Promoting Better Health for Young People Through Physical Activity and Sports Appendices

A Report to the President From the Secretary of Health and Human Services and the Secretary of Education

Fall 2000

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APPENDIX 1

THE WHITE HOUSE
Office of the Press Secretary
(Chula Vista, California)

For Immediate Release June 23, 2000

MEMORANDUM FOR THE SECRETARY OF HEALTH AND HUMAN SERVICES
THE SECRETARY OF EDUCATION

SUBJECT: Enhancing Efforts to Promote the Health of Our Young People
Through Physical Activity and Participation in Sports

Physical activity and participation in sports are central to the overall health and well-being of children and adults. Adolescence is an especially important time to establish the habit of participation in daily physical activity. Sports and physical activity can introduce young people to skills such as teamwork, self-discipline, and sportsmanship. Lack of recreational activity, on the other hand, may contribute to making young people more vulnerable to gangs, drugs, or violence. Studies consistently show that adolescents who engage in regular physical activity have higher self-esteem and lower anxiety and stress. Unfortunately, daily enrollment in high school physical education classes dropped from 42 percent to 29 percent between 1991 and 1999 and about 14 percent of young people ages 12-21 report no recent physical activity at all. Over the past 30 years, the percentage of young people who are overweight has more than doubled.

The extent of this problem should not be underestimated. Last year, for example, the United States spent over $68 billion, or 6 percent of the Nation's health care expenditures, on direct health care costs related to obesity. According to the landmark 1996 Surgeon General's Report on Physical Activity and Health, inactivity and poor diet contribute to nearly 300,000 deaths in the United States annually. In conjunction with the recent National Nutrition Summit hosted by my Administration -- the first in over three decades -- I released revised Dietary Guidelines for Americans, including a new guideline recommending regular physical activity.

My Administration has an ongoing multi-pronged effort to promote physical activity and fitness. The President's Council on Physical Fitness and Sports Participation continues to play an important role in promoting physical fitness and sports participation nationwide. A key part of the Council's work is the President's Challenge Youth Physical Fitness Awards Program, which offers awards for participation and excellence in a set of physical fitness assessments to encourage 2.9 million students to improve and maintain physical fitness. The Department of Health and Human Services' National Youth Sports Program collaborates with participating colleges to provide summer sports programs in college environments to youth living in areas of urban and rural poverty. Currently, over 70,000 children at over 200 colleges and universities through this program can improve their physical fitness and health habits while becoming acquainted with post-secondary educational opportunities.

The Department of Education also promotes physical activity and health in schools. My Elementary

and Secondary Education Act reauthorization proposal includes "Lifelong Physical Activity" discretionary grants as part of the Safe and Drug-Free Schools and Communities Act. Building on current demonstration projects by the Centers for Disease Control, this initiative would authorize funding for sites to implement programs that promote lifelong physical activity and health awareness during and after school by linking physical education with health education.-

These efforts, and many similar public and private initiatives around the country, are encouraging. We must now build on this groundwork by developing additional strategies for promoting physical fitness and participation in sports, which are essential to improving individual and community health.

Therefore, I direct you to identify and report back to me within 90 days on strategies to promote better health for our Nation's youth through physical activity and fitness, including:

1. Promoting the renewal of physical education in our schools, as well as the expansion of after-school programs that offer physical activities and sports in addition to enhanced academics and cultural activities;
2. Encouraging participation by private sector partners in raising the level of physical activity and fitness among our youth; and
3. Promoting greater coordination of existing public and private resources that encourages physical activity and sports.

In developing these strategies, you shall work with the U.S. Olympic Committee, and other private and nongovernmental sports organizations, as appropriate.

By identifying effective new steps and strengthening public-private partnerships, we will advance our efforts to prepare the Nation's young people for lifelong physical fitness.

WILLIAM J. CLINTON

# # #

A Report of the Surgeon General

Physical Activity and Health

At-A-Glance

1996

A New View of Physical Activity

This report brings together, for the first time, what has been learned about physical activity and health from decades of research. Among its major findings:

- People who are usually inactive can improve their health and well-being by becoming even moderately active on a regular basis.
- Physical activity need not be strenuous to achieve health benefits.
- Greater health benefits can be achieved by increasing the amount (duration, frequency, or intensity) of physical activity.

The Benefits of Regular Physical Activity

Regular physical activity that is performed on most days of the week reduces the risk of developing or dying from some of the leading causes of illness and death in the United States. Regular physical activity improves health in the following ways:

- Reduces the risk of dying prematurely.
- Reduces the risk of dying from heart disease.
- Reduces the risk of developing diabetes.
- Reduces the risk of developing high blood pressure.
- Helps reduce blood pressure in people who already have high blood pressure.
- Reduces the risk of developing colon cancer.
- Reduces feelings of depression and anxiety.
- Helps control weight.
- Helps build and maintain healthy bones, muscles, and joints.
- Helps older adults become stronger and better able to move about without falling.
- Promotes psychological well-being.

A Major Public Health Concern

Given the numerous health benefits of physical activity, the hazards of being inactive are clear. Physical inactivity is a serious, nationwide problem. Its scope poses a public health challenge for reducing the national burden of unnecessary illness and premature death.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
The President's Council on Physical Fitness and Sports

The Nation's Prevention Agency
CDC 50
Centers for Disease Control and Prevention

The President's Council on Physical Fitness and Sports

WHAT IS A MODERATE AMOUNT OF PHYSICAL ACTIVITY?

As the examples listed in the box show, a moderate amount of physical activity* can be achieved in a variety of ways. People can select activities that they enjoy and that fit into their daily lives. Because amount of activity is a function of duration, intensity, and frequency, the same amount of activity can be obtained in longer sessions of moderately intense activities (such as brisk walking) as in shorter sessions of more strenuous activities (such as running):†

EXAMPLES OF MODERATE AMOUNTS OF ACTIVITY

Washing and waxing a car for 45–60 minutes
Washing windows or floors for 45–60 minutes
Playing volleyball for 45 minutes
Playing touch football for 30–45 minutes
Gardening for 30–45 minutes
Wheeling self in wheelchair for 30–40 minutes
Walking 1 $^{3}/_{4}$ miles in 35 minutes (20 min/mile)
Basketball (shooting baskets) for 30 minutes
Bicycling 5 miles in 30 minutes
Dancing fast (social) for 30 minutes
Pushing a stroller 1 $^{1}/_{2}$ miles in 30 minutes
Raking leaves for 30 minutes
Walking 2 miles in 30 minutes (15 min/mile)
Water aerobics for 30 minutes
Swimming laps for 20 minutes
Wheelchair basketball for 20 minutes
Basketball (playing a game) for 15–20 minutes
Bicycling 4 miles in 15 minutes
Jumping rope for 15 minutes
Running 1 $^{1}/_{2}$ miles in 15 minutes (10 min/mile)
Shoveling snow for 15 minutes
Stairwalking for 15 minutes

Less Vigorous, More Time

More Vigorous, Less Time

*A moderate amount of physical activity is roughly equivalent to physical activity that uses approximately 150 Calories (kcal) of energy per day, or 1,000 Calories per week.

†Some activities can be performed at various intensities; the suggested durations correspond to expected intensity of effort.

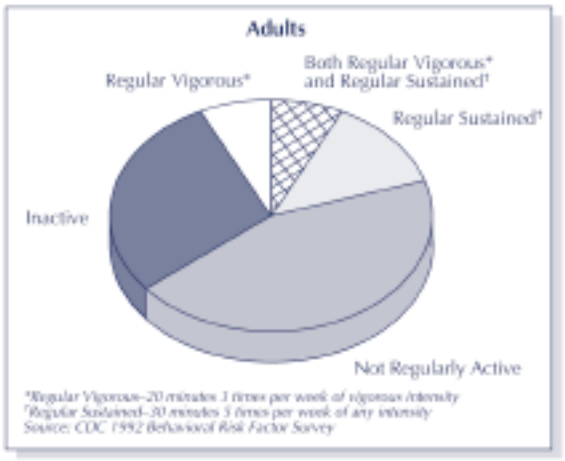
PRECAUTIONS FOR A HEALTHY START

To avoid soreness and injury, individuals contemplating an increase in physical activity should start out slowly and gradually build up to the desired amount to give the body time to adjust. People with chronic health problems, such as heart disease, diabetes, or obesity, or who are at high risk for these problems should first consult a physician before beginning a new program of physical activity. Also, men over age 40 and women over age 50 who plan to begin a new vigorousphysical activity program should consult a physician first to be sure they do not have heart disease or other health problems.

STATUS OF THE NATION—A NEED FOR CHANGE

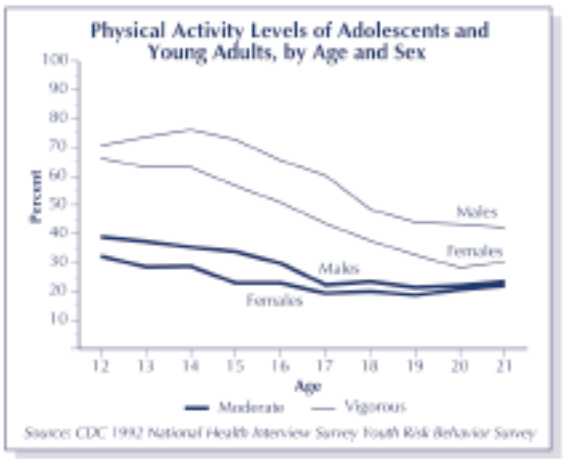
Adults

- More than 60 percent of adults do not achieve the recommended amount of regular physical activity. In fact, 25 percent of all adults are not active at all.
- Inactivity increases with age and is more common among women than men and among those with lower income and less education than among those with higher income or education.



Adolescents and Young Adults

- Nearly half of young people aged 12–21 are not vigorously active on a regular basis.
- Physical activity declines dramatically with age during adolescence.
- Female adolescents are much less physically active than male adolescents.



High School Students

- In high school, enrollment in daily physical education classes dropped from 42 percent in 1991 to 25 percent in 1995.
- Only 19 percent of all high school students are physically active for 20 minutes or more in physical education classes every day during the school week.

IDEAS FOR IMPROVEMENT

This report identifies promising ways to help people include more physical activity in their daily lives.

- Well-designed programs in schools to increase physical activity in physical education classes have been shown to be effective.
- Carefully planned counseling by health care providers and worksite activity programs can increase individuals' physical activity levels.
- Promising approaches being tried in some communities around the nation include opening school buildings and shopping malls for walking before or after regular hours, as well as building bicycle and walking paths separated from automobile traffic. Revising building codes to require accessible stairwells is another idea that has been suggested.

SPECIAL MESSAGES FOR SPECIAL POPULATIONS

Older Adults

No one is too old to enjoy the benefits of regular physical activity. Of special interest to older adults is evidence that muscle-strengthening exercises can reduce the risk of falling and fracturing bones and can improve the ability to live independently.

Parents

Parents can help their children maintain a physically active lifestyle by providing encouragement and opportunities for physical activity. Family events can include opportunities for everyone in the family to be active.

Teenagers

Regular physical activity improves strength, builds lean muscle, and decreases body fat. It can build stronger bones to last a lifetime.

Dieters

Regular physical activity burns Calories and preserves lean muscle mass. It is a key component of any weight loss effort and is important for controlling weight.

People with High Blood Pressure

Regular physical activity helps lower blood pressure.

People Feeling Anxious, Depressed, or Moody

Regular physical activity improves mood, helps relieve depression, and increases feelings of well-being.

People with Arthritis

Regular physical activity can help control joint swelling and pain. Physical activity of the type and amount recommended for health has not been shown to cause arthritis.

People with Disabilities

Regular physical activity can help people with chronic, disabling conditions improve their stamina and muscle strength and can improve psychological well-being and quality of life by increasing the ability to perform activities of daily life.

For more information contact:

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division of Nutrition and Physical Activity, MS K-46
4770 Buford Highway, NE
Atlanta, Georgia 30341
1-888-CDC-4NRG or 1-888-232-4674 (Toll Free)
http://www.cdc.gov

The President's Council on Physical Fitness and Sports
Box SG
Suite 250
701 Pennsylvania Avenue, NW
Washington, DC 20004

Appendix 3

Healthy People 2010 Physical Activity and Fitness Objectives Relevant for Children and Adolescents

- Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days.
- Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion.
- Increase the proportion of children and adolescents who view television 2 or fewer hours per day.
- Increase the proportion of trips made by walking.
- Increase the proportion of trips made by bicycling.
- Increase the proportion of the Nation's public and private schools that require daily physical education for all students.
- Increase the proportion of adolescents who participate in daily physical education.
- Increase the proportion of adolescents who spend at least 50 percent of school physical education class time being physically active.
- Increase the proportion of the Nation's public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours (that is, before and after the school day, on weekends, and during summer and other vacations).
- Increase the proportion of middle, junior high, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health.

Source: U.S. Department of Health and Human Services. Healthy people 2010: understanding and improving health. Washington, DC: U.S. Department of Health and Human Services, Government Printing Office, 2000.

Appendix 4

The Youth Risk Behavior Surveillance System

The Youth Risk Behavior Surveillance System (YRBSS) was developed in 1989 by the Centers for Disease Control and Prevention (CDC) to monitor priority health-risk behaviors that contribute to the leading causes of mortality, morbidity, and social problems among youth and adults in the United States. The YRBSS monitors six categories of behaviors: (1) behaviors that contribute to unintentional injuries and violence; (2) tobacco use; (3) alcohol and other drug use; (4) sexual behaviors that contribute to unintended pregnancy and sexually transmitted disease, including HIV infection; (5) dietary behaviors; and (6) physical activity.

