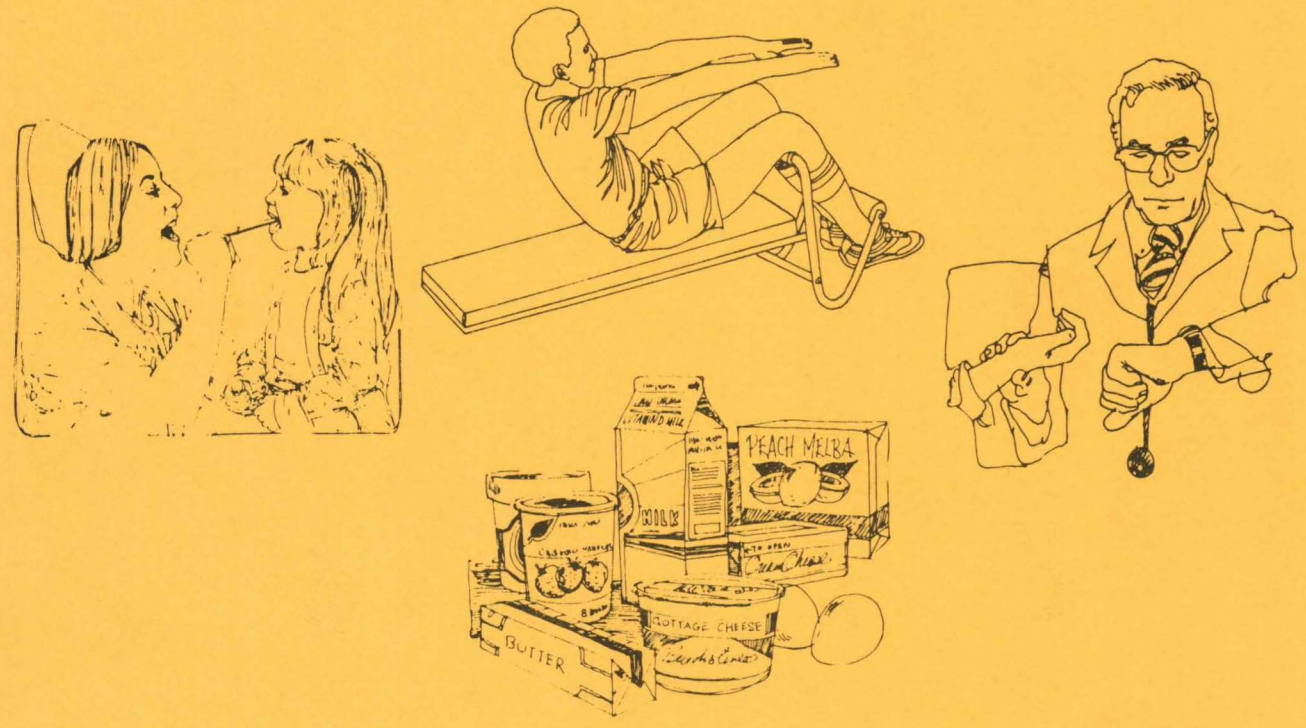
A Tool for Assessing and Designing

Comprehensive School Health Education



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1981

A TOOL FOR ASSESSING AND DESIGNING COMPREHENSIVE SCHOOL HEALTH EDUCATION IN IOWA SCHOOLS

Foreword

In 1978 a Task Force was appointed to study comprehensive school health education in Iowa and to make recommendations to the state Board of Education. Twenty persons served on the committee; they were assisted by sixteen additional persons as a committee of advisors and twelve staff members from the Department of Public Instruction. This document has been prepared during the 1980-81 school year as an extension and follow-up of the 1978-80 efforts of the Task Force, the DPI staff, and the State Board.

A committee of writers was selected during the summer of 1980 to extract ideas and recommendations from the Task Force Report. It was felt that such ideas and guidelines should be utilized in a tool for use at the local level to assess existing programs in school health education and to plan for a comprehensive program for the future. The committee of writers included the following:

Betty M. Atwood, Heartland AEA 11, Ankeny, Iowa 50021
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Later a steering committed was formed to provide ideas and reactions to the tool, and to assist with piloting the initial drafts of the tool. The steering committee consisted of:

Larry Benne, Western Hills AEA 12, Sioux City, Iowa 51106
Dennis Cryer, University of Northern Iowa, Cedar Falls, Iowa 50613
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INTRODUCTION

This curriculum tool is for local schools to use as a means of assessing their current programs in health education and to plan for a comprehensive health education program for the future. This tool and the process for curriculum study it suggests are recommended for use on a continuing basis. The tool includes the following major sections, each color coded as indicated:

1. A schedule and a plan for implementing a local curriculum study in health education (green)
2. A suggested framework for the school health education program (yellow)
3. Suggestions for curriculum development in health education (pink)
4. An instrument and a procedure for assessing curriculum programs and the identification of needed changes (blue)

The sections are color coded to assist the users in accomplishing the task of assessing their school health education programs and/or planning for new programs in different ways. Some prefer reading some statements of philosophy and implementation suggestions prior to beginning; others prefer to consider such suggestions as needed as they work on the task. The table of contents may serve as a guide in making such decisions.

Many of the suggestions included (i.e. framework, procedure for program development, and goal and content areas) arose from the 1978-79 Task Force efforts as approved by the State Board of Education. These sections are included for local school use and consideration when they seem appropriate. The underlying theme for curriculum tools in Iowa is to provide help and suggestions while not being prescriptive. Users are invited to

forward comments concerning their experiences with the tool and suggestions for changes and improvements. The tool, like the curriculum itself, should continue to develop each time it is used.

II. OUTLINE OF SCHEDULE FOR ASSESSING SCHOOL HEALTH EDUCATION PROGRAMS IN IOWA SCHOOLS

The following outline is suggested as a plan for assessing existing curricula for school health education or proposing new ones. Included with the suggested actions is a blank at the right for use in establishing a tentative calendar for the efforts.

