencing severe hypoglycemia. The designated employees shall only be authorized to administer glucagon, following training by the school nurse or other qualified health care professional, when a school nurse is not physically present at the scene.

Upon written request of the parent or guardian and as provided in the individualized health care plan, the student shall be allowed to attend to the management and care of his/her diabetes in the classroom, on school grounds or at any school-related activity, if evaluated and determined to be capable of doing so consistent with the plan. The student's management and care of his/her diabetes shall include the following:

- A. Performing blood glucose level checks;
- B. Administering insulin through the insulin delivery system the student uses;
- C. Treating hypoglycemia and hyperglycemia;
- D. Possessing on the student's person at any time the supplies or equipment necessary to monitor and care for the student's diabetes;
- E. Compliance with required procedures for medical waste disposal in accordance with district policies and as set forth in the individual health care plan; and
- F. Otherwise attending to the management and care of the student's diabetes.

New Jersey Family Care

The school nurse shall ensure that the parent/guardians of students who are without medical coverage are notified of and provided information on the accessibility of the New Jersey Family Care Program in accordance with N.J.S.A. 18A:40-34.

Nonpublic School Pupils

The board shall provide mandated nursing services to nonpublic school pupils as required by law (see policy 5200 Nonpublic School Pupils).

The operation of the pupil health program shall be in compliance with the rules and regulations of the state department of education, local board of health and the state department of health and senior services, and state department of human services. The board shall review and adopt the regulations developed to implement the district's health services.

Automated External Defibrillator (AED)

Because the board recognizes that medical emergencies may occur that justify the use of AEDs, the board shall acquire and maintain this equipment for use by qualified staff members. An applicable patient would exhibit all of the following signs as per American Heart Association standards on AED use:

- A. Is unconscious;
- B. Is not breathing;
- C. Have no signs of circulation (as confirmed by a pulse check).

Only those staff members documented as having completed the required training shall be authorized to use an AED. A coach, athletic trainer, or in the absence of the coach or athletic trainer and other designated staff member, who is appropriately trained and certified in the use of the AED shall be present during athletic events or team practices. In the event that no appropriately AED trained and certified staff person can be present at athletic events or team practices, the district shall ensure that a State-certified emergency services provider or other certified first responder is on site at the event or practice.

Placement, Accessibility and Maintenance of the AED

The AED shall be:

- A. Available in an unlocked location on school property with an appropriate identifying sign;
- B. Accessible during the school day and any other time when a school-sponsored athletic event or team practice is taking place in which pupils of the district or nonpublic school are participating;

- C. Within reasonable proximity of the school athletic field or gymnasium, as applicable;
- D. Tested and maintained according to the manufacturer's operational guidelines and notification shall be provided to the appropriate first aid, ambulance, or rescue squad or other appropriate emergency medical services provider regarding the defibrillator, the type acquired, and its location in accordance with section 3 of P.L.1999, c.34 (N.J.S.A. 2A:62A-25).

Implementation of Procedures for Cardio-Pulmonary Resuscitation and AED Use

The chief school administrator shall oversee the development and implementation of a district emergency action plan that establishes guidelines for use of the AED. The emergency action plan shall include:

- A. A list of no less than five school employees, team coaches, or licensed athletic trainers who hold current certifications from the American Red Cross, American Heart Association, or other training program recognized by the Department of Health, in cardio-pulmonary resuscitation and in the use of a defibrillator. The list shall be updated, as necessary, at least once in each semester of the school year; and
- B. Detailed procedures on responding to a sudden cardiac event including, but not limited to, the identification of the persons in the school who will be responsible for: responding to the person experiencing the sudden cardiac event, calling 911, starting cardio-pulmonary resuscitation, retrieving and using the defibrillator, and assisting emergency responders in getting to the individual experiencing the sudden cardiac event.

Any employee, student or other individual who inappropriately accesses and/or uses an AED will be subject to disciplinary action, up to and including expulsion from school and/or termination of employment. Civil and/or criminal liability may also be imposed on any student, employee or individual who inappropriately accesses and/or uses an AED. All usage will be reported to the board of education.

Immunity

A school district and its employees shall be immune from civil liability in the acquisition and use of defibrillators pursuant to the provisions of section 5 of P.L.1999, c.34 (C.2A:62A-27). A person who acts with gross negligence or willful misconduct in the use of defibrillators does not enjoy immunity.

Adopted:

NJSBA Review/Update:

Readopted:

Key Words

Health, Pupil Health, Student Health, Nursing Plan, Diabetes, Individualized Health Care Plan, Cardio-Pulmonary Resuscitation, Automated External Defibrillator, AED

Legal References:

- N.J.S.A. 2A:62A-23 to 27 AED emergency medical services
- N.J.S.A. 18A:16-6, -6.1 Indemnity of officers and employees against civil actions
- N.J.S.A. 18A:35-4.6 et seq. Parents Right to Conscience Act of 1979
- N.J.S.A. 18A:40-1 Employment of medical inspectors, optometrists and nurses; salaries; terms; rules
- N.J.S.A. 18A:40-3 Lectures to teachers
- N.J.S.A. 18A:40-4.3 Scoliosis; periodic examination; notice to parents or guardian
- N.J.S.A. 18A:40-5 Method of examination; notice to parent or guardian
- N.J.S.A. 18A:40-6 In general
- N.J.S.A. 18A:40-7, -8, -10, -11 Exclusion of pupils who are ill
- N.J.S.A. 18A:40-12.11 et seq. Findings, declarations relative to the care of students with diabetes
- N.J.S.A. 18A:40-23 et seq. Nursing Services for Nonpublic School Pupils
- N.J.S.A. 18A:40-34 New Jersey Family Care Program
- N.J.S.A. 18A:40A-1 et seq. Substance Abuse
- N.J.S.A. 44:6-2 Maintenance by boards of education of clinics for indigent children
- N.J.A.C. 6A:16-1.1 et seq. Programs to Support Student Development
- See particularly:
- N.J.A.C. 6A:16-1.1, -1.3, -2.1, -2.3, -2.4
- N.J.A.C. 6A:26-12.1 et seq. Operation and Maintenance of School
- See particularly: Facilities

N.J.A.C. 6A:26-12.3

N.J.A.C. 8:57-1.1 et seq. Reportable Communicable Diseases

See particularly:

N.J.A.C. 8:57-2 Reporting of AIDS and HIV

N.J.A.C. 8:61-1.1 Attendance at school by pupils or adults infected by Human Immunodeficiency Virus (HIV)

Plainfield Board of Education v. Cooperman, 105 NJ 587 (1987)

Possible

- Cross References:**
- *1410 Local units
 - 1420 County and intermediate units
 - *3510 Operation and maintenance of plant
 - *3516 Safety
 - *3542 Food service
 - *4112.4/4212.4 Employee health
 - *4131/4131.1 Staff development; inservice education/visitations/conferences
 - 4151.2/4251.2 Family illness/quarantine
 - *5111 Admission
 - *5125 Pupil records
 - *5131 Conduct/discipline
 - *5131.6 Drugs, alcohol, tobacco (substance abuse)
 - *5141.1 Accidents
 - *5141.2 Illness
 - *5141.3 Health examinations and immunizations
 - *5141.4 Child abuse and neglect
 - *5141.21 Administering medication

*5142 Pupil safety

*5200 Nonpublic school pupils

*6142.4 Physical education and health

*6142.12 Career education

*Indicates policy is included in the Critical Policy Reference Manual.