The YRBSS consists of national, state, and local school-based surveys of representative samples of 9th through 12th grade students, a national household-based survey of 12- through 21-year-olds, a national mail survey of college students, and other surveys of special populations of young people. The state and local surveys are conducted by state and local education and health agencies as part of cooperative agreement activities with the Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, CDC. The national surveys are conducted by CDC.

Data from the YRBSS are being used to (1) monitor progress in achieving 16 National Health Objectives for the year 2010 and three Leading Health Indicators, (2) monitor progress in achieving measures of success for the American Cancer Society's school health initiative, (3) focus school health education teacher training and instructional programs, and (4) support school health programs nationwide.

For more information about the YRBSS, visit the YRBSS Web site at http://www.cdc.nccdphp/dash/yrbs

CDC's Guidelines for School and Community Programs

Promoting Lifelong Physical Activity

An Overview

Young people can build healthy bodies and establish healthy lifestyles by including physical activity in their daily lives. However, many young people are not physically active on a regular basis, and physical activity declines dramatically during adolescence. School and community programs can help young people get active and stay active.

BENEFITS OF PHYSICAL ACTIVITY

Regular physical activity in childhood and adolescence

- Improves strength and endurance.
- Helps build healthy bones and muscles.
- Helps control weight.
- Reduces anxiety and stress and increases self-esteem.
- May improve blood pressure and cholesterol levels.

In addition, young people say they like physical activity because it is fun; they do it with friends; and it helps them learn skills, stay in shape, and look better.

CONSEQUENCES OF PHYSICAL INACTIVITY

- The percentage of young people who are overweight has almost doubled in the past 20 years.
- Inactivity and poor diet cause at least 300,000 deaths a year in the United States. Only tobacco use causes more preventable deaths.
- Adults who are less active are at greater risk of dying of heart disease and developing diabetes, colon cancer, and high blood pressure.

Percentage of Young People Who Are Overweight*

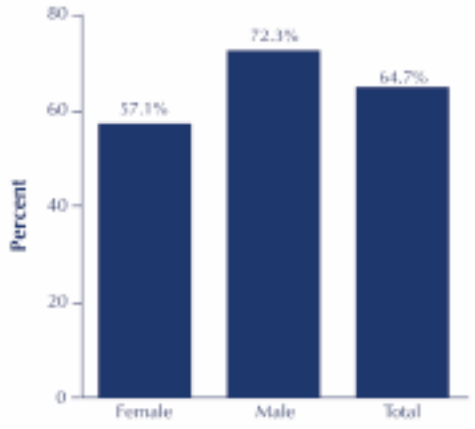
*Overweight defined by the age- and sex-specific 95th percentile of body mass index (1963–70 data).
Source: Troiano RP, Flegal KM. *Pediatrics* 1998;101(3):497–504.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
July 2000

PHYSICAL ACTIVITY AMONG YOUNG PEOPLE

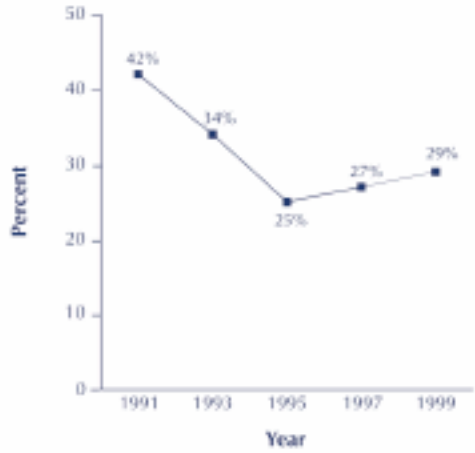
- Sixty-five percent of high school students participate in vigorous physical activity on 3 or more days a week, and 27% participate in moderate physical activity on 5 or more days a week.
- Seventy-three percent of 9th graders but only 61% of 12th graders participate in vigorous physical activity on a regular basis.
- Fifty-six percent of high school students are enrolled in a physical education class; daily participation in physical education classes by high school students dropped from 42% in 1991 to 29% in 1999.
- Male high school students are significantly more likely than female students to regularly participate in vigorous physical activity (72% vs. 57%) and in moderate physical activity (29% vs. 24%), and to participate in team sports (62% vs. 49%).

Percentage of High School Students Who Participate in Vigorous Physical Activity,* by Sex



*Activities that caused sweating and hard breathing for at least 20 minutes on 3 or more of the 7 days preceding the survey.
Source: CDC, National Youth Risk Behavior Survey, 1999.

Percentage of High School Students Who Attended Physical Education Classes Daily, 1991–1999



Source: CDC, National Youth Risk Behavior Survey.

HOW MUCH PHYSICAL ACTIVITY DO YOUNG PEOPLE NEED?

Everyone can benefit from a moderate amount of physical activity on most, if not all, days of the week. Young people should select activities they enjoy that fit into their daily lives. Examples of moderate activity include

- Walking 2 miles in 30 minutes or running 1½ miles in 15 minutes.
- Bicycling 5 miles in 30 minutes or 4 miles in 15 minutes.
- Dancing fast for 30 minutes or jumping rope for 15 minutes.
- Playing basketball for 15–20 minutes or volleyball for 45 minutes.

Increasing the frequency, time, or intensity of physical activity can bring even more health benefits—up to a point. Too much physical activity can lead to injuries and other health problems.

CDC's Guidelines for Promoting Lifelong Physical Activity

CDC's Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People *were developed in collaboration with experts from other federal agencies, state agencies, universities, voluntary organizations, and professional associations. They are based on an extensive review of research and practice.*

KEY PRINCIPLES

The guidelines state that physical activity programs for young people are most likely to be effective when they

- Emphasize enjoyable participation in physical activities that are easily done throughout life.
- Offer a diverse range of noncompetitive and competitive activities appropriate for different ages and abilities.
- Give young people the skills and confidence they need to be physically active.
- Promote physical activity through all components of a coordinated school health program and develop links between school and community programs.

RECOMMENDATIONS

The guidelines include 10 recommendations for ensuring quality physical activity programs.

1 Policy

Establish policies that promote enjoyable, lifelong physical activity.

- Schools should require daily physical education and comprehensive health education (including lessons on physical activity) in grades K–12.
- Schools and community organizations should provide adequate funding, equipment, and supervision for programs that meet the needs and interests of all students.

2 Environment

Provide physical and social environments that encourage and enable young people to engage in safe and enjoyable physical activity.

- Provide access to safe spaces and facilities and implement measures to prevent activity-related injuries and illnesses.
- Provide school time, such as recess, for unstructured physical activity, such as jumping rope.
- Discourage the use or withholding of physical activity as punishment.
- Provide health promotion programs for school faculty and staff.

3 Physical Education Curricula and Instruction

Implement sequential physical education curricula and instruction in grades K–12 that

- Emphasize enjoyable participation in lifetime physical activities such as walking and dancing, not just competitive sports.
- Help students develop the knowledge, attitudes, and skills they need to adopt and maintain a physically active lifestyle.
- Follow the National Standards for Physical Education.
- Keep students active for most of class time.

4 Health Education Curricula and Instruction

Implement health education curricula and instruction that

- Feature active learning strategies and follow the National Health Education Standards.
- Help students develop the knowledge, attitudes, and skills they need to adopt and maintain a healthy lifestyle.

5 Extracurricular Activities

Provide extracurricular physical activity programs that offer diverse, developmentally appropriate activities—both noncompetitive and competitive—for all students.

6 Family Involvement

Encourage parents and guardians to support their children's participation in physical activity, to be physically active role models, and to include physical activity in family events.

7 Training

Provide training to enable teachers, coaches, recreation and health care staff, and other school and community personnel to promote enjoyable, lifelong physical activity among young people.

8 Health Services

Assess the physical activity patterns of young people, refer them to appropriate physical activity programs, and advocate for physical activity instruction and programs for young people.

9 Community Programs

Provide a range of developmentally appropriate community sports and recreation programs that are attractive to all young people.

10 Evaluation

Regularly evaluate physical activity instruction, programs, and facilities.

This brochure and CDC's *Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People* can be reproduced and adapted without permission. The guidelines can be downloaded from the Internet at http://www.cdc.gov/nccdphp/dash/physact.htm. Print copies are available from the Division of Adolescent and School Health's Information Service, P.O. Box 9017, Silver Spring, MD 20907; phone: 888-231-6405, fax: 888-282-7681; E-mail: HealthyYouth@cdc.gov. CDC's Division of Adolescent and School Health also distributes guidelines for school health programs on preventing the spread of AIDS, promoting lifelong healthy eating, and preventing tobacco use and addiction.

Appendix 6

Classroom Health Education

Classroom health education, which includes instruction on physical activity topics, complements the instruction students receive in physical education. CDC's *Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People*[1] recommends that schools

- Provide planned and sequential health education curricula from kindergarten through grade 12 that promote health literacy including lifelong participation in physical activity.
- Use curricula consistent with the national standards for health education.
- Promote collaboration among physical education, health education, and classroom teachers.
- Use active learning strategies to emphasize enjoyable participation in physical activity in the school, community, and home.
- Develop students' mastery of and confidence in the self-management skills (e.g., self-assessment, self-monitoring, goal setting) needed to adopt and maintain a physically active lifestyle.
- Have credentialed or certified health educators teach health education courses.

Classroom health education also should give students the knowledge and skills they need to avoid a sedentary lifestyle that includes excessive use of electronic media. Preliminary research findings indicate that classroom education designed to encourage students to reduce the amount of time they spend watching television is a promising approach to reducing obesity among children and adolescents.[2,3] *Healthy People 2010*[4] includes a national health objective to increase the proportion of schools that provide comprehensive health education to prevent a number of health problems, including inadequate physical activity.

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1. Centers for Disease Control and Prevention. Guidelines for school and community programs to promote lifelong physical activity among young people. Morbidity & Mortality Weekly Report 1997;46(RR-6):1-36.
2. Gortmaker SL, Peterson K, Wiecha J, Sobol AM, Dixit S, Fox MK, Laird N. Reducing obesity via a school-based interdisciplinary intervention among youth: Planet Health. Archives of Pediatrics & Adolescent Medicine 1999;153(4):409-18.
3. Robinson TN. Reducing children's television viewing to prevent obesity: a randomized controlled trial. Journal of the American Medical Association 1999;282(16):1561-7.
4. U.S. Department of Health and Human Services. Healthy people 2010: understanding and improving health. Washington, DC: U.S. Department of Health and Human Services, Government Printing Office, 2000.

Appendix 7

Recess Periods

Recess periods, which are regularly scheduled periods within the elementary school day for unstructured physical activity and play, provide another opportunity for daily physical activity, along with social and cognitive benefits. Some large school districts have, in recent years, eliminated recess altogether, reportedly due to safety concerns and a desire to increase time for academic instruction. However, studies have found that (1) students who do not participate in recess become fidgety and less able to concentrate on tasks and (2) the longer children sit in classrooms without a recess break, the less attentive they become. Recess also offers students one of their few opportunities during the school day to interact and develop social skills, such as negotiating and cooperating, with minimal adult interference. The National Association of Elementary School Principals has endorsed recess as "an important component in a child's physical and social development."

To make recess periods effective, schools should

- Have enough trained adults on hand to enforce safety rules and prevent aggressive, bullying behavior.
- Work with police departments and community agencies to address safety concerns about children playing in school playgrounds in high-crime areas.
- Provide space, facilities, equipment, and supplies that can make active participation in physical activity during recess appealing to children.
- Have staff encourage students to be active during recess.
- Schedule recess before, rather than after, lunch; studies have found that students eat more of their lunches when recess comes before lunch.

Source: Wechsler H, Devereaux AB, Davis M, Collins J. Using the school environment to promote physical activity and healthy eating. Preventive Medicine 2000;31:S121-S137.

Appendix 8

Extracurricular Physical Activity Programs

Extracurricular physical activity programs provide students with additional opportunities to be active and to use the skills taught in physical education class. They also offer important social and psychological benefits: Studies have found that participation in extracurricular activities is negatively associated with tobacco and other drug use and positively associated with good conduct, academic achievement, and staying in school.

Extracurricular opportunities to engage in physical activity may be interscholastic or intramural. Interscholastic sports programs consist of team or individual competition between schools, and intramural programs consist of sports and recreational activities, both competitive and non-competitive, among students within one school. At present, interscholastic sports programs, which serve only a small portion of the student body, are more commonly available than intramural programs.

In keeping with a more inclusive approach to promoting physical activity, all schools should offer quality intramural programs that feature a diverse selection of competitive and non-competitive, structured and unstructured activities that meet the needs, interests, and abilities of all students. In addition to team sports, intramural programs could include physical activity clubs (e.g., dance, hiking, yoga). Because they can be designed for students with a wide range of abilities, intramural programs may be beneficial for the large group of students who have not participated much in physical activity: boys and girls who lack the skills or confidence to play interscholastic sports or who dislike competitive sports altogether. Whereas interscholastic sports emphasize competition and winning, intramurals emphasize participation and enjoyment without pressure. However, to promote physical activity among young people, high schools should continue to offer interscholastic sports programs.

Source: Wechsler H, Devereaux AB, Davis M, Collins J. Using the school environment to promote physical activity and healthy eating. Preventive Medicine 2000;31:S121-S137.

