THE SIGNIFICANCE OF CURRENT TRENDS IN SCHOOL AND COLLEGE HEALTH PROGRAMS

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of The Ohio State University

By

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* * * * * *

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INTRODUCTION

The school and college health program is a vital, dynamic segment of the educational panorama. It has lived through obstacles and progress, changing terminology and concepts, problems and perplexities. Today, health is frequently stated as a primary goal of modern education.

Optimal development of an individual's mental, social, emotional and physical well-being is considered essential to successful, effective living, particularly in a democracy. The conservation of human resources has long been acknowledged in the recognized listings of educational objectives. In the Cardinal Principles of Secondary Education published in 1918,\footnote{Commission on Reorganization of Secondary Education, \textit{Cardinal Principles of Secondary Education}, Bureau of Education, Bulletin 1918 No. 35 (Washington, D.C.: Government Printing Office, 1918), p. 11.} health appears first on the list of the seven objectives. In 1938, the Educational Policies Commission in its \textit{Purposes of Education in American Democracy} stated the following ways in which a person should be educated in health:

- The educated person understands the basic facts concerning health and disease.
- The educated person protects his own health and that of his dependents.
- The educated person works to improve the health of the community.\footnote{Educational Policies Commission, \textit{The Purposes of Education in American Democracy} (Washington, D.C.: National Education Association, 1938), pp. 60-63.}

\textsuperscript{1}
A Design for General Education prepared by the American Council on Education in 1944 placed the health objective first on the list of ten objectives; it further elaborated that to maintain this objective, the student must acquire knowledge and understanding, attitudes and appreciations, and skills and abilities in order to protect and improve his health status. Today, forty years after health was placed in the top position of the cardinal principles of secondary education, the American Association of School Administrators states as the legitimate and critically important goals of the secondary schools,

the maximum development of all the mental, social, emotional and physical powers of the individual, to the end that he may enjoy a rich life through the realization of worthy and desirable personal goals.

The maximum development of the ability and desire in each individual to make the greatest possible contribution to all humanity through responsible participation in, and benefit from, the greatest privileges of American citizenship.

With recognition and support by such authoritative educational groups, it is reasonable and feasible to recognize that education in health has a vital and significant role to play in the total school and college health program.

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Because it affects and permeates the total school and college educational program, directly and indirectly, from the very core to the fringe areas, the modern health program in schools and colleges is necessarily broad in scope. It encompasses many diversified but related elements and areas. It involves many different types of education and health personnel and agencies. Its various phases and objectives are geared toward the promotion, maintenance and protection of the total personality and well-being of the individual.

And although specialists in school health education are considered newcomers in the professional field, they have been bred and nurtured from the long established families of education and medicine. Their roots are the biological and behavioral sciences. Embracing several disciplines, health education seeks to advance the happy and effective adjustment and development of the individual. Professionally, therefore, the background or family tree of school and college health education is a sound and stable one.
CHAPTER I

THE PROBLEM

The use of trends as a topic for professional discussions, articles, and oral presentations has been a most popular one. The term trends means many things to many people. Often it is used synonymously with the term practices or as a reflection of prevailing conditions. It may appear in the title of a study summarizing the results of a questionnaire on a current topic. Its popularity of usage indicates that the term in its several connotations is of pertinent interest in professional circles, including the fields of school and college health education. Several pieces of research in the field of school health education have been concerned with trends, specifically in the latter part of the period of 1930-1945. The most comprehensive, an unpublished dissertation at Stanford University in 1943, "Origins and Development of the School Health Movement in the United States," by Edith M. Lindsay,\(^1\) contains in essence the tendencies and directions of most facets of the school health program through the year of 1940. Often the question is asked - exactly where today

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is this multi-disciplinary program of health education?
What are the directions and tendencies, the paths, which may more specifically be called trends, that the school and college health programs are following? To what degree are the major trends significant? And of what use is the recognition of major trends in the evolution of school and college health programs?

An exploration of these questions forms the purpose of this study which is to determine the significance of current trends in school and college health programs. A critical look at such a problem involves several sub-processes. These may be defined as --

1. An identification of the current trends of school and college health programs.

2. A survey of three different types of education and health personnel to obtain value judgments relative to the importance and desirability of the identified trends.

3. The processing of the data revealed by the value judgments to ascertain the desirable trends and the possible difference of opinion of the types of personnel surveyed.

4. A consideration of the desirable trends with a view to their significance and possible use as guidelines for the development of school and college health programs of the future.
Terminology Considerations and Definitions

As used in this study the term school and college health program is interchangeable with school and college health education. Both terms refer in essence to any part of, or to the total of, the activities taking place in the school or college which may influence the well-being of the students and school personnel. Although some authorities would refer to school and college health education as only the more direct instructional phase of this program, it is the firm conviction of the writer that each of the three major phases of the school and college health program - health services, healthful living and health instruction - is educational in nature; each of these phases provides learning experiences. Even though efforts have been made to define terminology, a survey of the current literature in the field indicates that there is no one pattern of terminology which strongly predominates. Therefore, for the purpose of this study, the terms school and college health program and health education are similar in scope and meaning.

Although the term trend is commonly used today in much of our oral and written communication, its exact meaning

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is not "spelled out" by the majority of its users. From an analysis of the definitions of the term trend found in dictionaries and other reference publications, the following definition was formulated for the purpose of this study:

A trend may be considered as a general prevailing movement, changing in a specific and indicated direction and thus reflecting a recognizable change of tendency or emphasis.

A strong plea is made for the recognition that this definition does not pinpoint a trend necessarily as a common practice, but rather it is viewed as an acceptable tendency or movement in a certain direction and thus indicates a change of some type. Many trends may not yet be in action universally, yet they are acceptable in theory universally.

Other terms and their definitions used in this study follow:

**Health** -- A state or quality of well-being, resulting from the harmonious, optimal, total functioning of the physical, social, emotional and mental characteristics of an individual.

**Current** -- A situation which prevails at the present time or season; timely.

**Value Judgment** -- An opinion concerning the quality or importance of a concept or situation.

**School and College Health Program** -- The college and school procedures that contribute to the understanding,
maintenance and improvement of the health of pupils and school personnel. 3

**School Health Services**

The school procedures which are established to
(a) appraise the health status of pupils and school personnel;
(b) counsel pupils and parents and other persons involved concerning appraisal findings;
(c) encourage the correction of remediable defects;
(d) help plan for the care and education of handicapped children
(e) help prevent and control disease
(f) provide emergency care for the sick or injured. 4

**Health Instruction** -- "...the translation of what is known about health into desirable individual and community behavior patterns by means of the educational process." 5

**Healthful School Living** -- "A term which designates the provision of a safe and healthful environment, the organization of a healthful school day, and the establishment of interpersonal relationships favorable to the best emotional, social and physical health of pupils." 6

**School Health Educator** -- A person professionally qualified in the area of school health who serves an elementary or secondary school or both in teaching or/and administration of all the facets of the school health program.

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3 Ibid.
4 Ibid.
6 American Association for Health, Physical Education and Recreation, *loc. cit.*
College Health Educator -- A person professionally qualified in the areas of higher education and health who serves an institution of higher learning either in conducting personal-community health courses or courses in the health education major or minor professional field or who conducts or administers the health service program.

Public Health Educator -- A person professionally qualified in the field of public health and education and whose primary responsibility is with a community health program.

General Educator -- A person professionally qualified in the field of education as a whole, as opposed to one who has strictly specialized in one particular branch of the profession.

Consultant -- A person who functions in an advisory capacity and "gives professional advice and services." (Webster's New Collegiate Dictionary).

Limitations of the Problem

1. The trends to be considered in this study are those reflected in the literature published in the field of school and college health during the period of January, 1948 - May, 1958.

2. The direction of the trend, that is, whether it indicated change for advancement or retardation, was not a consideration in the selection of the trends.
3. The significance of the identified trends is dependent upon the cooperation, conscientiousness and judgment of the personnel of whom opinions are requested - a limitation inherent in all survey type studies.
CHAPTER II

SURVEY OF RELATED LITERATURE

Broadly interpreted, every study and report written prior to 1948 that indicated one or several specific tendencies or emphases in the field of school and college health education might be viewed as related literature to this study. A survey of the literature related directly to the trends in the school and college health program revealed that four studies\(^1,2,3,4\) formed the nucleus of the unpublished material concerning the topic of trends per se prior to 1948. And within the past decade, several articles and reports in the field of health education have been published bearing or inferring the term trend in their titles. Therefore, for the purposes of this study, the survey of related literature has been divided into two sections: (1) selected literature

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\(^2\) Lloyd Michael Pekelsma, "Trends in Health and Physical Education in the United States" (unpublished Master's thesis, Purdue University, 1940).


\(^4\) Lindsay, loc. cit.
which affords some historical perspective to the topic, written prior to 1948, and (2) selected current studies, covering the same time period as the scope of this study, 1948-1958.

Selected Related Literature Written Prior to 1948

A group of four publications\(^5,6,7,8\) by the American Child Health Association should provide an historical perspective of trends in the school and college health program. *Some Tendencies in Health Education*, \(^9\) published by The Association in 1926, was an analysis of the health programs of sixteen normal schools and teacher's colleges relating to the evolution of health education courses, the health of the student teacher and the integration and administration of the health education program. No concluding or summarizing statements were made defining the actual tendencies that the programs revealed. *Health Trends in Secondary Education*, \(^10\)


\(^7\) American Child Health Association, *School Health Progress* (New York: The Association, 370 Seventh Ave., 1930).

\(^8\) American Child Health Association, *Advances in Health Education* (New York: The Association, 370 Seventh Ave., 1934).

\(^9\) American Child Health Association, *Some Tendencies in Health Education*, loc. cit.

a 1927 publication, was an appraisal of the health programs of 53 secondary schools who were vying for awards, totaling $1,000 which were offered to the three schools showing the best programs. Thus, this publication was a compendium of the actual practices of these schools which undoubtedly had better than average programs. Specific trends were not identified, but rather the information received in reports from these schools was compiled and discussed. School Health Progress\textsuperscript{11} was a record of the Fifth Health Education Conference arranged in 1929 by The Association; Advances in Health Education\textsuperscript{12} was the record of the 1933 conference of the same organization. Both of these publications reflected the consensus of those in attendance. The term trend was used in several places in the reports but in too nonchalant a manner to be of use in this study.

It is apparent that the casual reference to the terms tendencies, trends, progress and advances in these titles was not entirely consistent with the content of the publications. Since it was difficult to identify or single out the actual activities that could be referred to as trends, these studies gave little impetus to the direction of this study.

\textsuperscript{11} American Child Health Association, School Health Progress, loc. cit.

\textsuperscript{12} American Child Health Association, Advances in Health Education, loc. cit. (The four publications of the American Child Health Association (Notes 5, 6, 7, 8) are out-of-print.)
A United States Government publication by Rogers in 1930 was based on state laws, regulations and courses of study as sources of information. Rogers enumerated that in 1930 every state required instruction in regard to the effect of alcohol and narcotics, 31 states retained ventilation laws, 24 states required medical inspections of some type and 45 states included a type of health-habit teaching. This same pamphlet, *State-Wide Trends in School Hygiene and Physical Education*, was revised by Rogers in 1941. Changes in terminology and emphases brought about by World War II and the increase in automobiles were evidenced in the areas of health service and safety education.

An analysis and evaluation by Trifton in 1933 of the current methods of teaching health education in high schools entitled "Present Tendencies in Health Education" was actually an appraisal of state health education programs and not teaching methods per se. He indicated that "a changing trend toward a better health education program is evidenced by the increasing number of revisions of courses of study and of the inclusion in the curriculum of many of the essential parts of a complete program." Trifton further stressed

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15 Trifton, *loc. cit.*
16 Ibid., p. 129.
that too few states had realized the necessity for the changes inherent in the trend which he had identified and were still clinging to their old traditional standards of physical training in comparison to the newer ones of health education.

"Trends in Health and Physical Education in the United States 1930-1939" were identified by Pekelsma through an analysis of articles appearing in the Research Quarterly and the Journal of Health and Physical Education for the specified period of time. Pekelsma defined a trend as an underlying or prevailing inclination in the field of physical education. Health education trends per se were not identified and could only be assumed as existing within the general conclusions in which health education was not mentioned.

A rather complete picture of the trends in the health instruction phase of secondary school health programs was found in a study done by the use of a questionnaire in 1944 by Siemering. He found that the schools surveyed were organizing their instructional programs under the leadership of a health coordinator and/or health councils or committees. Separate classes were the pattern for instruction and there was an attempt to correlate health with the

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17 Pekelsma, loc. cit.
18 Siemering, loc. cit.
subject matter in other departments. A minimum of 135
minutes weekly for one semester was spent in the instruction;
only one-eighth of the schools had special classrooms for the
health classes. Many of the 46 instructors surveyed
revealed insufficient professional preparation but they also
indicated an interest in the field and a desire to become
better qualified. Widening the range of instructional topics
was another tendency revealed in this study, and particularly
the addition of units in mental hygiene, social hygiene and
sex education. Those schools who had a health coordinator
indicated the use of many varied methods of class procedure;
definite trends were also indicated that showed an increased
use of reference materials, individualized instruction, and
various testing and evaluation procedures.

The most comprehensive of the related studies done
prior to 1948 is Edith M. Lindsay's dissertation, "Origin
and Development of the School Health Movement in the United
States," completed in 1943, in which she identified many of
the trends of the school health program of the era of the
1940's and traced their development. The trends which
Lindsay found were classified in the broad areas of healthful
school living, health education, school health services and
the unification of the school health program. The term
trend itself was frequently used throughout the study; each

19 Lindsay, loc. cit.
trend was inferred to emerge as its origin and development was traced through the literature.

In the category of healthful school living trends were identified within the areas of schoolhouse planning and the school site, the building, the service systems and the hygiene of instruction. In the health education category, six specific statements concerning secondary pupil interests and needs, the integration of sex education into different subject matter courses, the gaining of approval of driver education as a separate subject, teacher selection on the basis of personality and other desirable characteristics, and the improvement of textbooks, materials and teaching methods were cited as tendencies and trends.

According to Lindsay, trends in school health services revolved around (1) methods of correcting remediable defects, such as health examinations, the services offered by the nurse, presence of parents at the health examination, the growing use of cumulative record cards and acceptance of non-professional personnel in the health program; (2) various types of personnel in the program; (3) the legislation and administration of medical examinations; (4) avoiding standardization of health supervision; (5) leadership by the school for developing agencies for treating pupil defects (6) placing of exceptional children in regular classrooms, if possible and (8) accepting by school authorities of responsibility for provision for the handicapped pupil.
A large, final trend concerned the general unification of the school health program - from separate parts to an interwoven whole or unit within the school, aided by the development and cooperation of official and voluntary health agencies. The cooperative projects between health and education groups were also cited as important steps in this unification.

A complete statement of each trend which Lindsay identified will be found and further discussed in Chapter VI.

Selected Current Studies Written within the Time Period of 1948-1953

Many of the studies, speeches and articles by

DeWeese, Kilander, Sellery, Jean, Gerlach, Maw

Wilson, Dvorak, Rarlck and Stoedefalke, Derryberry, Downey, Lesser, Young and Richardson have been used as references in the identification of the trends in this study and listed in Chapter IV. They are also briefly mentioned here since they form the body of the current related literature.

DeWeese based his trends on a comparison of a study conducted in 1935 by the American Student Health Organization.

31 Robert J. Downey, "An Identification of the Philosophical Beliefs of Educators in the Field of Health Education" (unpublished Ph.D. dissertation, University of Southern California, 1956).
34 Charles E. Richardson, "Recent Progress in Developing Total College Health Programs," Paper read before College Health Education, American Association for Health, Physical Education and Recreation, Kansas City, Missouri, April 1, 1958 (Typewritten).
35 DeWeese, loc. cit.
on the organization and administration of college hygiene and a similar type study made in 1948 by the American School Health Association. He considered the areas relating to the number of physicians in the health services, required courses in health with credit, elective courses in health, the relation of the health service to health instruction, the number of physicians teaching health, the supervision of health instruction and the health coordinator.

Kilander found five trends which reflected changes in types of health problems which are of greatest concern to youth today. His five trends were (1) guiding people to do for themselves what is desirable for their own health, (2) enlarging the scope of health instruction, (3) special health courses in secondary schools, (4) better teacher preparation for health instruction and (5) greater cooperation by national, state and local groups in school health programs.

Sellery outlined and discussed trends as they affect the school physician, nurse and health coordinator. The source of the trends was not stated.

Jean identified three particular "stars to steer by....to create a desire and an increasing respect for the science upon which health is built....to increase curiosity regarding health on the part of the public....to gain a

36 Kilander, loc. cit.
37 Sellery, loc. cit.
whole populace who will accept only publicized statements 
that are based upon well authenticated facts." These may 
have more inference for the public health educator than the 
school health educator, although they give definite direc­
tion for both of these groups. No source was given for these 
statements.

Gerlach\textsuperscript{39} discusses trends related to dental health 
programs in schools by (1) tracing the history of dental in­
spections in schools, (2) citing the nature of dental disease 
in children today and research related to this picture, 
(3) recognizing the relationship of health education programs 
with dental health education, and (4) basing future trends on 
present trends. An actual definition of the term trend was 
not stated.

Through his analysis of educational literature con­
cerning sex education in the public schools from 1900-1950, 
Maw\textsuperscript{40} identified six trends regarding sex education. Four 
of these trends concerned an increase in the emphasis on the 
development of attitudes, understandings and appreciations 
as compared merely to factual information, a movement to 
lower the age-grade level where sex education is introduced, 
an increase in subjects used to develop this topic and an in­
crease in developing comprehensive community programs to 
handle problems pertaining to sex.

\textsuperscript{38}Jean, loc. cit.
\textsuperscript{39}Gerlach, loc. cit.
\textsuperscript{40}Maw, loc. cit.
In a speech given in 1953, Wilson cited the coordination of efforts between school health and community agencies, the interest of professional groups, and emphasis on teacher preparation as definite bright spots in school health programs. He elaborated on these statements and other aspects of the program, using the areas of healthful school living, health services and health education as categories for his discussion. In 1954, Wilson commented on the innumerable changes that have occurred in school health programs since 1927, "some due to increased knowledge of specific problems and others to better understanding of the administrative procedures needed to attain desired goals." He then offered three changes that seemed particularly important from the viewpoint of future programs; these were cooperation between health and education departments, the relationship between school health programs, parents and practicing physicians, and the changes in the health problems of school-age children.

A review of pertinent literature and studies published since December, 1949, in the areas of school and college health services by Dvorak and health and safety

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41 Wilson, "Bright Spots in School Health," Paper read before Health Education Division, American Association for Health, Physical Education and Recreation, New York, April 20, 1954 (Mimeographed).


43 Dvorak, loc. cit.
education by Rarick and Stoedefalke\textsuperscript{44} is contained in the Review of Educational Research, December, 1956.

Derryberry\textsuperscript{45} reviewed the past quarter of a century from Derryberry's points as the health level and physical location of the people, disease problems, communication media, and economic and sociologic resources. He commented on the developments that have taken place within that time and the role that health education has to play regarding them in the future. He noted particularly what is known about behavior and motivation and their impact on health education.

In an effort to determine directions that teacher education in health education may be taking, Downey\textsuperscript{46} concluded that the chief influence being exerted was in the direction of pragmatism. His research instrument was a validated Teacher Education Beliefs-Indicator in Health Education.

Lesser\textsuperscript{47} stressed that the changes in the major health problems now confronting children necessitated changing emphases in the school health program. In keeping with this point, he examined the scope and problem of the

\begin{itemize}
\item \textsuperscript{44} Rarick and Stoedefalke, loc. cit.
\item \textsuperscript{45} Derryberry, loc. cit.
\item \textsuperscript{46} Downey, loc. cit.
\item \textsuperscript{47} Lesser, loc. cit.
\end{itemize}
medical examination as it is performed in the school. He emphasized the need of teamwork between educational and medical personnel as evidenced by the Astoria Study in 1942. Other phases of the health service program such as screening tests, referral and follow-up, the handicapped child and the problems of adolescence were considered, but not through an historical perspective.

Young⁴⁸ listed thirty-two trends in the areas of health services, healthful school living, health instruction, evaluation, and organization and administration; she further suggested basic questions which might be raised concerning these trends. The source of her trends was not stated.

Richardson,⁴⁹ confining his efforts to the college health program, traced the progress of health services and underlined both the research pertaining to the health of college students and the current emphasis on mental health. He cited earlier studies in the process of developing his statements of trends.

⁴⁸ Young, loc. cit.
⁴⁹ Richardson, loc. cit.
CHAPTER III

PROCEDURES

Four major procedures were essential to determine the significance of the trends in school and college health programs. These procedures were (1) the identification of the trends, (2) selection of personnel of whom value judgments were requested, (3) the value judgments to be requested, and (4) the statistical procedures to be applied to the data collected. A discussion of each of these procedures follows.

Identification of the Trends

The initial phase and one of the major sub-processes of this investigation was the identification of the current trends in the school and college health program.

The trends were identified from the literature of the field published during the period of January, 1948 - May, 1958. This entailed a thorough investigation of the prominent professional publications in the field of school and college health and the allied fields of education and public health. These included periodicals published by professional organizations in the field of school health; reports of national conferences such as those focused on undergraduate and graduate
preparation in school health, preparation of the classroom teacher and the basic college health course; books used in professional courses and as basic references in school health in colleges and universities; abstracts and summaries of research studies; unpublished speeches presented at professional meetings; annual proceedings of professional health and allied organizations; and the myriad of monographs and pamphlets published by the official, voluntary and professional agencies and insurance companies. Specific publications such as those by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association plus the Reports of the National Conferences on Physicians and Schools which represent a definite qualitative picture of the field were carefully perused.