APPENDIX G: Sample LEA Policy: Wellness and Nutrition

THE DISTRICT BOARD OF EDUCATION FILE CODE: 3542.1

The district, New Jersey X Monitored
 X Mandated Policy
 _____ Other Reasons

WELLNESS AND NUTRITION

The board believes that children need access to healthful foods and opportunities to be physically active in order to grow, learn, and thrive, and that good health fosters student attendance and education.

Obesity rates have doubled in children and tripled in adolescents over the last two decades, and physical inactivity and excessive calorie intake are the predominant causes of obesity. Heart disease, cancer, stroke, and diabetes are responsible for two-thirds of deaths in the United States, and major risk factors for those diseases, including unhealthy eating habits, physical inactivity, and obesity, often are established in childhood. Further, the items most commonly sold from school vending machines, school stores, and snack bars include low-nutrition foods and beverages, such as soda, sports drinks, imitation fruit juices, chips, candy, cookies, and snack cakes.

To promote healthful behavior in the school, the board is committed to encouraging its students to consume fresh fruits, vegetables, lowfat milk and whole grains. The board is also committed to encouraging students to select and consume all components of the school meal.

In order to promote and protect children’s health, well-being, and ability to learn, the board is committed to providing school environments that support healthy eating and physical activity and will ensure that:

- A. All students will have opportunities, support, and encouragement to be physically active on a regular basis;
- B. Foods and beverages sold or served at school will meet the nutrition recommendations of the U.S. Dietary Guidelines for Americans, and the USDA nutrition standards for National School Lunch, School Breakfast and/or After School Snack Programs. The district will regulate the types of food and beverage items offered outside the federal meal requirements, such as a la carte sales, vending machines, school stores, and fundraisers;
- C. All students will be provided with adequate time for student meal service and consumption in a clean, safe, and pleasant dining environment. Lunch and recess or physical education schedules will be coordinated with the meal service;

- D. To the maximum extent practicable, all schools in our district will participate in available federal school meal programs (including the School Breakfast Program, National School Lunch Program including- After-School Snack Programs, Summer Food Service Program, and Child and Adult Care Food Program);
- E. Schools will provide nutrition education and physical education to foster lifelong habits of healthy eating and physical activity, and will establish linkages between health education and school meal programs, and with related community services;
- F. The board will engage students, parents, teachers, food service professionals, health professionals, and other interested community members in developing, implementing, monitoring, and reviewing district-wide nutrition and physical activity policies.

The following items shall not be served, sold or given out as free promotion anywhere on school property at any time before the end of the school day:

- A. Foods of minimal nutritional value;
- B. All food and beverage items listing sugar, in any form as the first ingredient;
- C. All forms of candy.

Schools shall reduce the purchase of any products containing trans fats. All snack and beverage items sold or served anywhere on school property during the school day, including items sold in a la carte lines, vending machines, snack bars, school stores and fundraisers or served in the reimbursable After School Snack Program, shall meet the following standards:

- A. Based on manufacturers nutritional data or nutrient facts labels:
 - 1. No more than eight grams of total fat per serving, with the exception of nuts and seeds;
 - 2. No more than two grams of saturated fat per serving.
- B. All beverages shall not exceed 12 ounces, with the following exceptions:
 - 1. Water;
 - 2. Milk (plain or flavored) containing one percent or less fat.
- C. Whole milk shall not exceed eight ounces.

Elementary Schools

- A. 100 percent of all beverages offered shall be milk, water; or
- B. 100 percent fruit or vegetable juices;
- C. Serving size for fruit or vegetable juice shall not exceed 8 ounces.

Middle and High Schools

- A. At least 60 percent of all beverages offered, other than milk and water, shall be 100 percent fruit or vegetable juices;
- B. Serving size for fruit or vegetable juice shall not exceed 12 ounces;
- C. No more than 40 percent of all ice cream/frozen desserts shall be allowed to exceed the above standards for sugar, fat, and saturated fat.

General Requirements

Food and beverages served during special school celebrations or during curriculum related activities shall be exempt from this policy, with the exception of foods of minimal nutritional (FMNV) value.

This policy does not apply to: medically authorized special needs diets pursuant to federal regulations; school nurses using FMNVs during the course of providing health care to individual students; or special needs students whose Individualized Education Program (IEP) indicates their use for behavior modification.

Adequate time shall be allowed for student meal service and consumption. Schools shall provide a pleasant dining environment. The board recommends that physical education or recess be scheduled before lunch whenever possible.

The district's curriculum shall incorporate nutrition education and physical activity consistent with the New Jersey Department of Education Core Curriculum Content Standards.

The chief school administrator will specifically address the issue of biosecurity for the school food service. Biosecurity may be part of the plans, procedures and mechanism for school safety.

The board is committed to promoting the nutrition policy with all food service personnel, teachers, nurses, coaches and other school administrative staff so they have the skills they need to implement this policy and promote healthy eating practices. The board will work toward expanding awareness about this policy among students, parents, teachers and the community at large.

The chief school administrator shall develop regulations consistent with this policy, including a process for measuring the effectiveness of its implementation, and designating personnel within each school with operational responsibility for ensuring the school is complying with the policy.

Adopted:

NJSBA Review/Update:

Readopted:

Key Words

School Lunch, Food Service, Nutrition, Wellness,

Legal References:

N.J.S.A. 18A:11-1 General mandatory powers and duties

N.J.S.A. 18A:18A-4.1 f.,h. Use of competitive contracting in lieu of public bidding; boards of education

N.J.S.A. 18A:18A-5 Exceptions to requirement for advertising

See particularly:

N.J.S.A. 18A:18A-5a(6)

N.J.S.A. 18A:18A-6 Standards for purchase of fresh milk; penalties; rules and regulations

N.J.S.A. 18A:33-3 through -5 Cafeterias for pupils

N.J.S.A. 18A:33-9 through -14 Findings, declarations relative to school breakfast programs

See particularly:

N.J.S.A. 18A:33-10

N.J.S.A. 18A:33-15 through -19 Improved Nutrition and Activity Act (IMPACT Act)

N.J.S.A. 18A:54-20 Powers of board (county vocational schools)

N.J.S.A. 18A:58-7.1 through -7.2 School lunch program

N.J.A.C. 2:36-1.1 et seq. Child Nutrition Programs

See particularly:

N.J.A.C. 2:36-1.7 Local school nutrition policy

N.J.A.C. 6A:16-5.1(b) School safety plans

N.J.A.C. 6A:23A-1 et seq. Fiscal accountability, efficiency and budgeting procedures

See particularly:

N.J.A.C. 6A:23A-16.5 Supplies and equipment

N.J.A.C. 6A:30-1.1 et seq. Evaluation of the Performance of School Districts

N.J.A.C. 6A:32-12.1 Reporting requirements

N.J.A.C. 6A:32--14.1 Review of mandated programs and services

Sec. 204 at the Federal Child Nutrition and WIC Reauthorization Act of 2004 (P.L. 108-265)

42 U.S.C. 1751 et seq. Richard B. Russell National School Lunch Act

42 U.S.C. 1771 et seq. Child Nutrition Act of 1966

7 C.F.R. Part 210 Medically authorized special needs diets

7 C.F.R. Part 210.10 Foods of minimum nutritional value

Possible

- Cross References:**
- *1200 Participation by the public
 - *1220 Ad hoc advisory committees
 - *3000/3010 Concepts and roles in business and noninstructional operations; goals and objectives
 - *3220/3230 State funds; federal funds
 - *3450 Money in school buildings
 - *3510 Operation and maintenance of plant
 - *3542 Food Service
 - *3542.31 Free or reduced-price lunches/milk
 - *3542.44 Purchasing
 - *4222 Noninstructional aides
 - *5131 Conduct/discipline
 - 9123 Appointment of board secretary
 - 9124 Appointment of business official

*Indicates policy is included in the Critical Policy Reference Manual.

APPENDIX H: Sample LEA Policy: Drugs, Alcohol, Steroids, Tobacco

THE DISTRICT BOARD OF EDUCATION FILE CODE: 5131.6

The district, New Jersey Monitored
 Mandated Policy
 Other Reasons

DRUGS, ALCOHOL, STEROIDS, TOBACCO

(Substance Abuse)

It is the responsibility of the board of education to safeguard the health, character, citizenship, and personality development of the students in its schools. The board of education recognizes that the misuse of drugs, alcohol, steroids, and tobacco threatens the positive development of students and the welfare of the entire school community. We, therefore, must maintain that the use of drugs, alcohol, steroids, and tobacco and the unlawful possession of these substances are wrong and harmful. The board of education is committed to utilizing wellness strategies that encourage the prevention, intervention, and cessation of drug, alcohol, steroid, and tobacco abuse.

The board of education recognizes that tobacco is a gateway drug and highly addictive and that the use of tobacco products is a health, safety, and environmental hazard for students, employees, visitors, and school facilities. The board believes that the use of tobacco products on school grounds, in school buildings and facilities, on school property or at school-related or school-sponsored events is detrimental to the health and safety of students, faculty/staff and visitors. The board acknowledges that adult employees and visitors serve as role models for students. The board recognizes that it has an obligation to promote positive role models in schools and to promote a healthy learning and working environment, free from unwanted smoke and tobacco use for the students, employees, and visitors on the school campus. Finally, the board recognizes that it has a legal authority and obligation pursuant to P.L. 2005, Chapter 383 New Jersey Smoke-Free Air Act as well as the federal Pro-Children’s Act, Title X of Public Law 103-227 and the No Child Left Behind Act, Part C, Environmental Smoke, Section 4303.

Students

For the purpose of this policy, "drug" includes all controlled dangerous substances set forth in N.J.S.A. 24:21-1 et seq. and all chemicals that release toxic vapors set forth in N.J.S.A. 2C:35-10.4 et seq.

- A. The board of education prohibits the use, possession and/or distribution of any drug, alcohol, or steroids on school premises, and at any event away from the school provided by the board. Compliance with a drug-free standard of conduct at all school functions is mandatory for all students. Pupils suspected of being under the influence of drugs, alcohol, or steroids will be

identified, evaluated, and reported in accordance with the law. Assessment will be provided by individuals who are certified by the New Jersey State Board of Examiners as student assistance coordinators or by individuals who are appropriately certified by the New Jersey Board of Examiners and trained in alcohol and other drug abuse prevention. A pupil who uses, possesses, or distributes drugs, alcohol, or steroids on school premises or while attending a school-sponsored activity will be subject to discipline that may include suspension or expulsion, and may be reported to appropriate law enforcement personnel. Pupils suspected of involvement with alcohol, drugs or steroids away from school premises will be advised of appropriate treatment and remediation (N.J.S.A. 18A:40A-10). Treatment services for students who are affected by alcohol or other drug use will be provided by individuals who are certified as student assistance coordinators or who are otherwise appropriately trained in drug and alcohol prevention, intervention, and follow-up. Treatment will not be at the board's expense.

- B. The board directs the establishment of a program designed to provide short-term counseling and support services for pupils who are in care or returning from care for alcohol and other drug dependencies. Pursuant to N.J.S.A. 18A:40A-16 the district shall establish a parent/guardian substance abuse program offered at times and places convenient to the parents/guardians of the district on school premises or other facilities.

Enforcement of Drug-Free School Zones

The board of education recognizes its responsibility to ensure continuing cooperation between school staff and law enforcement authorities in all matters relating to the use, possession, and distribution of controlled dangerous substances and drug paraphernalia on school property. The board further recognizes its responsibility to cooperate with law enforcement authorities in planning and conducting law enforcement activities and operations on school property. The board shall, therefore, establish a formal Memorandum of Agreement with the appropriate law enforcement authorities and set forth the following policies and procedures after consultation with the county prosecutor and approval by the executive county superintendent of schools. The Memorandum of Agreement shall be consistent with the *Uniform State Memorandum of Agreement Between Education and Law Enforcement Officials*.

Law Enforcement Liaison

In order to ensure that such cooperation continues, the board directs the chief school administrator to designate a school district liaison(s) to law enforcement agencies and to prescribe the roles and responsibilities of the school liaison(s). Such assignment shall be in accordance with the district's collective bargaining agreement, if applicable.

Undercover Operations

The board hereby recognizes that the chief school administrator may request that law enforcement authorities conduct an undercover operation in the school if he/she has reason to

believe that drug use and/or drug trafficking is occurring in the school and that a less intrusive means of law enforcement intervention would be ineffective. The board hereby authorizes the chief school administrator to request such intervention under these circumstances. The board recognizes that the chief school administrator is not permitted to ask the board's approval for his/her action and is not permitted to discuss any aspect of the undercover operation until authorized to do so by law enforcement authorities.

The board recognizes that law enforcement authorities may contact the chief school administrator to request that an undercover operation be established in a district school. The board recognizes that the chief school administrator is prohibited from discussing the request with the board. The board hereby authorizes the chief school administrator to act upon any such request in the manner that he/she determines is in conformity with the law and the Attorney General's Executive Directive 1988-1 and that is in the best interests of the students and the school district.

The board directs the chief school administrator and school principal to cooperate with law enforcement authorities in the planning and conduct of undercover school operations. The chief school administrator, principal, or any other school staff or district board member who may have been informed about the undercover operation is required to immediately communicate information to the county prosecutor or designee if the integrity of the undercover school operation has been compromised in any way.