Appendix 9

Why Children Need Physical Education

Well-planned, well-implemented physical education programs can

- Improve physical fitness.
- Reinforce knowledge learned in other subject areas such as science, math, and social studies.
- Facilitate development of student self-discipline and responsibility for health and fitness.
- Develop motor skills that allow for safe, successful, and satisfying participation in physical activities.
- Give children the opportunity to set and strive for personal, achievable goals.
- Influence moral development by providing students with opportunities to assume leadership, cooperate with others, and accept responsibility for their own behavior.
- Help children become more confident, assertive, independent, and self-controlled.
- Provide an outlet for releasing tension and anxiety.
- Help children socialize with others more successfully.

Source: National Association for Sport and Physical Education. Sport and physical education advocacy kit (SPEAK) II. Reston, VA: National Association for Sport and Physical Education, 1999.

Appendix 10

Characteristics of Quality Physical Education

Quality physical education

- Emphasizes knowledge and skills for a lifetime of physical activity.
- Is based on national standards that define what students should know and be able to do.
- Keeps students active for most of class time.
- Provides many different physical activity choices.
- Meets needs of **all** students, especially those who are not athletically gifted.
- Features cooperative, as well as competitive, games.
- Develops student self-confidence and eliminates practices that humiliate students (e.g., having team captains choose sides, dodgeball and other games of elimination).
- Assesses students on their progress in reaching goals, not on whether they achieve an absolute standard.
- Promotes physical activity outside of school.
- Teaches self-management skills, such as goal-setting and self-monitoring.
- Focuses, at the high school level, on helping adolescents make the transition to a physically active adult lifestyle.
- Actively teaches cooperation, fair play, and responsible participation in physical activity.
- Is an enjoyable experience for students.

Source: Centers for Disease Control and Prevention.

Content Standards for Physical Education

The Physically Educated Person:

1. Demonstrates competency in many movement forms and proficiency in a few movement forms.
2. Applies movement concepts and principles to the learning and development of motor skills.
3. Exhibits a physically active lifestyle.
4. Achieves and maintains a health-enhancing level of physical fitness.
5. Demonstrates responsible personal and social behavior in physical activity settings.
6. Demonstrates understanding and respect for differences among people in physical activity settings.
7. Understands that physical activity provides opportunities for enjoyment, challenge, self-expression, and social interaction.

Resources

Published by NASPE/AAHPERD to support quality physical education programs. Available for purchase by calling 1-800-321-0789.

Moving into the Future: National Standards for Physical Education, A Guide to Content and Assessment, 1995. Four Parts:
- Full Document
- Introduction
- Poster
- Flyer

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NASPE, an association of the American Alliance for Health, Physical Education, Recreation and Dance (AAHPERD), is a non-profit membership organization.

Printed by Mosby-Year Book, Inc.

Book code: 28259

National Association for Sport and Physical Education

Moving Into The Future

National Standards for Physical Education

NASPE
1900 Association Drive
Reston, VA 22091-1599
(703)476-3410

The Development of Standards for School Physical Education: An Overview

To answer the question, "What should students know and be able to do?" in physical education, the Outcomes Committee of the National Association for Sport and Physical Education developed the *Outcomes of Quality Physical Education* (1992).

This document defined a physically educated person, expanded that definition by identifying twenty outcomes for physical education, and provided sample benchmarks for grades K-12 in two-year intervals. Following publication, the NASPE Standards and Assessment Task Force was appointed to develop content standards and assessment material based on the Outcomes work.

The work of the Task Force is consistent with the national reform movement in education, calling for the establishment of national content standards for each area of the school curriculum. The identification of content standards and the further clarification of what quality physical education should provide to students is the basis for addressing authentic assessment in physical education. *Moving Into The Future: National Standards for Physical Education* establishes a blue print for building quality physical education programs. It is not a curriculum, but rather a guide for the development of curricula that best address situational needs.

This first ever document provides a general description of each content standard followed by the presentation of standards for grades K-12 in two-year intervals. Also included with each grade level standard are suggested benchmarks and assessment examples.

Definition of a Physically Educated Person

The Physically Educated Person:

- **HAS** learned skills necessary to perform a variety of physical activities

  1. ...moves using concepts of body awareness, space awareness, effort and relationships.
  2. ...demonstrates competence in a variety of manipulative, locomotor and nonlocomotor skills.
  3. ...demonstrates competence in combinations of manipulative, locomotor and nonlocomotor skills performed individually and with others.
  4. ...demonstrates competence in many different forms of physical activity.
  5. ...demonstrates proficiency in a few forms of physical activity.
  6. ...has learned how to learn new skills.

- **IS** physically fit

  7. ...assesses, achieves and maintains physical fitness.
  8. ...designs safe, personal fitness programs in accordance with principles of training and conditioning.

- **DOES** participate regularly in physical activity

  9. ...participates in health enhancing physical activity at least three times a week.
  10. ...selects and regularly participates in lifetime physical activities.

- **KNOWS** the implications of and benefits from involvement in physical activities

  11. ...identifies the benefits, costs and obligations associated with regular participation in physical activity.
  12. ...recognizes the risk and safety factors associated with regular participation in physical activity.
  13. ...applies concepts and principles to the development of motor skills.
  14. ...understands that wellness involves more than being physically fit.
  15. ...knows the rules, strategies and appropriate behaviors for selected physical activities.
  16. ...recognizes that participation in physical activity can lead to multi-cultural and international understanding.
  17. ...understands that physical activity provides the opportunity for enjoyment, self-expression and communication.

- **VALUES** physical activity and its contribution to a healthful lifestyle

  18. ...appreciates the relationships with others that result from participation in physical activity.
  19. ...respects the role that regular physical activity plays in the pursuit of lifelong health and well-being.
  20. ...cherishes the feelings that result from regular participation in physical activity.

Appendix 12

Suggested Instructional Themes in Physical Education

- Physical, social, and mental health benefits of lifelong physical activity and physical fitness.
- Development of motor skills.
- Competency in movement forms.
- Components of health-related fitness.
- Phases of a workout.
- How much physical activity is enough.
- Safe and unsafe weight management and conditioning practices.
- Balancing food intake and physical activity.
- Personal assessment of one's own health-related fitness.
- Development of safe and effective personal activity plans.
- Monitoring progress toward achieving personal activity goals.
- Social aspects of physical activity including practicing responsible behaviors.
- Overcoming barriers to physical activity.
- How to find valid information or services related to physical activity and fitness.
- Opportunities for physical activity in the community.
- Dangers of using performance-enhancing drugs such as steroids.
- Weather-related safety.
- Disease and injury prevention and proper emergency response.

Source: National Association of State Boards of Education. Fit, healthy and ready to learn: a school health policy guide; Part I: physical activity, healthy eating and tobacco-use prevention. Alexandria, VA: National Association of State Boards of Education, 2000.

SHAPE OF THE NATION

Executive Summary

SPEAK III
SPORT AND PHYSICAL EDUCATION ADVOCACY KIT II

Purpose

The purpose of the Shape of the Nation Survey, which was last conducted in 1993, is to determine the availability and mandate for physical education programs in each state, provide an overview of who is teaching physical education and the requirements for students taking physical education in each state. To purchase the full Shape of the Nation document, call 1-800-321-0789.

Method

During the summer of 1997 NASPE sent a questionnaire to physical education consultants in all 50 state Departments of Education. Consultants were asked about the state mandate for physical education at the elementary, middle and secondary school levels, acceptance of substitutions, time allocation, qualification directives for teaching physical education, and issues and concerns. Follow-up phone calls were made to complete responses to the survey. All 50 states provided complete information for the survey. All information was returned to state Departments of Education for verification after it had been compiled and interpreted.

Results

Most states are not living up to recommendations of the *U.S. Surgeon General's Report on Physical Activity and Health* and Centers for Disease Control and Prevention to require daily physical education for all students in kindergarten through 12th grade. That is the major finding of the Shape of the Nation Report, which was conducted by the National Association for Sport and Physical Education (NASPE).

Forty-seven states (the same amount as in 1993) have state mandates for physical education.

As reported in 1993, Illinois is still the only state that requires daily physical education for all students, K-12. Alabama and Washington require daily physical education for all students K-8.

At the elementary school level, where mandated by the state, physical education time requirements range from 50 minutes a week to 200 minutes per week.

At the middle school level, where mandated by the state, physical education time requirements range from 55 minutes a week to 275 minutes per week.

The majority of high school students take physical education for only one year between 9th and 12th grades.

Ten years after the U.S. Congress passed Resolution 97 encouraging state and local governments and local educational agencies to provide high quality daily physical education programs for all children in kindergarten through grade 12, no progress has been made. This is despite concerns about the health of our nation's children and youth and the federal government calls for daily physical education programs for all students, kindergarten through 12th grade.

Other highlights include:

Only Illinois requires all students to take a specific amount of physical education in all grades, K-12. *In 1993 four states (Illinois, Hawaii, Kentucky, and Rhode Island) required all students to take a specific amount of physical education in all grades, K-12.*

Three states *(the same amount as in 1993)* do not have any state mandates relating to physical education. All requirements are left to the individual school districts. They are Colorado (now a local control state), Mississippi and South Dakota. Arizona, which did not have a mandate in 1993, does now have a mandate.

Only a few states do not require continuing education credits to maintain teacher certification. In some states the individual school districts either set or may add to the state requirement for continued teacher certification. The majority of states required five or six credit hours every five years to maintain teacher certification in physical education. This is the same requirement as in other fields of study.

Elementary Highlights:

Only certified physical education teachers teach physical education in Delaware, Idaho, Illinois, Michigan, Missouri, Nevada, and South Dakota.

Only classroom teachers teach physical education in California, Hawaii, Oklahoma and Washington.

In the remaining 39 states, both certified physical education specialists and classroom teachers teach physical education.

Middle School Highlights:

In 38 states certified physical education specialists teach physical education at the middle school level.

In 11 states (Alaska, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, New Hampshire, New Jersey, Oklahoma and Washington) certified physical education specialists and classroom teachers teach middle school physical education.

In Alabama, certified physical education specialists and physical education aides teach physical education.

Secondary School Highlights:

Certified physical education specialists teach physical education at the secondary school level in 46 states.

Certified physical education specialists and classroom teachers teach physical education at the secondary level in four states (Alaska, Massachusetts, Oklahoma and Oregon).

The majority of states – 19 (Alabama, Alaska, Connecticut, Delaware, Hawaii, Idaho, Indiana. Iowa, Kansas, Maine, Missouri, Montana, New Hampshire, New Mexico, North Carolina, North Dakota, Oregon, South Carolina, and West Virginia) require one unit or one year of physical education during 9th through 12th grades.

Two units or two years are required in six states (California, Nebraska, Nevada, New York, Virginia and Washington. Other requirements include zero units (Oklahoma, South Dakota and Tennessee); 1/2 unit (Arkansas, Florida, Georgia, Kentucky, Maryland and Ohio); and 1 1/2 units (Louisiana, Texas, Utah, Vermont and Wisconsin). The graduation requirements for the remaining 11 states are set by the local school districts.

Sixty-eight percent of the states (34) give a grade for physical education and include it in the grade point average. California does not include the physical education grade in the grade point average. The remainder of the states (13) decide at the local school district level if grades are included in the students' grade point average.

Forty-six percent of the states (23) do not allow any substitutions for physical education.

Forty-two percent of the states (21) allow substitutions for physical education. These may include medical reasons, religious, varsity athletics, ROTC and marching band. The remaining states make substitution options at the local school district level.

In the comments section, the answers varied quite a bit. Several states expressed very positive signs of physical education growth in their states. Others expressed concerns over the physical conditions of their students and the fact that students are allowed to avoid physical education by participating in other courses, activities, etc. One state feared that the requirement for physical education may be dropped. Most believed that physical educators need to get more involved at all levels to ensure positive physical education programs for all states in the future.

Recommendations for Action

Regarding physical education, the National Association for Sport and Physical Education (NASPE) recommends the following:

1. All students K-12 receive quality, regular physical education.
2. Elementary school children receive a minimum of 150 minutes per week of instructional physical education; middle and high school students receive a minimum of 225 minutes per week of instructional physical education.
3. All states require comprehensive physical education as part of their core curriculum and set minimum standards of achievement for each grade level.
4. Meeting standards for physical education be a requirement for graduation.
5. Other courses and activities that may include physical exercise should not be substituted for instructional physical education.
6. Teachers who are specially trained in physical education deliver physical education instruction at all levels.
7. All sport coaches be certified/licensed teachers and have additional education and certification for coaching.
8. Physical education programs be designed to facilitate achievement of the national standards for physical education.

Appendix 14

National Standards for Beginning Physical Education Teachers

Standard 1—Content Knowledge

The teacher understands physical education content, disciplinary concepts, and tools of inquiry related to the development of a physically educated person.

Standard 2—Growth and Development

The teacher understands how individuals learn and develop, and can provide opportunities that support their physical, cognitive, social, and emotional development.

Standard 3—Diverse Learners

The teacher understands how individuals differ in their approaches to learning and creates appropriate instruction adapted to diverse learners.

Standard 4—Management and Motivation

The teacher uses an understanding of individual and group motivation and behavior to create a learning environment that encourages positive social interaction, active engagement in learning, and self-motivation.