As the literature was surveyed, a compilation was made of the tendencies, practices, theories and directions most frequently inferred and mentioned in these publications. For each item that was frequently reflected in the literature, specific references to it were carefully noted. As the notations for each trend accumulated and increased in such a way as to establish it definitely as a trend, the notation of references was gradually discontinued. Publications by the groups mentioned above which represent a high quality of thought and endeavor in this field were given priority annotations. However, some trends had limited references since
they were established through a single, specific investigation or piece of research.

An overview of each trend appears in Chapter IV. The parenthetical citations which are found immediately following each overview may be numerous for some trends and singular for others due to the situation just described. A total of 104 trends was identified. By their very nature some of them were broad, major and general while others were more specific and perhaps even minor in some respect. However, if they fulfilled the requirements and description of the definition of a trend prepared for this study, they were included. Since a trend exemplified something which is changing or has changed in some form, it was felt that the statement of each trend should be introduced by using a word implying action.

Before the trends were assembled or duplicated, they were carefully reviewed by two members of the writer's doctoral committee for possible discrepancies and oversights.

In order to facilitate the use of the checklist by the respondents, the trends were grouped according to similarity and placed in five categories:

The General School and College Health Program
School Health Services
Healthful School Living
Health Instruction
The College Health Program
Selection of Personnel of Whom Value Judgments Were Requested

The school and college health program is a multidisciplinary one and thus a most complex one. Therefore, its success is dependent on more than just the efforts of a health specialist in an agency or institution. Although school and college health educators have primary responsibility for the instigation and development of a tendency or direction in this field, there are many types of personnel who are involved and responsible for its effectiveness and success. Health and physical educators, public health personnel, administrators, classroom teachers, parents and health agencies all play a part. Because the fields of education and public health are commonly held as the grass roots of the family tree of school and college health education, it was decided that the significance of the identified trends could be accurately established only by including and involving more than just school and college health personnel in the evaluative process. Therefore, three types of personnel were chosen to form the jury to whom the checklist of trends was sent. These included (1) school and college health educators, (2) public health educators and (3) general educators.

To insure the inclusion of the names of the leading school and college health educators, eight prominent professional leaders in this field were asked to submit the names
of the ten people whom they considered to be the current leading school and college health educators. The eight leaders from whom suggestions were sought were --

Wesley P. Cushman, Ed.D., Professor of Health Education, The Ohio State University, Columbus, Ohio. (Vice-President for Health Education, Midwest District, American Association for Health, Physical Education and Recreation, 1957-58).


Edward B. Johns, Ed.D., Professor and Chairman Health Education Unit, University of California, Los Angeles, California. (Vice-President-Elect for Health Education, American Association for Health, Physical Education and Recreation, 1958-59).

Edwina Jones, Supervisor of Physical Education, Board of Education, Cleveland, Ohio. (Vice-President-Elect for Physical Education, American Association for Health, Physical Education and Recreation, 1958-59).

Delbert Oberteuffer, Ph.D., Professor of Physical Education, The Ohio State University, Columbus, Ohio. (President, American School Health Association, 1958-59).

Elena M. Sliepcevich, D.P.E., Professor of Health Education, The Ohio State University, Columbus, Ohio. (Chairman, School Health Section, American Public Health Association, 1957-1958).

Elizabeth Avery Wilson, Ph.D., Consultant in Health Education and Assistant Secretary, American Association for Health, Physical Education and Recreation, Washington, D.C.

The combined lists of these professional leaders formed the nucleus of the sixty-six school and college health educators to whom the list of trends was sent for evaluation. The school and college health educators formed 45 per cent of the total number of personnel requested to take part in this study.

The prominent professional organization whose activities are devoted specifically to public health education is the Society of Public Health Educators. With the assistance of the writer's committee, the names of thirty-three individuals who served in a consulting capacity to school and community programs throughout the United States were selected from the membership list of this organization for 1956-57. This group comprised 22 per cent of the total number surveyed.

In order to obtain a cross section of individuals who qualified as general educators, a list was compiled of nine prominent educational organizations whose officers or those in executive positions would fulfill the role of a general educator. The organizations selected were --

American Association of Colleges for Teacher Education
American Association of College Administrators
American Council on Education
Association for Higher Education
Association for Supervision and Curriculum Development
Department of Classroom Teachers
Department of Elementary School Principals
National Education Association
The first eight of the organizations in this list, with the exception of the third, the American Council on Education, are Departments of the National Education Association.

The officers or those in executive positions for the past five years (1953-1958) plus four professors from the College of Education of the Ohio State University were selected as the forty-nine general educators to whom checklists were sent. These forty-nine individuals represented 33 per cent of the total number of personnel of whom judgments were requested.

All of the respondents were chosen with several factors in mind: specific type of employment, geographical location and sex. The three different categories of employment were classified as (1) school health educator, (2) college or university health educator and (3) consultant.

Value Judgments

One of the basic purposes of this study was to obtain judgments of value and discretion from the carefully selected jury concerning each of the identified one hundred and four trends. Such judgments would ascertain which trends were most important and acceptable to all of the respondents and also to each of the three groups of educators to whom the checklists were sent.

A rating scale of three types of judgments was formulated. The three point rating scale was used to avoid a
very fine type of discrimination and to facilitate an economi-
cal handling of the data. The following information concern-
ing the procedure relative to rendering judgment was
excerpted from the covering letter (Appendix A) sent to each
member of the jury:

It will probably occur to you that some trends
are more important and acceptable than others, and
it is this type of value judgment that you are being
asked to make in this survey. The code containing
the various judgments appears below; you are asked
to select the appropriate phrase which reflects your
judgment concerning each trend.

A - This trend is of utmost value and significance;
it should definitely be furthered, strengthened
and given great impetus!

B - This trend is of lesser value; it has some minor
significance and should be explored further.

C - This trend has little or no value; it is insig-
nificant and definitely need not be promoted.

The code and specific directions were included on the list
of trends (Appendix B) sent to each member of the jury.

It was believed that those trends which received a
majority of markings of value judgment "A" would definitely
be the most dynamic, important and major trends in school
and college health today and could form the basic guidelines
for the leaders in this field. Those trends receiving a
majority of value judgment "B" ratings should certainly be
recognized and acknowledged, but would reflect only some
minor importance. Those trends which were marked primarily
with value judgment "C" were those which are not important
and need not be considered or further developed.
**Statistical Procedures Applied to Data**

Two types of statistical procedures were used to determine any possible significance from the compilation of the value judgments for each trend. All checklists were thoroughly coded (type of educator, personal identification, sex, specific type of employment and geographical location), and this information plus the value judgment accorded each trend was punched into cards for use on numerical computers.

Following this step, the total number of "A," "B," and "C" judgments given each trend by each of the three groups of educators was compiled and totaled. From these totals the two statistical procedures to consider possible significance were developed. These were --

1. Rankings of ten places were made of the trends according to the "A," "B," and "C" judgments. These rankings were determined from the judgments of the total number of respondents as well as each of the three educator groups.

2. The Chi-square Test\(^1\) was applied to the value judgment totals accorded each trend by the three groups of respondents. These totals were arranged in 3 x 3 fold contingency tables. The computed Chi-squares of each trend were read at the .01 and .05 levels of significance in the

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\(^1\)The formula for Chi-square is \(X^2 = \sum (O-E)^2\). Henry E. Garrett, *Statistics in Psychology and Education* (New York: Longmans, Green and Company, 1953), p. 254.
Chi-square Table using the appropriate degrees of freedom to obtain the value of P which indicates the probability of significance.

The Chi-square Test was used in this study to determine if the three educator groups who were asked to evaluate the trends differed greatly as groups in the judgment they accorded each trend. Such a difference if it occurred would not be due to chance or a sampling error, but rather would be due to the variable of occupational difference.

From these two types of statistical procedures, the significance of the current trends in the school and college health program was clarified and defined; further interpretations were then considered.
CHAPTER IV

OVERVIEW OF TRENDS

One hundred and four trends were identified for this study from the literature published during the period of January, 1948 - May, 1958 in the field of health education and allied areas. The steps that were employed in this identification are outlined in the preceding chapter, Chapter III, "Procedures." The trends which emerged from the perusal of the literature reflected policies, concepts, philosophy, ideas, procedures and practices. As emphasized in Chapter I, all of the trends may not be in action or a common practice universally, but were generally accepted and advocated philosophically.

Included in this chapter is a statement of each trend and a brief overview of it. In presenting these overviews it was not the intent of the writer to offer a thorough description, discussion or defense of each trend, but rather to "set the stage" for the reader in order that he may become familiar with the general concept of each trend. As the trends themselves vary in generality and specificity, so also do the approach and content of the overviews.
Following each overview are parenthetical citations. These citations refer to the references (specific pieces of literature) in which the trend is stated or suggested, thus prompting identification of it as a trend by the writer. References for the figures in parentheses following each overview will be found at the end of Chapter IV in "Sources of Parenthetical Citations." All sources are listed alphabetically by author entry and numbered consecutively. The first figure in the parenthetical citation refers to the number assigned that particular source of reference while the figures following are the specific page or pages containing the statement and/or the discussion of the trend in that piece of literature. In cases where the entire piece of literature supports the trend, no page numbers are given. Reasons for the limited number or multiplicity of citations were discussed in Chapter III. Those references cited in superior figures will be found in the Bibliography.

The trends and their overviews appear in the same order as they did on the checklists sent to the jury (Appendix B). They are grouped according to similarity of subject matter in these five categories:

The General School and College Health Program
School Health Services
Healthful School Living
Health Instruction
The College Health Program
The General School and College Health Program

1. Promoting the multi-disciplinary approach to school and college health programs.

Emanating from the roots of education and public health early in the 1850's, the current composition of the school and college health program embraces in its principles some of the basic elements of the allied health sciences such as biology, medicine, dentistry and physiology plus sociology, psychology, guidance and physical education. Today, since this program permeates so many of the other specialized areas of education and public health, it is thus multi-disciplinary not only in foundation but also in influence. (21-p.80) (22-p.122) (143-p.308) (204) (246-pp.6,8) (247-pp. 2,5,8) (293-p.1).

2. Growing acceptance of the health program as a vital and necessary part of the total educational panorama.

Undoubtedly, there is no program which permeates as many parts of the total field of education as does the health program. Health is the hub of the educational wheel which strives to bring about effective living. Recognized in 1918 by the Commission on the Reorganization of Secondary Education as the first of the Cardinal Principles of Secondary Education, the social, emotional, physical and

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1Commission on Reorganization of Secondary Education, loc. cit.

3. Integrating the school and college health program with the total educational and community program.

As the school and college health programs are gradually moving into communities and making available their facilities and resources to various community groups and activities, they are attempting to meet community health education needs and interests. Such a process in turn enriches the school and college program and thus the two begin to dovetail in purpose and content. (18-p.24) (28-p.284) (35-p.28) (104-p.49) (129-pp.20-21) (151-pp.155-56) (168) (188-p.13) (277-pp.32,52-65).

4. Widening concern and expanding knowledge regarding child growth and development.

Partially because of the multi-disciplinary nature of health education in general and also the research conducted by and shared by personnel such as nutritionists, pediatricians, sociologists, psychologists and psychiatrists, home economists and educators, the basic facts of and interests in how children grow and learn have expanded tremendously in the past decade. The social and emotional factors
pertaining to growth and development have been particularly explored. (7-pp.3-42,47-73) (37) (64) (114) (134) (170) (229) (247) (256) (289-pp.31-85).

5. Accepting the positive concept of health as a state of total well-being.

Health as a state or quality of optimal well-being, involving the harmonious functioning of the physical, mental, social and emotional factors, and upheld as a means to an end—that of effective living, and not just a minimum of aliveness—is the concept of the term health advocated by current health educators. (9-p.17) (18-p.14) (35-pp.21,34, 278) (104-p.38) (107-p.25) (132-p.964) (142-p.2) (225-p.24) (277-p.33).

6. Clarifying the specific health responsibilities of the student, parent, teacher, administrator and specialized personnel serving the school.

Along with the crystallization of the school health program has also come a better understanding of the roles and duties of the various personnel who have parts to play in this program. It will be noted that all "levels" of personnel (including the home and parents) have some kind of responsibility. (18-pp.33-40, 343-46) (20-p.37) (21-p.16) (57) (99) (142-pp.77-95) (143-p.281) (225-pp.374-85) (248-p. 11) (294).
7. Accepting the concept that all teachers should and do contribute to the health program whether they are health teachers or teachers of other subjects.

The positive concept of health and health education finds all teachers contributing to the health program—some more directly than others, of course. Certain aspects of the area of healthful school living, for example, hold definite responsibilities and challenges to every educator, regardless of field of speciality. Just as the health educator is responsible for the major parts of the health program, so the minimum contribution of every teacher is the promotion of desirable inter-personal relations with his students and colleagues. (18-pp.16,25,263) (22-p.130) (107-pp.170,142-43) (142-pp.92,247) (188) (205-pp.6,8,13) (248) (250) (277-pp.73-86) (293).

8. Augmenting the number of qualified school health educators and health coordinators.

With the growth of the school and college health program has come also an increased demand for leadership in this field. Although far short from a reasonable quota, studies and committee reports do indicate that in the past decade there has been an increase in the number of undergraduate health education majors and also in the number enrolled in the dual curriculum of health and physical education. (28) (31) (81) (98) (107-p.20) (142-p.277) (235) (254).
9. Stressing the importance of the "team approach" to school and college health.


10. Attempting to include health learning experiences and concepts in all parts of the school and college curriculum.


11. Suggesting changes in the basic professional terminology used in health education.

To clarify and describe aspects of the school health program, the report of a Committee on Terminology in School
Health Education was published in 1951. The terms of school health program, school health services, health appraisal, school health counseling, school health council and school health educator were identified and suggested for usage.

12. Improving the quality of literature in the field of school and college health education.

Parallel with the growth of the school and college health program has been a qualitative increase in the literature of this field. With few exceptions, official, voluntary, professional and commercial health agencies have strived for quality in their publications. Qualities such as scientific accuracy of content, technical attractiveness and usefulness, and psychological appropriateness are reflected in their publications prepared for use in the school and college health program. (20-p.82) (58) (73) (105) (160) (163) (298-p.5).

13. Augmenting the quantity of literature in the field of school and college health education.

To meet the demands of a field which is increasing in professional competency and service, there has been a great increase in the amount of literature published in the

2American Association for Health, Physical Education and Recreation, loc. cit.
field—such as school and college textbooks, pamphlets, monographs, posters, periodical selections for both lay and professional personnel, and committee and conference reports. And the quantity of literature continues to increase as health agencies are also finding a health conscious public eager for information of this type. (18-p.9) (19) (53) (75) (76) (77) (79) (147-p.453-58) (205-p.36-42) (215).

14. Spotlighting the health aspects of physical education.

Because physical education is built on a foundation of exercise and recreation for healthful living, the health aspects continue to be emphasized and play a most important role in this program which is so vital to an individual's general education. Safety factors such as an individual's age, developmental level and fitness in relation to his activity are only a few of the health aspects to be considered in programs of physical education. Emotional and social maturity may also be considered health aspects of physical education. (18-p.183-84) (67-p.13-16) (102) (107-p.37,44,221) (142-p.159-71) (143-p.56,219) (145) (203-p.26-29) (225-p.402-17) (277-p.299-300).

15. Recognizing health education and physical education as complementary and supplementary but not identical fields.

Because both are members of the "general education" family, health education and physical education do have a great deal in common. They are both concerned with the
adjustment of the individual to himself and society, and as such they complement each other. However, because their activities are carried on in different media, they are not identical. Thus, they may properly be considered as supplementary and complementary but not identical fields.

16. Separating health education and physical education for purposes of administration, programming and professional preparation.

Because of the difference in the media in which they operate and the differences in the basic organization of their programs, health education and physical education now tend to be administered separately in many institutions, particularly those involving professional schools. This has emerged as health education has grown both quantitatively and qualitatively and developed its own distinguishing characteristics.

17. Emphasizing the concept of total fitness as an objective of health and physical education programs during peace-time.

Prior to 1956 the program for total fitness had been emphasized only during periods of national emergency. However, the formation of the President's Council on Youth
Fitness by Dwight D. Eisenhower, President of the United States, is the first federal peace-time emphasis of such a program. Total fitness infers the total well-being or condition of the individual, and not merely the physical aspect of conditioning. (10) (17) (97) (107-pp.16-17) (146) (236) (244) (245) (249) (276) (296).

18. Clarifying the role of the school in handling student personality and behavior problems.

Because of the impetus of the mental health movement which is a vital concern of all society today, schools and colleges are particularly aware of their responsibility to their students in this area. Educators acknowledge the extent to which personality characteristics affect learning and they are also well aware of the various factors influencing mental health in the classroom. The exact role of the school in this area may differ according to available local resources. (18-pp.119-21,135-40) (20-p.56) (22-p.28) (35-p.111) (99-p.2) (107-p.50) (147-pp.144-45) (225-pp.291-300) (258) (277-pp.254-68).

19. Increasing recognition of the special problems of the adolescent years and what the school can do to help the teenager meet them.

There is a greater interest in adolescence than ever before. In fact, some people believe that just as the period of infancy and early

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3"President's Conference on Fitness of American Youth," Journal of Health, Physical Education and Recreation, XXVII (September, 1956), 8-10, 30.
childhood formerly received a concentration of attention in pediatrics and public health, so we are now moving toward the adolescent and devoting more time to his problems of growing up....as teen-agers are apt to look elsewhere than to their own parents for guidance. The schools through counselors and others often have an opportunity to be helpful to them.4


20. Increasing awareness of health and health education by parents and the general public.

Due to the many available printed resources and the various media through which health information can be transmitted, parents and the general public are quite alert to many matters concerning health and health education. This intense interest of the public has been demonstrated by their support of health "exhibits," periodicals and radio and television programs. Public relations programs of both public health and educational organizations have also aided and promoted understandings in this area. Even the advertising of the many types of so-called "health products," the wide controversies concerning socialized medicine, and the coverage of the findings of physical examinations in World War II have promoted a health consciousness within the American public. (20-p. 82) (80) (95) (142-p. 283-99) (151-p. 160) (170-p. 14) (200) (204-Exhibit C and E) (250-p. 1) (293-p. 5).

21. Interpreting basic medical knowledge and progress to
the lay public by qualified experts through such media
as radio, television, newspapers and magazines.

The current mass media of communication are a con-
stant source of health information. Documentary health films
plus live surgical operations which are televised are no
longer unusual. The magazine, *Today's Health*, a medical
periodical for the lay public published by The American
Medical Association, has a wide circulation; and almost every
issue of the "popular" magazine includes some type of article
regarding personal or community health. Newspapers continu-
ally cite evidence of health and medical progress. (19) (80)
(277-pp.54-55).

22. Extending the research concerned with student health
interests, needs and problems.

Since the completion of the first health interest
type of research, *Personal Hygiene for College Students*5 by
Delbert Oberteuffer in 1930, many different techniques have
been used to identify student health interests, needs and
problems. The critical incident technique, questionnaires,
checklists, identification of health problems and the choice
of popular health topics in periodicals are a few of the
techniques which have been used to determine health interests.

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5 Delbert Oberteuffer, *Personal Hygiene for College
Students* (New York: Bureau of Publications, Teachers College,
Columbia University, 1930).
At least eleven major studies have been published in this area in the past decade and several times that number have been employed in schools and colleges for purposes of curriculum construction. (54) (116-p.6) (125) (128) (130) (131) (165) (166) (167) (179) (272) (285).

23. Gearing research studies to school and college health problems on state and local levels.

Studies such as the School Health Education Evaluative Study directed by Dr. Edward B. Johns\(^6\) of the University of California, Los Angeles, the New York City School Health Survey\(^7\) and the Kansas City, Missouri, study in Nutrition Education are examples of a few of the research projects that are being conducted in local areas to determine the effectiveness of health teaching. (107-pp.200-67:footnotes) (135) (164) (191) (230) (237) (240) (246-p.5).

24. Analyzing the health misconceptions which exist among students and teachers.

In order to identify the health knowledge and concepts commonly held by certain age groups and even professional personnel, several studies (only a few of which are


\(^8\)Patricia Ruth O'Keefe, "Research in Action (A Study in Nutrition Education)," The Journal of School Health, XXVI (February, 1956), 58-64.
conducted by the same researcher) have attempted to analyze common health misconceptions. Such information has served to underline the importance and need of health education in the elementary, secondary and college levels of instruction. (84) (85) (86) (96) (180) (295).

25. Developing increasingly valid and reliable evaluation instruments for functional use in the school and college health program.

As the goals and objectives of the school health program have become clearly defined and accepted, so have instruments to measure the attainment of these goals and objectives been more scientifically refined. Knowledge tests which include health problems and problem-solving instead of just the citing of health facts, checklists which encourage a self-appraisal rather than just an inspection, and health attitude and practice scales for various age groups are examples of the sensitive type of instrument now being used and devised to evaluate the various parts of the school health program. (13-selected) (25) (35-pp.476-506) (88) (91) (129-pp.333-47) (143-pp.299-307) (147-p.400) (162) (225-pp. 202-22) (292-pp.349-50).