At the completion of an undercover operation in a school, and with the consent of the appropriate law enforcement authority, the chief school administrator shall report to the board regarding the nature of the operation, the result of the operation, and any serious problems encountered during the operation.

Summoning Law Enforcement Authorities onto School Property for the Purpose of Conducting Investigations, Searches, Seizures, and Arrests

Any school employee who has reason to believe a student(s) or a staff member(s) is using or distributing controlled dangerous substances, including anabolic steroids, or drug paraphernalia on school premises shall bring that information to the school principal who, in turn, shall report same to the chief school administrator. The chief school administrator shall immediately report that information to the appropriate law enforcement agency. If, after consultation with the law enforcement official, it is determined that further investigation is necessary, the chief school administrator will cooperate with the law enforcement authorities in accordance with the law and administrative code. He/she will provide the officials with a room in an area away from the general student population in which to conduct their law enforcement duties. If law enforcement officials do not choose to investigate the incident, the chief school administrator may continue the investigation to determine if any school rules have been broken and whether any school discipline is appropriate.

If an arrest is necessary, and no exigent circumstances exist, the chief school administrator and staff will cooperate with the law enforcement officials and provide them access to the office of a school administrator or some other area away from the general student population. Every effort shall be made to enable law enforcement personnel to carry out the arrest in a manner that is least disruptive to the educational environment. The chief school administrator or the principal shall immediately notify the student's parent/guardian whenever a pupil is arrested for violating any laws prohibiting the possession, use, sale, or distribution of any controlled substance or drug paraphernalia.

Whenever the police have been summoned to a school building by the chief school administrator, the chief school administrator shall report the reason the police were summoned and any pertinent information to the board at its next regular meeting. If confidentiality is required, the report shall be made in executive session.

Student Searches and Securing Physical Evidence

The principal or his/her designee may conduct a search of a student's person or belongings if the search is necessary to maintain discipline and order in the school, and the school official has a reasonable suspicion that the student is concealing contraband. All searches and seizures conducted by designated school staff shall comply with the standards prescribed by the United States Supreme Court in State in re T.L.O. 94 N.J. 331 (1983), reversed on other grounds, New Jersey v. T.L.O. 569 U.S. 325 (1985) and the New Jersey School Search Policy Manual.

If, as a result of the search, a controlled dangerous substance or drug paraphernalia is found, or if a controlled dangerous substance or drug paraphernalia is by any means found on school property, the individual discovering the item or substance shall immediately notify the building principal; the principal shall immediately notify the chief school administrator who shall immediately, in turn, notify the appropriate law enforcement agency. The principal shall ensure that the controlled or dangerous substance and/or drug paraphernalia is labeled and secured in a locked cabinet or desk until law enforcement officials pick it up. The principal shall then contact the student's parents/guardians to inform them of the occurrence.

Whenever law enforcement officials have been called into the school, and a search of a student's person or belongings is necessary, or an interrogation is to be conducted, the chief school administrator shall request that the law enforcement officials conduct the search, seizure, or interrogation.

Police Presence at Extracurricular Activities

The chief school administrator is hereby authorized to contact the appropriate law enforcement agency and arrange for the presence of an officer(s) in the event of an emergency or when the chief school administrator believes that uniformed police presence is necessary to deter illegal drug use or trafficking or to maintain order or crowd or traffic control at a school function.

Resolving Disputes Concerning Law Enforcement Activities

The board authorizes the chief school administrator to contact the chief executive officer of the law enforcement agency involved with any dispute or objection to any proposed or ongoing law enforcement operation or activity on school property. If for any reason the dispute or objection is not satisfactorily resolved with the chief executive officer of the agency, the chief school administrator shall work in conjunction with the county prosecutor and, where appropriate, the division of criminal justice to take appropriate steps to resolve the matter. Any dispute that cannot be resolved at the county level shall be reported to the board and shall be resolved by the attorney general whose decision will be binding.

Confidentiality of Pupil Involvement in Intervention and Treatment Programs

Nothing in this policy shall be construed in any way to authorize or require the transmittal of any information or records that are in the possession of a substance-abuse counseling or treatment program including, but not limited to, the school district's own substance abuse programs. All information concerning a pupil's or staff member's involvement in a school intervention or treatment program shall be kept confidential. See 42 CFR 2 and N.J.A.C. 6A:16-6.5.

Tobacco

Tobacco use is now recognized as a chronic disease and public health hazard. Tobacco use is associated with conditions such as heart disease, emphysema, asthma, high blood pressure, diabetes, and many other chronic diseases. The most effective strategy for discouraging tobacco use by young people is a wellness strategy that supports prevention, intervention, and cessation.

A. Tobacco Use and Possession

1. No student, faculty/staff member or school visitor is permitted to use any tobacco product or electronic smoking device:
 - a. In any building, facility, or vehicle owned, leased, rented or chartered by the district;
 - b. On any school grounds and property—including athletic fields and parking lots—owned, leased, rented, utilized (e.g., adjacent parking lots) or chartered by the board of education;
 - c. At any school-sponsored or school-related event on-campus or off-campus (e.g., field trips, proms, off-campus sporting events, etc).

2. In addition, school district employees, school volunteers, contractors or other persons performing services on behalf of the school district (e.g., bus drivers) also are prohibited from using tobacco products at any time while on duty in accordance with their contracts or in the presence of students, either on or off school grounds.
3. Further, no student is permitted to possess a tobacco product while in any school building, while on school grounds or property or at any school-sponsored or school-related event, or at any other time that students are under the authority of school personnel.

B. Definition of Tobacco Products, Tobacco Use, and Electronic Smoking Device

For the purposes of this policy:

1. “Tobacco product” is defined to include but is not limited to cigarettes, cigars, blunts, bidis, pipes, chewing tobacco and all other forms of smokeless tobacco, rolling papers and any other items containing or reasonably resembling tobacco or tobacco products (excluding quit products);
2. “Tobacco use” includes smoking, chewing, dipping, or any other use of tobacco products;
3. “Electronic smoking device” means an electronic device that can be used to deliver nicotine or other substances to the person inhaling from the device, including, but not limited to, an electronic cigarette, cigar, cigarillo, or pipe.

C. Signage

Signs will be posted in a manner and location that adequately notify students, faculty/staff and visitors about the Comprehensive Tobacco-Free School Policy.

D. Compliance for Students

In recognition that tobacco use is a public health issue and that tobacco is a gateway drug and highly addictive, the board of education recognizes that intervention rather than punishment is the most effective way to address violations of this policy. Students who violate the school district’s tobacco-use policy will be referred to the student assistance coordinators (SAC), guidance counselor, a school nurse, or other health or counseling services for all offenses for health information, counseling, and referral. The administration will consult with appropriate health organizations in order to provide student violators with access to an Alternative-to-Suspension (ATS) program. The ATS program will provide up-to-date information on the many consequences of tobacco use, offer techniques that students can use to stop tobacco use at school, and provide referrals to local youth tobacco cessation programs.