Standard 5—Communication

The teacher uses knowledge of effective verbal, nonverbal, and media communication techniques to foster inquiry, collaboration, and engagement in physical activity settings.

Standard 6—Planning and Instruction

The teacher plans and implements a variety of developmentally appropriate instructional strategies to develop physically educated individuals.

Standard 7—Learner Assessment

The teacher understands and uses formal and informal assessment strategies to foster physical, cognitive, and social and emotional development of learners in physical activity.

Standard 8—Reflection

The teacher is a reflective practitioner who evaluates the effects of his/her actions on others (e.g., learners, parents/guardians, and other professionals in the learning community) and seeks opportunities to grow professionally.

Standard 9—Collaboration

The teacher fosters relationships with colleagues, parents/guardians, and community agencies to support learners' growth and well-being.

Source: Beginning Teacher Standards Task Force of the National Association for Sport and Physical Education. National standards for beginning physical education teachers. Reston, VA: National Association for Sport and Physical Education, 1995.

Appendix 15

Adapted Physical Education National Standards

Standard 1 HUMAN DEVELOPMENT
The foundation of proposed goals and activities for individuals with disabilities is grounded in a basic understanding of human development and its applications to those with various needs.

Standard 2 MOTOR BEHAVIOR
Teaching individuals with disabilities requires knowledge of typical physical and motor development as well as understanding the influence of developmental delays on these processes.

Standard 3 EXERCISE SCIENCE
The focus of this standard is on the principles that address the physiological and biomechanical applications encountered when working with diverse populations.

Standard 4 MEASUREMENT AND EVALUATION
Understanding the measurement of motor performance is, to a large extent, based on a good grasp of motor development and the acquisition of motor skills covered in other standards.

Standard 5 HISTORY AND PHILOSOPHY
This standard traces legal and philosophical factors involved in current day practices in adapted physical education (APE). A review of history and philosophy related to special and general education is also covered.

Standard 6 UNIQUE ATTRIBUTES OF LEARNERS
This standard refers to information based on the disability areas found in the Individuals with Disabilities Education Act (IDEA).

Standard 7 CURRICULUM THEORY AND DEVELOPMENT
Certain curriculum theory and development concepts, such as selecting goals based on relevant and appropriate assessment, must be understood.

Standard 8 ASSESSMENT
Assessment goes beyond data gathering to include measurements for the purpose of making decisions about special services and program components for individuals with disabilities.

Standard 9 INSTRUCTIONAL DESIGN AND PLANNING
Instructional design and planning must be developed before an APE teacher can provide services to meet legal mandates, educational goals and, most importantly, the unique needs of individuals with disabilities.

Standard 10 TEACHING
Many of the principles addressed earlier in such standard areas as human development, motor behavior, and exercise science, are applied to this standard to effectively provide quality physical education to individuals with disabilities.

Standard 11 CONSULTATION AND STAFF DEVELOPMENT
This standard identifies key competencies an adapted physical educator should know related to consultation and staff development.

Standard 12 STUDENT AND PROGRAM EVALUATION
Program evaluation involves evaluation of the entire range of educational services.

Standard 13 CONTINUING EDUCATION
This standard focuses on ways teachers of APE can remain current in their field.

Standard 14 ETHICS
This standard has been developed to ensure that teachers of APE not only understand the importance of sound ethical practices, but also adhere to and advance such practices.

Standard 15 COMMUNICATION
This standard includes information on how to effectively communicate with families and other professionals, using a team approach to enhance service delivery to individuals with disabilities.

A team made up of members of different groups within the school—parents, teachers, students, administrators, and other staff—and concerned community members is responsible for completing a questionnaire for each module. Responses to each questionnaire are scored to help you identify your school's strengths and weaknesses. The School Health Index also includes a Planning for Improvement section that helps schools use their Index scores to develop an action plan for each module and for the school as a whole.

The School Health Index is available at no cost and can be completed in as little as 5 hours. Many of the improvements that you'll want to make after completing the Index can be done with existing staff and resources. A small investment of time can pay big dividends in improving students' well-being, readiness to learn, and prospects for a healthy life.

To obtain a copy of the School Health Index, choose one of the following options:

- Download from CDC web sites:
  http://www.cdc.gov/nccdphp/dash
  or
  http://www.cdc.gov/nccdphp/dnpa
- Request by e-mail: ccdinfo@cdc.gov
- Call the CDC Division of Adolescent and School Health Resource Room: 770-488-3168
- Request by toll-free fax: 888-282-7681

When ordering, please specify either the elementary school version or the middle school/high school version.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention (CDC)
Atlanta, GA 30333

Official Business
Penalty for Private Use $300
Return Service Requested

SHI

School Health Index

FOR PHYSICAL ACTIVITY AND HEALTHY EATING

A Self-Assessment and Planning Guide

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

Helping Students Get Ready to Learn

Promoting healthy behaviors among students is an important part of the fundamental mission of schools: to help young people acquire the knowledge and skills to become healthy and productive adults. By promoting healthy behaviors, schools can increase students' capacity to learn, reduce absences, and improve physical fitness and mental alertness.

To help schools meet this challenge, the Centers for Disease Control and Prevention (CDC) has developed the School Health Index. This self-assessment and planning tool will enable you to:

- Identify the strengths and weaknesses of your school's health promotion policies and programs.
- Develop an action plan for improving student health.
- Involve teachers, parents, students, and the community in improving school services.

Focusing on Key Health Behaviors: Physical Activity and Healthy Eating

The following six health risk behaviors are largely responsible for the leading causes of death and illness among young people and adults in the United States:

- Physical inactivity.
- Poor eating habits.
- Tobacco use.
- Sexual behaviors that result in HIV infection, other sexually transmitted diseases, or unintended pregnancy.
- Behaviors that result in intentional or unintentional injury.
- Abuse of alcohol and other drugs.

Because these behaviors are often established in childhood, positive choices need to be promoted early in life. The first version of the School Health Index addresses physical activity and healthy eating. Future versions will also address other key health behaviors.

Here Are the Facts . . .

- Regular physical activity helps build and maintain healthy bones and muscles and reduce fat, but nearly half of young people aged 12–21 years do not engage in physical activity on a regular basis.
- Research suggests that skipping breakfast can affect children's intellectual performance, and even moderate undernutrition can have lasting effects on cognitive development. Children who are hungry are more likely to have behavioral, emotional, and academic problems at school.
- Less than one in three children and adolescents meets dietary recommendations for limiting intake of saturated fat, less than one in five eats enough fruits and vegetables, and less than one in five adolescent girls has an adequate intake of calcium.
- The percentage of children and adolescents who are overweight has almost doubled since 1980: about 11% are now overweight. Overweight children are more likely to have high blood pressure, high cholesterol, and high insulin levels. They are also more likely to become overweight adults, who are at increased risk for heart disease and diabetes.

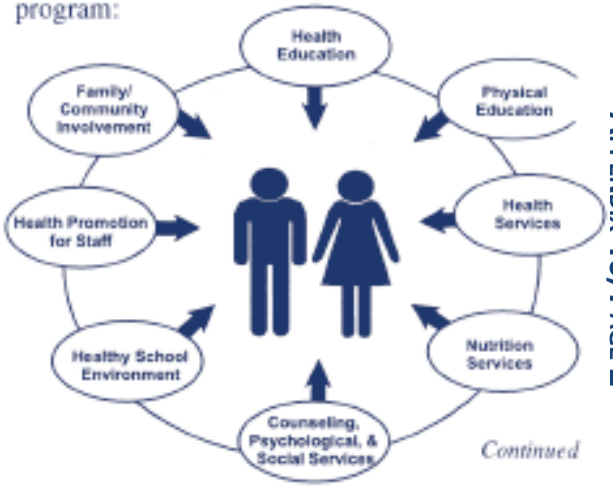
What the School Health Index Can Do for Your School

The School Health Index will provide structure and direction to your school's efforts to improve health promotion policies and programs. School administrators and staff who have used the Index have said:

- *"The School Health Index was easy to use and enabled us to clearly identify what is working and what needs to be improved."*
- *"It's a real energizer—it makes you think of ideas that are relatively easy to implement."*
- *"The school staff had a very positive attitude toward the Index. They liked its comprehensive view of health promotion and its involvement of many different stakeholders."*
- *"The School Health Index can help every school become a center for a healthier, more physically fit community."*

How the School Health Index Works

The physical activity and eating habits of students are influenced by the entire school environment, not just the cafeteria and gymnasium. Therefore, the Index has eight different modules, each corresponding to a component of a coordinated school health program:



Continued

Appendix 17

Fit, Healthy, and Ready to Learn: A School Health Policy Guide

Fit, Healthy, and Ready to Learn: A School Health Policy Guide was developed by the National Association of State Boards of Education (NASBE), in partnership with the Centers for Disease Control and Prevention (CDC) and in cooperation with the National School Boards Association, to help state and local decision makers establish effective policies to help students achieve their academic potential and adopt lifelong healthy habits. Part I of the Policy Guide addresses general school health program policies and specific school policies to promote physical activity and healthy eating and discourage the use of tobacco.

Features of the policy guide include the following:

- A detailed orientation to effective "policy levers" and the education policy-making process.
- Concrete policy language, based on the CDC school health guidelines, that states, school districts, and schools can use or adapt.
- Scientific data, notable quotations, excerpts from actual state and local policies, and technical assistance resources that school health proponents can use to support recommended policies.
- A chapter on cross-cutting policies that establishes an overall policy framework for coordinated school health programs, addressing topics such as health education goals and curriculum design, staff preparation and professional development.
- Additional chapters that add depth to the CDC school health guidelines, addressing such topics as physical education, extracurricular physical activity programs, school food service, food vending machines, prohibition of tobacco use, and smoking cessation services.
- Practical guidance on controversial topics such as the role of schools in promoting good health, physical education requirements, fitness testing, food vending machines, closed campuses, no-tobacco-use policies that apply to adults, and tobacco enforcement measures.

Fit, Healthy, and Ready to Learn, Part 1 (March 2000, 236 pages) is distributed as a set of binder contents for ease of use and future expansion. It is available for $22 (plus $4 shipping and handling) by calling NASBE at 800-220-5183. Volume discounts are available. The sample policy language can be downloaded from the NASBE Web site at http://www.nasbe.org/healthyschools/fithealthy.mgi.

Source: National Association of State Boards of Education.

Physical Fitness Demonstration Centers

The President's Council on Physical Fitness and Sports (PCPFS) invites all states to participate in the cooperative project. It aims to focus attention on individual schools, recognized by State Departments of Education, which have outstanding programs of physical education that contribute to students' physical fitness.

What is a Physical Fitness Demonstration Center?

- **A school—elementary or secondary—which has an outstanding program of physical education, emphasizing physical fitness.**
- **A school—whose pupils:**
  - participate in vigorous developmental conditioning activities
  - are instructed in healthful and safe living practices
  - are taught skills which will enhance fitness and leisure throughout their lives and increase their social and emotional competencies and self-confidence.
- **A school open to visitors—teachers, administrators, parents, and other interested persons—which provides:**
  - a sound fitness program in action
  - effective methodology and innovative practices
  - facts about curriculum, staff, scheduling, facilities and costs.
- **A school which is selected by its State Department of Education according to criteria developed in cooperation with the President's Council on Physical Fitness and Sports.**

Why Have Demonstration Centers?

- It motivates school officials, teachers and other interested persons to develop high-quality programs aimed at improving the health and fitness of school-age children and youth.
- To assist school personnel and the public to obtain first-hand information on sound and innovative procedures useful in improving their own schools.
- To recognize individual schools that have responded to contemporary needs for a fitness emphasis and for effective instruction in health and physical education.
- To spotlight youth fitness needs and call attention to strengthening school programs to meet these needs at the national, state and local level.

Who Selects the Demonstration Center?

- The State Department of Education selects and certifies schools which serve as Demonstration Centers. Each state determines its most effective administrative procedures for implementing the project within its own unique educational policies and standards.
- A State Coordinator of the PCPFS Demonstration Center project is named by the State Department of Education.
- The President's Council recommends that a *State Advisory Committee* be formed for this project or that an appropriate existing committee be used. Representation on this committee should include such organizations as the Governor's Council on Physical Fitness and Sports, State Board of Health, State Medical Society, State School Board Association, Elementary and Secondary Principals' Association, State Parent-Teacher Association and the State Association for Health, Physical Education, Recreation and Dance, plus representative citizens.

What Criteria are Used to Qualify Schools as Demonstration Centers?

- The Council recommends, as a minimum, that Demonstration Center Schools make provisions for:
  1. Periodic health appraisals for all students.
  2. Identification of physically underdeveloped pupils and a program to eliminate or alleviate their problems.
  3. Physical achievement tests at least twice a year to evaluate and motivate pupil progress.
  4. Opportunities for students to win the Presidential, National and Participant Physical Fitness Award or the New Health Fitness Award.
  5. A daily physical education period emphasizing physical fitness for all pupils.
  6. Community education on physical fitness in physical education through various public affairs activities.
  7. Visitations as necessary and appropriate to accommodate observers of the program.
- Individual states are expected to require additional criteria to assure that Demonstration Center Schools are representative of the best within their state, meaning high quality programs with strong emphasis on physical fitness.
- The following items appearing in the PCPFS Basic Beliefs Statement should also be used in the selection of centers:
  1. Required daily physical education programs are necessary for all pupils in grades K-12 in order to develop their physical fitness and sports skills.
  2. Medical authorities recommend regular vigorous exercise during school years, which is essential to development of healthy individuals.
  3. In order to enjoy a sport, master the necessary skills and participate safely, a person must be physically fit. The popular slogan, "Get Fit by Playing", should be, "Get Fit by Playing Safely."
  4. Within the educational context of physical education programs, students should develop knowledge of the effects of activities for conditioning as well as the relationship of activities to various aspects of health throughout life. Students should understand the basic elements of physiology of exercise and the value of participating in regular vigorous physical activities. The need to continue physical activities in adulthood should be stressed at an early age and throughout the school physical education experience. Knowledge, understanding and participation should result in the development

of desirable attitudes concerning the values of participation in regular vigorous physical activity.