Proposed Date

1. Identify K-12 health education coordinator. _____

2. Secure administrative and school board support. _____

3. Identify community advisory group; establish meeting schedule to coordinate with the ongoing effort. _____

4. Select curriculum committee for comprehensive school health education. A curriculum committee with representatives from each of these areas has proven effective: _____

    *Administration (principle, assistant superintendent, curriculum coordinator, etc.)

    *K-12 teacher (all buildings represented) and representatives from sciences, home economics, social studies, physical education, and health education

    *Outside consultant (area education agency, college/university, DPI, etc.)

    *Others [counselors, school nurse, lay person, minority representation according to the Code of Iowa 257.25(11), 670-3.5(25b), etc.]

5. Schedule time and budget for curriculum work. _____

6. Examine local health education needs of students. _____

7. Examine existing school health education programs. _____

8. Review rationale for comprehensive school health education approved by the State Board of Education (Appendix I Page 39). _____

9. Review Code of Iowa. _____

10. Review a philosophy for health education (page 8). _____
Using the philosophy statement provided (page 8), the health education curriculum committee should develop a written philosophy for health education specific to local needs. The comprehensive nature of health education and its essential purposes should be a major feature of the statement. The philosophy statement should be duplicated and sent to the entire staff for reaction, additions, deletions and correction.

11. Seek input and recommendations from the community advisory committee. _____

12. Examine existing school and/or Board policies that could influence the work of the committee; consider how the curriculum effort can support such existing policies. _____

13. Discuss current trends and problems in health education. It is highly recommended that outside talent be employed to meet with the committee (and others interested in its work) at least once. A knowledgeable consultant should speak with the committee concerning contemporary trends and problems in health education as they relate to the local district. _____

14. Study goals for school health education approved by the State Board of Education (pages 39 through 40). Get feedback from staff and prepare local goal statements. _____

15. Modify goals and objectives in terms of local statements. The health education curriculum committee should modify the goals and objectives provided in the tool (pages 15 through 37). These should represent an ideal curriculum and assure consistency with those developed above (No. 14). Goals and objectives should be added or deleted as appropriate. At this point, the goals and objectives should be duplicated and sent to the entire faculty involved with health education for additions, deletions, reactions and corrections. Teachers' written comments concerning the objectives should be encouraged in the space provided on the extreme right part of the pages (15-37). _____

16. Assess current program in terms of new goals and objectives (pages 15 - 37). The curriculum committee should have teachers assess the degree to which each objective is emphasized in the present instructional program _____

using pages 15 - 37. Each health education teacher should decide the degree to which the objective is emphasized in his/her grade level or course by assessing the degree to which each objective is being met. Appropriate designations should be entered on the form. Teachers' written comments concerning placement of the objectives in their present program should be encouraged in the white space provided on pages 15 - 37). _____

17. Decide on level of revision required. If major weaknesses and duplications are identified in the program, the health education curriculum committee should recommend a major revision. If only isolated weaknesses are identified, the committee may explore supplements to these areas only. Individual teachers should be encouraged and assisted in improving areas of weaknesses specific to their grade level or course. _____

18. Examine curriculum materials and programs in terms of local needs. _____

19. Observe comprehensive school health education programs and procedures in use in other school districts. _____

20. Develop or revise local curriculum program. _____

    a. Introduce revised program and provide teacher in-service. _____

    b. Implement revised program and continue teacher in-service, and in-service new teachers. _____

    c. Evaluate new health education curriculum. _____

    d. Assess student achievement and other indicators of success of the program.

    e. Arrange for regular curriculum review; seek input and recommendation from community advisory group. _____

FRAMEWORK FOR SCHOOL HEALTH

1. Definition

Comprehensive school health education is a continuous process which enables the student to assume individual responsibility for developing and maintaining personal attitudes and behaviors which promote total wellness.

2. The Rationale

The concept of health is not a fact, but a unified, generalized, and comprehensive concept with physical, mental, cultural, spiritual values, emotional, and social dimensions. It includes knowledge, attitudes, feelings, and practices concerning an interaction among individuals, the family, peers, the school, and the community. Education is a fundamental for decision making in all fields of human endeavor; however, with increasing numbers of social and cultural forces, options, and persuasive influences affecting the quality of life, its importance is more apparent. For these reasons, health education is logically provided in the progressive school program. Personal and social goals of modern society, as well as the wise use of human resources, depend upon this linkage for the well being of persons and their communities.

Each year, billions of dollars are spent to ensure continued advances in medical research, to prepare manpower for the health professions, to provide health care services, and to build better facilities for research, care and service. Such expenditures, however, do not ensure their use.

Education can help maintain quality services and programs and make them more accessible; education can help promote and maintain optimal health

levels; a health education program can and should help students to make knowledgeable decisions regarding health issues. Less than one-fifth of one percent of the funds spent on health care is available for health education purposes. Without health education, health goals will remain remedial and therapeutic with little real advance from generation to generation. It is only when advances are made in realizing all health goals that health education becomes comprehensive.

It is important to remember that: a) education is used as a preventive tool, requiring total community involvement; b) concerned people are the keys to action; c) health problems have causes; d) facts are not enough; action too is needed; e) people make their own decisions; and f) open communication is essential among all.

3. Philosophy

Healthy people are essential for an effective society. To achieve optimal health, a person needs a breadth of knowledge about health and the motivation to apply such knowledge to daily living. Information regarding health changes rapidly and must be continuously updated and related to the changing needs of persons at different age levels.

A comprehensive school health program encompasses: a) school health education; b) school health services; c) healthful school environment and d) effective school, home and community relations. The education phase is designed to expose students to health concepts, and to help them attain knowledge that can be used to develop desirable attitudes and health behaviors.

Health services undergird the school program by assisting students and families in identifying problems and seeking solutions to them. Such services provide guidance and opportunities for learning experiences.

The school assumes the responsibility to provide a safe, sanitary, and emotionally healthful environment in which students are provided the opportunity to learn.