Parents/guardians will be notified of all violations and actions taken by the school. Schools may also use community service as part of the consequences. Ordinarily, and consistent with a wellness strategy, suspension will only be used after a student has three or more prior violations or has refused to participate in other outlined measures.

E. Compliance for Faculty, Staff, and Visitors

As with students, intervention rather than punishment is the most effective way to address adult violations of this policy. Faculty or staff who violate the school district's tobacco-use policy will be referred to the Employee Assistance Program (EAP) or a tobacco cessation program.

Employees who repeatedly violate the policy or do not comply with intervention or cessation referrals may be subject to consequences in accordance with district policy and their contract. Visitors using tobacco products will be informed about the policy and asked to refrain while on school property. Visitors who continue to violate the policy will then be asked to leave the premises. Law enforcement officers may be contacted to escort the person off the premises or cite the person for trespassing if the person refuses to leave the school property.

F. Opportunities for Cessation

The administration will consult with the county health department and other appropriate health organizations (e.g., American Lung Association, American Cancer Society, etc.) to provide students and employees with information and access to support systems, programs and services (e.g., NJDHSS Quitline 1 866 NJSTOPS (657-8677) and njquitline.org) to encourage them to abstain from the use of tobacco products.

Prevention Education

The administration will consult with appropriate health organizations to identify and provide programs or opportunities for students to gain a greater understanding of the health hazards of tobacco use and the impact of tobacco use as it relates to providing a safe, orderly, clean and inviting school environment.

G. Procedures for Implementation

The administration will develop a plan for communicating the policy that may include information in student and employee handbooks, announcements at school-sponsored or school-related events, and appropriate signage in buildings and around campus. A process that identifies intervention and referrals for students, faculty/staff, and visitors who violate the policy will be created and communicated to all students, faculty/staff and parents.

Ongoing Implementation of this Policy

A. Prevention Education for Students

The board will enforce the laws of New Jersey requiring a program of drug, alcohol, steroid, and tobacco education. The chief school administrator shall prepare and submit to the board for its

approval a comprehensive curriculum for such instruction in grades seven through 12 of alcohol and other drug education in accordance with department of education chemical health guidelines, pursuant to N.J.S.A. 18A:40A-1 *et seq.* Drug, alcohol, steroid, and tobacco education shall be integrated with the health curriculum

B. Faculty Education and Inservice Training

All district personnel shall be alert to signs of alcohol, drug, steroid, and tobacco use by pupils and shall respond to those signs in accordance with procedures established by the chief school administrator of schools. The board of education will provide inservice training to assist teaching staff members in identifying the pupil who uses drugs, alcohol, steroids, and/or tobacco and in helping pupils with drug-, alcohol-, steroid-, and tobacco-related problems in a program of rehabilitation. The chief school administrator will ensure that all district employees receive annual inservice training to make them aware of their responsibilities in accordance with board policies and N.J.A.C. 6A:16-3.1.

C. Annual Review and Distribution of Policy

The board will review annually the effectiveness of these policies and the Memorandum of Agreement entered into with the appropriate law enforcement agency. As part of this review, the board will consult with the executive county superintendent, local community members, and the county prosecutor's office.

In accordance with N.J.S.A. 18A:40A-10, copies of the policy statement shall be distributed to pupils and their parents/guardians at the beginning of each school year. Board policy and procedures shall disseminated be annually to all school staff, students and parents through its website or other means (N.J.A.C. 6A:16-4.2).

D. Administrative Regulations

The chief school administrator may develop administrative regulations for:

1. A comprehensive program of drug, alcohol, steroid, and tobacco education;
2. The identification and remediation of pupils involved with drugs, alcohol, steroids, and tobacco;
3. The examination and treatment of pupils suspected of being under the influence of drugs, alcohol, steroids, or tobacco to determine the extent of the pupil's use or dependency;
4. The treatment of pupils who use, possess or distribute drugs, alcohol, steroids, and tobacco in violation of law or this policy through referral to an appropriate drug/alcohol/tobacco abuse program as recommended by the department of health; and
5. The readmission to school and treatment of pupils who have been convicted of drug, alcohol, steroid, or tobacco offenses.

E. Reporting and Liability

The chief school administrator will annually submit a report utilizing the Electronic Violence and Vandalism Reporting system (EVVRS) accurately reporting on each incident of violence, vandalism including harassment, intimidation and bullying, and alcohol and other drug abuse within the school district. Any allegations of falsification of data will be reviewed by the board of education using the requirements and procedures set forth in N.J.A.C. 6A:16-5.3(g). Board action shall be based on a consideration of the nature of the conduct, the circumstances under which it occurred, and the employee's prior employment record.

At an annual hearing the chief school administrator shall report to the board all acts of violence and vandalism and incidents of alcohol and other drug abuse that occurred during the previous school year.

Any staff member who reports a pupil to the principal or his/her designee in compliance with the provisions of this policy shall not be liable in civil damages as a result of making such a report as provided for under N.J.S.A. 18A:40A-1 et seq.

F. Confidentiality Requirements

All policies and procedures must comply with the confidentiality requirements established in federal regulation found at 42 CFR Part II.

G. Parental Compliance

Substance abuse in the district is considered a health risk. It is the expressed position of the district that when school rules have been violated, and when a student's health is at risk, we must notify the student's parents/guardians and attempt to involve the family in the rehabilitation plan subject to the confidentiality restrictions of 42 CFR Part II.

NOTE: IF THE BOARD WISHES TO INCLUDE A SECTION IN THIS POLICY ON RANDOM DRUG TESTING, IT MAY DO SO HERE.

Optional Random Drug Testing of High School Students

School districts have the option to conduct random testing of high school students who possess a school parking permit or who participate in extracurricular activities, including sports, for alcohol or other drug use. Testing, if conducted, will comply with the requirements of N.J.A.C. 6A:16-4.4, "voluntary policy for random testing of student alcohol or other drug use." Before instituting testing, a public hearing will be held concerning the district's policy and procedures. Collection and testing of specimens will be only by the individuals authorized by the regulations. The district's procedures will include a procedure whereby students or their parents may challenge a positive result from alcohol or other drug tests.