26. Using the self-appraisal technique more continuously as a major type of health program evaluation.

Using a team composed of local personnel rather than an "inspector" from outside an institution or community for purposes of rating certain aspects of the school health

27. Including representatives of the entire school or college faculty in health curriculum building and policy making.

Since all teachers and college faculty contribute to the health program in some manner—directly or indirectly—all areas of the school and college curriculum should have a representative and voice in the making of the health policies and constructing the health curriculum. Such representation may be via membership on a school or college health council or committee. (18-pp.262-63) (107-pp.142-47) (116) (129-p.35) (142-pp.195-96) (203-p.2) (225-pp.367-73) (240-p. 544) (277-p.83) (278).

28. Recognizing a need for school and community representatives to cooperatively develop and carry out school and college health policies.

"No development in school health programs has been more gratifying and stimulating than the integration and coordination of school health efforts with those of other community agencies and organizations."9 Such integration and

coordination in an inverse relationship, also, stress the
desirability for educational and community health groups to
consider and develop basic policies together. The in-
clusion of the community health representative is just as
important to the formulation of the school health program as
is the inclusion of the general educator. (18-pp.181,413)
1) (298).

29. Establishing inter-agency committees and health councils
at state and local levels.

The formulation of the health council at the city,
county or state level has been one of the avenues by which
school and official, voluntary and professional community
health groups have integrated and coordinated their efforts.
Cooperation and policy decisions at these levels give direc-
tion and focus to the school committee. Such teamwork has
resulted in and produced a great deal of progress and im-
provement in school health programs. (43) (94) (107-pp.18,

30. Pointing up the function, as opposed to the structure,
of the advisory school and community health council in
promoting cooperation in the school health program.

A health council which exists primarily in name and
organization is absolutely inert in a school health program.
A health council dedicated to a program of action which achieves short range goals within a pattern of long-range planning, and involves a minimum of personnel who are used only as needed, will become a most functional group in promoting the school health program. (21-pp.43,52) (107-pp.162-63) (147-p.388) (149) (190-pp.14-17) (202-p.2-4) (225-pp.370-73) (293-p.2) (298).

31. Sharing of responsibilities by state departments of education and state departments of health for the school health program.

As exemplified by the publication, Responsibilities of State Departments of Education and Health for School Health Services, published in 1951, joint planning between these two state agencies has become a keynote, not only in the area of school health services, but also in promoting the total school health program. Such joint planning was commended in a resolution published by The Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association in 1948. 

The acceptance of this concept has strengthened many of the

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Inter-agency committees which have developed and progressed so effectively on city and state levels.

In state after state during the last decade, an Inter-Departmental Committee has been organized to mobilize the resources of both the health department and education department....for the purpose of protecting and improving the health of school age children.\textsuperscript{12}


32. Implementing the principles by which schools and voluntary agencies can cooperate to improve school and college health programs.

In 1955 a series of statements and recommended activities entitled "How Schools and Voluntary Health Agencies Can Work Together to Improve School Health Programs"\textsuperscript{13} was prepared by the American Association for Health, Physical Education and Recreation. The publication now serves as a guideline for schools and voluntary health agencies in the implementation of their respective programs. The National Conference for Cooperation in Health Education is an excellent example of such cooperation in action at a "top-level." (12) (66) (107-pp.287,302-308) (143-p.289) (204-Exhibit E).


33. Utilising the leadership of medical societies at state and local levels for school and college health programs.

California, Connecticut, Montana, Ohio, Oregon, Wisconsin and Michigan are all examples of states which have followed the general plan of the National Conference of Physicians and Schools (initiated in 1947) and sponsored by the American Medical Association. These states have put similar conferences into action on the state level. Such state conferences were initiated by school health committees of the state medical associations and have utilized the leadership offered by the medical personnel and societies. A study conducted by the American Medical Association shows that many physicians now serve on school health committees.

34. Providing for leadership by professional health organizations in school and college health programs.

Such professional health organizations as the American Association for Health, Physical Education and Recreation, The American School Health Association, The American Public Health Association (School Health Section), The American Medical Association, The American Dental Association, The American College Health Association, The American Academy of


Pediatrics (Committee on School Health), The Society of Public Health Educators and The Society of State Directors have all provided leadership which have promoted and influenced the direction of school and college health programs. (22-pp.108,128) (107-pp.308-12) (147-pp.446-50) (224) (255) (293) (298).

35. Increasing cooperation between medical and educational organization as evidenced by their activities at state and local levels.

With the Joint Committee on Health Problems in Education of the National Education Association and The American Medical Association as a model and guide, many similar types of joint committees have been developed on state and local levels. Closer working relationships between city and county medical societies and school personnel have evolved as also have conferences and publications sponsored by these local and state groups. (21-p. 81) (23) (43) (107-pp.18-19) (117-pp.43-44) (147-pp.382-83) (293) (298).

36. Organizing adult and community health education programs.

Health education within the community for adults may take many forms. Grout suggests the following as the most frequent forms: "individual interviewing....group instruction...use of the mass media of communication...community action programs...professional health education."16 The

16 Grout, loc. cit., pp. 7-8.
National Congress of Parents and Teachers and other civic, religious, business, and professional groups have offered numerous programs which are concerned primarily with health and health problems of the adult and the community. (18-pp.18-19, 239-56) (39) (51-p.259) (67-p.8) (107-pp.3-4, 7-9, 97-98) (142-pp.85, 283-99) (203-pp.11, 13-14) (277-p.56).

37. Upgrading standards for desirable competition in schools and colleges.

Publications such as School Athletics\(^1\) by the Educational Policies Commission and Desirable Athletics for Children\(^2\) by the Joint Committee on Athletic Competition for Children of Elementary and Junior High School Age of the American Association for Health, Physical Education and Recreation have emphasized particular policies and procedures applicable to the health aspects of desirable competition. The Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association\(^3\) has underlined these positive standards.

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\(^3\) Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, loc. cit.
and practices through their resolutions concerning the participation of pupils below the tenth grade in athletics, interscholastic boxing equipment and conditions, the administration of oxygen to athletes, elementary school sports and games and the use of drugs to stimulate the athletes' performance. (4) (7-p.156-68) (16) (18-p.188-90, 201-06) (20-p.18) (21-p.38,89) (22-p.44) (87) (146-p.4-8) (147-p. 339-44) (203-p.27-28) (277-p.296-97) (243).

38. Utilizing student values as a basis for planning the school and college health program.

The use of student values as well as needs and interests serve as excellent signposts and motivating devices in the development of effective health instruction programs. Recognition of these values by both students and teachers followed by the translation of desirable understandings, attitudes and practices into values that have merit is no easy task. Health educators recognize that an individual's values control to a large extent his actions and choices concerning healthful living. (7-p.171-78) (9-p.58-59) (40) (52) (107-p.87-89) (183) (187-p.11-12, 17-20) (222) (248-p.1) (292-p.129-30).
School Health Services

39. Pointing up communication and public relations as the key factor in interpreting the school health programs to parents, professional organizations and other community groups.

The role of communication in interpreting the school health program cannot be undersold, particularly in a program that is so dependent upon "team action" and the cooperation of all members of the faculty and staff. The liaison between the school, home and community is an important link in the success of the school health program, since each school must custom-make its program according to its own needs and locale. A two-way system of communication that works will help insure an effective program. (8-pp.81-82) (14) (20-p.92) (21-p.87) (53) (65) (80) (104-pp.52-55) (187-pp.14-16) (190-pp.17-20) (203-p.21) (204-Exhibit C) (205-p.26) (292-pp.325-41).

40. Developing standing orders and policies covering school emergency care and disaster procedures.

Policies concerning the care and disposition of cases of sudden illness or injury with discretion and dispatch and with respect to the wishes of parents must be known by all members of the school faculty and personnel. Such orders and procedures are for the protection of not only the individual and home involved, but also the teacher and the educational system. (18-pp.18, 385-410) (21-p.87) (27) (35-pp.227-31) (143-p.72) (147-pp.229-65) (190-pp.13-14) (203-pp.21-22) (225-pp.349-52) (228).
41. Organizing the school health program with the realization that the family has the primary responsibility for the health of the student.

Undoubtedly one of the most widely accepted principles upon which the school health program is founded is that the parents have the primary responsibility for all aspects of the student's health while the student is in school. However, the educational system assists the parent with this responsibility within certain limitations. A child's health attitudes, values and choices reflect particularly in the early years the health education received in, and exemplified by the home. (18-p.263) (20-pp.69,96) (21-p.91) (22-p.128) (60-p.2) (83-p.525) (147-pp.10,18) (203-p.2) (256) (293-p.4).

42. Varying of the school health services and policies according to locale, as influenced by community resources, customs and other factors.

The health services and policies developed in each school must be custom-made for that school according to its needs, the community resources and other variables. There is no one exact pattern that will fit every situation, yet there are certain common ingredients found in most high school patterns. Price advances the theory that "variations in school health services are most marked in respect to (a) the distribution of responsibilities between local education and health authorities; (b) the amount of responsibility assumed for children under private physicians' care, (c) the extent of treatment provided, especially for indigent cases;
and (d) the quality and frequency of "periodic" or regular examinations arranged for the children.  

43. Utilizing the many facets of the health service program containing opportunities for learning about health and its protection.

Much of the real value of the health service program is attained only when the particular service which is rendered is translated into a learning experience for the student or students concerned. Vision testing programs, emergency care procedures, communicable disease control—all these phases of the health service program may turn into mere "busytme" activities unless the student involved understands the "what" and "why" of the whole procedure and his future responsibilities concerning the present experience.

44. Increasing responsibility taken by boards of education for the administration of school health services.

Elizabeth A. Neilson found that 74 per cent of the representative sampling of two hundred and fifty cities of varying populations charged the board of education with the direction and responsibility of the health services. Neilson also found that the extensiveness of services was greater in those cities in which the services were administered by the board of education. (30-pp.2,12) (138) (156-pp.11-14) (212) (219) (223-pp.37-38) (225-p.389) (292).

45. Involving the classroom teacher to a greater degree as part of the health team in the health service program.

To a large extent, the classroom teacher is the key member of the health team due to his close daily relationship with the students. Therefore, as health services are incorporated into the total school health program, the classroom teacher will be playing progressively more important roles in this part of the health program. This does not imply that diagnostic services of any type will be incorporated into the responsibilities, but rather the recognition that activities such as observation, vision screening, and a follow-up program can be accomplished effectively by the classroom teacher with the assistance and advice of professional personnel when needed. (18-p.296) (146) (147-pp.17, 73,91) (170) (186-p.19) (187-p.10) (206-p.8) (223-p.39) (293-p.4) (298).
46. Recognizing the value of the continuous observation and appraisal of students by all teachers.

The alert teacher often automatically becomes a "seeing-eye teacher," through his recognition of deviations in the ordinary appearance or behavior of the students with whom he has hourly or daily contact. Such informal observation is the basis of an effective health appraisal program which seeks to assess or evaluate the health of the student. Observation requires only an ability to realize that there is a deviation; it does not delve into the area of diagnosis. The value of continuous observation and follow-through to assure parental or/and medical responsibility cannot be overestimated. (5-pp.75-76) (9-pp.213,220-21) (18-pp.273-74) (117-p.45) (139) (147-pp.20-25) (170-p.11) (190-pp.9-13) (203-pp.15-16) (277-pp.247-48) (289).

47. Utilizing parents and other non-school personnel in administering screening tests, such as those for vision and hearing.

Through the cooperation of such groups as the local Parent Teacher Association, Hearing Societies, Junior League, Societies for the Prevention of Blindness and other community services and health agencies, parents and other personnel who are not directly connected with the school have been used as volunteers in administering vision and hearing screening tests. Such volunteers, of course, receive adequate training from professional personnel preceding the screening.
Examples of programs that have enthusiastically and successfully used volunteers include Birmingham, Michigan, Louisville, Kentucky, and many counties and cities in Illinois.

48. Clarifying the professional roles of the nurse and physician as consultants in the school and college health program.

The role of consultant has replaced the role of the "health inspector" which formerly had been so often expected of both the nurse and the physician in the school. Policies and practices have been "spelled out" for both the school nurse and physician, identifying their responsibilities and using their skills in an efficient and educational manner.


49. Promoting the concept of periodic health appraisal for well children from birth through high school.

A recommendation adopted by the Board of Managers of the National Congress of Parents and Teachers on May 24, 1956 stated

...that the National Congress of Parents and Teachers adopt a policy supporting and encouraging a program of continuous health supervision of children from birth through
their school experience, rather than only a program of single appraisal on school entrance.\textsuperscript{22}

The expectation of such a program is that it will bring both parents and teachers into an effective utilization and understanding of the community health resources via an emphasis on maintaining a state of well-being, rather than simply treating an illness when it occurs. (146) (211) (256).

50. Changing the philosophy related to the responsibility for medical and dental examinations from the educational institution to the family physician and dentist.

Instead of "importing" physicians and dentists into the school for cursory examinations or trying to stretch the service of one physician for an entire school population with no assurance of follow-up, further diagnosis and treatment, and the promotion by the school of the use of the family physician and dentist appears to be both educationally and medically sound. Not only are community health personnel of one's choice utilized, but the opportunity for more thorough diagnosis and follow-up care is greatly enhanced. The necessary interchange of information may then be made between the school and family physician to insure the best welfare of the student. (20-p.23) (21-pp.75,86) (60-p.2) (69) (147-pp.38-39) (190-pp.5-7) (211) (233) (237-p.59) (298).

51. Releasing the student during school hours to obtain medical and dental treatment.

"Since one of the aims of the school health program is to help children establish the habit of making periodic visits to the dentist, it is now common practice to excuse pupils from school to keep dental appointments."\(^{23}\) This practice also pertains to medical appointments when Saturday or after-school appointments are not possible. The suggestion "what is best for the child" as the determining factor is made by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association in their 1955 Resolution\(^{24}\) concerning "Procedure for Release from School." (67-p.11) (139-p.34) (143-p.35) (146) (147-pp.127-28) (184) (237-p.32) (298).

52. Using the cumulative health record effectively, i.e., as the focal point of communication between members of the school health team.

A health record is only as good as the use which is made of it; the data it contains are valuable only to the extent in which they are reviewed and interpreted by the


\(^{24}\)Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, "Resolutions" 1944-1958 (Chicago: American Medical Association, 1958) (Mimeoographed).

53. Emphasizing the use of the conference as a technique to promote effective follow-up and interpretation of health problems discovered by school personnel.

The exchange of information through the media of the personal conference between and among members of the health team, both formally and informally, has brought a much more effective and productive interpretation, understanding and exchange of ideas in a program that has many facets and requires good communications. The real core of the program, namely following through on suspected health deviations, is much more effectively accomplished through face to face communication. (18-pp.291-93) (67-p.11) (99-p.2) (107-p.151) (129-pp.65-66) (139-pp.8-9) (142-pp.88, 146-48) (147-p.25) (203-pp.19-20) (225-p.260).

54. Promoting the concept of the health counseling role of the school health team.

Since school health counseling involves an interpretation of the significance of health deviations plus outlining possible plans of action, the school health team occupies the obvious position of responsibility in this area.
Since each member of the health team plays a separate but cooperative role, the process of counseling may be limited to the specific area of responsibility of each individual but may also be enlarged to encourage cooperative and coordinated efforts. (18-pp.30,287,292-93) (20-p.44) (36) (120) (126) (147-pp.168-73) (232) (252) (293-p.4).

55. Including psychological testing and other mental health services in the school program.

A majority of schools expect their teachers to make some reasonable attempt to deal with the 10 per cent of their pupils who may be behavioral deviates. The particular use of health and other records, the administration of selected tests, the use of special visits, conferences and observations, meeting special individual needs through program adaptation, and securing help from specialized personnel when necessary are all parts of a program of mental health services. (6-pp.6-7) (18-pp.135-40, 286-87) (22-p.28) (147-pp.133-56) (203-p.18) (225-p.299) (277-pp. 266-68).

56. Developing effective follow-up programs via the team approach in the area of health service.

A successful follow-up program often requires the help of many types of health personnel. Besides the school personnel, private physicians and dentists, representatives of official and voluntary agencies, and civic groups may be needed. A team approach in this instance might naturally
57. Providing health appraisal and medical services for the indigent student through increased community services.

Hein and Dukelow\footnote{Fred V. Hein and Donald A. Dukelow, \textit{loc. cit.}, pp. 22-23.} reported in 1950 that 82 per cent of 1,000 medical societies indicated that some method was available to provide needed medical care for children whose families could not afford to pay for services. It was further reported that only slightly more than 40 per cent of the subsidization for this service for underprivileged children was from public funds. (9-p.214) (18-p.294) (21-pp.87, 91) (117-pp.22-23, 44-45) (147-p.428) (225-p.359) (277-pp.150-52).

58. Adjusting the school program to individual needs with particular reference to those students with special health problems.

The special health needs of an average class of students will vary a great deal—from minor emotional deviates to a partially-sighted pupil or the child with cerebral palsy. Adjusting the school program, therefore, varies accordingly. The essential factor is that the adjustments provide the opportunity for as much learning as possible
under the most optimal of conditions for each student.

59. Including the physically handicapped students in regular classes in the public school or in special classes arranged for those students by the school system.

"Most handicapped children can be educated in regular classes or in special classes in regular schools. The trend is clearly in this direction. Special classes in day school are becoming increasingly common." Besides emotional and intellectual handicaps, the physical handicaps most frequently found in the school population include orthopedic, visual and hearing malfunctions plus conditions such as diabetes, epilepsy, cerebral palsy, heart disease and allergies. It is estimated that approximately 10 per cent of the student population need "special education" of some type.

60. Making special provisions and adaptations for the mentally exceptional student in either regular or special classes in the school.

Challenging the intellectually superior or gifted student by making special provisions to meet his needs and

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interests is as important as are similar procedures for the physically handicapped child.

Schools have used four major methods to provide optimal opportunities for the educational development of gifted children. These are: (a) rapid advancement (acceleration), (b) enrichment of the regular curriculum, (c) special classes, and (d) elective courses. These methods are not mutually exclusive in every respect, for all four are concerned to some extent with enriching the school program.

From the health point of view, the development of programs that meet the needs of mentally retarded pupils is aimed at preventing problems of an emotional and social nature. School programs that are adapted to pupils' mental capacities are personally satisfying and help pupils to make acceptable social adjustments. Such programs help retarded children develop their endowments to the maximum, limited though they may be.

Ability and age are considered when special classes are provided. Opportunities are afforded for contacts with pupils in regular classes as much as possible and desirable.

61. Recognizing the opportunities of the school to promote the control of communicable diseases and to educate concerning them.

Opportunities for turning control measures and responsibilities into educational experiences are particularly


inherent in the area of communicable disease. Because certain disease control procedures are necessary for health-ful living from both an individual and school viewpoint, parents, teachers and students all need to be "exposed" to scientifically correct concepts regarding communicable disease and to their responsibilities concerning these concepts. It is hoped that such exposures will "take" and thus become continuous health practices through understanding. (18-p.330) (21-p.92) (107-pp.6,70) (142-pp.146-53) (l47-pp.270-74) (203-pp.22-25) (277-pp.38,175-76) (293).


A recommendation made by the Executive Committee of the American Trudeau Society in a report entitled "X-Ray Radiation Effects and Protection from Radiation Exposure" following a conference in Chicago on October 6, 1957 states:

3. Tuberculin testing in infants, children, young adults, prenatais and young diabetics should be developed as a primary guide to tuberculosis contacts and as one case-finding method. X-ray of the chest, for the detection of tuberculosis could then be limited to those with a positive tuberculin test.

4. Reassessment of case-finding programs should be done concerning those segments of the population most deserving of chest X-ray surveys or tuberculin testing.


Healthful School Living

63. Increasing recognition that the emotional health of the teacher influences the emotional tone of the classroom.

"Nothing is more important to the general emotional health of a class than the personality of the teacher and the type of emotional setting he develops. His feelings and mood affect all the group." An atmosphere conducive to the optimal learning, creativity and growth for each member of the class is primarily dependent upon the teacher -- his emotional and professional characteristics. Thus the aura of the classroom directly reflects in a large measure the mental and emotional status of the teacher. (9-pp.57-75, 217) (18-pp.45-46, 125) (27) (35-p.473) (143-pp.6-8, 41-55) (174) (185) (203-pp.5-6) (247) (293-p.3).

64. Emphasizing the importance of the health of all school personnel.

Periodic physical examinations of all teachers, including annual check-ups for tuberculosis, are of prime concern in educational circles today. Modern theories of disease control which stress the possible transmission of pathogens through close relationships underlie this concern. No longer is just the food handler a possible source of infection, but the custodian, the bus driver and administrative

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personnel are just as potentially dangerous. Optimal physical and mental well-being is a requisite to a job well-done by every school employee as well as pupils. (18-pp. 45-70) (21-p.70) (22-p.50) (83) (146) (147-pp.355-70) (187-pp.5-8) (203-p.6) (286) (298).

65. Utilizing educational procedures for effective student-teacher planning and interaction.

The effect of certain educational methods on health, particularly mental health, cannot be denied. Likewise, the use of certain educational procedures to foster effective pupil-teacher rapport and pupil-pupil interaction is not to be denied and is to be encouraged! The use of various techniques such as pupil-teacher conferences in initiating a teaching unit, small group projects and buzz groups in developing units are types of pupil-teacher and pupil-pupil interaction which can be effective components so essential to the area of healthful school living. (8-pp.180-94, 282-95, 475-96) (18-p.113) (35-pp.473-74) (107-pp.187-94) (142-pp.123-28) (143-pp.41-55) (204-pp.23-25) (225-p.58) (274) (277-pp.235-36).