A health education program in schools can only be completely comprehensive with the involvement of parents and others in the community. Health education is too important to assume that the total responsibility rests with the school.

Comprehensive school health education should:

* consider ways of preventing individual physical, emotional, and social health problems while concentrating on optimal health for all;

* be designed to promote and develop positive attitudes and practices toward the solution of public health problems;

* include instruction in the major areas of physical health, social health, mental health, environmental and community health, and education for life skills;

* be developed and evaluated through cooperative planning by educators, students, parents, and other community members;

* be based upon current and scientifically accurate health information;

* provide the link between health information and health practices;

* be a carefully planned and coordinated K-12 program including direct and correlated instruction in the total school offering;

*focus on the positive aspects of optimal health (wellness) and not be totally centered on the study of health problems;

* facilitate the exploration and use of innovative and creative instructional methods which actively involve students in the achievement of established objectives.

FEATURES OF A COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM

These suggestions have been prepared to address Iowa rural and urban health education needs. The interrelationships of physical, mental, emotional, spiritual values, and social health should be stressed throughout. For each of the content areas, more than memorization of facts and figures is expected. Health education programs should motivate and teach students to do something with the information they discover; the program should facilitate the application of information to personal lifestyles since health education is the process linking health information, health attitudes, and healthful behaviors.

It is important to develop a program which helps students to: a) identify which personal and community health goals they desire in their communities; b) learn to make decisions about matters affecting their health; and c) act upon their decisions. A health education program based on these concepts is student-centered rather than content-centered.

It is important for persons who are involved in the development of health education curricula to keep in mind several assumptions for any process of curriculum development:

1. The total curriculum includes the processes of program development, a written program of instruction, suggestions for actual delivery of instruction, and a continuous process of evaluation;

2. Curriculum planning, implementation, and evaluation is a continuous process;

3. Any local curriculum must be based upon the needs of the students and the philosophy and goals of the district;

4. Significant outcomes of the curriculum development and implementation process are the professional growth of all those involved and a written curriculum guide which is used thorughout the local district;

5. The specifics of a program will vary when local needs and priorities have been identified;

6. A curriculum outline identifies what presently is provided (real), along with what should be (ideal), and thus serves as a vehicle for change.

The following are some basic features of comprehensive health education which should be considered in developing local curricula:

1. Health education should be a planned, sequential program, K-12. Such a program:

   a. focuses on student achievement of desired outcomes
   b. includes relevant health concepts at the most appropriate developmental levels of children and youth (there is progression in content and expected outcomes)
   c. represents the planned inclusion of basic health education content areas (see pages 19 - 27).
   d. presents current, accurate, scientific knowledge related to current health issues and problems
   e. effects the formation of positive student health attitudes and behaviors

2. Health education is responsive to the needs of students and the demands of society. Students and other citizens are involved in curriculum development in order to assure the inclusion of learning goals related to local health needs, interests, and problems.

3. Health instruction must be more than a textbook course concerned only with a mastery of facts. It should be primarily an activity program consisting of numerous learning experiences such as: experiments, communication projects, demonstrations, field excursions, visual aids, outside consultants, and group discussion.

4. Teachers are encouraged to explore innovative and creative instructional techniques which actively involve students in the achievement of the goals and objectives. Such techniques as small discussion groups, independent study, team teaching, and values clarification activities based on teacher-student dialogue have been used successfully in many districts.

5. Class size should be maintained at a level which will provide adequate opportunities for interaction among students and between students and teachers.

6. Health education should be a part of the regular, formal instructional program offered in the elementary shcool. One full year of health education during grades 7-12 is recommended for all students (one unit of credit).

7. Typical classrooms should be provided which facilitate the use of modern teaching and learning resources. The environmental setting should enhance health learning.

8. Sufficient funds should be allocated to provide up-to-date and adequate instructional resources for teacher and students.

9. Title IX requires that health education classes be coeducational. The following is excerpted from a summary of Title IX Regulations:

> Classes in health education...may not be conducted separately on the basis of sex, but the final regulation allows separate sessions for boys and girls at the elementary and secondary level during times when the materials and discussion deal exclusively with human sexuality.

Although individual districts may exercise their own judgment, much value is apparent when the health education is approached co-educationally, K-12.

10. School districts should employ a person who is qualified to assume responsibility for the development, coordination, and implementation of the total health education program. This person should possess appropriate academic credentials, display interest in health education, and serve as a positive role model. Ideally, the person should have a bachelor's degree with a major in health education.

11. Local school districts are responsible for making final decisions concerning curriculum emphasis and content and the manner in which the curriculum is implemented.

12. Local school districts are responsible for scheduling health education. At the middle, junior, and senior high school levels, the methods of scheduling health education determines to a large extent the manner in which the curriculum is incorporated into the program. Each district should be aware of the specific health areas which must be included in the curriculum as specified by the Code of Iowa.

13. Teachers involved in health education will need ongoing inservice training, time to plan for instruction, and support and encouragement for their efforts.

14. Health education programs should include well-designed evaluation components which consider both cognitive and affective areas and behavioral areas.

THE ASSESSMENT INSTRUMENT

1. Introduction

The following sections contain sample recommended goals, instructional actions, evaluation plans, and plans for program coordination. Local schools and local curriculum groups are encouraged to alter and/or add items, especially specific behavioral objectives, as they develop curriculum materials for the local setting. The items in this instrument are for purposes of discussion and not meant to be prescriptive nor exhaustive.

Placement/use of objectives, concepts or practices in the health education programs should be discussed and determined locally. Following is a suggested system for use with the various sections of the instrument concerned with general concepts, content areas, instruction, and evaluation:

I -- Introduce. The first time presented as planned portion of the district curriculum.

S -- Stress. The objective, concept, or practice to be stressed.

M -- Maintain. Review and reinforce objective, concepts, or practices introduced previously.

N -- Not applicable at this level.