Adopted:

NJSBA Review/Update:

Readopted:

Key Words

Drugs, Alcohol, Tobacco, Steroids, Substance Abuse, Smoking, Drinking, Drug Testing

Legal References: N.J.S.A. 2A:62A-4 Reports by educational personnel on dependency upon or illegal use of controlled dangerous substances or use of intoxicating vapor releasing chemicals; immunity from liability

N.J.S.A. 2C:29-3a Hindering apprehension or prosecution

N.J.S.A. 2C:33-15 Possession or consumption of alcoholic beverage by person under legal age, penalty

N.J.S.A. 2C:33-16 Alcoholic beverages; bringing or possession on school property by person of legal age; penalty

N.J.S.A. 2C:33-17 Offer or service of alcoholic beverage to underage person; disorderly persons; exceptions

N.J.S.A. 2C:33-19 Paging devices, possession by students

N.J.S.A. 2C:35-1 et seq. New Jersey Comprehensive Drug Reform Act of 1987

See particularly:

N.J.S.A. 2C:35-7, -10

N.J.S.A. 2C:35-2 Definitions

N.J.S.A. 9:6-1 et seq. Abuse abandonment, cruelty, and neglect of child; what constitutes

N.J.S.A. 9:17A-4 Consent by minor to medical care or treatment; venereal disease, sexual assault or drug use or dependency; notice and report of treatment; confidentiality

N.J.S.A. 18A:25-2 Authority over pupils

N.J.S.A. 18A:36-19.2 Student locker or other storage facility; inspections; notice to students

N.J.S.A. 18A:37-1 Submission of pupils to authority

N.J.S.A. 18A:37-2 Causes for suspension or expulsion of pupils

N.J.S.A. 18A:38-25 Attendance required of children between six and sixteen, exceptions

N.J.S.A. 18A:38-31 Violation of article by parents or guardian, penalties

N.J.S.A. 18A:40A-1 et seq. Substance abuse

See particularly:

N.J.S.A. 18A:40A-1, -2, -3, -4, -5, and -9

N.J.S.A. 18A:40A-22 to -25 Random student drug testing

N.J.S.A. 24:21-2 Definitions (New Jersey controlled dangerous substances)
N.J.S.A. 26:3D-55 et seq. New Jersey Smoke-Free Air Act
N.J.A.C. 6A:8-3.1 Curriculum and instruction
N.J.A.C. 6A:9B-12.2 Student assistance coordinator
N.J.A.C. 6A:14-2.8 Discipline/suspension/expulsion
N.J.A.C. 6A:16-1.1 et seq. Programs to Support Student Development

See particularly:

N.J.A.C. 6A:16-4.4 Voluntary policy for random testing of student alcohol or
See also: other drug use.

N.J.A.C. 6A:16-1.3, -2.2, -2.4, -3.1, -3.2, -4.1 through -4.3, -5.3, -6.1 -6.5

N.J.A.C. 6A:32-12.1 et seq. Pupil Behavior

Drug Free Workplace Act of 1988 Enacted November, 1988 (Pub. L. 100-690, Title V, Subtitle D) 102 Stat. 4305-4308

Regulations Under Drug Free Workplace Act, C.F.R. 4946 (1/31/89)
42 CFR Part 2--Confidentiality of alcohol and drug abuse patient records

F.G. v. Bd. of Ed. of Hamilton, 1982 S.L.D. 382

G.L.H. v. Bd. of Ed. of Hopewell Valley Regional School District, et al., 1987 S.L.D.
April 20, aff'd St. Bd. 1987 S.L.D. Sept. 2

State in re T.L.O., 94 N.J. 331 (1983), reversed on other grounds, New Jersey v. T.L.O.,
569 U.S. 325 (1985).

State of New Jersey v. Jeffrey Engerud, 93 N.J. 308 (1983)

Honig v. Doe 484 U.S. 305 (1988)

Vernonia School District v. Acton, 515 U.S. 646 (1995)

In the Matter of the Tenure Hearing of Graceffo, 2000 S.L.D. (September 2002)

Board of Education of Independent School District No. 92 of Pottawatomie County et al.
v. Earls et al., 536 U.S. (2002)

No Child Left Behind Act of 2001, Pub. L. 107-110, 20 U.S.C.A. 6301 et seq.

The New Jersey School Search Policy Manual, New Jersey Attorney General (1998)
A Uniform State Memorandum of Agreement Between Education and Law Enforcement
Officials

Possible

Cross References:

- *1120 Board of Education Meetings
- *1330 Use of school facilities
- *1410 Local units
- *4131.1 Inservice education/visitations/conferences
- *4231.1 Inservice education/visitations/conferences
- *5114 Suspension and expulsion
- *5124 Reporting to parents/guardians
- *5125 Pupil records
- *5131 Conduct/discipline
- *5131.7 Weapons and dangerous instruments
- *5141.3 Health examinations and immunizations
- *5141.21 Administering medication
- *5145.12 Search and seizure
- *6145.1/6145.2 Intramural competition; interscholastic competition
- 6145.7 Social events/meetings
- *6154 Homework/makeup work
- *6172 Alternative educational programs
- *6173 Home instruction

*Indicates policy is included in the Critical Policy Reference Manual.

APPENDIX I: Sample LEA Policy: Health Examinations and Immunizations

THE DISTRICT BOARD OF EDUCATION FILE CODE: 5141.3

The district, New Jersey X Monitored
 X Mandated Policy
 X Other Reasons

HEALTH EXAMINATIONS AND IMMUNIZATIONS

Pupils who enter the district schools for the first time shall have a medical examination conducted at the medical home of the student, and a full report sent to the school. If a student does not have a medical home, the district shall provide this examination at the school physician's office or other appropriately equipped facility. "Medical home" means a health care provider and that provider's practice site chosen by the student's parent/guardian for the provision of health care. As the school physician is also a health care provider, the parent/guardian may request that the school physician provide the medical examination.

A pupil shall be exempted from mandatory immunization if the parent/guardian objects to immunization in a written statement submitted to the principal, signed by the parent/guardian, explaining how the administration of immunizing agents conflicts with the pupil's exercise of bona fide religious tenets or practices. General philosophical or moral objection to immunization shall not be sufficient for an exemption on religious grounds.

Every pupil who enters the district schools for the first time shall present an immunization record as required by law. At the parent/guardian's request, these immunizations may be administered by the school physician.

NOTE: THIS IS PERMISSIVE, NOT REQUIRED.

In order to protect the health of the children and staff in district schools, all regulations of the state department of education, the state department of health and the local board of health shall be scrupulously observed, particularly those dealing with contagious/infectious diseases or conditions. Pupils seeking to enter school who have been identified as having a communicable/infectious disease or condition shall not be enrolled unless they qualify under the above agencies' rules pertaining to periods of incubation, communicability, quarantine, and reporting.

The chief school administrator or his/her designee shall formulate regulations that ensure immunization records are reviewed and updated annually pursuant to N.J.A.C. 8:57-4.1 through 4.16. The chief school administrator shall also formulate regulations for this policy and for regular pupil health examinations at appropriate grade levels; before participation in sports programs; and for tuberculosis, scoliosis, hearing loss, visual acuity and any other physical examinations required by law. Any health defects revealed by any examination given by the

school health services must be reported to the parent/guardian. The board shall review the regulations and adopt those required by law.