66. Promoting the health and welfare of students by providing a school program organized and administered with these factors in mind.

Organizing a school program which acknowledges the health aspects of such factors as the length of the class period and the school day, recesses, grading, testing,

67. Recognizing the school environment as providing for the enrichment of health instruction.


68. Accepting standards of safety, housekeeping procedures and sanitation as recognizable factors that affect learning.

The areas of safety, housekeeping practices and sanitation, now viewed as important links in the great gamut of the learning process, require constant surveillance and attention. Definite standards must be acknowledged and maintained to insure their functioning and use as components

69. Acknowledging that the physical factor of the school environment affects student health.

The physical factors of the school environment -- color, decoration, seating, lighting, ventilation, heating, acoustics, schoolhouse construction and equipment must be considered as potential student health hazards or helps. The relationship between student achievement and lighting specifically has been established by illumination engineers. The Coordinated Classroom\textsuperscript{31} by D. B. Harmon further stresses the interrelationships between learning, student health and correct seating. (9-pp.216-17) (18-pp.89-90) (83-p.534) (112) (143-pp.159-93) (186-pp.49-50) (201) (277-p.214) (293-pp.3-4).

70. Including functional health suites and health service units in modern school building construction.

As school health service programs have expanded in the past decade so also has developed an acknowledgment of the need of and in many cases the inclusion of, health suites or health service units in many new educational institutions.

\textsuperscript{31}Darell Boyd Harmon, The Coordinated Classroom (Grand Rapids: American Seating Company, 1951).

71. Directing attention to the hazard of overemphasis on perfect school attendance.

The well-being of each student in conjunction with current concepts concerning the control of disease have joined to minimize the "honor" of perfect attendance records for students. Authorities now agree that the exclusion of students from the classroom who are in the initial stages of upper respiratory infections, for example, may prevent more serious complications of the infection besides controlling to a large extent the exposure of others to the condition. Such policies are effective for all types of school personnel. (18-p.327) (67-p.12) (143-pp.34-35) (147-p.301) (186-pp.4-6) (203-p.24) (225-p.268) (237-pp.6-7) (250-p.22) (277-p.240).

72. Emphasizing the educational, nutritional and sanitary aspects of the school food service.

The school lunch is an important part of the total school health program. Its value is twofold -- A well-conducted lunch program provides children with health-giving foods and more important, it teaches principles of good nutrition and food sanitation in a practical manner. Through the school lunch, children may
develop active interest in their own nutritional needs and improve their eating habits. When the school lunch program is integrated with classroom instruction and parent education, its educational values are further increased.32

Health Instruction

73. Producing ACTION in health education through the functional approach to health instruction.

The real test of effective health instruction is the extent to which the facts, the attitudes and the values gained are put into practice or ACTION, plus the extent to which action-type teaching, or the so-called functional approach is incorporated into the teaching methodology. Functional teaching attempts to emotionally involve the student in such a way that constructive ACTION is a natural result! "Action is the thing. To live healthfully, to practice what one knows, to do the scientific thing - that is the principal objective for which teaching exists."33


74. Accepting the purpose of health education as a process which favorably influences knowledge, attitudes and practices.

That all-important ACTION resulting from effective health instruction has a three-pronged approach -- the acquisition of health knowledge, the formation of desirable attitudes and the development of positive health practices. It is generally accepted that through the educational process these three interrelated factors form a chain reaction with one triggering another into favorable reactions and results. In most instances all three factors are necessary for health education to achieve its true purpose. (7-pp.112-14) (18-p.17) (35-pp.38,276-79) (107-pp.2-4) (129-p.90) (142-p.4) (197) (225-pp.2-5) (277-pp.34,43) (292-p.130).

75. Stressing the emphasis on desirable student behavior and practices as the end product of the health instruction program.

Translating understandings, attitudes and values into desirable behavior patterns is the ultimate goal of health instruction. Gaining just knowledge and facts in themselves is not enough; that is vacuum-learning since there is little reason to believe that putting these facts into practices will necessarily follow. Even the formation of favorable attitudes does not automatically assure good health skills. When a definite, positive skill pattern emerges as a result of understandings and attitudes, then the essential purpose of education in health has been achieved. "Behavior is more
important than either knowledge or the elusive attitude because without the action the thought is impotent.  

76. Widening interest in the understanding of motivation as it is involved in the psychology of teaching health.

The dynamic quality of the health instruction is greatly dependent upon an understanding of the factors which move or incite an individual to healthful living. Most successful health instruction is that which is psychologically sound; this implies that an awareness of desirable motivational bases and techniques is essential. Health education that strives to help an individual to live happily and effectively must employ a strong psychological motive and impetus through which health becomes a means and not an end in itself.

77. Implementing the students' "need and interest" approach in curriculum planning.

As stated in the overview to Trend 22, the concept of health instruction based on student needs and interests has long been accepted as a springboard to the planning of the health curriculum. The concept has been considerably

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Ibid., p. 5.

78. Developing health curricula and policies by means of the team approach which includes parents and community groups as resource consultants.

The success of the team approach in helping solve school health problems has extended into the area of policy making and planning the health curricula. Involving personnel such as parents and representatives of community groups in policy and curriculum planning sessions introduces points of view that are important. Grout states that "...parents and other citizens may likewise give service in the planning. They see problems from a realistic angle, unhampered by professional biases, and they often have a keen sense of what is practical and workable."35 Public relations with these groups is also strengthened by the use of this approach to

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35 Grout, loc. cit., p. 158.

79. Gearing of state and local curricula and teacher's guides to help meet students' health needs and interests more effectively.

In order to assist teachers in planning and viewing their health instruction to meet student problems, needs and interests that are of vital concern in a given community, many health curricula and guides are being developed by state and city groups. Such a process enables a teacher to stress the use of particular community resources besides attempting to solve problems peculiar to the students, in so far as the problems may be of local origin. (18-p.167) (22-p.131) (29-p.285) (35-p.292) (107-pp.179,200) (129-p.105) (142-pp.200-201) (225-p.151) (277-p.325) (298).

80. Providing and requiring patterns of direct health instruction through specific, graded courses carrying academic credit for junior and senior high school students.

A form of direct, planned, organized health instruction for which credit is received is an essential part of a health program in the high school program. In most instances separate concentrated health courses meeting daily for one semester are recommended as the most satisfactory arrangement, with one scheduled for the junior high school experience and another during the senior high school years.
(Anderson states that the present trend is to require one credit in health for graduation and that it is an unusual senior high school which does not offer classroom instruction in health). Several professional associations have gone on record recommending such a plan. In 1951 "Thirty-three states required health education in the secondary schools--27 by state law and 6 by regulation of the state departments of education." Generally credit is limited to one unit of the sixteen ordinarily required for graduation. (6-pp.11-14) (35-p.399) (51-p.250) (92) (119) (146) (154) (155-p.11) (157) (203-pp.12-13) (225-pp.90-92).

81. Organizing planned, flexible and sequential health curricula in schools.

Curriculum construction requires organization and planning--a great deal of it. A well-planned curriculum does not just "happen"--it grows and develops as a result of study and research. The characteristics of flexibility and sequence are important aspects of its acceptance and effectiveness. It must be flexible in order to fit and thus serve many and varied teaching situations in a worthwhile manner. An overly flexible curriculum lacks strength and

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82. Implementing the concepts of correlation and integration of health with the majority of subjects in the school program.

With the recognition that health is a subject which permeates practically all subject matter areas in the school program to some degree, the use of the methods of correlation and integration as implements of health instruction is gaining wider recognition and acceptance. Although not recommended as the sole means of health instruction, correlation and integration afford the application of the obvious relationships of health with English, Physics, Social Studies, Chemistry, Biology, and other subjects in a natural way and at a most "teachable moment." (18-pp.169-72) (35-pp.435-41) (51-pp.260-61) (142-pp.222-23, 245-50, 271) (177) (182) (225-pp.96-141) (240-p.545) (250-pp.34-35) (271).

83. Acknowledging the need of a variety of methods, group procedures and resources in teaching health.

When working with almost as many different social and economic backgrounds, health mores and misconceptions, and family customs as there are students in a class, health instructors are most aware that no one method, resource or
group procedure will be equally successful with the individual members who comprise a health class. If health instruction is to result in desirable health behavior, the use of the many and varied methods, group procedures and audiovisual resources is practically a necessity. Fortunately there is no dearth of information and material relative to these teaching methods and aids. The challenge and extent of their effectiveness lies in the manner in which they are used by the instructor. (18-pp.154-61, 178-80, 432-59) (42) (50) (56) (107-pp.101-41) (124) (129-pp.153-69, 194-332) (142-pp.306-22, 324-35) (205-pp.19-21) (225-pp.153-62) (251).

Augmenting the variety of health instruction materials and resources available from official and voluntary health organization.

One of the many evidences of the increase of the services and scope of the official and voluntary health agencies is the wealth and variety of instructional materials and other resources now made available to the public by these groups. Films, speakers and printed materials of all types are ready examples of services that are being extended and selected to meet specific health needs. In many instances these materials and resources represent extensive research and study projects and are excellent sources of reference for the school and college health program. (74) (79) (107-p.141) (129-pp.316-32) (142-pp.330-31) (215) (225-p.199) (267) (298).
85. Increasing number of acceptable health resources available from commercial organizations.

The influx of acceptable health resources available from all types of commercial organizations, trade and industrial associations concerned with health and health products has been noteworthy. In most instances a desirable health concept and not a specific product has been promoted through such media as leaflets, films, filmstrips, pamphlets, teaching units, posters, bulletins and charts. Resources for use by both the teacher and the student are available and these form a large and valuable part of the many printed and audio-visual teaching aids from which the health instructor may choose. (18-pp.434-36) (74) (79) (107-pp.114,313) (129-pp.318-19) (132-p.967) (215) (267) (277-pp.426-29) (298).

86. Increasing number of textbooks published for school and college health courses.

Most of the major publishers of school and college textbooks now have one or more health publications on the market. Texts and references for the elementary and secondary school, the college course in personal-community health and the professional health education curriculum have been introduced or revised with great rapidity within the past six years. At least seven companies now publish an elementary health series,\(^\text{38}\) most of them complete with teachers guides;

\(^{38}\)Department of Physical Education, Women's Division, The Ohio State University, "Health Education Elementary and Junior High Series of Textbooks and Workbooks," 1958 (Mimeographed).
there is a minimum of fifteen firms which have published a textbook for junior-senior high school health instruction.\(^\text{39}\)

Eighteen college texts for just the personal-community health course have publication dates of no later than 1953.\(^\text{40}\)

\((32\text{-pp.}\, 967-68)\, (75)\, (76)\, (77)\, (129\text{-pp.}\, 314-15)\, (223\text{-p.}\, 38)\, (298)\).

87. Utilizing of research methods to determine the accuracy and readability of health textbooks.

Parallel with the influx of textbooks within the field of health in the schools have been great interest and activity concerning the accuracy and readability of these texts. Since 1952, at least ten papers and studies (primarily by personnel at the University of Illinois and Indiana University) and a report by a special committee of the School Health Section, American Public Health Association, have been formulated on these topics. \((63)\, (101)\, (111)\, (115)\, (121)\, (123)\, (158)\, (175)\, (273)\, (299)\).

88. Growing acceptance of the problem-solving method as an approach to the consideration of health problems.

Problem-solving, a general method of teaching health, can be utilized in many specific ways since it is the investigation of student problems and interests, the basis of

\[^\text{39}\text{Department of Physical Education, Women's Division, The Ohio State University, "Health Textbooks, Workbooks and Courses of Study for Junior and Senior High Schools," 1957 (Mimeographed).}\]

\[^\text{40}\text{Department of Physical Education, Women's Division, The Ohio State University, "General References for Health," 1958 (Mimeographed).}\]
effective instruction. Any method which poses a problematic situation which needs to be solved or recognized by small group projects, buzz groups, research, field trips and so forth could be identified as the use of the problem-solving method. This method becomes exceedingly important when it is realized that the more practice a student has in solving his immediate health problems, the better prepared he is to use reflective thinking concerning his well-being as an adult. (35-p.278) (49) (61) (72) (107-pp.102-104) (129-pp. 167-68) (142-p.252) (161) (203-p.11) (277-p.350).

89. Incorporating the important special problem area of sex education into the course pattern centered around family living or family life education.

In the attempt to place the important special area of sex education into its proper perspective in the larger concept of family living or family life education, many units centering around the physiology of sex and sexual adjustment are being incorporated into the larger broader courses if they are available to all students. The problems of family living become increasingly more important to the teen-ager as high school marriages appear to be increasing. The lack of understanding of the true value and meaning of sex due to its highly dramatic and over-emphasized portrayal in much of our literature and many commercial films makes this phase of family life education a most vital one. (89) (122) (148) (159) (181) (193) (239) (240-pp.546-47) (262) (267) (270).
90. Spotlighting such special content areas as alcohol, tobacco and narcotics, consumer health and mental hygiene.

Often high in the interest lists of high school and college students, these particular special content areas hold special appeals, problems and challenges. Naturally, other content areas are not to be excluded and have a definite important place in both school and college curricula. Surveys indicate that many young people make decisions and cultivate habits regarding the use of alcoholic beverages and tobacco before attaining adulthood. As teen-agers, they are constantly bombarded with many types of health information. An intelligent approach to both verbal and written advertisements, old-wives tales and periodical selections becomes imperative. Parallel with these areas and perhaps even more vital is the need for the ability to expect, accept, reduce and live with the tensions and pressures of the twentieth century. (6-p.15-18) (93) (107-p.76-77, 248-54) (142-p.55-60) (169) (171) (173) (176) (225-p.165-86) (259) (275) (277-p.40) (290) (291) (300).

91. Including driver training and driver education in school health and health education programs.

In 1957 drivers under twenty-five years of age were responsible for 22 per cent of the fatal accidents in this country and 17 per cent of the accidents not involving a fatality; "...young drivers have consistently been involved
in almost twice as many accidents as their members warrant." 41
Such statistics are one of the reasons for the inclusion in curriculums of driver training classes for high school (and college) students and the driver education courses in many teacher education programs. Many states have indicated that this instruction properly belongs in and should be administered within the school health program, either as a separate concentrated course or as one unit in the gamut of health instruction.

The College Health Program

92. Enlarging and enriching the effectiveness of the basic college required course.

In January, 1956, over one hundred and thirty health educators attended the National Conference on College Health Education sponsored by the American Association for Health, Physical Education and Recreation to consider the basic personal health course for all college students. This conference gave impetus and direction to more effective organization and presentation of the basic college required courses. A follow-up questionnaire 42 sent in September of the same

42 Mary K. Beyrer, "A Summary of the Follow-Up Questionnaire on The National Conference on College Health Education." Paper read before College Health Section, American Association for Health, Physical Education and Recreation, Kansas City, Kansas, April 1, 1958. (Mimeographed.)
year to faculty representatives who attended the conference indicated that a majority of the thirty respondents had definitely enriched their courses and reappraised their teaching outlines. Also reflecting this theme is the fact that a minimum of eight selections which focus on this topic has appeared in the professional publications of the Journal of Health, Physical Education and Recreation and The Journal of School Health during the period of 1952-1957.

93. Accepting the basic health course as a part of student's general education, particularly on the college level.

Life in a democratic society demands many types of adjustments of each citizen. General education is popularly accepted as that phase of the total educational program which gives an individual the knowledge and skills to make these adjustments in the hope that he may enjoy happy and effective living. In this light, the basic health course with its concept of well-being as a means of enabling the individual to achieve desirable individual satisfactions and values becomes an integral part of the general education of every individual.

94. Accepting of greater responsibility by colleges and universities for the physical and emotional welfare of students.

Figures revealed by a study in 1953 by the American College Health Association concerning health services in
colleges and universities indicated that of the 1,157 institutions surveyed, approximately 80 per cent reported a clinical program for the care of student accidents or illness. However, more than half of these programs were for minor illnesses only. Seventeen per cent of the institutions assumed no formal responsibility for student health. 43

This may be contrasted to a survey conducted by Diehl and Shepard in 1939 who reported, "Slightly more than one-third of 549 colleges report dispensary or outpatient clinics with facilities to care for students with minor illnesses." 44

A questionnaire in 1956 by Gundle and Kraft sent to eleven hundred institutions indicated that 51 per cent of those responding had facilities to deal with mental and emotional problems of students. 45 This is in contrast to a study made in 1936 by Raphael, Gordon and Dawson when only 30 per cent of the respondents reported such programs. 46

43 Norman S. Moore and John Summerskill, Health Services in American Colleges and Universities (Ithaca: Cornell University, 1954), p. 11.


45 Sigmund Gundle and Alan Kraft, "Mental Health Programs in American Colleges and Universities," Bulletin of the Menninger Clinic, XX (March, 1956), 62.

46 Theopile Raphael, Mary A. Gordon and Emma M. Dawson, "Mental Hygiene in American Colleges and Universities," Mental Hygiene, XXII (April, 1938), 229-30.
95. Coordinating the many facets of health service and health education on the college campus which promote student health.

There must be concern, conviction and action on the part of the administration and the whole faculty to establish and maintain the importance of the health and the health education of the students, college employees, and community. This concern, conviction and action must be manifested through appropriate and vital administrative provisions pertaining to services, environment and instruction in health courses and related courses, and providing for the correlation of these.47

The survey by Moore and Summerskill48 in 1953 revealed that special committees or boards on student health exist at some four hundred colleges, with one-half of this number having over-all supervisory functions. (104-pp.18-44) (142-pp. 267-68) (194) (195) (205-pp.21-28) (206-pp.20-21) (208) (297).

96. Recognizing the need for basic professional health courses for all prospective teachers.

Data on professional health courses for all prospective teachers were prepared prior to the National Conference on College Health Education in 1956 which devoted three days to this specific topic. These data revealed that of two hundred and sixty-seven institutions preparing teachers, 74 per cent of these required both a general course in personal health and a professional health course of all


elementary education majors. Thirty-nine per cent had a similar requirement for secondary education majors.\textsuperscript{49} The theme of the entire conference was a keen and searching recognition of the responsibilities for student health which every teacher must assume and the need for adequate professional courses to provide the information in order that teachers may adequately meet these responsibilities.

\textsuperscript{97} Extending the health education requirements for certification of classroom teachers.

In an address presented in October, 1955, to the Fifth National Conference on Physicians and Schools by S. M. Brownell, at that time Commissioner of Education, United States Office of Education, it was stated that high lights in school health included "improvement of professional preparation in health education...also increase in the health requirements for certification of classroom teacher and specialist in some states."\textsuperscript{50} Haag\textsuperscript{51} reported in the

\begin{itemize}
  \item \textsuperscript{49} National Conference on College Health Education, \textit{Health Education for Prospective Teachers} (Washington, D.C.: American Association for Health, Physical Education and Recreation, 1956), p. 29.
  \item \textsuperscript{50} American Medical Association, \textit{Report of the Fifth National Conference on Physicians and Schools} (Chicago: American Medical Association, 1955), p. 82.
  \item \textsuperscript{51} Jessie Helen Haag, "Health Education as a Requirement for Certification of Secondary School Teachers," \textit{The Research Quarterly}, XXV (October, 1954), 286-97.
\end{itemize}

98. Increasing the opportunities for in-service education of professional personnel in the form of workshops and conferences.

The promotion of in-service education for professional personnel via the medium of conferences is particularly noteworthy. Initiated by the National Conference on Undergraduate Professional Preparation in Physical Education, Health Education and Recreation at Jacksons Mills, West Virginia in 1948, there followed in succession the First Washington Conference in 1949, The Pere Marquette Conference in 1950, the Second Washington Conference in 1953, The National Conference on The Undergraduate Health Education Major Program in 1955, and the National Conference on College Health Education in 1956. These do not include the six national conferences on Physicians and Schools, initiated on a biennial plan in 1947 or the several fitness conferences. All of these have been held on a national level with attendance by invitation only. (9-p.228-31) (18-p.160-61) (27) (29-p.284) (116) (142-p.111) (203-p.34-35,37) (225-p.189) (248-p.8).
99. Emerging of school and college health education as a recognized professional field of specialization with an established curriculum of professional preparation.

As the school health program per se has gained momentum, so likewise have the professional aspects of school health education developed. Now recognized as a special field within the total area of professional education, this area of specialization was given significant impetus during World War II. The first undergraduate bachelor's degree in health education was awarded in 1920 at Georgia State College for Women. In 1954 more than 40 institutions reported offering undergraduate majors in this field. This is increasing evidence of the growth and expansion of this field. (28) (29) (31) (81) (118) (142-p.277) (260) (279) (281) (293-p.3).

100. Recognizing the professional status of the field of health education.

The series of five national conferences, outlined in Trend 98, is one of the indications of the status of health education as a profession. These conferences were concerned with the professional preparation of students majoring or minoring in health education, desirable health education emphases for the physical education major program, graduate study in health education, the basic college health course and health education for all prospective teachers.

The position of Assistant Secretary and Consultant in Health Education, one of ten such national-staff members
associated with the American Association for Health, Physical Education and Recreation, a Department of the National Education Association, is further suggestive of the professional status acquired by school and college health educators. The American Association for Health, Physical Education and Recreation plus the School Health Section of the American Public Health Association, the American School Health Association and the American College Health Association are all professional organizations who serve the field and provide much of its leadership. (See also Trend 101). (107-pp.19, 161) (109) (132-p.967) (136) (198) (205) (206) (225-p.187) (248-p.5) (293-p.5).