2. Goals

There has never been a greater need for dynamic and relevant curriculum in health education. Most health education issues are multi-faceted, requiring critical judgment in order to determine wise courses of action. Young people need guidance to clarify for themselves what they, as healthy individuals, can believe and value. A major goal of health education is to motivate people to help themselves and others to live healthy, happy, productive lives.

A. PROCESS GOALS

Three process goals are directed toward the fostering of skills that promote optimal growth of learners. They provide opportunities for self-actualization and motivate the student to develop values. The local comprehensive health education program should be planned and evaluated to enable students to grow in self-awareness, to develop skills for effective decision-making, and to grow in coping behavior. Local committees are encouraged to consider these process goals as major dimensions for discussion of general concepts, content areas, modes of instruction, and evaluation which follow.

WHAT EMPHASIS DOES OUR PRESENT/PROPOSED PROGRAM PLACE ON THE FOLLOWING GOALS?

PROCESS GOAL	None	Limited	Adequate	High	Proposed Changes
1. Self-awareness. The students should be provided opportunities to develop a positive sense of identity and self-esteem.					
2. Effective decision-making skills. Such process skills involve the ability to recognize and clarify problems, to reason critically and creatively in developing and evaluating alternative solutions, and to choose and affirm solutions based on a system of values.					
3. Coping behavior. Coping behavior has to do with the ability of the individual to get along effectively in the world. To cope effectively means not only to possess the competencies to deal positively and creatively with life situations, but also to be open or accepting of new experiences, to interact in resolving problems including actively seeking professional advice and assistance, and to participate through social action in the planning of new environments.					

B. CONCEPT GOALS

A major purpose of school health education is to improve the quality of living for the individual, the family, and the community. The following concept goals, built around individual and community needs, may serve as suggestions in the development of local school health education programs. Each school district may add, delete, or alter these concept goals to meet local needs.

WHAT EMPHASIS DOES OUR PRESENT/PROPOSED PROGRAM PLACE ON THE FOLLOWING GOALS?

CONCEPT GOALS	None	Limited	Adequate	High	Proposed Changes
1. The family serves to perpetuate humanity and to fulfill certain health needs.					
2. The family, parenting, and human sexuality are inter-related.					
3. Human growth and development follows a predictable sequence, yet is unique for each individual.					
4. Human beings undergo continuous physical, psychological and emotional changes from birth through dying and death.					
5. Practice of sound nutrition enhances physical and emotional well-being.					
6. Personal health practices are affected by a complexity of forces which are often conflicting in nature.					
7. Many diseases and accidents can be prevented by proper practices and behavior.					

B. CONCEPT GOALS (Cont.)	None	Limited	Adequate	High	Proposed Changes
8. The use of tobacco, alcohol and other drugs may lead to changes in physical and/or mental behavior.					
9. Use of substances that modify mood and behavior arises from a variety of motivations.					
10. The protection and promotion of health is an individual, community and international responsibility.					
11. A variety of community health services and related agencies are available.					
12. Use of health information products and services is guided by values and perceptions.					
13. Solving problems which affect the health of the individual, the community, and the world is the responsibility of each individual.					
14. A relationship exists between physical, social, mental and emotional health.					
15. Many careers are available in the area of health.					

3. CONTENT AREAS

A comprehensive school health education curriculum should be based on clearly identified student outcomes in each of the following content areas. Each school district may add, delete, or alter these concepts to meet local needs.

THE TEN GENERALLY ACCEPTED CONTENT AREAS INCLUDE:

CONTENT AREAS:	Current Placement (K-3)	(4-6)	(7-9)	(10-12)	Desired Placement (K-3)	(4-6)	(7-9)	(10-12)	Comments on How Changes Are to Be Accomplished
1. Personal Health a. Cleanliness and grooming habits									
b. Care of teeth, skin, nails and hair									
c. Physical fitness and posture									
d. Rest and sleep									
e. Functions of the body systems: 1) Respiratory									
2) Circulatory									
3) Digestive									
4) Reproductive									
5) Skeletal									
6) Endocrinal									
7) Excretory									
8) Muscular									
9) Nervous									
f. Other									

3. CONTENT AREAS (Cont.)	Current Placement (K-3)	(4-6)	(7-9)	(10-12)	Desired Placement (K-3)	(4-6)	(7-9)	(10-12)	Comments on How Changes Are To Be Accomplished
2. Food and Nutrition:									
a. Eating habits									
b. Balance in diet									
c. Weight control									
d. Food sources									
e. Composition of foods									
f. Food supplements									
g. Food production									
h. Food storage									
i. Food preparation									
j. Food sanitation									
k. Fads and fallacies									
l. Other									
3. Environmental Health:									
a. Causes and prevention of pollution									
b. Implications of population growth									
c. Role and functions of agencies which deal with environment									

3. CONTENT AREAS (Cont.)	Current Placement (K-3)	(4-6)	(7-9)	(10-12)	Desired Placement (K-3)	(4-6)	(7-9)	(10-12)	Comments on How Changes Are To Be Accomplished
d. Factors and issues related to changing environment									
e. Environmental protection agencies									
f. Individuals' responsibility in control of problems									
g. Other									
4. Safety and Survival Skills									
a. Safety and accident prevention measures to be followed at/ with:									
1) Home									
2) School									
3) Playground									
4) Streets/roads									
5) Water									
6) Bicycles									
7) Motorized vehicles									
8) Work									
9) Recreation									
b. Emergency measures and techniques to deal with:									
1) Physical fitness									

3 . CONTENT AREAS (Cont.)	Current Placement (K-3)	(4-6)	(7-9)	(10-12)	Desired Placement (K-3)	(4-6)	(7-9)	(10-12)	Comments on How Changes Are To Be Accomplished
2) Accidents (e.g. CPR and Heimlich method)									
3) Natural disasters									
c. Laws and/or regulations related to safety and accident prevention									
d. Survival skills related to the environment such as:									
1) Weather									
2) Lack of food									
3) Water									
4) Shelter									
5) Being lost									
e. Other									
5. Consumer Health									
a. Classification and selection of available health care and services:									
1) Medical									
2) Dental									
3) Community									
4) Social services related to health									