Adopted:

NJSBA Review/Update:

Readopted:

Key Words

Immunizations, Inoculations, Examinations, Pupil Physical Examinations, Student Physical Examinations, Health

Legal References:

N.J.S.A. 18A:35-4.6 through -4.8 Parents Right to Conscience Act of 1979

N.J.S.A. 18A:40-4 Examination for physical defects and screening of hearing of pupils; health records

N.J.S.A. 18A:40-4.3 Scoliosis; periodic examination; notice to parents or guardian

N.J.S.A. 18A:40-4.4 Exemption

N.J.S.A. 18A:40-4.5 Immunity from action of any kind due to provisions of act

N.J.S.A. 18A:40-5 Method of examination; notice to parent or guardian

N.J.S.A. 18A:40-6 In general

N.J.S.A. 18A:40-11 Exclusion of pupils having communicable tuberculosis

N.J.S.A. 18A:40-16 through -19 Tuberculosis infection; determination of presence ...

N.J.S.A. 18A:40-20 Immunization at public expense

N.J.S.A. 18A:61D-8 through -10 Findings, declarations relative to Hepatitis B vaccinations....

N.J.S.A. 26:1A-9.1 Exemption of pupils from mandatory immunizations

N.J.S.A. 26:4-6 Prohibiting attendance of teachers or pupils

N.J.S.A. 26:2T-5 through -9 Findings, declarations relative to Hepatitis C

N.J.A.C. 6A:14-3.4 Evaluation

N.J.A.C. 6A:16-1.1 et seq. Programs to Support Student Development

See particularly:

N.J.A.C. 6A:16-1.3, -2.1, -2.2, -2.3, -2.4, -4.1, -4.3

N.J.A.C. 6A:32-9.1 Athletics Procedures

N.J.A.C. 8:57-2 Reporting of acquired immunodeficiency syndrome and infection with Human Immunodeficiency Virus

N.J.A.C. 8:57-4.1 Applicability

N.J.A.C. 8:57-4.2 Proof of immunization

N.J.A.C. 8:57-4.3 Medical exemptions

N.J.A.C. 8:57-4.4 Religious exemptions

N.J.A.C. 8:57-4.5 Provisional admission

N.J.A.C. 8:57-4.6 Documents accepted as evidence of immunization

N.J.A.C. 8:57-4.7 Records required

<u>N.J.A.C.</u> 8:57-4.8	Reports to be sent to the State Department of Health
<u>N.J.A.C.</u> 8:57-4.9	Records available for inspection
<u>N.J.A.C.</u> 8:57-4.10	Diphtheria and tetanus toxoids and pertussis vaccine
<u>N.J.A.C.</u> 8:57-4.11	Poliovirus vaccine
<u>N.J.A.C.</u> 8:57-4.12	Measles virus vaccine
<u>N.J.A.C.</u> 8:57-4.13	Rubella vaccine
<u>N.J.A.C.</u> 8:57-4.14	Mumps vaccine
<u>N.J.A.C.</u> 8:57-4.15	Haemophilus influenza type b (Hib) conjugate vaccine
<u>N.J.A.C.</u> 8:57-4.16	Hepatitis B virus vaccine
<u>N.J.A.C.</u> 8:57-4.17	Varicella virus vaccine
<u>N.J.A.C.</u> 8:57-4.18	Pneumococcal conjugate vaccine
<u>N.J.A.C.</u> 8:57-4.19	Influenza vaccine
<u>N.J.A.C.</u> 8:57-4.20	Meningococcal vaccine
<u>N.J.A.C.</u> 8:57-4.21	Providing immunization
<u>N.J.A.C.</u> 8:57-4.22	Emergency power of the Commissioner, Department of Health and Senior
<u>N.J.A.C.</u> 8:61-2.1	Attendance at school by students or adults infected by Human Immuno-deficiency Virus (HIV)

Plainfield Board of Education v. Cooperman, 105 NJ 587 (1987)

No Child Left Behind Act of 2001, Pub. L. 107-110, 20 U.S.C.A. 6301 et seq.

Possible

<u>Cross References:</u>	*1410	Local units
	*4123	Classroom aides
	*5111	Admission
	*5113	Absences and excuses
	*5131.6	Drugs, alcohol, tobacco (substance abuse)
	*5141	Health
	*5141.21	Administering medication
	*5200	Nonpublic school pupils
	*6142.4	Physical education and health
	*6145.1/6145.2	Intramural competition; interscholastic competition
	*6162.5	Research
	*6164.4	Child study team
	*6171.4	Special education

*Indicates policy is included in the Critical Policy Reference Manual.

- B. Medications shall be securely stored and kept in the original labeled container;
- C. The school nurse shall maintain a record of the name of the student to whom medication may be administered, the prescribing physician, the dosage and timing of medication and a notation of each instance of administration;
- D. All medications shall be brought to school by the parent/guardian or adult student and shall be picked up at the end of the school year or the end of the period of medication, whichever is earlier;
- E. A student may self-administer medication without supervision of the school nurse for asthma or other life-threatening illnesses. "Life-threatening illness" has been defined as an illness or condition that requires an immediate response to specific symptoms or sequelae that if left untreated may lead to potential loss of life such as, but not limited to, the use of an inhaler to treat an asthma attack or the use of an adrenalin injection to treat a potential anaphylactic reaction.

Nebulizers

Each school in the district shall have and maintain at least one nebulizer in the office of the school nurse or at a similar accessible location. The chief school administrator shall prepare and the board shall adopt regulations on the administration of asthma medication through the use of a nebulizer by the school nurse or his/her designee(s). Regulations shall be in accord with New Jersey statute and administrative code and shall include, but not be limited to the following:

- A. Requirement that each school nurse shall be authorized to administer asthma medication through use of a nebulizer;
- B. Requirement that each school nurse receive training in airway management and in the use of nebulizers and inhalers consistent with nationally recognized standards;
- C. Requirement that each student authorized to use asthma medication or a nebulizer have an asthma treatment plan prepared by the student's physician that identifies, at a minimum, asthma triggers and an individualized health care plan for meeting the medical needs of the student while attending school or a school-sponsored event.

Student Self-Administration of Medication

The board shall permit self-administration of medication for asthma, diabetes or other potentially life-threatening illnesses by students who have the capability for self-administration of medication, both on school premises during regular school hours and off-site or after regular school hours when a student is participating in field trips or extracurricular activities.

Parents/guardians of the student must meet the following conditions:

- A. Provide the board with written authorization for the student's self-administration of medication;

- B. Provide written certification from the student's physician that the student has asthma or another potentially life-threatening illness and is capable of and has been instructed in the proper method of self-administration of medication;
- C. Sign a statement acknowledging that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student and that the parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the student.

The board shall:

- A. Inform the student and his/her parents/guardians that permission is effective for the school year for which it is granted and must be renewed for each subsequent school year upon fulfillment of requirements listed above;
- B. Inform parents/guardians in writing that the district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication;
- C. Maintain the right to revoke a student's permission to self-medicate if he/she has failed to comply with all conditions of this policy and/or has violated in any way the tenets of the agreement to self-medicate. The chief school administrator shall confer with the school physician and school nurse prior to recommending termination of a student's permission to self-medicate and shall also consult with the student, the student's parents/guardians and the student's physician.