101. Identifying the competencies and experiences which are needed by school and college health educators.

Further recognition of the professional status of the field of health education is the comprehensive report prepared in 1956 by the Committee on Professional Preparation in Health Education of the American School Health Association which identified the essential functions, competencies and experiences needed by school and college health educators. The detail and thoroughness of such a report

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which outlined the health education competencies and experiences needed by all types of school personnel, from the past, present and future points of view, leaves little question of the tremendous scope, depth and responsibility of professional education in this area. (28) (29) (31) (118) (136) (142-pp.272-74) (207) (210) (261-pp.138-50) (282).

102. Offering of graduate curricula in health education by a greater number of colleges of education.

"By the end of 1949 it was estimated that 25 colleges and universities had established distinct graduate programs in school health education." 53 A June, 1954, U. S. Office of Education bulletin 54 lists the names of thirty-four colleges and universities in which graduate degrees in health education are offered. Degrees offered by schools of public health are not included in the above figure. (28) (29) (31) (178) (207) (261) (277-p.28) (281).

103. Emphasizing recruitment and the career aspects of school health education.

The increased interest by the lay public in health affairs and the impetus afforded health education in many

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schools and colleges have created demands for more trained personnel in this field. The current lack of personnel in the educational and health fields in general has further aggravated the problem of supply and demand. Therefore, the factor of recruitment has become a vital and great concern to professional health educators. Since many community health agencies welcome students well grounded in the area of school health education, the supply of qualified personnel to school and college is further diminished. Therefore, definite programs of recruitment and emphasis of the career aspects of school health education are underway. (3) (11) (28) (31) (146) (189) (213) (214).

104. Increasing the number of health workshops and conferences at state and national levels to consider the school, college and teacher education programs.

At the Fifth National Conference of Physicians and Schools, Samuel Brownell\textsuperscript{55} reported that six hundred or more health workshops were held in the United States in 1954. In 1957 at the Sixth National Conference of the same group, Charles C. Wilson, M.D.,\textsuperscript{56} sighted the phenomenal growth of summer workshops in health and health education. These statements corroborate the report prepared by the Committee

\textsuperscript{55} American Medical Association, \textit{loc. cit.}, p. 83.

on Professional Preparation in Health Education of the American School Health Association which stated that "reports made by a total of 31 colleges and universities show that participation in the summer workshop type or in-service health education was approximately 500 in 1950 and 1,800 in 1955." The increase in conferences at local and state levels has followed a similar pattern. Both workshops and conferences have been geared to meet the needs of all the many types of personnel working in this multi-faceted field.


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57 American School Health Association, loc. cit., p. 284.
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1The Journal of the American Association for Health, Physical Education and Recreation carried this title from 1948 to September, 1954. In this section of this dissertation, "Sources of Parenthetical Citations," this publication for these dates will be referred to as the Jour. of AAHPER.

2In September, 1954, the Journal of the American Association for Health, Physical Education and Recreation changed its title to Journal of Health, Physical Education and Recreation. In this section of this dissertation, "Sources of Parenthetical Citations," these publications from September, 1954 to May, 1958 will be referred to as JOHPER.


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CHAPTER V

FINDINGS

Of the one hundred and forty-four checklists which were mailed on May 20, 1958, one hundred and nine were returned. Of these a total of one hundred and seven checklists were deemed useable for this study. This represents a 72.3 per cent return of the checklists which were mailed. Table 1 indicates the number of checklists which were mailed and the number returned by each of the three different groups of educators. The per cent of the returns in relation to the total group surveyed as well as each educator group is also given. Of the total one hundred and seven checklists returned, from which the data for this study are compiled, slightly over one-half of them were returned by school health educators and approximately one-fourth of them were returned by each of the other two educator groups. The names, titles, and addresses of all respondents appear in Appendix C. Appendix D shows a classification according to sex, type of employment and geographical location of the educators selected for this study who replied to the checklist.

The raw scores were treated by means of two different procedures: (1) the ranking of the trends as determined
by the "A," "B" and "C" value judgments accorded them by the respondents and (2) the application of the Chi-Square Test.

As described in Chapter III, the "A," "B" and "C" evaluations connote the following judgment:

A - This trend is of utmost value and significance; it should definitely be further strengthened and given great impetus.

B - This trend is of lesser value; it has some minor significance and should be explored further.

C - This trend has little or no value; it is insignificant and definitely need not be promoted.

Results of the Rankings of the Trends

Twelve tables of rankings of ten places have been formulated from the raw scores. The trends which received the highest number of "A" value judgments from the total one hundred and seven respondents as well as the fifty-five
school health educators, the twenty-five public health educators and the twenty-seven general educators are ranked in Tables 2 through 5. A similar type of ranking for the "B" value judgments is found in Tables 6 through 9 and for "C" evaluations in Tables 10 through 13.

The trends receiving the ten highest number of "A," "B" and "C" value judgments were selected for these rankings. However, due to ties that occurred in many of the rankings, more than ten trends will appear in most of the tables. Therefore, Tables 2 through 13 contain the trends which rank in the highest ten places for each given situation.

Each table includes (1) the number of the rank assigned the trend in that table; (2) the percentage of the value judgment in relation to the total judgments of the group being considered (3) coded initials that indicate in which of the five categories the trend appeared in the checklist; (4) the statement of the trend; and (5) in parentheses, following the statement of the trend, the number of the trend as it was found in the checklist.

Recorded in Table 2 are the trends accorded the highest ten places of the "A" value judgments from all one hundred and seven respondents. Trend 63, Increasing recognition that the emotional health of the teacher influences the emotional tone of the classroom, and Trend 2, Growing acceptance of the health program as a vital and necessary part of the total educational panorama, received 94 and 95
per cent "A" evaluations respectively. The range for this table extended from 94 - 83 per cent; the trends represented all five of the categories in the checklist.

Table 3, with a 95 - 89 per cent range, showed two trends receiving 95 per cent of the "A" value judgments. The fifty-five school health educators gave one of their top ratings also to Trend 2, **Growing acceptance of the health program as a vital and necessary part of the total educational panorama.** Trend 92, **Enlarging and enriching the effectiveness of the basic college required course,** received a similar 95 per cent of "A" value judgments.

Two 100 per cent ratings were recorded in Table 4. All twenty-five public health educators gave "A" value judgments to Trend 45, **Involving the classroom teacher to a greater degree as part of the health team in the health service program,** and to Trend 46, **Recognizing the value of the continuous observation and appraisal of students by all teachers.** The top trends in this table ranged from 100 - 84 per cent, with three additional trends besides those named each receiving a 96 per cent "A" evaluation.

In Table 5, the general educators evaluated Trend 63, **Increasing recognition that the emotional health of the teacher influences the emotional tone of the classroom,** as the top one by giving it 96 per cent of the "A" evaluations. The range of 96 - 81 per cent in this table did not include any trends appearing in the category of the checklist dealing with the college program.
Tables 6 through 9 were concerned with the trends receiving the ten highest places of "B" value judgments. Trend 86, Increasing number of textbooks published for school and college health courses, placed first in all four of the tables. Not only was it in the top ranked position in each table, but it also received 60 per cent of the "B" evaluations in Tables 6, 7 and 8. Table 9, the compilation of the "B" value judgments of the general educators, recorded Trend 86 as sharing the top ranking with two other trends. These two others were Trend 80, Providing and requiring patterns of direct health instruction through specific, graded courses carrying academic credit for junior and senior high school students, and Trend 85, Increasing number of acceptable resources available from commercial organizations. The range of the trends in Tables 6 and 7 was 60 - 40 per cent; in Table 8 it was 60 - 48 per cent and in Table 9, 59 - 44 per cent. None of these four tables recorded any ranked trends from the checklist categories devoted to healthful school living or the college program.
TABLE 2.— "A" Value Judgments as Assigned to Trends by the Total 107 Respondents (Highest Ten Places)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Per cent of Total</th>
<th>Category</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>94</td>
<td>HSL</td>
<td>Increasing recognition that the emotional health of the teacher influences the emotional tone of the classroom. (63)</td>
</tr>
<tr>
<td>2</td>
<td>93</td>
<td>GP</td>
<td>Growing acceptance of the health program as a vital and necessary part of the total educational panorama. (2)</td>
</tr>
<tr>
<td>3.5</td>
<td>87</td>
<td>HSL</td>
<td>Emphasizing the importance of the health of all school personnel. (64)</td>
</tr>
<tr>
<td>3.5</td>
<td>87</td>
<td>GP</td>
<td>Increasing the opportunities for in-service education of professional personnel in the form of workshops and conferences. (96)</td>
</tr>
<tr>
<td>5</td>
<td>86</td>
<td>HI</td>
<td>Producing ACTION in health education through the functional approach to health instruction. (73)</td>
</tr>
<tr>
<td>6</td>
<td>85</td>
<td>HI</td>
<td>Accepting the purpose of health education as a process which favorably influences knowledge, attitudes and practices. (74)</td>
</tr>
<tr>
<td>8</td>
<td>84</td>
<td>GP</td>
<td>Accepting the positive concept of health as a state of total well-being. (5)</td>
</tr>
<tr>
<td>8</td>
<td>84</td>
<td>SHS</td>
<td>Organizing the school health program with the realization that the family has the primary responsibility for the health of the students. (41)</td>
</tr>
<tr>
<td>8</td>
<td>84</td>
<td>SHS</td>
<td>Recognizing the value of the continuous observation and appraisal of students by all teachers. (46)</td>
</tr>
<tr>
<td>Rank (107)</td>
<td>Category</td>
<td>Trend</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>----------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>SHS</td>
<td>Involving the classroom teacher to a greater degree as part of the health team in the health service program. (45)</td>
<td></td>
</tr>
</tbody>
</table>

**Code:**
- GP = General Program
- SHS = School Health Services
- HSL = Healthful School Living
- HI = Health Instruction
- CP = College Program

**Value Judgments:**
- "A" = Utmost value and significance
- "B" = Lesser value and minor significance
- "C" = Little or no value and insignificant
TABLE 3.—"A" Value Judgments as Assigned to Trends by 55 School Educators (Highest Ten Places)

<table>
<thead>
<tr>
<th>Rank (55)</th>
<th>Category</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5</td>
<td>GP</td>
<td>Growing acceptance of the health program as a vital and necessary part of the total educational panorama. (2)</td>
</tr>
<tr>
<td>1.5</td>
<td>CP</td>
<td>Enlarging and enriching the effectiveness of the basic college required course. (92)</td>
</tr>
<tr>
<td>3</td>
<td>HSL</td>
<td>Increasing recognition that the emotional health of the teacher influences the emotional tone of the classroom. (63)</td>
</tr>
<tr>
<td>6</td>
<td>SHS</td>
<td>Changing the philosophy related to the responsibility for medical and dental examinations from the educational institution to the family physician and dentist. (50)</td>
</tr>
<tr>
<td>6</td>
<td>HI</td>
<td>Stressing the emphasis on desirable student behavior and practices as the end product of the health instruction program. (75)</td>
</tr>
<tr>
<td>6</td>
<td>HI</td>
<td>Acknowledging the need of a variety of methods, group procedures and resources in teaching health. (83)</td>
</tr>
<tr>
<td>6</td>
<td>CP</td>
<td>Accepting the basic health course as a part of a student's general education, particularly on the college level. (93)</td>
</tr>
<tr>
<td>6</td>
<td>CP</td>
<td>Recognizing the need for basic professional health courses for all prospective teachers. (96)</td>
</tr>
<tr>
<td>10.5</td>
<td>SHS</td>
<td>Organizing the school health program with the realization that the family has the primary responsibility for the health of the student. (41)</td>
</tr>
<tr>
<td>Rank</td>
<td>Total (55)</td>
<td>Category</td>
</tr>
<tr>
<td>------</td>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>10.5</td>
<td>89</td>
<td>HSL</td>
</tr>
<tr>
<td>10.5</td>
<td>89</td>
<td>HI</td>
</tr>
<tr>
<td>10.5</td>
<td>89</td>
<td>HI</td>
</tr>
</tbody>
</table>

**Code:**
- GP = General Program
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- HSL = Healthful School Living
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- CP = College Program

**Value Judgments:**
- "A" = Utmost value and significance
- "B" = Lesser value and minor significance
- "C" = Little or no value and insignificant
TABLE 4.—"A" Value Judgments as Assigned to Trends by 25 Public Health Educators (Highest Ten Places)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Per cent of Total (25)</th>
<th>Category</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5</td>
<td>100</td>
<td>SHS</td>
<td>Involving the classroom teacher to a greater degree as part of the health team in the health service program. (45)</td>
</tr>
<tr>
<td>1.5</td>
<td>100</td>
<td>SHS</td>
<td>Recognizing the value of the continuous observation and appraisal of students by all teachers. (46)</td>
</tr>
<tr>
<td>4</td>
<td>96</td>
<td>GP</td>
<td>Growing acceptance of the health program as a vital and necessary part of the total educational panorama. (2)</td>
</tr>
<tr>
<td>4</td>
<td>96</td>
<td>HSL</td>
<td>Increasing recognition that the emotional health of the teacher influences the emotional tone of the classroom. (63)</td>
</tr>
<tr>
<td>4</td>
<td>96</td>
<td>SHS</td>
<td>Utilizing the many facets of the health service program containing opportunities for learning about health and its protection. (43)</td>
</tr>
<tr>
<td>6.5</td>
<td>92</td>
<td>HI</td>
<td>Producing ACTION in health education through the functional approach to health instruction. (73)</td>
</tr>
<tr>
<td>6.5</td>
<td>92</td>
<td>CP</td>
<td>Recognizing the need for basic professional health courses for all prospective teachers. (96)</td>
</tr>
<tr>
<td>8</td>
<td>88</td>
<td>HI</td>
<td>Widening interest in the understanding of motivation as it is involved in the psychology of teaching health. (76)</td>
</tr>
<tr>
<td>10.5</td>
<td>84</td>
<td>HSL</td>
<td>Emphasizing the importance of the health of all school personnel. (64)</td>
</tr>
<tr>
<td>10.5</td>
<td>84</td>
<td>HI</td>
<td>Accepting the purpose of health education as a process which favorably influences knowledge, attitudes and practices. (74).</td>
</tr>
</tbody>
</table>
**TABLE 4—(contd.)**

<table>
<thead>
<tr>
<th>Rank</th>
<th>(%)</th>
<th>Category</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.5</td>
<td>84</td>
<td>HI</td>
<td>Stressing the emphasis on desirable student behavior and practices as the end product of the health instruction program. (75)</td>
</tr>
<tr>
<td>10.5</td>
<td>84</td>
<td>HI</td>
<td>Growing acceptance of the problem-solving method as an approach to the consideration of health problems. (88)</td>
</tr>
</tbody>
</table>

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- CP = College Program

**Value Judgments:**
- "A" = Utmost value and significance
- "B" = Lesser value and minor significance
- "C" = Little or no value and insignificant
<table>
<thead>
<tr>
<th>Rank</th>
<th>Per cent of Total (27)</th>
<th>Category</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>96</td>
<td>HSL</td>
<td>Increasing recognition that the emotional health of the teacher influences the emotional tone of the classroom. (63)</td>
</tr>
<tr>
<td>2</td>
<td>89</td>
<td>GP</td>
<td>Growing acceptance of the health program as a vital and necessary part of the total educational panorama. (2)</td>
</tr>
<tr>
<td>4</td>
<td>85</td>
<td>GP</td>
<td>Accepting the positive concept of health as a state of total well-being. (5)</td>
</tr>
<tr>
<td>4</td>
<td>85</td>
<td>GP</td>
<td>Emphasizing the importance of the health of all school personnel. (64)</td>
</tr>
<tr>
<td>4</td>
<td>85</td>
<td>HSL</td>
<td>Emphasizing the educational, nutritional and sanitary aspects of the school food service. (72)</td>
</tr>
<tr>
<td>8</td>
<td>81</td>
<td>GP</td>
<td>Widening concern and expanding knowledge regarding child growth and development. (4)</td>
</tr>
<tr>
<td>8</td>
<td>81</td>
<td>GP</td>
<td>Clarifying the role of the school in handling student personality and behavior problems. (18)</td>
</tr>
<tr>
<td>8</td>
<td>81</td>
<td>SHS</td>
<td>Organizing the school health program with the realization that the family has the primary responsibility for the health of the student. (41)</td>
</tr>
<tr>
<td>8</td>
<td>81</td>
<td>HSL</td>
<td>Promoting the health and welfare of students by providing a school program organized and administered with these factors in mind. (66)</td>
</tr>
</tbody>
</table>
TABLE 5—(contd.)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Percentage of Total (27)</th>
<th>Category</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>81</td>
<td>HI</td>
<td>Accepting the purpose of health education as a process which favorably influences knowledge, attitudes and practices. (74)</td>
</tr>
</tbody>
</table>

Code:
- GP = General Program
- SHS = School Health Services
- HSL = Healthful School Living
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- CP = College Program

Value Judgments:
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- "B" = Lesser value and minor significance
- "C" = Little or no value and insignificant
### TABLE 6—"B" Value Judgments as Assigned to Trends by the Total 107 Respondents (Highest Ten Places)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Category</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HI</td>
<td>Increasing number of textbooks published for school and college health courses. (66)</td>
</tr>
<tr>
<td>2</td>
<td>GP</td>
<td>Suggesting changes in the basic professional terminology used in health education. (11)</td>
</tr>
<tr>
<td>3</td>
<td>HI</td>
<td>Increasing number of acceptable health resources available from commercial organizations. (85)</td>
</tr>
<tr>
<td>4.5</td>
<td>GP</td>
<td>Augmenting the quantity of literature in the field of school and college health education. (13)</td>
</tr>
<tr>
<td>4.5</td>
<td>SHS</td>
<td>Utilizing parents and other non-school personnel in administering screening tests, such as those for vision and hearing. (47)</td>
</tr>
<tr>
<td>6</td>
<td>GP</td>
<td>Providing of leadership by professional health organizations in school and college health programs. (34)</td>
</tr>
<tr>
<td>7</td>
<td>GP</td>
<td>Analyzing the health misconceptions which exist among students and teachers. (24)</td>
</tr>
<tr>
<td>9</td>
<td>GP</td>
<td>Attempting to include health learning experiences and concepts in all parts of the school and college curriculum. (10)</td>
</tr>
<tr>
<td>9</td>
<td>SHS</td>
<td>Releasing the student during school hours to obtain medical and dental treatment. (51)</td>
</tr>
<tr>
<td>Rank (107)</td>
<td>Category</td>
<td>Trend</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
<td>-------</td>
</tr>
<tr>
<td>9</td>
<td>HI</td>
<td>Implementing the concepts of correlation and integration of health with the majority of subjects in the school program. (82)</td>
</tr>
</tbody>
</table>

**Code:**
- GP = General Program
- SHS = School Health Services
- HSL = Healthful School Living
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- CP = College Program

**Value Judgments:**
- "A" = Utmost value and significance
- "B" = Lesser value and minor significance
- "C" = Little or no value and insignificant
<table>
<thead>
<tr>
<th>Rank</th>
<th>Per cent of Total (55)</th>
<th>Category</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>60</td>
<td>HI</td>
<td>Increasing number of textbooks published for school and college health courses. (86)</td>
</tr>
<tr>
<td>2</td>
<td>58</td>
<td>GP</td>
<td>Suggesting changes in the basic professional terminology used in health education. (11)</td>
</tr>
<tr>
<td>3.5</td>
<td>53</td>
<td>GP</td>
<td>Providing of leadership by professional health organizations in school and college health programs. (34)</td>
</tr>
<tr>
<td>3.5</td>
<td>53</td>
<td>HI</td>
<td>Increasing number of acceptable health resources available from commercial organizations. (85)</td>
</tr>
<tr>
<td>5</td>
<td>49</td>
<td>GP</td>
<td>Augmenting the quantity of literature in the field of school and college health education. (13)</td>
</tr>
<tr>
<td>6.5</td>
<td>47</td>
<td>GP</td>
<td>Attempting to include health learning experiences and concepts in all parts of the school and college curriculum. (10)</td>
</tr>
<tr>
<td>6.5</td>
<td>47</td>
<td>SHS</td>
<td>Utilizing parents and other non-school personnel in administering screening tests, such as those for vision and hearing. (47)</td>
</tr>
<tr>
<td>8.5</td>
<td>45</td>
<td>HI</td>
<td>Implementing the concepts of correlation and integration of health with the majority of subjects in the school program. (82)</td>
</tr>
<tr>
<td>8.5</td>
<td>45</td>
<td>HI</td>
<td>Augmenting the variety of methods, group procedures and resources in health. (84)</td>
</tr>
<tr>
<td>11.5</td>
<td>40</td>
<td>GP</td>
<td>Spotlighting the health aspects of physical education. (14)</td>
</tr>
</tbody>
</table>
### TABLE 7—(contd.)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Total (55)</th>
<th>Category</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.5</td>
<td>40</td>
<td>GP</td>
<td>Including representatives of the entire school or college faculty in health curriculum building and policy making. (27)</td>
</tr>
<tr>
<td>11.5</td>
<td>40</td>
<td>GP</td>
<td>Recognizing a need for school and community representatives to cooperatively develop and carry out school and college health policies. (28)</td>
</tr>
<tr>
<td>11.5</td>
<td>40</td>
<td>SHS</td>
<td>Changing the case finding techniques for tuberculosis. (62)</td>
</tr>
</tbody>
</table>