5. Special physical education programs should be provided to pupils with orthopedic problems, obesity, perceptual motor problems and other health-related problems. Such students must be identified, along with those who may suffer from physical underdevelopment, malnutrition or inadequate coordination.
6. Physical education programs should be planned to include physiological fitness goals along with other educational aims to meet the developmental needs of children. Activities must be adapted to individual needs and capacities and be vigorous enough to increase energy utilization and heart rate significantly.
7. Physical education programs should include a core of developmental and conditioning activities appropriate for each grade level. Activities should be identified and stressed in progressive order. Demonstration standards for survival activities, particularly including swimming, should be established; periodic testing and training should be conducted to maintain students' physical competency.
8. Every pupil should have continuing supervision by a family physician and dentist, including periodic examinations and correction of remediable defects. Through these resources, supplemented wherever necessary and feasible by school and community services, the health appraisal procedures include:
   a. Identification of pupils with correctable orthopedic defects and other health problems and subsequent referral to medical authorities.
   b. A posture check, including foot examination; pupils with acute problems should be referred to medical authorities.
   c. Height and weight measurements, interpreted in terms of individual needs; pupils who are obviously obese, underweight or malnourished should be identified and referred to medical authorities.

What Recognition is Given to Demonstration Centers?

- Recognition awards in the form of a certificate and a pennant for each Demonstration Center are furnished by the President's Council on Physical Fitness and Sports at the time of certification. The pennant may be flown on the school's flagpole or displayed inside the school during the time it serves as a Demonstration Center. Both the certificate and pennant are sent directly to the State Director for distribution to the schools.
- The Council recommends that some appropriate ceremony be arranged for presenting the school with the pennant or the certificate. Involvement of the Governor's Council on Physical Fitness and Sports and other related organizations and individuals is suggested.
- The Co-Chairs of the President's Council on Physical Fitness and Sports send a letter of congratulations to the school principal soon after the school is certified.
- The Council maintains a list of Demonstration Centers. Individuals requesting information about school physical education programs from the PCPFS are informed about the Demonstration Centers in their area and encouraged to visit.
- Council staff members will visit the Demonstration Centers when possible.
- An annual report on the Demonstration Center project is prepared by the PCPFS and included in its report to the President.

What is an Honor Roll School?

In order to distribute recognition and provide opportunity for more schools to qualify, a school may serve as a Demonstration Center for no more than three years. The Council encourages those schools which have attained the high level that characterizes Demonstration Centers to maintain quality physical education programs.

Schools that have served as Demonstration Centers for three years and still meet all Council and State criteria may be recommended for the PCPFS *Honor Roll*. These recommendations are made by the State Coordinator and the state committee also. These schools receive a certificate from the PCPFS and are listed as *Honor Roll* schools.

What Procedures Should be Followed by States to Establish Demonstration Centers?

- The State Department of Education staff member primarily in charge of physical education programs accepts the responsibility as State Coordinator of the PCPFS Demonstration Center project.
- The Coordinator establishes an Advisory Committee.
- The Coordinator and the committee determine the state's criteria for selecting Demonstration Centers, and send this information to the Council for acceptance.
- The project is publicized to school officials. Schools are encouraged to apply.
- The Coordinator, and, if feasible, a visitation team visit each school being considered to determine whether the program meets established criteria.
- Upon qualifying as a Demonstration Center school, the State Coordinator and the school principal are responsible for completion of the PCPFS Demonstration Center or Honor Roll school application and the *Certification of Demonstration Center School* form. The coordinator sends one certification form and the application for each individual school to the PCPFS.
- The Coordinator receives the pennants and certificates from the PCPFS and distributes them to the schools.
- During the school year, the State Coordinator maintains contact with Demonstration Centers and visits them when possible. He seeks various opportunities to inform the public about the project and encourages interested persons to visit the centers. The Coordinator works with colleagues in the State Department of Education and in colleges and universities to maximize the values inherent in the Demonstration Center project.

President's Council on Physical Fitness and Sports
200 Independence Avenue, SW, Room 738H
Washington, DC 20201
General PCPFS line: 202-690-9000
Fax: 202-690-5211

A list of state Demonstration Centers and Honor Roll Schools is available on the President's Challenge web site. WE ENCOURAGE ALL STATES TO APPLY.

Appendix 19

Programs That Work

In response to requests from schools for effective prevention programs, the Centers for Disease Control and Prevention (CDC) developed Programs That Work. Programs That Work identifies and disseminates programs that reduce risk behaviors for HIV infection and other sexually transmitted diseases, unintended pregnancy, and tobacco use among young people. The decision to use any of the Programs That Work programs is entirely a local one. CDC funding is not contingent on the use of these or any other programs.

Purposes of Programs That Work

- To identify programs with credible evidence of effectiveness in reducing health risk behaviors among young people.
- To provide information and training on effective programs for interested educators from state and local education and health agencies and national nongovernmental organizations.
- To help inform state and local decisions about adopting programs that have been proven effective.

Selecting Programs That Work

CDC staff review electronic databases, published literature, meta-analyses, and other reports to identify prevention programs that have been evaluated according to the Programs That Work scientific criteria. Two external panels of experts, one comprised of evaluation experts and the other of program experts, review the programs and the evaluation studies. If both panels recommend adoption of a program, CDC designates the program as a "Program That Works."

Disseminating Programs That Work

CDC provides information and training on these programs to interested state and local education and health agencies and national nongovernmental organizations. CDC uses a variety of strategies to enable these programs to be implemented at the local level, including: (1) working with the developers to prepare the programs for dissemination, (2) providing fact sheets and other information on the Programs That Work Web site, (3) providing technical assistance to state and local education and health agencies who choose to implement the programs, and (4) conducting national workshops to train those who will train teachers and others at the local level who choose to implement the programs.

For more information, visit the Programs That Work Web site at http://www.cdc.nccdphp/dash

Appendix 20

Guidelines for School Intramural Programs A Position Paper From the National Intramural Sports Council

The purpose of this position paper is to provide teachers, intramural directors, school administrators and curriculum planners with basic guidelines for planning and providing intramural programming in the school setting for grades K-12.

We believe that all children should receive basic instruction in motor skills as well as sport and recreational activities through a comprehensive program of physical education. We believe that such a program includes not only training in motor development, physiological integrity and the knowledge necessary to support an active, productive and healthy quality of life but also sport and recreational opportunities so that such skills can be practiced and reinforced. Intramural/recreational sports programs as a part of the school curriculum insure that all children are provided the opportunity, regardless of athletic skill level, to learn an energetic approach to life that can contribute to their enjoyment of leisure and maintain a style of living that contributes to their emotional, social, and physiological well-being. We believe that such programs should be available to children during their entire school career.

What are Intramurals?

The term "intramural" simply means "within the walls." It has been traditionally applied to sports tournaments, meets, and/or special events which are limited to participants and teams from within a specific defined community such as a school or other institutional setting. Today's programs are broader in nature, encompassing recreational as well as sports activities.

While the emphasis in a physical education intramural program should focus upon sports and active recreational pursuits such as hiking, dance, leadup games, fitness etc., a school intramural program might also encompass leisure activities such as photography, philately, board games, music, art, etc.

Much of what constitutes an "intramural" program depends upon the imagination and creativity of the leadership within individual school programs.

Other than being limited to participants from a specific school, there are three things that distinguish an intramural program—

1. Intramural activities are intended to be voluntary in nature, i.e. the student has a choice of activities.

2. Every student is given an equal opportunity to participate regardless of physical ability.

3. Students have the opportunity to be involved in the planning, organization and administration of programs. Such involvement is always under supervision and guidance of the intramural director and must be age-appropriate. However, even at the elementary level, students can participate in program development and operation.

What are the Objectives and Goals of an Intramural Program?

- Provide an opportunity to participate in sport and recreational activities without regard for high performance skill or ability.
- Provide activities in a safe and professionally supervised environment.
- Nurture a healthy spirit of competition, sportsmanship and teamwork.
- Develop a sense of community within the school.
- Enhance social interaction.
- Expose students to leisure activities that will contribute to an active lifestyle and enhance physical fitness.
- Provide an opportunity to practice and internalize the skills, attitudes, and knowledge acquired in the physical education class.

The Intramural Program:

Organization and Administration:

- Intramurals should be considered a part of the curriculum. Adequate time should be set aside to facilitate maximum participation.
- Intramurals should be seen as an outgrowth of the physical education program. Skills and activities used in the intramural program should be taught in the physical education program. Intramural programming does not replace physical education instruction.
- Intramurals should be funded to provide for appropriate leadership, facilities, equipment and safety.
- A specialist in physical education should be designated to plan and supervise the program. Appropriate compensation in terms of salary and adjusted work load should be provided to the intramural specialist.
- A student leadership program should be established. Student advisory boards can help with administration of the program, especially in the areas of participant policy development and enforcement, activity selection, and officiating.

Professional Intramural Leadership:

Professional training in physical education is the most appropriate qualification for persons selected to provide intramural leadership in the school setting.

Specific competencies should include:

- Understanding growth, psychosocial, and motor development.
- Knowledge of physical fitness and a variety of sports activities including rules and officiating techniques.
- Knowledge of sports safety requirements and first aid.
- Knowledge of tournament planning and various methods of establishing leagues, brackets, etc.
- A sense of fun.

Activities:

The program of activities should be broad-based, provide for variety, and include sports tournaments, clubs, self-directed activities, special events, etc.

Guidelines for selection should include:

- Program should be an outgrowth of instruction in physical education.
- Programming for males, females, and co-recreation.
- Programming that meets the needs of all skill levels and physical abilities, including the disabled.
- Modification of activities so that they are appropriate to the age, physical development and skill levels of individual participants. (In some cases, height and weight may be of more importance than grade level in determining groupings for team and individual competition. Leagues may need to be established based upon low, moderate, and high skill levels.)
- Specific rules and regulations should be established that ensure equal opportunity, fair play, and safe participation.

Facilities/Equipment:

Critical to any sports activity program are adequate facilities and equipment to support the program. However, lack of sophisticated gymnasium facilities and large budgets for equipment should not deter provision of programs. Programs may be modified and adapted to meet the budget and space available.

Basic guidelines include:

- Facilities should be adequate to meet the needs, interests, safety and number of students participating.
- Equipment and supplies for the intramural program should be budgeted apart from the physical education instructional budget. While some equipment may be shared, each program's needs should be considered.
- Equipment must be modified when required by the age, size and/or physical ability of the participants.
- Appropriate maintenance should be provided for facilities and equipment so that they meet basic standards for cleanliness and safety.
- When new facilities are to be built, or new equipment purchased, all physical education/intramural staff should be consulted to ensure that needs are met. Students should also be given an opportunity for input.

Health and Safety of Participants:

An intramural sports program seeks to enhance the health of its participants; therefore, the following guidelines are critical to the success of the program:

- All activities should be structured to ensure that safety requirements are met including consideration of each student's readiness for the activity based upon age, skill, and physical condition.

- All participants should have medical clearance to participate.
- Clothing should be appropriate to the activity.
- Locker rooms should be supervised to ensure safety.
- All activities should be supervised to ensure safety and orderly progression of each event.
- Recognize that because of the nature of physical activity, injuries will occur. Parents must be given the opportunity for informed consent. Immediate first aid must be available from trained providers any time the program is in progress. Attention must be given to communication with emergency services in the event of a serious injury. All students and staff should know the emergency procedures to be followed.

Awards:

The emphasis of an intramural program should be on participation and fun. Winning and losing are part of the process but should not be a primary focus. If awards are to be given they should be for recognition of achievement and not excessive in nature. If possible, some recognition should be available for participation regardless of win/loss records. All students should be made to feel that they are a winner by virtue of their participation and not because of the relative points scored.

Evaluation:

Intramural programming, just as with other curricula, must be subjected to continuous, on-going evaluation. Areas to be reviewed include:

- Objectives.
- Programming.
- Facilities/equipment.
- Safety.
- Organization/Administration.

Information gleaned from the evaluation process allows for modification of objectives, planning and implementation of program needs, justification for budgets, and program changes.

Useful Publications:

Bonanno, D., editor. (1986). *Intramurals and Club Sports*. Reston, VA:AAHPERD

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Stein, E., editor. (1983)."Starting Intramural Programs in Elementary/Secondary Schools." *Journal of PERD*, V.54, No.2, pp.19-31.

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NISC is a joint structure of GWS and NASPE

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NASPE is an Association of the American Alliance for Health, Physical Education, Recreation and Dance.
-1995-

Appendix 21

The National School-Age Care Alliance Standards for Quality School-Age Care

Human Relationships

1. Staff relate to all children and youth in positive ways.
2. Staff respond appropriately to individual needs of children and youth.
3. Staff encourage children and youth to make choices and to become more responsible.
4. Staff interact with children and youth to help them learn.
5. Staff use positive techniques to guide the behavior of children and youth.
6. Children and youth generally interact with one another in positive ways.
7. Staff and families interact with each other in positive ways.
8. Staff work well together to meet the needs of children and youth.