3. CONTENT AREAS (Cont.)	Current Placement (K-3)(4-6)(7-9)(10-12)	Desired Placement (K-3)(4-6)(7-9)(10-12)	Comments on How Changes Are To Be Accomplished
5) Holistic			
b. Controversial forms of health care such as:			
1) Superstitions			
2) Folk medicine			
3) Quackery			
4) Other			
c. Comparing costs in health care:			
1) Drugs			
2) Insurance			
3) Medical personnel			
4) Hospital			
d. Evaluating commercial appeal of health related products and services			
e. Consumer protection agencies:			
1) Who are they?			
2) Where are they?			
3) What do they do?			
f. Other			
6. Family Life			
a. The family:			
1) Structure			

3. CONTENT AREAS (Cont.)	Current Placement (K-3)	(4-6)	(7-9)	(10-12)	Desired Placement (K-3)	(4-6)	(7-9)	(10-12)	Comments on How Changes Are To Be Accomplished
2) Roles									
3) Responsibilities									
b. Parenting and health promotion: 1) Role									
2) Responsibilities									
3) Privileges									
c. Understanding sexual development and maturation: 1) Normal									
2) Deviant behavior									
d. Other									
7. Substance Use and Nonuse									
a. Knowledge of common substances including opiates, amphetamines, barbituates, tobacco, alcohol, etc.									
b. Effects of tobacco, alcohol and drugs on: 1) Human body									
2) Society									
3) Economics									

3. CONTENT AREAS (Cont.)	Current Placement (K-3)	(4-6)	(7-9)	(10-12)	Desired Placement (K-3)	(4-6)	(7-9)	(10-12)	Comments on How Changes Are To Be Accomplished
c. Referral agencies or personnel for drug users or potential users: 1) Community resources									
2) Hotlines, etc.									
d. Other									
8. Emotional and Social Health									
a. Factors which affect mental health: 1) Social maturity									
2) Emotional maturity									
3) Feelings									
4) Stress									
5) Aging process - death and dying									
6) Peer influence									
7) Self concept									
b. Methods and techniques for dealing with stress									
c. Application of problem-solving skills									
d. Acceptance of responsibility for his/her health as well as for the health of others									

3. CONTENT AREAS (Cont.)	Current Placement (K-3)	(4-6)	(7-9)	(10-12)	Desired Placement (K-3)	(4-6)	(7-9)	(10-12)	Comments on How Changes Are To Be Accomplished
e. Other									
9. Prevention and Control of Disease									
a. Common communicable diseases and disorders									
b. Sexually transmitted diseases									
c. Cause, treatment and prevention of major diseases									
d. Research as it relates to control, prevention and treatment of illness and disease									
e. Individual responsibility									
f. Other									
10. Health Resources and Careers									
a. Role and function of health service agencies in solving community health problems									
b. Career and vocational opportunities within the health field:									
1) Professional careers									
2) Volunteerism									

3. CONTENT AREAS (Cont.)	Current Placement (K-3)	(4-6)	(7-9)	(10-12)	Desired Placement (K-3)	(4-6)	(7-9)	(10-12)	Comments on How Changes Are To Be Accomplished
c. Funds for health									
d. Community resource services									
e. Other									

SUMMARY OF CHANGES NEEDED AND COMMENTS ON HOW THEY ARE TO BE ACCOMPLISHED:

4. INSTRUCTION

Health instruction should make students aware of the importance of health in their daily lives. As a result of such instruction, students should have information upon which to base intelligent decisions and develop skills for applying these decisions in daily living. Health education should be related to life and should go beyond the classroom into the community. It should include in the total program:

INSTRUCTION	Current Placement (K-3)(4-6)(7-9)(10-12)	Desired Placement (K-3)(4-6)(7-9)(10-12)	Comments on how changes to be accomplished:
1. Direct Instruction--direct health instruction is carefully planned, follows a definite course, and is given at a specific time in the regular schedule. Health instruction should stress the development of positive habits and attitudes, not merely the acquisition of knowledge. To be effective, such instruction must be developed from experiences with which students are involved directly. The materials used in the instructional program must be adapted to the needs, interests, and capabilities of the student. Learner processes including decision-making skills, critical thinking, moral reasoning, goal setting, and valuing should be emphasized.			
2. Correlated Instruction--correlated health instruction may be considered collateral or supplementary to direct instruction. Health education is a continuous			

INSTRUCTION (continued)	Current Placement (K-3)(4-6)(7-9)(10-12)	Desired Placement (K-3)(4-6)(7-9)(10-12)	Comments on how changes to be accomplished:
process and no one method of incorporating health education into the curriculum will suffice. All opportunities for providing health information, influencing health behavior, and developing a better understanding of health. should be used. Health education is the product of a variety of experiences in the home, school, and community.			
3. Incidental Instruction--incidental health instruction is the stimulation for learning about health provided in the school, home, and community-at-large outside the regular curriculum of the school. Surely the role of parents is a vital one in developing desired student behavior with respect to health. Ideally, actual community issues, problems and concerns can be used with advantages to enhance direct and correlated health instruction.			