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- CP = College Program

**Value Judgments:**
- "A" = Utmost value and significance
- "B" = Lesser value and minor significance
- "C" = Little or no value and insignificant
<table>
<thead>
<tr>
<th>Rank</th>
<th>Per cent of Total</th>
<th>Category</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(25) Category</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5</td>
<td>60</td>
<td>HI</td>
<td>Increasing number of textbooks published for school and college health courses. (86)</td>
</tr>
<tr>
<td>1.5</td>
<td>60</td>
<td>GP</td>
<td>Interpreting basic medical knowledge and progress to the lay public by qualified experts through such media as radio, television, newspapers and magazines. (21)</td>
</tr>
<tr>
<td>4.5</td>
<td>56</td>
<td>GP</td>
<td>Augmenting the quantity of literature in the field of school and college health education. (13)</td>
</tr>
<tr>
<td>4.5</td>
<td>56</td>
<td>GP</td>
<td>Spotlighting the health aspects of physical education. (14)</td>
</tr>
<tr>
<td>4.5</td>
<td>56</td>
<td>GP</td>
<td>Analysing the health misconceptions which exist among students and teachers. (24)</td>
</tr>
<tr>
<td>4.5</td>
<td>56</td>
<td>SHS</td>
<td>Utilizing parents and other non-school personnel in administering screening tests, such as those for vision and hearing. (47)</td>
</tr>
<tr>
<td>7.5</td>
<td>52</td>
<td>GP</td>
<td>Suggesting changes in the basic professional terminology used in health education. (11)</td>
</tr>
<tr>
<td>7.5</td>
<td>52</td>
<td>SHS</td>
<td>Increasing responsibility taken by boards of education for the administration of school health services. (44)</td>
</tr>
<tr>
<td>11.5</td>
<td>48</td>
<td>SHS</td>
<td>Clarifying the professional roles of the nurse and physician as consultants in the school and college health program. (48)</td>
</tr>
</tbody>
</table>
### TABLE 8—(contd.)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Per cent of Total (25)</th>
<th>Category</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.5</td>
<td>48</td>
<td>GP</td>
<td>Clarifying the specific health responsibilities of the student, parent, teacher, administrator and specialized personnel serving the school. (6)</td>
</tr>
<tr>
<td>11.5</td>
<td>48</td>
<td>GP</td>
<td>Emphasizing the concept of total fitness as an objective of health and physical education programs during peace-time. (17)</td>
</tr>
<tr>
<td>11.5</td>
<td>48</td>
<td>GP</td>
<td>Providing of leadership by professional health organizations in school and college health programs. (34)</td>
</tr>
<tr>
<td>11.5</td>
<td>48</td>
<td>SHS</td>
<td>Releasing the student during school hours to obtain medical and dental treatment. (51)</td>
</tr>
<tr>
<td>11.5</td>
<td>48</td>
<td>HI</td>
<td>Utilizing of research methods to determine the accuracy and readability of health textbooks. (87)</td>
</tr>
</tbody>
</table>

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- **"C"** = Little or no value and insignificant
TABLE 9.—"B" Value Judgments as Assigned to Trends by 27 General Educators (Highest Ten Places)

<table>
<thead>
<tr>
<th>Per cent of Total</th>
<th>Rank</th>
<th>Category</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>HI</td>
<td>Providing and requiring patterns of direct health instruction through specific, graded courses carrying academic credit for junior and senior high school students. (80)</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>HI</td>
<td>Increasing number of acceptable health resources available from commercial organizations. (85)</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>HI</td>
<td>Increasing number of textbooks published for school and college health courses. (86)</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>SHS</td>
<td>Utilizing parents and other non-school personnel in administering screening tests, such as those for vision and hearing. (47)</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>GP</td>
<td>Augmenting the number of qualified school health educators and health coordinators. (8)</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>GP</td>
<td>Augmenting the quantity of literature in the field of school and college health education. (13)</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>GP</td>
<td>Establishing the inter-agency committees and health councils at state and local levels. (29)</td>
</tr>
<tr>
<td></td>
<td>8.5</td>
<td>SHS</td>
<td>Emphasizing the use of the conference as a technique to promote effective follow-up and interpretation of health problems discovered by school personnel. (53)</td>
</tr>
<tr>
<td></td>
<td>8.5</td>
<td>SHS</td>
<td>Promoting the concept of the health counseling role of the school health team. (54)</td>
</tr>
<tr>
<td>Rank</td>
<td>(%)</td>
<td>Category</td>
<td>Trend</td>
</tr>
<tr>
<td>------</td>
<td>-----</td>
<td>----------</td>
<td>-------</td>
</tr>
<tr>
<td>10</td>
<td>44</td>
<td>OP</td>
<td>Suggesting changes in the basic professional terminology used in health education. (11)</td>
</tr>
</tbody>
</table>

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**Value Judgments:**
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The highest place assigned any trend in Tables 10 through 13, which present the trends which received the high "C" value judgments, was assigned Trend 11 by the public health educators in Table 12; it received 44 per cent "C" value judgments. Trend 11 was suggesting changes in the basic professional terminology used in health education. The trend which the public health educators placed second with 40 per cent "C" value judgments was Trend 85, increasing number of acceptable health resources available from commercial organizations. Trend 11 also placed first in Table 10 with 37 per cent "C" judgments, first in Table 11 with 36 per cent and first in a four-way tie in Table 13.

Besides Trend 11, four additional trends also appeared in all four of the tables, but not in the same relative positions. These were Trend 91, including driver training and driver education in school health and health education programs; Trend 86, increasing number of textbooks published for school and college health courses; Trend 13, augmenting the quantity of literature in the field of school and college health education; and Trend 10, attempting to include health learning experiences and concepts in all parts of the school and college curriculum.
TABLE 10.— "C" Value Judgments as Assigned to Trends by the Total 107 Respondents (Highest Ten Places)

<table>
<thead>
<tr>
<th>Rank of Total</th>
<th>Category</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>37</td>
<td>GP</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>25</td>
<td>HI</td>
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</tr>
<tr>
<td>4.5</td>
<td>21</td>
<td>SHS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.5</td>
<td>21</td>
<td>SHS</td>
</tr>
<tr>
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</tr>
<tr>
<td>4.5</td>
<td>21</td>
<td>HI</td>
</tr>
<tr>
<td></td>
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<tr>
<td>4.5</td>
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<td>HI</td>
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</tr>
<tr>
<td>7</td>
<td>20.5</td>
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<td></td>
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<td>GP</td>
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<td></td>
</tr>
<tr>
<td>9</td>
<td>19</td>
<td>GP</td>
</tr>
</tbody>
</table>

1 Suggesting changes in the basic professional terminology used in health education. (11)
2 Including driver training and driver education in school health and health education programs. (91)
4.5 Utilizing parents and other non-school personnel in administering screening tests, such as those for vision and hearing. (47)
4.5 Releasing the student during school hours to obtain medical and dental treatment. (51)
4.5 Increasing number of acceptable health resources available from commercial organizations. (85)
4.5 Increasing number of textbooks published for school and college health courses. (86)
7 Augmenting the quantity of literature in the field of school and college health education. (13)
8 Attempting to include health learning experiences and concepts in all parts of the school and college curriculum. (10)
9 Separating health education and physical education for purposes of administration, programming and professional preparation. (16)
### TABLE 10—(contd.)

<table>
<thead>
<tr>
<th>Rank (107)</th>
<th>Category</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>18</td>
<td>SHS</td>
</tr>
</tbody>
</table>

**Code:**

- **GP** = General Program
- **SHS** = School Health Services
- **HSL** = Healthful School Living
- **HI** = Health Instruction
- **CP** = College Program

**Value Judgments:**

- "A" = Utmost value and significance
- "B" = Lesser value and minor significance
- "C" = Little or no value and insignificant
TABLE 11.—"C" Value Judgments as Assigned to Trends by 55 School Health Educators (Highest Ten Places)

<table>
<thead>
<tr>
<th>Rank</th>
<th>(55) Category</th>
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<tbody>
<tr>
<td>1</td>
<td>GP</td>
<td>Suggesting changes in the basic professional terminology used in health education. (11)</td>
</tr>
<tr>
<td>2.5</td>
<td>SHS</td>
<td>Utilizing parents and other non-school personnel in administering screening tests, such as those for vision and hearing. (47)</td>
</tr>
<tr>
<td>2.5</td>
<td>HI</td>
<td>Including driver training and driver education in school health and health education programs. (91)</td>
</tr>
<tr>
<td>4.5</td>
<td>SHS</td>
<td>Augmenting the quantity of literature in the field of school and college health education. (13)</td>
</tr>
<tr>
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<td>Releasing the student during school hours to obtain medical and dental treatment. (51)</td>
</tr>
<tr>
<td>6</td>
<td>HI</td>
<td>Increasing number of acceptable health resources available from commercial organizations. (85)</td>
</tr>
<tr>
<td>8</td>
<td>GP</td>
<td>Attempting to include health learning experiences and concepts in all parts of the school and college curriculum. (10)</td>
</tr>
<tr>
<td>8</td>
<td>GP</td>
<td>Separating health education and physical education for purposes of administration, programming and professional preparation. (16)</td>
</tr>
<tr>
<td>8</td>
<td>HI</td>
<td>Spotlighting such special content areas as alcohol, tobacco and narcotics, consumer health and mental hygiene. (90)</td>
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</table>
### TABLE 11—(contd.)

<table>
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<tr>
<th>Rank (55)</th>
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<td>Upgrading standards for desirable athletic competition in schools and colleges. (37)</td>
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<tr>
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<td>HI</td>
<td>Implementing the concepts of correlation and integration of health with the majority of subjects in the school program. (82)</td>
</tr>
<tr>
<td>11 11</td>
<td>HI</td>
<td>Increasing number of textbooks published for school and college health courses. (86)</td>
</tr>
</tbody>
</table>

**Code:**
- GP = General Program
- SHS = School Health Services
- HSL = Healthful School Living
- HI = Health Instruction
- CP = College Program

**Value Judgments:**
- "A" = Utmost value and significance
- "B" = Lesser value and minor significance
- "C" = Little or no value and insignificant
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<td>Including driver training and driver education in school health and health education programs. (91)</td>
</tr>
<tr>
<td>3.5</td>
<td>32 HI</td>
<td></td>
<td>Increasing number of textbooks published for school and college health courses. (86)</td>
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<td>Spotlighting the health aspects of physical education. (14)</td>
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<td>Changing the case finding techniques for tuberculosis. (62)</td>
</tr>
<tr>
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TABLE 12—(contd.)

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</tr>
</tbody>
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Code:  
GP = General Program  
SHS = School Health Services  
HSL = Healthful School Living  
HI = Health Instruction  
CP = College Program

Value Judgments:  
"A" = Utmost value and significance  
"B" = Lesser value and minor significance  
"C" = Little or no value and insignificant
**TABLE 13.—"C" Value Judgments as Assigned to Trends by 27 General Educators (Highest Ten Places)**

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<td>2.5</td>
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<td>SHS</td>
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<td>Increasing responsibility taken by boards of education for the administration of school health services. (44)</td>
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<td>Utilizing parents and other non-school personnel in administering screening tests, such as those for vision and hearing. (47)</td>
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**TABLE 13—(contd.)**

<table>
<thead>
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<th>Rank</th>
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<td>8.5</td>
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<td>Including driver training and driver education in school health and health education programs. (91)</td>
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</table>

**Code:**
- GP = General Program
- SHS = School Health Services
- HSL = Healthful School Living
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**Value Judgments:**
- "A" = Utmost value and significance
- "B" = Lesser value and minor significance
- "C" = Little or no value and insignificant
Results of Application of Chi-Square Test

The Chi-square formula was applied to each trend using a 3 x 3 fold contingency table. In some instances, where only a small number of "B" and "C" value judgments were awarded a trend, the "B" and "C" value judgments were combined and the formula was again applied using a 3 x 2 fold contingency table. Table 14 lists the Chi-squares for each trend and indicates the trends in which the P value exists at the .01 and .05 levels at four and two degrees of freedom.

When using four degrees of freedom, a trend is considered significant (P = .05) if the Chi-square is at least 9.5; when the P = .01, the Chi-square must register at least 13.3. When two degrees of freedom are used, significance (P = .05) is indicated when the Chi-square is 6.0 and P = .01 if the Chi-square is 9.2.
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</table>
Table 14 indicates that some measure of statistical significance was found in forty-one trends which is 39 percent of the total one hundred and four trends. When four degrees of freedom were used in the computation, thirty-two trends had a P value at the .05 level. Fourteen of these thirty-two trends were significant at the .01 level, also. Thirty-six trends showed some P value at the .05 level when two degrees of freedom were used; nineteen of these thirty-six were significant at the .01 level at two degrees of freedom.

<table>
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<td>11.9</td>
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<td>102</td>
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<td>103</td>
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<td>.05</td>
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<td>.05</td>
</tr>
<tr>
<td>104</td>
<td>7.1</td>
<td>.05</td>
<td>0.2</td>
<td></td>
</tr>
</tbody>
</table>
All of the five categories included in the checklist had at least one trend which showed some significant P value; one category, The General School and College Health Program, had fifteen statistically significant trends at either four or two degrees of freedom.
CHAPTER VI

DISCUSSION

For purposes of organization and clarity, the interpretation and discussion of the findings of the data are divided into four sections: (1) a comparison of trends in school health as outlined by Lindsay\(^1\) in 1943 with those identified in this study; (2) a discussion of the findings reflected in the rankings of the trends; (3) an analysis of the findings concerning the five categories of the checklist; and (4) an interpretation of the results of the application of the Chi-square Test as it was used to treat the data.

**Comparison of Trends in School Health Outlined by Lindsay\(^2\) in 1943 with Those Identified in This Study**

In the process of tracing the origin and development of the school health movement, Lindsay identified trends as they emerged throughout the study. This identification was not the primary purpose of her study but occurred as a natural result of the treatment of the subject matter. It seemed feasible, therefore, to compare the trends which

\(^1\) Lindsay, loc. cit.
\(^2\) Ibid.
emerged from the 1943 study with those which have been identified in this study. The comparison appears in Table 15. The four titles which Lindsay used to classify her subject matter have been used as the basis of organization of Table 15. In this Table, the statement of each trend established by Lindsay was in many cases a condensed one; each of these phrases or statements was preceded by the term trend or a similar type of action word denoting change or tendency or progress. When a trend from this study was considered similar in meaning, it was placed opposite the statement by Lindsay. It will be noted that in some instances more than one trend from this study was included in the parallel position. The numbers in the parentheses following the statements from this study refer to the number of the trend as it appeared in the checklist (Appendix B); statements of these trends have also been condensed in some cases.

The 1943 study mentioned thirty-nine trends, some of which were specific; the 1958 study named one hundred and four trends, many of which were specific. As shown in Table 15, sixteen or 41 per cent of the thirty-nine trends in the 1943 study were not directly mentioned in the 1958 study; likewise, thirty-one or 30 per cent of the total one hundred and four trends identified in the 1958 study were considered to be parallel in meaning or scope to those established by Lindsay.
TABLE 15.—Comparison of Trends in School Health as Outlined by Lindsay3 in 1943 and Those Identified in This Study

<table>
<thead>
<tr>
<th>1943</th>
<th>1958</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. HEALTHFUL SCHOOL LIVING</td>
<td>HEALTHFUL SCHOOL LIVING</td>
</tr>
<tr>
<td><strong>A. Schoolhouse Planning and the School Site</strong></td>
<td></td>
</tr>
<tr>
<td>1. State Agency's assuming of authority over the school site and ground.</td>
<td></td>
</tr>
<tr>
<td>2. Location of elementary schools in large cities in residential areas.</td>
<td></td>
</tr>
<tr>
<td>3. Wider use of school plant.</td>
<td></td>
</tr>
<tr>
<td>4. Increased size of school plant.</td>
<td></td>
</tr>
<tr>
<td>5. Scientific planning for community needs.</td>
<td></td>
</tr>
<tr>
<td><strong>B. The Building</strong></td>
<td></td>
</tr>
<tr>
<td>1. Design influenced by curriculum design.</td>
<td></td>
</tr>
<tr>
<td>2. Attention given materials of construction, interior arrangements, utility and adaptation for specialized work.</td>
<td></td>
</tr>
<tr>
<td>3. Architectural change from ecclesiastical to simple campus plan.</td>
<td></td>
</tr>
<tr>
<td><strong>C. Service systems</strong></td>
<td></td>
</tr>
<tr>
<td>1. Lighting considered in relation to human efficiency and achievement.</td>
<td>Accepting standards of safety, housekeeping procedures and sanitation as affecting learning. (68)</td>
</tr>
<tr>
<td>2. Janitors replaced by custodians or janitor-engineers.</td>
<td></td>
</tr>
<tr>
<td>3. Classrooms supported by scientific principles for child health.</td>
<td>Acknowledging that physical factors of school environment affect health. (69)</td>
</tr>
</tbody>
</table>

---

3 Ibid.
TABLE 15—(contd.)

<table>
<thead>
<tr>
<th>1943</th>
<th>1958</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.</strong> Attention given sound qualities in auditoriums and study halls.</td>
<td>Recognizing that emotional health of teacher influences classroom tone. (63)</td>
</tr>
<tr>
<td><strong>5.</strong> Angle or slope type desk-tops used; furniture moveable.</td>
<td>Promoting health and welfare by providing a school program organized and administered with these factors in mind. (66)</td>
</tr>
</tbody>
</table>

D. Hygiene of Instruction

1. Importance of teacher influence on pupil mental adjustment. | Accepting purpose of health education as process influencing knowledge, attitudes and knowledge. (74) |
2. Program arranged to prevent undue fatigue. | |
3. Realization that attitudes influence learning and behavior. | |
4. Hygiene of instruction assuming prominent place in health program. | |

II. HEALTH EDUCATION

A. Subject matter determined by pupil needs and interests. | Implementing the students' "needs and interest" approach in curriculum planning. (77) |
B. Sex education accepted as part of school curriculum. | Incorporating the important special problem area of sex education into family life education. (89) |
C. Safety taught as school activity; driver education gains favor. | Including driver training in school health programs. (91) |
TABLE 15—(contd.)

<table>
<thead>
<tr>
<th>1943</th>
<th>1958</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D. Professional preparation of teachers included health knowledge, methods of teaching and health appraisal techniques.</strong></td>
<td>Acknowledging need of variety of methods, group procedures and resources. (83) Recognizing need for basic professional health courses for teachers. (95) Analyzing the health misconceptions which exist among students and teachers. (24)</td>
</tr>
<tr>
<td><strong>E. Selection of teachers according to personality characteristics.</strong></td>
<td>Gearing curricula and teacher's guides to help meet needs and interests. (79) Organizing planned, flexible and sequential health curricula. (81) Augmenting variety of materials and resources from official and voluntary agencies. (84) Increasing acceptable resources from commercial agencies. (85) Increasing number of health textbooks. (86)</td>
</tr>
<tr>
<td><strong>F. Improvement in health teaching materials and methods.</strong></td>
<td>III. SCHOOL HEALTH SERVICES SCHOOL HEALTH SERVICES</td>
</tr>
<tr>
<td><strong>A. Attempt to make health service functional, educational through correction of remediable defects:</strong></td>
<td><strong>Changing philosophy...for medical and dental examinations to family physician and dentist.</strong> (50)</td>
</tr>
<tr>
<td>1. Medical examination given prior to school entrance and in secondary grades by family physician.</td>
<td></td>
</tr>
<tr>
<td>1943</td>
<td>1958</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>2.</strong> Effort made to have parent present at examination.</td>
<td>Utilizing parents and other non-school personnel in administering screening tests. ... (47)</td>
</tr>
<tr>
<td><strong>3.</strong> Acceptance of non-professional participation in program.</td>
<td>Using the cumulative health record effectively, i.e., focal point of communications of health team. (52)</td>
</tr>
<tr>
<td><strong>4.</strong> Use of adequate cumulative record card.</td>
<td>Clarifying professional roles of nurse and physician as consultants in program. (48)</td>
</tr>
<tr>
<td><strong>5.</strong> Generalized service provided by nurse.</td>
<td>Stressing the importance of the &quot;team approach.&quot; (9)</td>
</tr>
</tbody>
</table>

B. Program personnel include many types of people and agencies. | Increasing responsibility taken by boards of education for administration of school services. (44) |

C. Recognition of education departments as source of authority. | Varying of school health services and policies according to locale... (42) |

D. Avoidance of standardization of school health supervision; plan must fit situation. | |

E. Schools assume leadership for developing agencies to treat defects of school children. | |

F. Placement of exceptional child in regular classroom, if feasible. | Including physically handicapped students in regular classes...or in special classes arranged by school. (59) |
| Making special provisions and adaptations for the mentally exceptional student in either regular or special classes in the school. (60) |
### TABLE 15—(contd.)

<table>
<thead>
<tr>
<th>1943</th>
<th>1958</th>
</tr>
</thead>
<tbody>
<tr>
<td>G. Desegregation of under-par children; open-air classes available to all.</td>
<td>Providing health appraisal and medical services for the indigent student through increased community services. (57)</td>
</tr>
<tr>
<td>H. Provision of other corrective services for all age groups in the community.</td>
<td></td>
</tr>
</tbody>
</table>

**IV. UNIFICATION OF SCHOOL HEALTH PROGRAM**

**A. Interweaving of all segments into unified whole - environmental factors, hygiene instruction, health service, physical education and mental health.**

**B. Organization of agencies brought cooperative group effort as opposed only to individual effort.**

**C. Efforts by three national groups evidenced by:**

1. Educational Policies Commission plea for cooperation between public schools and public health.
2. The publication: *Suggested School Health Policies*.
3. The publication: *Health in Schools*.