Indoor Environment

9. The program's indoor space meets the needs of children and youth.
10. The indoor space allows children and youth to take initiative and explore their interests.

Outdoor Environment

11. The outdoor play area meets the needs of children and youth, and the equipment allows them to be independent and creative.

a) Each child has a chance to play outdoors for at least 30 minutes out of every three-hour block of time at the program.

b) Children can use a variety of outdoor equipment and games for both active and quiet play.

c) Permanent playground equipment is suitable for the sizes and abilities of all children.

d) The outdoor space is suitable for a wide variety of activities.

Activities

12. The daily schedule is flexible, and it offers enough security, independence, and stimulation to meet the needs of all children and youth.
13. Children and youth can choose from a wide variety of activities.

a) There are regular opportunities for active, physical play.

14. Activities reflect the mission of the program and promote the development of all the children and youth in the program.
15. There are sufficient materials to support program activities.

Safety, Health, & Nutrition

16. The safety and security of children and youth are protected.
17. The program provides an environment that protects and enhances the health of children and youth.
18. The program staff try to protect and enhance the health of children and youth.
19. Children and youth are carefully supervised to maintain safety.
20. The program serves foods and drinks that meet the needs of children and youth.

Administration

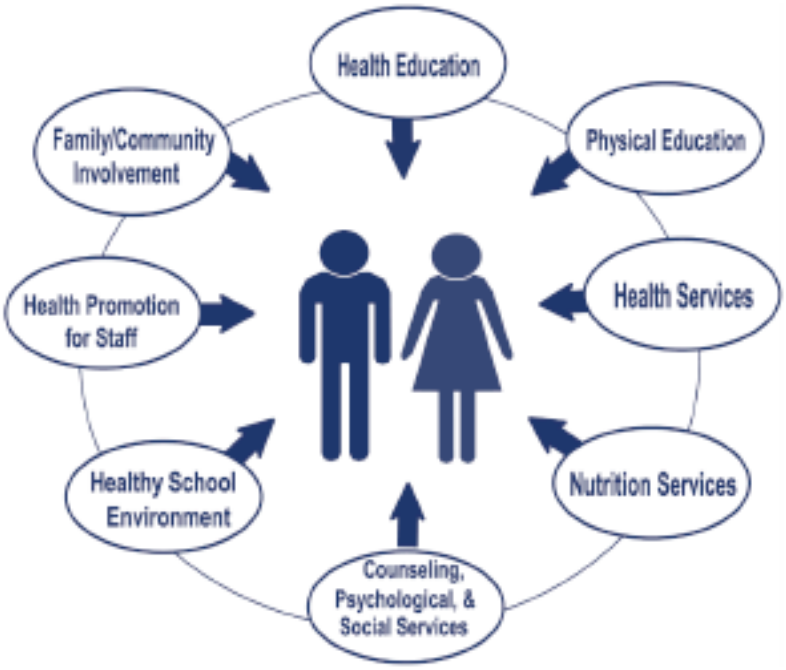
21. Staff-child ratios and group sizes permit the staff to meet the needs of children and youth.
22. Children and youth are supervised at all times.
23. Staff support families' involvement in the program.
24. Staff, families, and schools share important information to support the well-being of children and youth.
25. The program builds links to the community.
26. The program's indoor space meets the needs of staff.
27. The outdoor space is large enough to meet the needs of children, youth, and staff.
28. Staff, children, and youth work together to plan and implement suitable activities, which are consistent with the program"s philosophy.

29. Program policies and procedures are in place to protect the safety of the children and youth.
30. Program policies exist to protect and enhance the health of all children and youth.
31. All staff are professionally qualified to work with children and youth.
32. Staff (paid, volunteer, and substitute) are given an orientation to the job before working with children and youth.
33. The training needs of the staff are assessed, and training is relevant to the responsibilities of each job. Assistant Group Leaders receive at least 15 hours of training annually. Group Leaders receive at least 18 hours of training annually. Senior Group Leaders receive at least 21 hours of training annually. Site Directors receive at least 24 hours of training annually. Program Administrators receive at least 30 hours of training annually.
34. Staff receive appropriate support to make their work experience positive.
35. The administration provides sound management of the program.
36. Program policies and procedures are responsive to the needs of children, youth, and families in the community.

School Health Programs:

An Investment in Our Nation's Future

AT-A-GLANCE
2000



"Schools could do more than perhaps any other single institution in society to help young people, and the adults they will become, to live healthier, longer, more satisfying, and more productive lives."

Carnegie Council on Adolescent Development

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Health Challenges of Young People

Many of the health challenges facing young people today are different from those of past decades. Advances in medications and vaccines have largely addressed the ravages once wrought on children by infectious diseases.

Today, the health of young people, and the adults they will become, is critically linked to the health-related behaviors they choose to adopt.

Damaging Behaviors

A limited number of behaviors contribute markedly to today's major killers, such as heart disease, cancer, and injuries. These behaviors, often established during youth, include

- Tobacco use.
- Unhealthy dietary behaviors.
- Inadequate physical activity.
- Alcohol and other drug use.
- Sexual behaviors that can result in HIV infection, other sexually transmitted diseases, and unintended pregnancies.
- Behaviors that may result in intentional injuries (violence and suicide) and unintentional injuries (motor vehicle crashes).

These behaviors place young people at significantly increased risk for serious health problems, both now and in the future.

Young People Are at Risk

- Every day, nearly 3,000 young people take up daily smoking.
- Daily participation in high school physical education classes dropped from 42% in 1991 to 27% in 1997.
- Almost three-fourths of young people do not eat the recommended number of servings of fruits and vegetables.
- Every year, almost 1 million adolescents become pregnant, and about 3 million become infected with a sexually transmitted disease.

School Health Education Proven Effective

Every school day, 50 million young people attend more than 110,000 schools across our nation. Given the size and accessibility of this population, our schools can make an enormous, positive impact on the health of the nation.

Rigorous studies show that health education in schools effectively reduces the prevalence of health risk behaviors among young people. For example,

- Planned, sequential health education resulted in a 37% reduction in the onset of smoking among seventh-grade students.
- The prevalence of obesity was decreased by half among girls in grades 6–8 who participated in a school-based intervention program.
- Forty-four percent fewer students who were enrolled in a school-based life skills training program used tobacco, alcohol, and marijuana one or more times per month than those not enrolled in the program.

In 1998, Congress emphasized the opportunity afforded by our nation's schools when it urged CDC to "expand its support of coordinated health education programs in schools."

Enthusiasm for addressing health among young people has grown in the private sector as well. National health and education organizations, including the American Medical Association, the American Cancer Society, and the National PTA, actively endorse a coordinated approach to health education in the school setting.

CDC Program Elements

With FY 2000 funding, CDC is strengthening national efforts and providing support to 22 states for coordinated school health programs that focus on chronic disease prevention.

National Framework

CDC has established a national framework to support coordinated school health programs. More than 40 professional and voluntary organizations work with CDC to develop model policies, guidelines, and training to assist states in implementing high-quality school health programs.

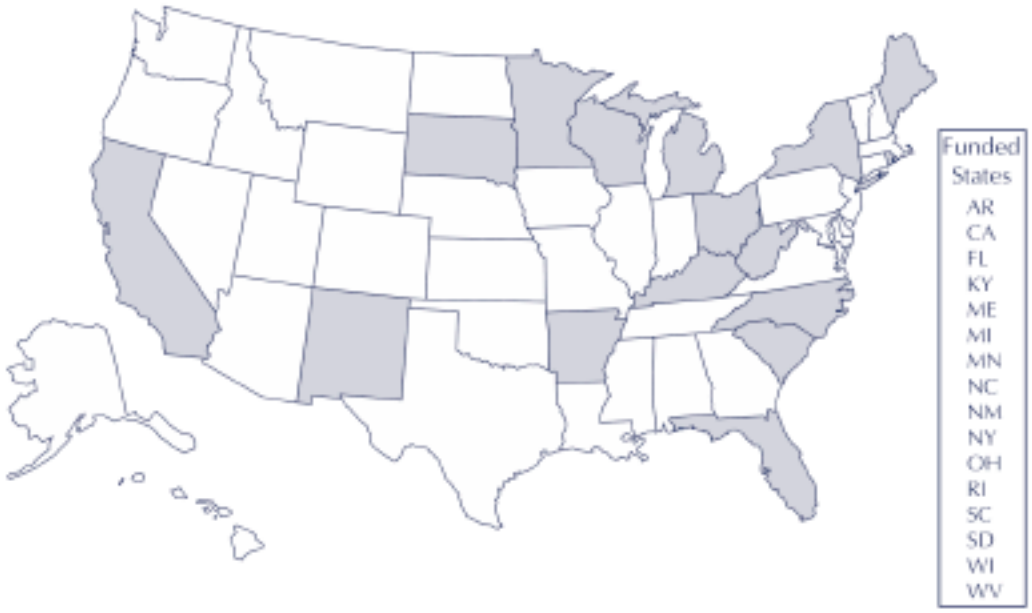
As part of this effort, CDC collaborates with scientists and education experts to identify curricula that have successfully reduced health risk behaviors among young people. CDC provides resources to ensure that these curricula, including training for teachers, are available nationwide for state and local education agencies interested in using them. Schools themselves decide which curricula best meet their students' needs.

State-Based Programs

Through the established national framework and in collaboration with health and education partners, CDC assists funded states in providing young people with information and skills needed to avoid risk behaviors, including tobacco use, unhealthy dietary behaviors, and inadequate physical activity. In addition to receiving instruction, students practice decision-making, communication, and peer-resistance skills to enable them to make positive health behavior choices.

In addition to the 16 states funded for coordinated school health programs, CDC helps all 50 states, seven territories, the District of Columbia, and 18 major cities provide HIV education for young people. Through cooperative efforts with national organizations and the states, CDC supports training for more than 180,000 teachers annually on effectively administering HIV-prevention programs. These programs are designed to equip young people with the skills and knowledge to avoid becoming infected with HIV and other sexually transmitted diseases. Fiscal year 2000 funding for HIV prevention in schools is approximately $47 million.

States Funded by CDC for Coordinated School Health Programs, Fiscal Year 1999



School Health: Coordinated Efforts

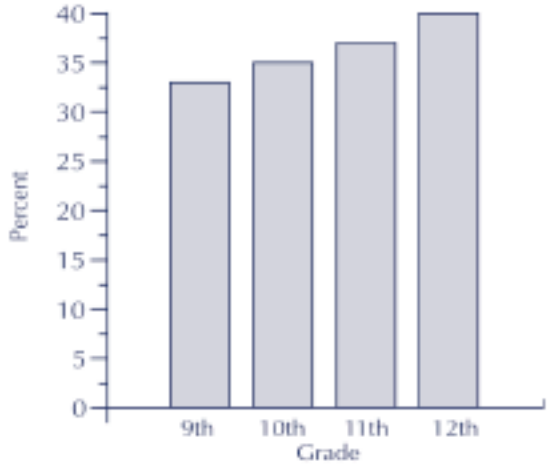
Research Benefits Schools

National efforts for coordinated school health programs have been hampered by a lack of information on school health policies and programs. To address this need, CDC has conducted the School Health Policies and Programs Study to obtain valuable answers to specific questions about school health programs at the state, district, school, and classroom levels. For example, although most schools have a written policy prohibiting tobacco use, only about half have a policy that bans all smoking in school buildings and on school grounds.

Surveillance Plays a Key Role

Until recently, little was known about the prevalence of health risk behaviors among young people. The Youth Risk Behavior Surveillance System (YRBSS) now provides such information. Developed by CDC in cooperation with federal, state, and private-sector partners, this voluntary system includes a national survey of about 12,000 students and smaller surveys conducted by state and local education agencies. The YRBSS focuses on priority risk behaviors such as tobacco use and provides vital information to improve health programs.

Adolescents' Current Cigarette Use,* by Grade



*Reported smoking one or more cigarettes in the last 30 days.
Source: CDC, Youth Risk Behavior Survey, 1997.

CDC's Funded National Partners
Fiscal Year 1999

Advocates for Youth
American Association for Health Education
American Association of Colleges for Teacher Education
American Association of Community Colleges
American Cancer Society
American College Health Association
American Psychological Association
American School Health Association
Association of American Colleges and Universities
Association of Maternal & Child Health Programs
Association of State and Territorial Health Officials
Bacchus and Gamma Peer Education Network
Comprehensive Health Education Foundation
Council of Chief State School Officers
Education Development Center
Education, Training, and Research Associates
GIRLS, Inc.
National Alliance of State and Territorial AIDS Directors
National Assembly on School-Based Health Care
National Association for Equal Opportunity in Higher Education
National Association of Community Health Centers, Inc.
National Association of People with AIDS
National Association of State Boards of Education
National Association of Student Personnel Administrators
National Center for Health Education
National Coalition of Advocates for Students
National Coalition of Hispanic Health and Human Services Organizations
National Commission of Correctional Health Care
National Conference of State Legislatures
National Council of LaRaza
National Education Association
National Governor's Association
National Latina Health Network
National Middle School Association
National Network for Youth
National School Boards Association
National Youth Advocacy Coalition
Public Education Network
Sexuality Information and Education Council of the United States
Society of State Directors of Health, Physical Education, and Recreation
United Negro College Fund

For more information or additional copies of this document, please contact the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Mail Stop K–32, 4770 Buford Highway NE, Atlanta, GA 30341-3717, (770) 488-3168.
ccdinfo@cdc.gov
http://www.cdc.gov/nccdphp/dash

Active Community Environments

What are Active Community Environments?