Upon written request of the parent or guardian and as provided in the individualized health care plan, the student shall be allowed to attend to the management and care of his/her diabetes in the classroom or on school grounds, if evaluated and determined to be capable of doing so consistent with the plan, and N.J.S.A. 18A:40-12.15 and board policy 5141 Health for specific rules regarding diabetes management.

Emergency Administration of Epinephrine

The board shall permit the school nurse or medical inspector to administer epinephrine via epi-pen or other pre-filled auto-injector mechanism in emergency situations. In their absence, a designee or designees who are employees of the board may do so.

The designees must be properly trained by the school nurse in the administration of the epi-pen or other pre-filled auto-injector mechanism using the standardized training protocol designated by the State Department of Education. Each designee shall receive individual training for each student for whom he/she is designated.

The board shall inform the student's parents/guardians in writing that if the specified procedures are followed, the district, its employees and agents shall have no liability as a result of any injury

arising from the administration of the epi-pen or other pre-filled auto-injector mechanism to the student.

Parents/guardians shall provide the board with the following:

- A. Written orders from the physician that the student requires the administration of epinephrine for anaphylaxis and does not have the capability for self-administration of the medication;
- B. Written permission for the administration of epinephrine via epi-pen or other pre-filled auto-injector mechanism by the school nurse or designee(s);
- C. A signed statement acknowledging their understanding that if the specified procedures are followed, the district shall have no liability as a result of any injury arising from the administration of the epi-pen or other pre-filled auto-injector mechanism by the school nurse or designee(s) to the student and that the district, its employees, and agents shall be indemnified and held harmless against any claims arising out of the administration of the epi-pen or other pre-filled auto-injector mechanism to the student.

Permission for the administration of epinephrine via epi-pen or other pre-filled auto-injector mechanism shall be granted annually and must be renewed each school year upon the fulfillment of the above requirements.

Placement and Availability of Epinephrine, and Transportation to Hospital Emergency Room

Pursuant to N.J.S.A. 18A:40-12.6, school policy requires:

- A. The placement of a student's prescribed epinephrine in a secure but unlocked location easily accessible by the school nurse and designees to ensure prompt availability in the event of an allergic emergency at school or at a school-sponsored function. The location of the epinephrine shall be indicated on the student's emergency care plan. Back-up epinephrine shall also be available at the school if needed;
- B. The school nurse or designee to be promptly available on site at the school and school-sponsored functions in the event of an allergic reaction; and
- C. The transportation of the student to a hospital emergency room by emergency services personnel after the administration of epinephrine, even if the student's symptoms appear to have resolved.

Emergency Administration of Epinephrine for First Time Allergic Reactions at School

The school nurse or trained designee shall be permitted to administer epinephrine via a pre-filled auto-injector mechanism to any student without a known history of anaphylaxis. This includes students whose parents/guardians have not submitted prior written permission or obtained

prescribed medication as indicated in the rules above. Epinephrine may be administered to any student without a known history of anaphylaxis when the nurse or trained designee in good faith believes that the student is having an anaphylactic reaction

The district shall maintain a supply of epinephrine auto-injectors that is prescribed under a standing protocol from a licensed physician or an advanced practice nurse in a secure but unlocked and easily accessible location. The supply of epinephrine auto-injectors shall be accessible to the school nurse and trained designees for administration to a student having an anaphylactic reaction.

Liability

No school employee, including a school nurse, or any other officer or agent of a board, or a physician or an advanced practice nurse providing a prescription under a standing protocol for school epinephrine shall be held liable for any good faith act or omission consistent with the provisions of law for the administration of epinephrine (N.J.S.A. 18A:40-12.5 et seq.). No action shall be taken before the New Jersey State Board of Nursing against a school nurse for any such action taken by a person designated in good faith by the school nurse to administer epinephrine according to law (N.J.S.A. 18A:40-12.6). Good faith shall not include willful misconduct, gross negligence or recklessness.

Implementation

The board may adopt additional regulations on all aspects of the administration of medication. When implementing school policy and N.J.S.A. 18A:40-12.6, staff will consult these New Jersey Department of Education guidance documents:

- A. Training Protocols for the Emergency Administration of Epinephrine (9/08);
- B. Guidelines for the Management of Life-Threatening Food Allergies in Schools (9/08).

Adopted:

NJSBA Review/Update:

Readopted:

Key Words

Administering Medication, Medication in School, Nebulizer, Epinephrine, Anaphylaxis, Asthma

Legal References:

N.J.S.A. 18A:11-1 General mandatory powers and duties

N.J.S.A. 18A:40-1 Employment of medical inspectors, optometrists and nurses; salaries; terms; rules

N.J.S.A. 18A:40-3.2 et seq. Medical and Nursing Personnel

N.J.S.A. 18A:40-4 Examination for physical defects and screening of hearing of students

N.J.S.A. 18A:40-7 Exclusion of students who are ill

N.J.S.A. 18A:40-12.3 through -12.4 Self-administration of medication by student; conditions

N.J.S.A. 18A:40-12.5 Policy for emergency administration of epinephrine to public school students

N.J.S.A. 18A:40-12.6 through -12.6d Administration of epinephrine; primary responsibility; parental consent

N.J.S.A. 18A:40-12.7 Nebulizer

N.J.S.A. 18A:40-12.8 Administration of asthma medication by school nurse through nebulizer; training; student asthma treatment plan

N.J.S.A. 18A:54-20 Powers of board (county vocational schools)

N.J.S.A. 45:11-23 Definitions

N.J.A.C. 6A:16-1.1 et seq. Programs to Support Student Development

See particularly:

N.J.A.C. 6A:16-1.3, -2.1, -2.2, -2.3, -2.4

Bernards Township Education Association v. Bernards Township Board of Education, 1981 S.L.D. (9/29/81), aff'd State Board, 1982 S.L.D. 4/7/82, aff'd App. Div., unpublished opinion (A-4211-81T3, 5/18/83)

Communications Workers of America, Local 1033, On behalf of Karen Norton, Barbara Woolston, Mary Ellen Schoen et al. v. New Jersey State Department of Education, Marie H. Katzenbach School for the Deaf, State Board Docket #52-91

Policy Advisory #1 on N.J.S.A. 18A:40-12.3 et seq. Self-Administration of Medication By a Student, New Jersey State Department of Education, June 5, 1995

Protocol and Implementation Plan for the Emergency Administration of Epinephrine by a Delegate Trained by the School Nurse, New Jersey State Department of Education, October, 1998

Possible

Cross References:

*5131.6 Drugs, alcohol, tobacco (substance abuse)

- *5141 Health
- *5141.1 Accidents
- *5141.2 Illness
- *5141.3 Health examinations and immunizations
- *5141.8 Sports related concussion and head injury
- *6153 Field trips

*Indicates policy is included in the Critical Policy Reference Manual.