**UNIFICATION OF SCHOOL HEALTH PROGRAM**

Recognizing health education and physical education as complementary and supplementary but not identical fields. (15)

Utilizing the leadership of medical societies at state and local levels. (33)

Increasing cooperation between medical and educational organizations at state and local levels. (35)

Implementing the principles by which schools and colleges can cooperate to improve health programs. (32)

Providing of leadership by professional health organizations in school and college health programs. (34)

Numbers in parenthesis indicate the number of the trend as identified in this study.
Lindsay established trends relating to schoolhouse planning and the school site, the school building, the role of the custodian, type of furniture, the prominence of hygiene of instruction, selection of teachers, presence of parents at medical examination, assuming of leadership by schools for developing agencies to treat pupil defects and desegregation of under-par children - none of which were identified as trends in this study. This difference in the trends identified in the two studies might signify that the preceding statements are no longer trends as of 1956 or that a treatment of these concepts simply does not appear extensively in the literature of the field of school and college health during the 1948-1958 time period. They might have been replaced by other concepts and actions.

In the present study many more specific trends were identified, particularly in the general program of school health, its relation to the total educational and community program, and the professional health education program. It was noticeable that many of the 1958 trends considered parallel to the 1943 trends were actually implementations of the 1943 trends. They inferred a continuation and a process of furthering and broadening of the initial activity as specified in the 1943 trend. This might be interpreted as an indication of growth and progress in the school and college health program.
Findings Reflected in the Ranking of the Trends

To determine which trends were assigned the highest number of "A," "B" and "C" evaluations, rankings of ten places were used in this treatment of the data. The rankings were computed for all the respondents as well as each of the three educator groups and may be found in Tables 2 through 13, in Chapter V.

Rankings Assigned by All Respondents (Tables 2, 6 and 10)

Data concerning the trends assigned the highest ten places of value judgments from the total one hundred and seven respondents revealed that no one trend received an 100 per cent evaluation of any one of the value judgments. The ten highest evaluations by the total respondents were all of the "A" type value judgment denoting trends of utmost value and significance; the highest single percentage accorded any one trend by all respondents was a 94 per cent received by Trend 63, Increasing recognition that the emotional health of the teacher influences the emotional tone of the classroom. Likewise, 93 per cent "A" evaluations was received by Trend 2, Growing acceptance of the health program as a vital and necessary part of the total educational panorama. The highest "B" value judgment assigned by the total respondents was a 60 per cent given Trend 86, Increasing number of textbooks published for school and college health courses. The greatest number of "C" evaluations, indicating those trends having little or
no value, by all respondents was a 37 per cent received by Trend 11, \textit{Suggesting changes in the basic professional terminology used in health education}. Only eight trends (7.7 per cent of the total 104) received 20 per cent or more "C" evaluations from the total group replying to the checklist.

Trend 64, \textit{Emphasizing the importance of the health of all school personnel}, plus Trends 63 and 2, previously stated, appeared in Tables 3, 4 and 5 as well as in Table 2. Tables 3, 4 and 5 list the top "A" value judgment choices of the three educator groups. Trend 2 was in one of the top three places of all of the "A" value judgment tables and Trend 63 was similarly in one of the top four positions.

The trends concerning \textit{Increasing the number of textbooks}, Trend 86; \textit{Health resources from commercial organizations}, Trend 85; and the \textit{Quantity of literature in the field}, Trend 13, all of which were found in Table 6, were high in the "B" value judgment list of the total respondents and each educator group. Those trends awarded a "B" were felt to be of lesser value, but having some minor significance. An exception was Trend 85 which the public health educators placed high in their "C" value judgments. \textit{Suggesting changes in the basic professional terminology...}, Trend 11, and the \textit{Utilizing parents and other non-school personnel...}, Trend 47, also ranked high in all the "B" judgment lists.

It should not be overlooked, however, that each one of Trends 86, 85, 11, 13 and 47 also ranked in the top seven
listings of the "C" evaluations of the total respondents in Table 10. Perhaps these five trends should be examined carefully as to their general value and worth since it is apparent that there might be some conflict in the evaluations regarding them. They appeared in the top rankings of both the "B" (lesser value) and "C" (little or no value) judgments of the total respondents. It was obvious that the respondents did not consider them major and important trends.

Trend 91, Including driver training and driver education in school health and health education programs, and Trend 13, Augmenting the quantity of literature in the field of school and college health education, were found in all four of the top "C" evaluation tables (Tables 10, 11, 12 and 13). This was indicative that the respondents considered these trends to be insignificant. Trend 11, Suggesting changes in the basic professional terminology used in health education appeared in the top places of each educator group and the total respondents. It may also be noted in the "C" rankings that no trends from either the Healthful School Living or the College Health Program categories were listed. Three trends received no "C" evaluations whatsoever from any of the total one hundred and seven respondents. These trends were 8, Augmenting the number of qualified school health educators and health coordinators; 46, Recognizing the value of continuous observation and appraisal of students by all teachers; and 53, Emphasizing the use of the conference as
a technique to promote effective follow-up and interpretation of health problems discovered by school personnel. Twelve trends (2, 4, 20, 41, 58, 59, 63, 75, 94, 95, 99 and 100) received only a single "C" evaluation from the total number of respondents.

It will be noted that all five categories of the checklist were included in Tables 2, 3 and 4. Only the category concerning the College Health Program was missing from the top "A" evaluations of the general educators. All of the trends listed in Table 2 were very broad and general concepts. They were particularly concerned with the personnel and personal aspects of the health program since they stressed the emotional climate of the classroom, the importance of health for all personnel, the health education responsibilities of the classroom teacher, the primary obligation of the family for a student's health and increasing in-service opportunities for professional personnel. With the recognition of the importance of the health program in all education and the directive to action through knowledge, attitude and skills via functional teaching, the ten trends listed in Table 2 might be considered the real corner stones of the school and college health program as revealed by this study. Perhaps the basic school and college health program could be formulated around these ten trends.
Rankings Assigned by School Health Educators

When the rankings of the trends by the school health educators were viewed separately, one is immediately aware of the number of trends given a high percentage of "A" evaluations, trends that were of utmost value, that were in the categories of Healthful School Living, Health Instruction and the College Health Program. Perhaps this was a reflection of the philosophy of the 51.4 per cent of the total respondents who are school health educators. Ninety-nine per cent of this group singled out Trend 92, Enlarging and enriching the effectiveness of the basic college required course. This trend did not appear in the top "A" listings of the total respondents, the public health educators or the general educators. Neither did Trend 50, Changing the philosophy related to the responsibility for medical and dental examinations from the educational institution to the family physician and dentist, nor Trends 83, 93, 96 and 81. The top trends selected by the school health educators stressed health education as playing an important part in both general and professional education and the ultimate purposes of health education, in addition to the personal and personnel factors underlined by all the respondents. The highest "C" value judgment given (which denoted a trend of little or no value) was a 36 per cent recorded for Trend 11, Suggesting changes in the basic professional terminology.
used in health education. This was noteworthy since it is
the school health educators who made these changes in 1951.
The next highest "C" value judgment was a 21 per cent given
Trend 47, Utilizing parents and other non-school personnel
in administering screening tests, such as those for vision
and hearing. These same trends received 58 and 47 per cent
ratings respectively of "B" or lesser value judgments, also.
The school health educators were concerned to a degree with
the Increasing number of textbooks, Trend 86, since they
placed it the highest (60 per cent) in their "B" value judg-
ments in Table 7.

Rankings Assigned by Public Health Educators
(Tables 4, 8 and 12)

As a group, the public health educators were the only
ones to agree 100 per cent on any trends. As previously
mentioned, they cast twenty-five "A" value judgments for
Trends 45 and 46, both of which were concerned with the
classroom teacher in the category of health services and
therefore deemed highly significant by this group. They
also had a high agreement (96 per cent) on another trend in
this category, Trend 43, Utilizing the many facets of the
health service program containing opportunities for learning
about health and its protection. Similar 96 per cent "A"
judgments were given Trends 2 and 63 which were discussed in
relation to the high "A" responses of the total group. It
should not be overlooked that this group also chose several
trends that appeared in the category dealing with health instruction as shown by Table 4. They also, along with the school health educators, were cognizant of Trend 96, **Recognizing the need for basic professional health courses for all prospective teachers.** This group singled out the following three trends which neither the total respondents, the school health educators nor the general educators ranked at all in their top ten listings: Trend 43, stated above; Trend 76, **Widening interest in the understanding of motivation as it is involved in the psychology of teaching health,** and Trend 86, **Growing acceptance of the problem-solving method as an approach to the consideration of health problems.** Perhaps the public health educators by way of training and responsibility were particularly sensitive to the roles that motivation and problem-solving play in the approach to health problems. Four of the trends previously mentioned in this discussion, Trends 11, 85, 91 and 86, were ranked high in the "C" evaluations and therefore were deemed to be of little or no value by this group (Table 12). The two highest "C" evaluations given by any group or the total respondents were the 44 per cent and 40 per cent given Trends 11 and 85 by the public health educators.

One of the trends that was noticeable in the "B" value judgments given by the public health educators was Trend 21, **Interpreting basic medical knowledge and progress to the lay public by qualified experts through such media as**
radio, television, newspapers and magazines. This was the only place in Tables 2 through 13 that this trend appeared and it received 60 per cent of the public health educator "B" value judgments. Perhaps this was also a reflection of a professional characteristic of this group. It should also be noted that a large number of trends in Table 8 was included when assigning the trends ten places, indicating a rather extensive use of the "B" value judgment, or the citing of trends of some minor importance by this group.

**Rankings Assigned by the General Educators (Tables 5, 9 and 13)**

When comparing the top "A" rankings of the total respondents (Table 2) with the general educators as a group (Table 5), it was immediately noticeable that the two trends which held the two top positions in each table were identical. Also, six of the ten trends in the two tables were the same (Trends 63, 2, 5, 64, 41 and 75), though holding different places in several instances. This might be noteworthy since, generally speaking, general educators hold a great deal of the responsibility for the health program in schools and colleges but may not be thoroughly grounded in all its details. The broad concepts which these trends reflected might be considered very vital ones since they included the recognition of the importance of health to all personnel and especially of the emotional phase to the teacher, the place of the health program in the total educational picture, the
positive concept of health as a state and health education as a process and the primary responsibility of the family for the health of the child.

It was also pertinent that the other four trends receiving the highest number of "A" value judgments and considered of utmost importance by this group were not mentioned by either of the other groups or in any of the totals by all the respondents. These included Trends 72, 4, 18 and 66. Inherent in three of these four trends were the growth and development, behavioral, and organizational factors which might be considered as the basic concepts and elements of all general education.

Although many of the general educators have college and university affiliations, they did not place any trend regarding the College Health Program in the top ten places of their "A" value judgments.

Also worthy of observation was the trend heading the list of Table 9 which included the greatest number of "B" value judgments for this group. Trend 80 was concerned with the provision and requirement of direct health instruction which carried academic credit. Generally speaking, school health educators might hope that general educators would think this worthy of an "A" rating. School health educators might also entertain similar ideas regarding Trend 8, **Augmenting the number of qualified school health educators**, and Trend 29, **Establishing inter-agency committees and**
health councils at state and local levels, to which the general educators also assigned "B" ratings.

Two of the four trends occupying the top "C" value judgments, that is, trends that 33 per cent of this group felt definitely should not be promoted, should be mentioned. These are Trend 10, Attempting to include health learning experiences and concepts in all parts of the school and college curriculum, and Trend 51, Releasing the student during school hours to obtain medical and dental treatment. Do these judgments reflect desirable points of view?

Questions might also be raised concerning Trend 62, Changing the case finding techniques for tuberculosis, and Trend 44, Increasing responsibility taken by boards of education for the administration of school health services. Is the general educator really cognizant of these trends and believes they are not important?

**Analysis of Findings Concerning the Five Categories of the Checklist**

In an attempt to gain some insight into the manner in which each of the three educator groups plus the total respondents evaluated each of the five categories of the checklist - the general school and college health program, school health services, healthful school living, health instruction and the college health program - Table 16, was compiled. This table included information for each of the
three educator groups and the total respondents relative to each of the five categories and the total one hundred and four trends. It presented the (A) percentage of trends for each category receiving a minimum of 50 per cent "A" value judgments, (B) the range of percentage of the "A" value judgments in each category, (C) the percentage of trends for each category receiving a minimum of 50 per cent "B" value judgments and (D) the percentage of trends in each category receiving no "C" value judgments.

The General School and College Health Program:
Trends 1 through 38.

Of the thirty-eight trends in this category, a great majority received at least 50 per cent "A" value judgments indicating they are definitely significant. The school health educators awarded a minimum of 50 per cent "A" ratings to thirty-three of the total thirty-eight trends; the public health educators and general educators respectively, gave a similar rating to twenty-five and twenty-six of the trends in this category. With such a large percentage of "A" ratings, the "B" (lesser value) and "C" (little or/no value) ratings were relatively low with the exception of the "B" ratings of the public health educators. In this category, the public health educators awarded at least 50 per cent "B" value judgments to five of the thirty-eight trends. Twenty-nine of the thirty-eight trends were not awarded a single "C" evaluation by the school health educators; the two other
### TABLE 16.—Analysis of Group Responses Concerning the Five Checklist Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Educators</th>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>School</td>
<td>Public</td>
<td>Health</td>
<td>Health</td>
<td>Total</td>
</tr>
<tr>
<td>A. Percentage of trends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>receiving minimum of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50% &quot;A&quot; judgments</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. General program</td>
<td>87</td>
<td>66</td>
<td>68</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>II. Health Services</td>
<td>88</td>
<td>79</td>
<td>75</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>III. Healthful living</td>
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<td>100</td>
<td>90</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>IV. Instruction</td>
<td>68</td>
<td>68</td>
<td>68</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>V. College program</td>
<td>100</td>
<td>92</td>
<td>84</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Total of all 104 trends</td>
<td>87</td>
<td>76</td>
<td>74</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>B. Range of percentages</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of &quot;A&quot; value judgments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. General program</td>
<td>94-1.8</td>
<td>96-4.0</td>
<td>89-15</td>
<td>93-7.0</td>
<td></td>
</tr>
<tr>
<td>II. Health Services</td>
<td>89-22</td>
<td>100-28</td>
<td>81-22</td>
<td>84-23</td>
<td></td>
</tr>
<tr>
<td>III. Healthful living</td>
<td>93-58</td>
<td>96-52</td>
<td>96-44</td>
<td>94-57</td>
<td></td>
</tr>
<tr>
<td>IV. Instruction</td>
<td>91-22</td>
<td>92-4.0</td>
<td>81-4.0</td>
<td>86-13</td>
<td></td>
</tr>
<tr>
<td>V. College program</td>
<td>94-51</td>
<td>92-44</td>
<td>78-44</td>
<td>87-49</td>
<td></td>
</tr>
<tr>
<td>Total of all 104 trends</td>
<td>94-1.8</td>
<td>100-4.0</td>
<td>96-4.0</td>
<td>94-7.0</td>
<td></td>
</tr>
<tr>
<td>C. Percentage of trends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>receiving minimum of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50% &quot;B&quot; judgments</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>I. General program</td>
<td>5</td>
<td>13</td>
<td>8</td>
<td>5</td>
<td></td>
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<tr>
<td>II. Health Services</td>
<td>0</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>III. Healthful living</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>IV. Instruction</td>
<td>11</td>
<td>5</td>
<td>16</td>
<td>11</td>
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</tr>
<tr>
<td>V. College program</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total of all 104 trends</td>
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<td>7</td>
<td>7</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>D. Percentage of trends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>receiving no &quot;C&quot; judgments</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>I. General program</td>
<td>29</td>
<td>34</td>
<td>11</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>II. Health Services</td>
<td>33</td>
<td>45</td>
<td>33</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>III. Healthful living</td>
<td>0</td>
<td>90</td>
<td>30</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>IV. Instruction</td>
<td>26</td>
<td>37</td>
<td>11</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>V. College program</td>
<td>54</td>
<td>62</td>
<td>8</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total of all 104 trends</td>
<td>28</td>
<td>46</td>
<td>17</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
educator groups differed in this respect, however. The public health educators awarded "C" judgments in this category to four trends while the general educators gave some "C" judgments to 11 trends.

The trend awarded the highest percentage of "A" (utmost value) judgments by all respondents and all groups in this area was Trend 2, Growing acceptance of the health program as a vital and necessary part of the total educational panorama. The lowest number of "A" judgments awarded by all respondents and the school and public health educators was to Trend 11, Suggesting changes in the basic professional terminology used in health education. The general educators awarded their lowest number of "A" judgments to Trend 13, Augmenting the quantity of literature in the field of school and college health education. A 91 per cent of "A" evaluations was given Trend 5, Accepting the positive concept of health as a state of total well-being, by the school health educators. The range of 93.7 per cent for "A" judgments for all respondents was the widest range for all respondents in any of the five categories.

School Health Services; Trends 39 through 62

The twenty-four trends which comprised this category showed a range of 82 - 23 per cent of "A" value judgments with twenty of the total twenty-four trends or 83 per cent of the trends accorded at least 50 per cent "A" evaluations.
Once again, the highest percentage of "A" ratings was awarded by the school health educators; at the same time they gave no trend a 50 per cent or higher "B" rating. To 33 per cent of the trends they did not award a single "C" value judgment. The greatest number of "A" evaluations, 89 per cent, was given Trend 41, Organizing the school health program with the realization that the family has the primary responsibility for the health of the students. Trend 47, Utilizing parents and other non-school personnel in administering screening tests, such as those for vision and hearing, received the least "A" ratings from the school health educators.

As discussed previously, it was in this category that the public health educators awarded their total twenty-five or 100 per cent "A" ratings to Trends 45 and 46. They also awarded a 96 per cent rating of "A" to Trend 43, Utilizing the many facets of the health service program containing opportunities for learning about health and its protection. Only two trends or 8 per cent in this category received a minimum of 50 per cent "B" evaluations from the public health educators.

Although the general educators gave the lowest percentage of the minimum 50 per cent "A" ratings, they awarded 81 per cent "A's" to Trend 41, which is stated above. To eight trends in this category they gave no "C" ratings.
Healthful School Living; Trends 63 through 72

This category occupied a rather unique position in this analysis. It was the only category in which all the trends received at least 50 per cent "A" value judgments denoting major significance from the school health educators, the public health educators and the total respondents. Perhaps it was due to this that not one trend received as many as 50 per cent "B" evaluations denoting minor significance from any of the three educator groups or total respondents. The range of the "A" judgments was 94 - 57 per cent; it should be noted, however, that there were only ten trends included in this category. Another pertinent characteristic of this category was that all of the ten trends received at least one "C" rating denoting little or no significance from the school health educators and nine of them did not receive a single "C" rating from the public health educators. The public health educators were the extreme group on each item in this category. The trend receiving the greatest number of "A" value judgments of all the one hundred and four trends was found in this category; it was Trend 63, Increasing recognition that the emotional health of the teacher influences the emotional tone of the classroom.
Health Instruction; Trends 73 through 91

A noteworthy feature of this category was the fact that each educator group and the total respondents gave thirteen of the total nineteen trends, or 68 per cent, at least 50 per cent "A" evaluations. This was the lowest percentage of "A" evaluations given the trends in any category. Some variance, however, appeared in the percentage of trends receiving no "C" value judgments in this category, and also the percentage of trends having as much as a 50 per cent of "B" ratings. The range of percentage of the "A" value judgments was quite wide in each of the groups. The trend receiving the least number of "A" judgments by the total respondents was Trend 86, Increasing number of textbooks published for school and college health courses; the trend receiving the highest number of "A" value judgments by the total respondents was Trend 73, Producing ACTION in health education through the functional approach to health instruction.

The greatest number of "B" judgments, signifying minor value, awarded any of the one hundred and four trends by the school health educators was Trend 86, stated above. Trend 91 in this category received 25 per cent of "C" evaluations from all the respondents which was the second largest number of "C" evaluations, signifying little or no value, received by any trend. Trend 91 is -- Including driver training and driver education in school health and
health education programs. Two trends, 86 and 91, received "C" evaluations of 33 per cent from the public health educators, second highest "C" evaluations given by that group also.

The College Health Program; Trends 92 through 104

Several notable features were present in the analysis of this category. All of the thirteen trends received the minimum of 50 per cent "A" value judgments from the school health educators. The public health educators awarded the minimum of 50 per cent "A" ratings to twelve trends or 92 per cent of the trends in this category. This same group gave no trend a 50 per cent minimum "B" judgment nor did any of the other groups. The public health educators were high in the number of trends to which they gave no "C" evaluations - 62 per cent - while the general educators gave no "C" judgments to 8 per cent. The range of the percentage of a minimum of 50 per cent "A" value judgments of all respondents was only 87 - 49 per cent.

The highest percentage, 94 per cent, of "A" evaluations in this category was awarded by the school health educators to Trend 92, Enlarging and enriching the effectiveness of the basic college required course. Trends 93, 95 and 96 were also relatively high in this and other groups. The least number of "A" value judgments of all respondents was 49 per cent for Trend 102, Offering of graduate curricula in
health education by a greater number of colleges of education.