SUMMARY OF CHANGES NEEDED AND COMMENTS ON HOW THEY ARE TO BE ACCOMPLISHED:

5 . EVALUATION

Students, teachers, parents and others should be involved in the evaluative process. The evaluation efforts should relect the various dimensions of health, namely physical, mental, emotional, social, and spiritual values. The evaluation plan should reflect the specific learning experiences which involve the community-at-large. Some possible data sources include:

POSSIBLE SOURCES OF EVALUATIVE DATA	Current Placement (K-3)	(4-6)	(7-9)	(10-12)	Desired Placement (K-3)	(4-6)	(7-9)	(10-12)	Comments on How Changes Are To Be Accomplished
1. Student input concerning the degree to which school health education is meeting personal needs									
2. Teachers involved meet with coordinator on a regular basis for program planning									
3. Achievement information is collected on a regular basis and reported to students, parents, and community									

5. EVALUATION (Cont.)

POSSIBLE SOURCES OF EVALUATIVE DATA	Current Placement (K-3)	(4-6)	(7-9)	(10-12)	Desired Placement (K-3)	(4-6)	(7-9)	(10-12)	Comments on How Changes Are To Be Accomplished
4. Specific Information is sought from school and community leaders (concerning comprehensive health education).									
5. Student self-assessment is structured into the program.									
6. Information is collected for the attainment of each goal/objective.									
7. Students are more aware of health services and products as a result of instructional programs.									
8. The school environment is more healthful as a result of a comprehensive health program.									

5. EVALUATION (Cont.)

POSSIBLE SOURCES OF EVALUATIVE DATA	Current Placement (K-3)	(4-6)	(7-9)	(10-12)	Desired Placement (K-3)	(4-6)	(7-9)	(10-12)	Comments on How Changes Are To Be Accomplished
9. Parents and others in the community are involved with instructional programs.									
10. As health information is increased, student actions concerning health improves.									
11. A review of health records is conducted as one means for assessing the effectiveness of program.									

SUMMARY OF CHANGES NEEDED AND COMMENTS ON HOW THEY ARE TO BE ACCOMPLISHED:

6. Epilogue: COORDINATION AND COOPERATION

For effective health education, the school health education program must be designed to obtain maximum cooperation and coordination within each school and school system, and between each school and the community.

Effective coordination of all phases of the program is essential in promoting the healthful development of all students. The designation of a school person to fulfill the role of health education coordinator is vital to the successful development, coordination and implementation of the program. The coordinator serves as a liaison with parents, community groups, health agencies, and health-interest groups as a communication link within the total school.

Cooperation must exist among school personnel, community health agencies and health professions designed to promote and maintain health. Intelligent home and school care must supplement each other. The vital role of parents in health education should not be ignored by the teachers and the coordinator for comprehensive school health education. Community involvement and cooperation in health education is important for achieving maximum development of each student physically, mentally, spiritually, emotionally, and socially.

It is recommended that a school/community advisory committee be constitued in each district. Such a committee should meet periodically with the school coordinator and the school health education committee. The local committee should develop and maintain a list of local resources (agencies, facilities, and persons) for enriching the local health education program.

APPENDIX 1

SCHOOL HEALTH AND THE IOWA CODE

Following are three references in the Code of Iowa which affect health institutions in Iowa schools. These regulations should be considered in each curriculum committee study and plan for their K-12 program:

1. Legislation and Regulations

A. 257.25(3)

3. The following areas shall be taught in the grades one through six; English-language arts, including reading, handwriting, spelling, oral and written English, and literature; social studies, including geography, history of the United States and Iowa, cultures of other peoples and nations, and American citizenship, including the study of national, state, and local government in the United States; mathematics; science, including conservation of natural resources and environmental awareness; health and physical education, including the effects of alcohol, tobacco, drugs and poisons on the human body; the characteristics of communicable diseases; traffic safety procedures; music; and art.

(Grades 1-6)

B. 257.25(4)

4. The following shall be taught in grades seven and eight as a minimum program; science, including conservation of natural resources and environmental awareness; mathematics; social studies; cultures of other peoples and nations, and

(Grades 7-8)

American citizenship; English-language arts which shall include reading, spelling, grammar, oral and written composition, and may include other communication subjects; health and physical education, including the effects of alcohol, tobacco, drugs and poisons on the human body, the characteristics of communicable diseases, including venereal diseases and current crucial health issues; music and art.

C. 257.25(6)(j)

6. (j) Health education, including an awareness of physical and mental health needs, the effects of alcohol, tobacco, drugs and poisons on the human body, the characteristics of communicable diseases, including venereal diseases and current crucial health issues.

(Grades 9-12)

APPENDIX 2
MODELS FOR PROMOTING A COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM

Initiating and maintaining a comprehensive school health education program is a complex undertaking. Unlike many curriculum areas, health education is included in many traditional departments. An effective school health program involves many people if the program is to be comprehensive and effective.

Figure 1 is a model for organizing programs in school health education. It provides a means for graphically noting the parameters for school health education, the planning, instruction/implementation, and evaluation components, the persons associated with each phase, and the support resources which should be used.

Figure 2 is an interactive model. It illustrates the focus for any program upon the student. It identifies the areas of concern in school health education, as well as the involvement of various individuals and groups. It suggests the complexity of organizing, planning, and conducting an effective program.

School health education must involve a variety of agencies and persons at various levels. It exemplifies well the importance of interdisciplinary approaches and the interdependence of students, teachers, school leaders, professional agencies, educational levels, an community interest groups. Schools contemplating a review of their health education programs are advised to think broadly and to review the organizational and interactive models (Figures 1 and 2) which follow.