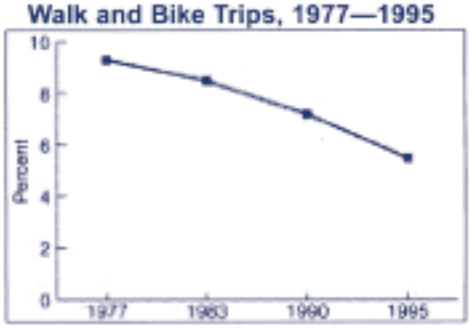
Active Community Environments (ACES) are places where people of all ages and abilities can easily enjoy walking, bicycling, and other forms of recreation. These areas:

- Support and promote physical activity.
- Have sidewalks, on-street bicycle facilities, multi-use paths and trails, parks, open space, and recreational facilities.
- Promote mixed-use development and a connected grid of streets, allowing homes, work, schools, and stores to be close together and accessible by walking and bicycling.

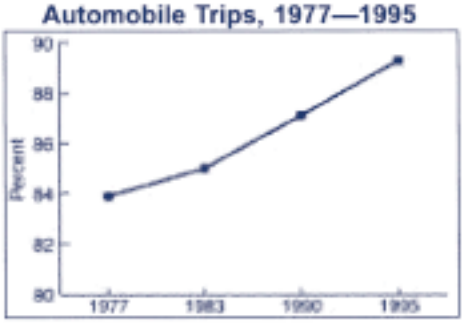
Most communities today were designed to favor one mode of travel—the automobile—and usually do not have many sidewalks or bicycle facilities. Building roads, schools, shopping centers, and other places of interest only for convenient access by cars often keeps people from safely walking around town, riding bicycles, or playing outdoors. This is one important reason why people in the United States are not as active as they used to be.

- Between 1977 and 1995, trips made by walking declined while driving trips increased.[1] (See charts at right.)
- One-fourth of all trips people make are one mile or less, but three-fourths of these short trips are made by car.[1]
- Children between the ages of 5 and 15 do not walk or ride their bicycles as much as they used to (40% less from 1977 to 1995).[1] For school trips one mile or less, only 31% are made by walking; within two miles, just 2% of school trips are made by bicycling.[2]

Walk and Bike Trips, 1977—1995



Automobile Trips, 1977—1995



These trends pose an important public health problem when the effects of physical inactivity and excess weight are considered.

- Physical inactivity and unhealthy eating are risk behaviors that contribute to at least 300,000 preventable deaths each year.[3]
- Almost a third (29%) of adults get little or no exercise (they are sedentary), and almost three-fourths (73%) are not active enough.[4] (Engaging in 30 minutes of physical activity at least 5 days per week is recommended.)
- More than 3 in 10 adults are overweight.[4]
- More than a third (36%) of young people in grades 9-12 do not participate in vigorous activities 3 or more days a week,[5] and one-fourth (25%) of those aged 6-17 are overweight.[6]

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

What are the benefits of Active Community Environments?

ACEs have the potential to help people be more physically active. This is because they give people more (and safer) places to walk, ride bicycles, and enjoy other recreational activities.

- People are more active in neighborhoods that are perceived as safe. Of those who report living in unsafe neighborhoods, about half of women and the elderly are inactive.[4]
- In neighborhoods with square city blocks, people walk up to three times more than in neighborhoods with cul-de-sac streets or other features that keep streets from connecting.[7]
- Up to twice as many people may walk or cycle in neighborhoods that are transit-oriented than in neighborhoods that are auto-oriented.[7,8]
- People are more likely to be physically active if they have recreational facilities close to their homes.[7,8]

What is CDC doing to promote Active Community Environments?

CDC and its Division of Nutrition and Physical Activity are taking the lead in promoting ACEs. Their activities include:

- Development of a guide (KidsWalk-to-School) to promote walking and bicycling to school.
- Collaboration with public and private agencies to promote National and International Walk-to-School Day (www.walktoschool-usa.org and www.iwalktoschool.org).
- Development of an ACEs manual to help state and local public health workers develop similar initiatives.
- A partnership with the National Park Service's Rivers, Trails, and Conservation Assistance Program to promote the development and use of close-to-home parks and recreational facilities (www.ncrc.nps.gov/rtca/index.htm).
- Collaboration on an Atlanta-based study to review the relationships of land use, transportation, air quality, and physical activity.
- Collaboration with the Environmental Protection Agency on a national survey to study attitudes of the American public toward the environment, walking, and bicycling.

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For more information...

Write to:
National Center for Chronic Disease Prevention and Health Promotion
Division of Nutrition and Physical Activity
Physical Activity and Health Branch
Active Community Environments (ACES) Initiative
4770 Buford Highway, N.E., MS/K-46
Atlanta GA 30341-3717

Web site:
www.cdc.gov/nccdphp/dnpa/aces.htm

The guide contains:

- Step by Step: Steps to guide you through organizing a KidsWalk-to-School program in your neighborhood
- KidsWalk-to-School Tools: Sample letters, surveys, evaluations, and press release forms
- Safety Tips: Walking, Biking, School Bus, and Stranger Danger Tips for Children
- Having Fun: Ideas to make walking to school an active and exciting part of a child's day

How can I get a copy of KidsWalk-to-School?

To obtain a copy of the KidsWalk-to-School guide, choose one of the following options:

- Download from CDC Web site: www.cdc.gov/nccdphp/dnpa/kidswalk.htm
- Request by e-mail: ccdinfo@cdc.gov
- Call to request the guide: 1-888-CDC-4NRG

KidsWalk-to-School

A Guide to Promote Walking to School

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

APPENDIX 24

Remember when…

Remember when children walked and rode bikes everywhere—to school, their friends' houses, the park or the store—and parents seldom feared for their safety?

Unfortunately, young people today are not as free to walk and play outdoors because many of our communities have been designed to be convenient for cars, not for children.

Today, only 13% of all trips to school are made by walking and bicycling. Of school trips one mile or less, a low 31% are made by walking; within two miles of school, just 2% are made by bicycling.

Sadly, this deprives neighborhoods of the activity and laughter of children walking and bicycling to and from school together.

Is there a solution?

Yes! KidsWalk-to-School is a program that aims to get children to walk and bicycle to and from school in groups accompanied by adults. This gives kids a chance to be more physically active, to practice safe pedestrian skills, and to learn more about their environment.

At the same time, KidsWalk-to-School encourages people to change their neighborhoods for the better, working together, to make walking a safe and enjoyable part of everyone's lives.

Who should use KidsWalk-to-School?

KidsWalk-to-School is for anyone who wants to make traveling to and from school a safe, active, and enjoyable part of children's lives again. The program is great for neighborhoods that have an elementary school within walking distance—usually within a mile. But the KidsWalk-to-School program can also be adapted for children of all ages, those who live in neighborhoods further from the school, and those living in neighborhoods without safe walking routes.

Why is it important for children to walk to school?

Kids today don't have as many opportunities to be physically active as they once did.

Most schools do not have physical education classes every day, and many elementary schools are removing recess from the daily schedule. At home, today's children have a wider variety of television programs and video games to entertain them.

These realities have contributed to fewer kids getting regular physical activity and may be contributing to a growing number of overweight children, which has increased by 63% over the past 30 years.

Is KidsWalk-to-School just for children?

No. Participating in KidsWalk-to-School is good for the whole neighborhood, not just for children. Here are some of the benefits you may not have thought of:

- Children and adults in the neighborhood get more physical activity.
- Fewer people driving means less traffic in and around homes and schools.
- Crimes are less likely to happen when more people are outside keeping an eye on their neighborhood.
- Neighbors have more chances to get to know each other and become friends.

What can you do?

Get together with your neighbors to bring back the days when children traveled safely through their neighborhoods.

Use the KidsWalk-to-School guide to help you develop your program. Get into action and walk with a child on the path to better health for you, your children, and your community!

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Fact Sheet: Physical Education

CDC

From CDC's 1994 School Health Policies and Programs Study (SHPPS)

About the School Health Policies and Programs Study (SHPPS)

SHPPS is a national survey periodically conducted to assess school health policies and programs at the state, district, school, and classroom levels. Results from the 1994 SHPPS were published in the Journal of School Health, Volume 65, Number 8, October 1995.

Requirements

- 94% of middle/junior and senior high schools required at least one physical education course.
- 23% of middle/junior and senior high schools exempted students from required physical education courses because they participate in other school activities such as band, chorus, or cheerleading.
- 17% of middle/junior high schools and 2% of senior high schools required students to take physical education 5 days a week for each year they attended the school.

Course Characteristics

- 53% of required physical education courses in middle/junior and senior high schools met for 46-60 minutes, while 37% met for 30-45 minutes.
- 82% of states and 93% of districts had a written curriculum, guidelines, or framework for physical education.
- The most widely taught activities in middle/junior and senior high school physical education courses were basketball, volleyball, baseball/softball, flag/touch football, and soccer.
- 15% of physical education teachers in middle/junior and senior high schools required their students to develop individualized physical activity programs.

Frequency of Required Physical Education Classes,* by School Level

Frequency of Meetings	Middle/Junior High Schools (%)	Senior High Schools (%)
5 days/week	45	67
3-4 days/week	15	8
5 days/2 weeks	13	11
1-2 days/week	18	13
Varies by grade	9	3

*among schools with required physical education courses

Professional Certification and Training

- 88% of states required secondary school physical education teachers to be certified in physical education; 16% required it for elementary school physical education teachers.
- 75% of middle/junior and senior high school physical education teachers were certified in physical education or health and physical education.
- 75% of middle/junior and senior high school physical education teachers majored in physical education or health and physical education.
- During the two years preceding the survey, 72% of states and 50% of districts offered in-service training in physical education.
- During the two years preceding the survey, 63% of middle/junior and senior high school physical education teachers received four or more hours of in-service training in physical education.
- The most common topics on which teachers received training were teaching sports or activities, increasing students' physical activity in physical education class, staff wellness, and individual fitness programs.

Extracurricular Programs

- 90% of middle/junior and senior high schools had an interscholastic sports program; 43% had an intramural program.
- 33% of states and 31% of districts required coaches to complete in-service training on coaching.

Testing and Assessment

- 89% of senior high schools, but only 28% of middle/junior high schools, required students who fail a required physical education course to take it again.
- Grades in required physical education courses were counted the same as other subjects for academic recognition in 64% of middle/junior and senior high schools.

Among physical education teachers in middle/junior and senior high schools:

- 70% required students to demonstrate basic competence in a variety of skills.
- 36% required intermediate or advanced competence in at least one skill.
- 77% conducted fitness tests.

Amount of Physical Education Required, by School Level

Amount Required	Middle/Junior High Schools (%)	Senior High Schools (%)
At least 3 years	41	21
2 years	22	25
1 year	19	36
Less than 1 year	4	9
None	6	3
Unknown	8	7

For More Information

For additional information on SHPPS, contact the Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health, 4770 Buford Highway, NE, Mailstop K-33, Atlanta, GA 30341-3717, telephone 770-488-3257, http://www.cdc.gov/nccdphp/dash

Q. Does the study have national support?

A. Yes. The following organizations have endorsed the study:

American Association for Health Education
American Association of School Administrators
American Medical Association
American Nurses Association
American School Food Service Association
American School Health Association
Association of State and Territorial Health Officials
Council of Chief State School Officers
National Assembly on School-Based Health Care
National Association of School Nurses
National Association of State Boards of Education
National Association of State School Nurse Consultants
National Education Association
National Education Goals Panel
National Middle School Association
National Parent Teacher Association
National School Boards Association
President's Council on Physical Fitness and Sport
Society of State Directors of Health, Physical Education, and Recreation

Q. Who is collecting the SHPPS 2000 data?

A. Research Triangle Institute (RTI), a non-profit research company in Research Triangle Park, North Carolina, has received a contract from CDC to work with states, districts, and schools to conduct the study. RTI is working with CDC to select a sample of districts and schools; develop the SHPPS questionnaires; arrange and conduct visits to schools; and analyze data.

Q. Where can additional information be obtained?

A. To obtain additional information about SHPPS 2000, contact CDC or RTI. Inquiries to CDC should be directed to:

Laura Kann, Ph.D., Chief
Surveillance Research Section
Division of Adolescent and School Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention
4770 Buford Highway, NE, MS-K33
Atlanta, GA 30341-3724
770/488-3202
LKK1@cdc.gov

Inquiries to RTI should be directed to:

Judy Thorne, Ph.D., Project Director
Center for Research in Education
Research Triangle Institute
3040 Cornwallis Road
Research Triangle Park, NC 27709
800/647-9664 extension 6495
THORNE@rti.org

SHPPS 2000

SCHOOL HEALTH POLICIES AND PROGRAMS STUDY

The Division of Adolescent and School Health (DASH), National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC) is conducting a national survey of school health policies and programs.

SHPPS 2000 will describe school policies and programs at the state, district, school, and classroom levels nationwide related to health education, physical education and activity, health services, mental health and social services, food service, faculty and staff health promotion, school policy and environment, and family and community involvement.