Figure 1

Organizational Model for Comprehensive School Health Education in Iowa

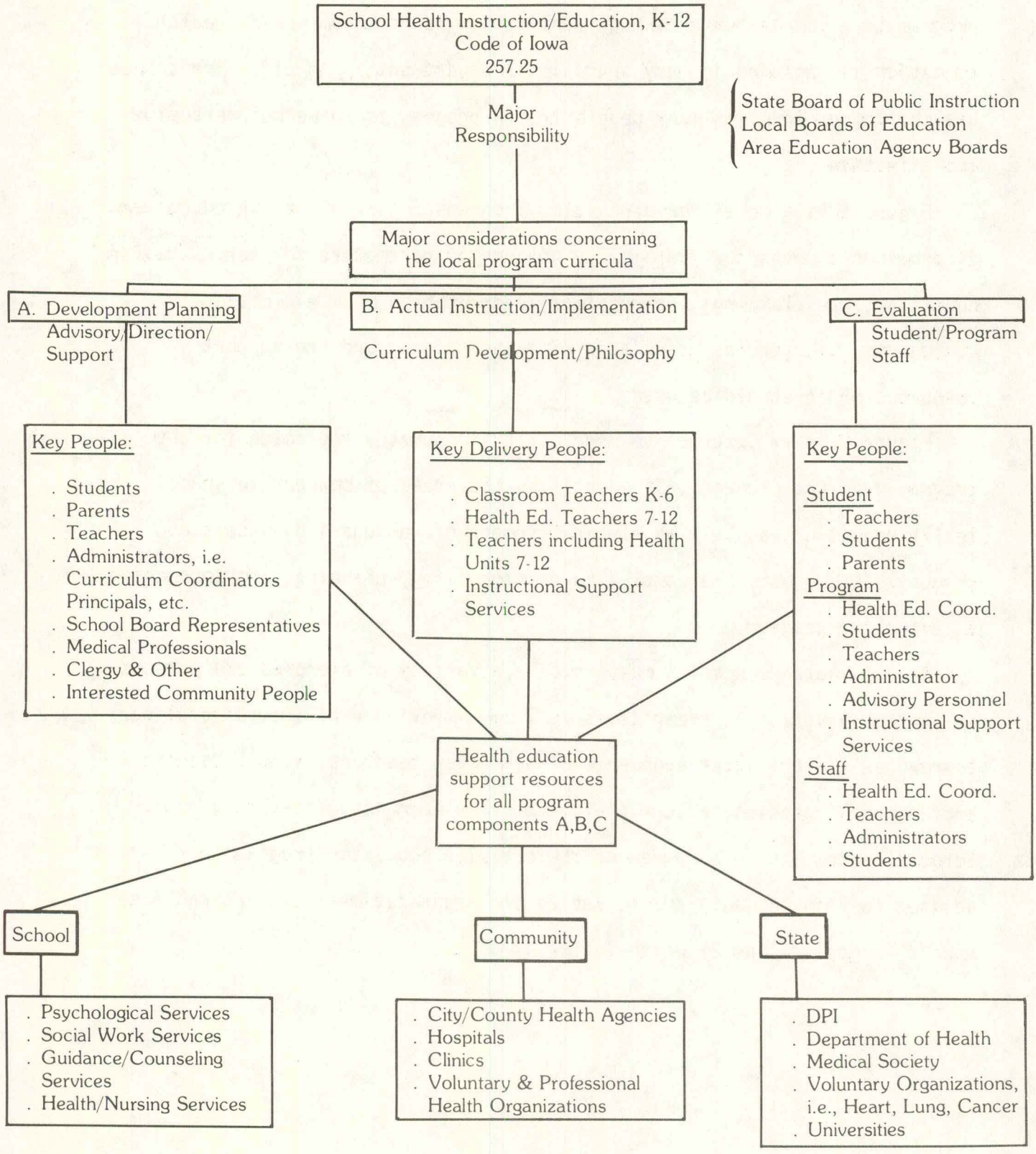
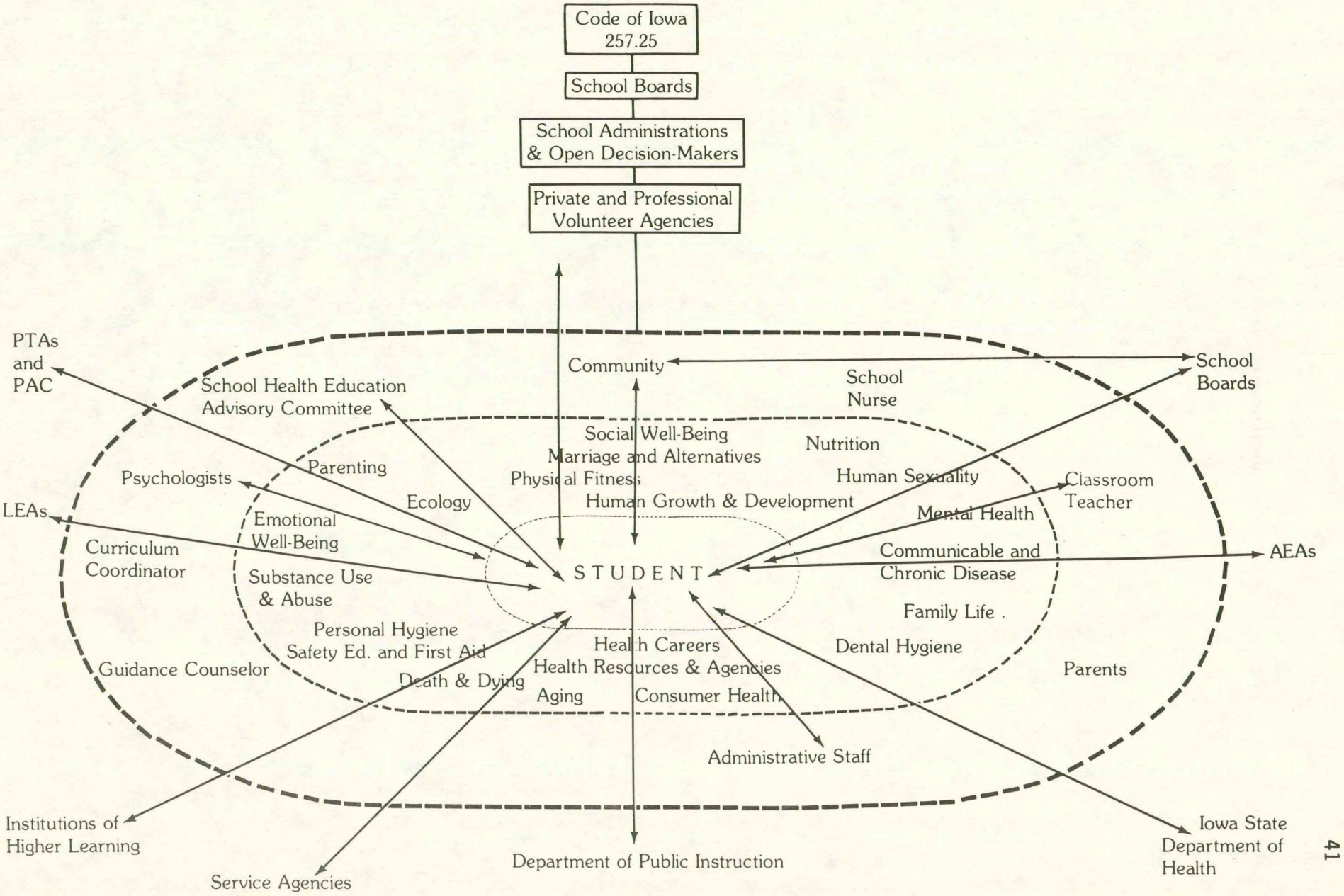