This brochure answers important questions about the study. Another source of information about the study is the SHPPS 2000 site on the world wide web: www.rti.org/shpps.

CDC

Q. Why is the study being conducted?

A. The health problems of adolescents, many of which are caused by their own behavior, have attracted national attention. However, little is known about the current status of school health programs designed to promote healthy behaviors and address the health needs of children and youth. Study participants will provide information that will be used at the national, state, and local levels to assess and shape the future of school health programs.

Q. From whom will the data be collected and how?

A. Data will be collected from state, district, school, and classroom personnel who are responsible for school health policies and programs. State and district staff will be asked to complete paper-and-pencil questionnaires by mail or, if they prefer, by telephone. School staff will be interviewed at their schools by specially trained interviewers.

Q. Will any data be collected from students?

A. No. Interviews will be conducted only with school faculty and staff.

Q. Do states, school districts, schools, or school staff have to participate?

A. Participation in SHPPS 2000 is entirely voluntary, but the participation of every state and every sampled district and school is important to ensure the completeness and accuracy of results. Development of valid national estimates of school health policies and programs requires a high response rate. No one selected to participate can be replaced.

Q. Will the responses of participants be kept confidential?

A. District, school, and classroom information will be reported only in aggregate form. No districts, schools, or schooll staff will be named in any study reports. However, differences in state-level school health policies and programs will be described state by state.

Q. Who completes the state and district questionnaires?

A. The seven state questionnaires should be completed by whomever the Chief State School Officer designates as most knowledgeable about each of the topic areas. Similarly, the seven district questionnaires should be completed by whomever the district superintendent selects as most knowledgeable about each area.

Q. Who will be interviewed at the school level?

A. The principal will be asked to identify the most knowledgeable person to report on each of the study components. In addition, several teachers of health education and physical education will be asked to take part in interviews on classroom practices.

Q. How is SHPPS 2000 coordinated at the state, district, and school levels?

A. It is preferable to have one contact person at each level. At the state and district levels, the contact person (designated by the Chief State School Officer or district superintendent) will identify the most appropriate person to complete each questionnaire. Questionnaires will be sent to these people through the contact person. At the school level, the principal or a contact person will identify the appropriate staff to be interviewed.

Q. How long will it take to complete the questionnaires?

A. All questionnaires will take 45 minutes to one hour to complete.

Q. When will data for the study be collected?

A. State and district questionnaires will be mailed in January 2000. Data collection in the schools will occur from January through June 2000. A suitable time for school interviews will be identified by each school's principal.

Q. When will the results be available?

A. Results will be released by the fall of 2001. All study participants can receive a copy of the results.

Q. Is the study limited to certain grade levels or schools?

A. No. Information will be collected on elementary, middle/junior high, and senior high school policies and programs in both public and private schools.

Q. How many states, districts, and schools will be involved?

A. All 50 state education agencies and the District of Columbia will be invited to participate. However, districts and schools will not be selected in every state. Nationwide, about 750 districts and 1400 schools will be invited to participate.

Appendix 27

Action Steps

Following is a list of suggested action steps mentioned in this report. Although this is certainly not an exhaustive list of action steps that could be taken to promote youth participation in physical activity and sports, it could be a starting point for the working group that will meet to develop an implementation plan.

Schools

- Help ensure that all students, from prekindergarten through grade 12, receive quality, daily physical education.
- Help ensure that only certified physical education specialists teach physical education.
- Help improve preservice training of and staff development programs for physical education teachers.
- Help ensure that physical education classes have appropriate class sizes.
- Help provide adequate facilities, equipment, and supplies for physical education.
- Involve parents in the planning and implementation of school physical activity programs.
- Assign physical activity-related homework that involves parents.
- Disseminate educational flyers to parents.
- Involve parents in booster clubs.

Youth sports and recreation programs

- Help provide youth sports and recreation programs that meet the needs of all young people.
- Provide appropriate training for sports coaches and recreation staff.
- Provide transportation to and from youth physical activity programs.
- Disseminate educational flyers to parents.
- Involve parents in booster clubs.

After-school programs

- Enable more after-school programs to provide regular opportunities for active, physical play.

Media campaign

- Implement a media campaign to promote physical education that targets parents as well as children.

Health care providers

- Provide assessment, counseling, and referral on physical activity as part of health care for all young people.

Researchers and evaluation specialists

- Monitor physical activity among young people.
- Monitor physical fitness among young people.
- Monitor physical education and other school physical activity programs.
- Study the effects of participation in physical activity, physical education, and sports on academic performance and youth violence.
- Help schools and youth sports and recreation programs evaluate the effectiveness of their programs.
- Develop standardized assessments of students' performance in physical education.
- Conduct studies on the effects of community infrastructure changes.

Government agencies

- Disseminate existing tools to help improve school and community programs and provide staff development on using these tools.
- Expand the President Council's *Physical Fitness Demonstration Centers* and the CDC's *Programs That Work*.
- Engage full-time state-level coordinators for school physical activity programs.
- Expand state-level coordinated school health programs that include physical activity promotion.

Communities

- Develop community structural environments that promote safe walking and bicycling.
- Use school facilities for community recreation.

Appendix 28

National Coalitions

I. National Coalition for Promoting Physical Activity (NCPPA)

MEMBER ORGANIZATIONS (146)

Lead Organizations with Board Representation:

American Alliance for Health, Physical Education, Recreation and Dance

American Cancer Society

American College of Sports Medicine

American Diabetes Association

American Heart Association

Association for Worksite Health Promotion

International Health, Racquet & Sportsclub Association

National Athletic Trainers' Association

National Recreation and Park Association

Full Members:

American Council on Exercise

National Association for Sport and Physical Education

The Sugar Association, Inc.

Associate Members:

American Association for Active Lifestyles and Fitness

Arizona Association for Health, Physical Education, Recreation & Dance

American Heart Association—Midwest Affiliate

Calorie Control Council

Center for Science in the Public Interest

The Cooper Institute for Aerobics Research

Health Promotion/Disease Control-—Tennessee Department of Health

Heart Saver's Coalition of Coconino County

Rome Memorial Hospital

Society of State Directors of Health, Physical Education & Recreation

University of South Carolina

Wheat Foods Council

Affiliate Members:

Aerobics & Fitness Foundation of America

Akron General Medical Center—Lifestyles

American Academy of Kinesiology and Physical Education

American Association of Cardiovascular & Pulmonary Rehabilitation

American Chiropractic Association Sports Council

American Diabetes Association

American Dietetic Association (SCA Practice Group)

American Heart Association—California

American Heart Association—Idaho/Montana Affiliate

American Heart Association—Michigan Affiliate

American Heart Association—West Virginia Affiliate

American Kinesiotherapy Association

American Medical Association

American Orthopedic Society for Sports Medicine

American Osteopathic Academy of Sports Medicine

American Physical Therapy Association

American Running & Fitness Association

Anderson Hospital

Arkansas State University Wellness Program

Association of State & Territorial Directors of Health Promotion & Public Health Education

Baptist Memorial Hospital

Bernard Weinger Jewish Community Center

Botsford General Hospital/TRACC

California Society for Cardiac Rehabilitation

Carillon Communication

Carraway Methodist Medical Center

Cayuga County Health Department

Center for Health Fitness

Church Health Center of Memphis, Inc.

Coalition of American to Protect Sports

Colorado Action for Healthy People, Inc.

Colorado Governor's Council for Physical Fitness

Community & Worksite Wellness

Community Hospitals of Indianapolis

Corporate "Battle" Services

Council on Geriatric Cardiology

Dallas Federal Employer Wellness Center

Downtown Dallas YMCA

Downtown San Diego YMCA

Evangelical Community Hospital

Fifty-Plus Fitness Association

FitLife

Fitness for Youth

Florida AAHPERD

Florida International University

Functional Fitnes

Georgia State University

Golden Strip YMCA

Green Thumb

HealthPartners

Healthy Caldwellians

Healthy Chico Kids 2000

Henrick Health Club

High School Martial Arts

Horton Medical Center

HRS State Health Office/Health Promotion and Wellness

Institute for Research & Education

International In-line Skating Association

International Institute for Sport & Human Performance

International Life Sciences Institute

Jacksonville State University

Jewish Community Center

Joint Commission on Sports Medicine & Science

Kinsmen REH-FIT Center

Lorain County Community College

Melpomene Institute for Women's

Miami-Dade County Public Schools

Michigan Governor's Council on Physical Fitness & Sports

Mid-County YMCA

Missouri Governor's Council on Physical Fitness & Health

Moline School District No. 40

Monroe County Office for the Aging

More & Associates

National Association for Health and Fitness

National Association for Physical Education in Higher Education

National Association for Sport & Physical Education

National Association of State Boards of Education

National Center for Women & Wellness

National Collegiate Athletic Association

National Junior College Athletic Association

National Strength & Conditioning Association

New York State Federation of Professionals Health Educators

North American Society for Pediatric Exercise Medicine

Northeast Louisiana University

Oakland Fitness Council

Omaha/Council Bluffs Metropolitan YMCA

Providence Hospital

Providence Rehabilitation & Wellnes Center

Providence Wellness Center

Red Oak Cardiovascular Center

Renton Technical College

Society for Public Health Education

Society of Geriatric Cardiology

Southern Academy of Women in Physical Activity, Sport, and Health

Sporting Goods Manufacturers Association

Sports Medicine Grant

Susquehanna Health Systems—LifeCenter

Texas Department of Health

The Hillary Commission for Sport, Fitness and Leisure

The Sugar Association

Union Memorial Hospital

United States Water Fitness Association

University of Florida

University of Massachusetts School of Public Health and Health Services

University of Michigan

University of New Hampshire

University of New Mexico

University of Oregon

Wasilla Middle School

Wellness Institute of Greater Buffalo & Western New York, Inc.

William Beaumont Hospital

Williamsport YMCA

Women's Commission USA Triathlon

Woodson YMCA

Wyoming Dept of Health

YMCA of the USA

Youth Fitness Coalition/Project ACES

Yuma on the Move

ADVISORY PANEL

Department of Criminal Justice Training (Kentucky)

Florida Department of Health

New Mexico State Department of Education

President's Council on Physical Fitness & Sports

Utah State Council on Health and Physical Activity

STATE COALITIONS (41)

Alabama
Alaska
Arizona
Arkansas
Colorado
Connecticut
Delaware
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
New Hampshire
New Jersey
New York
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Washington
West Virginia
Wyoming

II. NATIONAL ALLIANCE FOR NUTRITION AND ACTIVITY

Steering Committee Members

American Cancer Society
American Dietetic Association
American Heart Association
American Public Health Association
Association of State and Territorial Chronic Disease Program Directors
Association of State and Territorial Directors of Health Promotion and Public Health Education
Association of State and Territorial Public Health Nutrition Directors
Center for Science in the Public Interest
Susan Foerster, MPH, RD
National Association for Sport and Physical Education
Society of State Directors of Health, Physical Education and Recreation
Jeff Sunderlin
United Fresh Fruit and Vegetable Association

Alliance Members

100 Black Men of America
Alliance for Aging Research
American Association of Family and Consumer Sciences
American Chiropractic Association Council on Nutrition
American College of Nurse-Midwives
American College of Nutrition
American College of Preventive Medicine
American Geriatrics Society
American Health Foundation
American Institute for Cancer Research
American Medical Athletic Association
American Running Association
American School Food Service Association
American School Health Association
American Society of Bariatric Physicians
Association for Worksite Health Promotion
Association of Schools of Public Health
Bikes Belong Coalition, Ltd.
Cancer Research Foundation of America
Child Health Foundation
The Children's Foundation
Citizens for Public Action on Blood Pressure and Cholesterol
ComLinks Gleaning
Consumer Federation of America
The Cooper Institute
Dole Food Company, Inc.
Food Marketing Institute
Girl Scouts of the USA
IDEA, The Health and Fitness Source
International Health, Racquet, and Sportsclub Association
International Lactation Consultant Association
International SPA Association

League of American Bicyclists
Meals on Wheels Association of America
National Association of County and City Health Officials
National Association of Farmers' Market Nutrition Programs
National Association of Governor's Councils on Physical Fitness and Sports
National Association of School Nurses
National Association of WIC Directors
National Athletic Trainers' Association
National Black Women's Health Project
National Caucus and Center on Black Aged
National Center for Bicycling and Walking
National Coalition for Promoting Physical Activity
National Conference of State Legislatures
National Consumers League
National Council of Senior Citizens
National Dental Association
National Heart Savers Association
National Hispanic Council on Aging
National Recreation and Park Association
National Student Nurses Association
National Women's Health Network
North American Association for the Study of Obesity
Nutrition Screening Initiative
Oldways Preservation and Exchange Trust Partnership for Prevention
People's Medical Society
Produce for Better Health Foundation
Produce Marketing Association
Rails to Trails Conservancy
Road Runners Club of America
Shape Up America!
Society for Nutrition Education
Society for Women's Health Research
Surface Transportation Policy Project
Walkable Communities, Inc.
Women's Sports Foundation
YMCA of the USA
YWCA of the USA

III. NATIONAL FITNESS COALITION

Participants

American Aerobics and Fitness Association
American College of Sports Medicine
American Council on Exercise
American Physical Therapy Association
Association of Fitness Professionals
International Health, Racquet, and Sportsclub Association
IDEA
International Spa Association
Sporting Goods Manufacturers Association