Figure 2

Interaction Model for Comprehensive School Health Education in Iowa



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STATE OF IOWA • DEPARTMENT OF PUBLIC INSTRUCTION
GRIMES STATE OFFICE BUILDING • DES MOINES, IOWA 50319

Iowa
a place to grow

ROBERT D. BENTON, Ed.D., STATE SUPERINTENDENT
David H. Bechtel, M. S., Administrative Assistant
JAMES E. MITCHELL, Ph.D., DEPUTY SUPERINTENDENT

August 17, 1981

Dear Educator:

This is a growing, changing document on Comprehensive School Health Education. It has been designed for Iowa by Iowans. It is hoped that the three-hole punch design will make it flexible so you may add or change the tool as needed. One change is already necessary:

Please remove the 2 green pages 3 and 5 and replace with these enclosed sheets.

Best wishes in assessing and designing your school program.

Sincerely,

Paul L. Kabarec

Paul L. Kabarec
Consultant, Health, Physical
Education and Recreation
Basic Instructional Programs Section

PLK:jh

Enclosures

II. OUTLINE OF SCHEDULE FOR ASSESSING SCHOOL HEALTH EDUCATION PROGRAMS IN IOWA SCHOOLS

The following outline is suggested as a plan for assessing existing curricula for school health education or proposing new ones. Included with the suggested actions is a blank at the right for use in establishing a tentative calendar for the efforts.

Proposed Date

1. Identify K-12 health education coordinator. _____
2. Secure administrative and school board support. _____
3. Identify community advisory group; establish meeting schedule to coordinate with the ongoing effort. _____
4. Select curriculum committee for comprehensive school health education. A curriculum committee with representatives from each of these areas has proven effective: _____

    *Administration (principal, assistant superintendent, curriculum coordinator, etc.)

    *K-12 teacher (all buildings represented) and representatives from sciences, home economics, social studies, physical education, and health education

    *Outside consultant (area education agency, college/university, DPI, etc.)

    *Others [counselors, school nurse, lay person, minority representation according to the Code of Iowa 257.25(11), 670-3.5(25b), etc.]

5. Schedule time and budget for curriculum work. _____
6. Examine local health education needs of students. _____
7. Examine existing school health education programs. _____
8. Review rationale for comprehensive school health education approved by the State Board of Public Instruction (Page 7). _____

9. Review Code of Iowa. (Appendix I Page 37 & 38) _____

10. Review a philosophy for health education (page 8). Using the philosophy statement provided (page 8), the health education curriculum committee should develop a written philosophy for health education specific to local needs. The comprehensive nature of health education and its essential purposes should be a major feature of the statement. The philosophy statement should be duplicated and sent to the entire staff for reaction, additions, deletions and correction. _____

11. Seek input and recommendations from the community advisory committee. _____

12. Examine existing school and/or Board policies that could influence the work of the committee; consider how the curriculum effort can support such existing policies. _____

13. Discuss current trends and problems in health education. It is highly recommended that outside talent be employed to meet with the committee (and others interested in its work) at least once. A knowledgeable consultant should speak with the committee concerning contemporary trends and problems in health education as they relate to the local district. _____

14. Study framework and features for school health education approved by the State Board of Public Instruction (pages 7 through 14). Get feedback from staff and prepare local framework and feature statements. _____

15. Modify goals and objectives in terms of local statements. The health education curriculum committee should modify the goals and objectives provided in the tool (pages 15 through 34). These should represent an ideal curriculum and assure consistency with those developed above (No. 14). Goals and objectives should be added or deleted as appropriate. At this point, the goals and objectives should be duplicated and sent to the entire faculty involved with health education for additions, deletions, reactions and corrections. Teachers' written comments concerning the objectives should be encouraged in the space provided on the extreme right part of the pages (16-34). _____

16. Assess current program in terms of new goals and objectives (pages 15-34). The curriculum committee should have teachers assess the degree to which each objective is emphasized in the present instructional program _____

using pages 15-34. Each health education teacher should decide the degree to which the objective is emphasized in his/her grade level or course by assessing the degree to which each objective is being met. Appropriate designations should be entered on the form. Teachers' written comments concerning placement of the objectives in their present program should be encouraged in the space provided on pages (16-34).

17. Decide on level of revision required. If major weaknesses and duplications are identified in the program, the health education curriculum committee should recommend a major revision. If only isolation weaknesses are identified, the committee may explore supplements to these ideas only. Individual teachers should be encouraged and assisted in improving areas of weaknesses specific to their grade level or course. _____

18. Examine curriculum materials and program in terms of local needs. _____

19. Observe comprehensive school health education programs and procedures in use in other school districts. _____

20. Develop or revise local curriculum program. _____

    a. Introduce revised program and provide teacher in-service. _____

    b. Implement revised program and continue teacher in-service, and in-service new teachers. _____

    c. Evaluate new health education curriculum. _____

    d. Assess student achievement and other indicators of success of the program. _____

    e. Arrange for regular curriculum review; seek input and recommendation from community advisory group. _____