Treatment of Data with the Chi-square Test

Treating the data with the Chi-square Test resulted in the determination of the specific trends about which the three educator groups differed in their value judgments.

In this study, a Chi-square which had a significant $P$ value at the .05 or .01 level indicated that a difference existed among the three groups of educators in the way in which they rated a trend; there were ninety-five out of one hundred chances or ninety-nine out of one hundred chances that the difference would occur again and was, therefore, not due merely to chance or a sampling error. The difference in the composition of the score could be traced to certain variables, in this study those variables might be occupational ones.

As applied to this study, a Chi-square with a high $P$ value, that is one above the .05 level of significance, indicated that the educator groups tended to be more homogeneous in their responses. There were sixty-three trends, which carried $P$ values higher than the .05 level; this is 61 per cent of the total one hundred and four trends. These may be noted in Chapter V, where the omission of the $P$ values following the Chi-square opposite a trend indicates
educator responses with a P value too high to be considered significant.

It should not be assumed that those trends to which the responses of the three educator groups carried a P value higher than .05 necessarily were trends about which the educator groups reflected agreement. These were only trends in which there was not a statistically significant difference of opinion. It was the ranking of the trends by the ten highest places, as stated in Tables 2 through 13, that was the procedure used in this study to indicate educator group agreement.

In the trends with the statistically significant scores which indicated that the three educator groups differed greatly in their rating of the trends, the proportion of the percentages of "A," "B" and "C" value judgments for a given trend for one group was different from those of another group. The philosophy and experiential background of the three educator groups might be cited as examples of the variables which influenced the differences in the responses.

There were forty-one trends or 39 per cent of the total one hundred and four trends that had significant P values. This might indicate that these trends with significant scores listed in Table 17, should be scrutinized carefully since the three educator groups viewed them and thus evaluated them differently.
When considered by category, fifteen or 39.4 per cent of the thirty-nine trends in the General School and College Health Program had significant P values. The category of School Health Services had nine trends or 36 per cent. Healthful School Living had one trend or 10 per cent, Health Instruction had eight trends or 42.1 per cent and the College Health Program had eight or 61.5 per cent statistically significant trends. This could be viewed as indicating that the three educator groups differed most as groups on the trends concerning the College Health Program and the least on the trends concerning Healthful School Living. They appraised the other three categories about equally in so far as statistical significance was concerned.

The three educator groups reflected the highest statistical difference of opinion about fourteen of the total one hundred and four trends. These were the trends which showed a P value at the .01 level with four degrees of freedom. These fourteen trends listed consecutively as they appeared in the checklist were:

Trend 14 -- **Spotlighting the health aspects of physical education.**

Trend 16 -- **Separating health education and physical education for purposes of administration, programming and professional preparation.**
Trend 21 -- Interpreting basic medical knowledge and progress to the lay public by qualified experts through such media as radio, television, newspapers and magazines.

Trend 29 -- Establishing inter-agency committees and health councils at state and local levels.

Trend 44 -- Increasing responsibility taken by boards of education for the administration of school health services.

Trend 45 -- Involving the classroom teacher to a greater degree as part of the health team in the health service program.

Trend 56 -- Developing effective follow-up programs via the team approach in the area of health services.

Trend 75 -- Stressing the emphasis on desirable student behavior and practices as the end product of the health instruction program.

Trend 80 -- Providing and requiring patterns of direct health instruction through specific, graded courses carrying academic credit for junior and senior high school students.

Trend 88 -- Growing acceptance of the problem-solving method as an approach to the consideration of health problems.

Trend 92 -- Enlarging and enriching the effectiveness of the basic college required course.
Trend 93 -- **Accepting the basic health course as a part of a student's general education, particularly on the college level.**

Trend 97 -- **Extending the health education requirements for certification of classroom teachers.**

Trend 99 -- **Emerging of school and college health education as a recognized professional field of specialization with an established curriculum of professional preparation.**

It will be noted that of these fourteen trends only two, Trends 56 and 99, did not appear in some place in Tables 2 through 13 which listed the trends assigned the highest ten places by a ranking of the "A" "B" and "C" value judgments. Table 5, containing trends assigned the highest places in the "A" value judgments by the general educators, and Table 6, containing trends receiving the highest places in the "B" value judgments from the total respondents, did not include any of the fourteen trends just listed; others, Tables 3, 4 and 8, contained as many as three of these trends.

Thus, no definite pattern can be traced in comparing the fourteen trends reflecting statistical differences of opinion and their presence or omission in the tables of rankings. Three of these fourteen trends were deemed major and
significant by the school health educators (Trends 75, 92 and 93) and also by the public health educators (Trends 43, 75 and 88). Therefore, it would seem highly desirable that each of the three educator groups become cognizant of and alerted to these and other differences of opinion indicated by the P values as each group strives to improve and strengthen the role it plays in the school and college health program.
TABLE 17.—Trends Showing a Chi-square Value at .05 and .01 Levels of Significance

<table>
<thead>
<tr>
<th>P(df1)</th>
<th>P(df2)</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>.05</td>
<td>.01</td>
<td>.05                   .01                   Trend</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Integrating the school and college health program with the total educational and community program. (3)</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td>Accepting the positive concept of health as a state of total well-being. (5)</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td>Clarifying the specific health responsibilities of the student, parent, teacher, administrator and specialized personnel serving the school. (6)</td>
</tr>
<tr>
<td>x</td>
<td></td>
<td>Accepting the concept that all teachers should and do contribute to the health program whether they are health teachers or teachers of other subjects. (7)</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td>Augmenting the number of qualified school health educators and health coordinators. (8)</td>
</tr>
<tr>
<td>x</td>
<td></td>
<td>Stressing the importance of the &quot;team approach&quot; to school and college health. (9)</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td>Suggesting changes in the basic professional terminology used in health education. (11)</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td>Spotlighting the health aspects of physical education. (14)</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td>Separating health education and physical education for the purposes of administration, programming, and professional preparation. (16)</td>
</tr>
</tbody>
</table>

TABLE 17—(contd.)

<table>
<thead>
<tr>
<th>P(df1)</th>
<th>P(df2)</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>.05</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>.05</td>
<td>.01</td>
<td></td>
</tr>
</tbody>
</table>

- Emphasizing the concept of total fitness as an objective of health and physical education programs during peace-time. (17)
- Interpreting basic medical knowledge and progress to the lay public by qualified experts through such media as radio, television, newspapers and magazines. (21)
- Gearing research studies to school and college health problems on state and local levels. (23)
- Establishing inter-agency committees and health councils at state and local levels. (29)
- Pointing up the function, as opposed to the structure, of the advisory school and community health council in promoting cooperation in the school health program. (30)
- Increasing cooperation between medical and educational organizations as evidenced by their activities at state and local levels. (35)
- Pointing up communication and public relations as the key factors in interpreting the school health program to parents, professional organizations and other community groups. (39)
- Developing standing orders and policies covering school emergency care and disaster procedures. (40)
TABLE 17—(contd.)

<table>
<thead>
<tr>
<th>P(df1)</th>
<th>P(df2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>.05</td>
<td>.01</td>
</tr>
</tbody>
</table>

- **x** Utilizing the many facets of the health service program containing opportunities for learning about health and its protection. (43)
- **x** Increasing responsibility taken by boards of education for the administration of school health services. (44)
- **x** Involving the classroom teacher to a greater degree as part of the health team in the health service program. (45)
- **x** Recognizing the value of the continuous observation and appraisal of students by all teachers. (46)
- **x** Changing the philosophy related to the responsibility for medical and dental examinations from the educational institution to the family physician and dentist. (50)
- **x** Developing effective follow-up programs via the team approach in the area of health services. (56)
- **x** Adjusting the school program to individual needs with particular reference to those students with special health problems. (58)
- **x** Including functional health suites and health service units in modern school-building construction. (70)
- **x** Producing ACTION in health education through the functional approach to health instruction. (73)
<table>
<thead>
<tr>
<th></th>
<th>P(df1)</th>
<th></th>
<th>P(df2)</th>
<th></th>
<th>Trend</th>
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<tr>
<td>.05</td>
<td>.01</td>
<td>.05</td>
<td>.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td><strong>Stressing the emphasis on desirable student behavior and practices</strong> as the end product of the health instruction program. (75)</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td><strong>Implementing the students' &quot;need and interest&quot; approach in curriculum planning.</strong> (77)</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td><strong>Providing and requiring patterns of direct health instruction through specific, graded courses carrying academic credit for junior and senior high school students.</strong> (80)</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td><strong>Acknowledging the need of a variety of methods, group procedures and resources in teaching health.</strong> (83)</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td><strong>Increasing number of textbooks published for school and college health courses.</strong> (86)</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td><strong>Utilizing of research methods to determine the accuracy and readability of health textbooks.</strong> (87)</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td><strong>Growing acceptance of the problem-solving method as an approach to the consideration of health problems.</strong> (88)</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td><strong>Enlarging and enriching the effectiveness of the basic college required course.</strong> (92)</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td><strong>Accepting the basic health course as a part of a student's general education, particularly on the college level.</strong> (93)</td>
</tr>
</tbody>
</table>
TABLE 17—(contd.)

<table>
<thead>
<tr>
<th>Trend</th>
<th>P(df1)</th>
<th>P(df2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognizing the need for basic professional health courses for all prospective teachers. (96)</td>
<td>.05</td>
<td>.01</td>
</tr>
<tr>
<td>Extending the health education requirements for certification of classroom teachers. (97)</td>
<td>.05</td>
<td>.01</td>
</tr>
<tr>
<td>Increasing the opportunities for in-service education of professional personnel in the form of workshops and conferences. (98)</td>
<td>.05</td>
<td>.01</td>
</tr>
<tr>
<td>Emerging of school and college health education as a recognized professional field of specialization with an established curriculum of professional preparation. (99)</td>
<td>.05</td>
<td>.01</td>
</tr>
<tr>
<td>Recognizing the professional status of the field of health education. (100)</td>
<td>.05</td>
<td>.01</td>
</tr>
<tr>
<td>Emphasizing recruitment and the career aspects of school health education. (103)</td>
<td>.05</td>
<td>.01</td>
</tr>
</tbody>
</table>

32 14 36 19 Total
CHAPTER VIII

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The school and college health program is broad in purpose, complex in nature and multi-disciplinary in scope. Embracing medicine and education as its foundation, the program is now playing a recognized and vital role in the total educational pattern. Like all other professions, the field of school and college health is experiencing change and progress; it is not static, but moving. The purpose of this study was to determine the significance of the current trends in the evolution of the school and college health program.

Summary

The term trend has varied connotations; it is used casually in many oral and written presentations. For the purpose of this study the following definition of a trend was formulated:

A trend may be considered as a general prevailing movement, changing in a specific and indicated direction, and thus reflecting a recognizable change of tendency or emphasis.

Identification was made of one hundred and four trends reflected in the literature published in the field of
school and college health education during the time period of January, 1948 - May, 1958. A checklist containing these trends was sent to selected school and college health educators, public health educators and general educators. These three educator groups were asked to assign a value judgment to each trend; the value judgments were of three types - "A," which indicated trends of utmost importance and significance, "B," denoting trends of lesser value with minor significance and "C," signifying trends of little or no value and insignificant. Of the one hundred and forty-four checklists which were distributed, one hundred and seven or 72.3 per cent of them were useable returns. Of the total respondents, 51.4 per cent were school health educators, 23.4 per cent were public health educators and 25.2 per cent were general educators.

The trends identified for this study were compared with trends established in a 1943 study by Lindsay.\(^1\) Of the thirty-nine statements that named or inferred trends in the 1943 study, thirty-one of the total one hundred and four trends in this study were deemed similar in general content. Sixteen of the trends in the 1943 study were not identified in the 1958 study; seventy-three of the trends established in the 1958 study were not mentioned in earlier research. Of the trends in the two studies that were similar, many of

\(^1\) Lindsay, loc. cit.
the 1958 trends had a slight variation; they were an implementa-
tion of the original activity as described by Lindsay.

Data compiled from the checklists were treated by
two methods. Rankings of ten places were made of the trends
assigned the highest number of "A," "B" and "C" value judg-
ments by the checklist respondents. The Chi-square Test was
also applied to the judgments assigned each trend by each of
the three educator groups.

Conclusions

As a result of these methods of treatment, the con-
cclusions for this study follow:

1. No single trend received 100 per cent of any one
of the three value judgments from the total respondents.

2. A large number of trends received a majority of
judgments indicating that they were of utmost value and
significance. The ten highest placed trends assigned this
value judgment by a minimum of 83 per cent of the total
respondents were:

Trend 63 -- Increasing recognition that the emotional
health of the teacher influences the emotional tone of the
classroom.

Trend 2 -- Growing acceptance of the health program as a
vital and necessary part of the total educational panorama.

Trend 64 -- Emphasizing the importance of the health of
all school personnel.
Trend 96 -- **Increasing the opportunities for in-service education of professional personnel in the form of workshops and conferences.**

Trend 73 -- **Producing ACTION in health education through the functional approach to health instruction.**

Trend 74 -- **Accepting the purpose of health education as a process which favorably influences knowledge, attitudes and practices.**

Trend 5 -- **Accepting the positive concept of health as a state of total well-being.**

Trend 41 -- **Organizing the school health program with the realization that the family has the primary responsibility for the health of the students.**

Trend 46 -- **Recognizing the value of the continuous observation and appraisal of students by all teachers.**

Trend 45 -- **Involving the classroom teacher to a greater degree as part of the health team in the health service program.**

3. The five trends judged by at least 50 per cent of the total respondents to be of lesser value and minor significance were concerned with the increase in the quantity of health education literature, health education textbooks, and resources available from commercial organizations plus changes in the basic professional terminology and the utilization of parents and non-school personnel in administering screening tests.
4. The three educator groups differed regarding the specific trends to which they assigned the greatest number of evaluations denoting little or no value. However, the judgments of the total respondents ranged from 37 per cent to 18 per cent agreement for the following ten trends:

Trend 11 -- **Suggesting changes in the basic professional terminology used in health education.**

Trend 91 -- **Including driver training and driver education in school health and health education programs.**

Trend 47 -- **Utilizing parents and other non-school personnel in administering screening tests, such as those for vision and hearing.**

Trend 51 -- **Releasing the student during school hours to obtain medical and dental treatment.**

Trend 85 -- **Increasing number of acceptable health resources available from commercial organizations.**

Trend 86 -- **Increasing number of textbooks published for school and college health courses.**

Trend 13 -- **Augmenting the quantity of literature in the field of school and college health education.**

Trend 10 -- **Attempting to include health learning in all parts of the school and college curriculum.**

Trend 16 -- **Separating health education and physical education for purposes of administration, programming and professional preparation.**
Trend 62 -- Changing the case finding techniques for tuberculosis.

5. The three educator groups indicated the most homogeneity concerning the trends in the category of Healthful School Living; the category in which the groups reflected the most statistical difference of opinion was the College Health Program.

6. The application of the Chi-square Test to the total one hundred and four trends indicated that forty-one or 39 per cent of the trends had a P value no higher than .05 or .01 when either four or two degrees of freedom were used. The greatest degree of difference was evident in the fourteen trends which follow. Listed consecutively as they appeared in the checklist, they were --

Trend 14 -- Spotlighting the health aspects of physical education.

Trend 16 -- Separating health education and physical education for purposes of administration, programming and professional preparation.

Trend 21 -- Interpreting basic medical knowledge and progress to the lay public by qualified experts through such media as radio, television, newspapers and magazines.

Trend 29 -- Establishing inter-agency committees and health councils at state and local levels.
Trend 44 -- Increasing responsibility taken by boards of education for the administration of school health services.

Trend 45 -- Involving the classroom teacher to a greater degree as part of the health team in the health service program.

Trend 56 -- Developing effective follow-up programs via the team approach in the area of health services.

Trend 75 -- Stressing the emphasis on desirable student behavior and practices as the end product of the health instruction program.

Trend 80 -- Providing and requiring patterns of direct instruction through specific, graded courses carrying academic credit for junior and senior high school students.

Trend 88 -- Growing acceptance of the problem-solving method as an approach to the consideration of health problems.

Trend 92 -- Enlarging and enriching the effectiveness of the basic college required course.

Trend 95 -- Accepting the basic health course as a part of a student's general education, particularly on the college level.

Trend 99 -- Emerging of school and college health education as an established curriculum of professional preparation.
Recommendations

On the basis of research conducted for this study, recommendations for implementation were that --

1. A greater degree of discretion should be used when utilizing the term trend in oral and written communication. The source of the statements established as trends should be identified.

2. The trends receiving the highest rankings which indicated that they were of "utmost value and significance and should definitely be furthered" could be considered as guidelines to strengthen present programs and direct future programs in school and college health education.

3. The trends whose Chi-square values indicated a statistical difference of opinion operating among the groups of school and college health educators, public health educators and general educators should be further analyzed to determine if this lack of agreement is interfering with the progress and multi-disciplinary cooperation regarding the school and college health program.

4. Each of the three educator groups should alert itself to the trends which the remaining two groups deem desirable and valuable.

5. School and college health educators should assume the initiative to clarify and interpret more adequately the worth of those trends they deemed of utmost
significance, but which did not appear as valuable or important to their colleagues in public health and general education.

6. The trends peculiar to the elementary school health program, the secondary school health program and the college health program should be considered on each level as a directive for future planning.

7. A future study should consider to what extent the trends judged to be of utmost importance actually exist in practice.
APPENDIX A

Covering Letter Sent With Checklist to Respondents
Dear [Name],

Your judgment is being sought relative to the importance and desirability of current trends in the evolution of school and college health programs. The field is not static but moving, and the direction in which it is moving may or may not be good.

You have been recommended by an advisory committee as one qualified to assist in judging these trends. I would greatly appreciate your participation in this project.

Enclosed you will find a suggested listing of current trends in school and college health programs. These trends have been selected as a result of a thorough investigation of the literature in this field. For the purpose of this study the following definition of a trend has been formulated:

A trend may be considered as a general prevailing movement taken by something changing in a specific and indicated direction and thus reflecting a recognizable change of tendency or emphasis.

It will probably occur to you that some trends are more important and acceptable than others, and it is this type of value judgment that you are being asked to make in this survey. The code containing the various judgments appears below; you are asked to select the appropriate phrase which reflects your judgment concerning each trend.

A - This trend is of utmost value and significance; it should definitely be furthered, strengthened and given great impetus!

B - This trend is of lesser value; it has some minor significance and should be explored further.

C - This trend has little or no value; it is insignificant and definitely need not be promoted.

This code and specific directions are found on the enclosed listing of trends.
This study is being conducted under the direction of Dr. Elena M. Sliepcevich, Professor of Health Education, The Ohio State University.

Your cooperation in completing and returning the enclosed trends in the self-addressed envelope by June 6 will be greatly appreciated. If you should desire an additional copy of the trends, I shall be happy to send one at your request.

Thank you so much for taking time out from your busy schedule to give me the benefit of your experience and judgment.

Yours very truly,

Mary K. Beyrer
Instructor in Health Education
APPENDIX B

A Survey to Determine the Significance of Current Trends in School and College Health Programs
A SURVEY TO DETERMINE THE SIGNIFICANCE OF CURRENT TRENDS IN SCHOOL AND COLLEGE HEALTH PROGRAMS

Directions: In the blank at the left of each trend, place one of the following three letters (A, B or C) which designates the phrase reflecting your value judgment concerning each trend:

A - This trend is of utmost value and significance; it should definitely be furthered, strengthened and given great impetus.

B - This trend is of lesser value; it has some minor significance and should be explored further.

C - This trend has little or no value; it is insignificant and definitely need not be promoted.

For your convenience, the statements have been grouped under five categories:

I. The General School and College Health Program

II. School Health Services

III. Healthful School Living

IV. Health Instruction

V. The College Health Program

---

I. The General School and College Health Program

1. Promoting the multi-disciplinary approach to school and college health programs.

2. Growing acceptance of the health program as a vital and necessary part of the total educational panorama.

3. Integrating the school and college health program with the total educational and community program.

4. Widening concern and expanding knowledge regarding child growth and development.

5. Accepting the positive concept of health as a state of total well-being.
6. Clarifying the specific health responsibilities of the student, parent, teacher, administrator and specialized personnel serving the school.

7. Accepting the concept that all teachers should and do contribute to the health program whether they are health teachers or teachers of other subjects.

8. Augmenting the number of qualified school health educators and health coordinators.

9. Stressing the importance of the "team approach" to school and college health.

10. Attempting to include health learning experiences and concepts in all parts of the school and college curriculum.

11. Suggesting changes in the basic professional terminology used in health education.

12. Improving the quality of literature in the field of school and college health education.

13. Augmenting the quantity of literature in the field of school and college health education.

14. Spotlighting the health aspects of physical education.

15. Recognizing health education and physical education as complementary and supplementary but not identical fields.

16. Separating health education and physical education for purposes of administration, programming, and professional preparation.

17. Emphasizing the concept of total fitness as an objective of health and physical education programs during peace-time.

18. Clarifying the role of the school in handling student personality and behavior problems.

19. Increasing recognition of the special problems of the adolescent years and what the school can do to help the teen-ager meet them.

20. Increasing awareness of health and health education by parents and the general public.
21. Interpreting basic medical knowledge and progress to the lay public by qualified experts through such media as radio, television, newspapers and magazines.

22. Extending the research concerned with student health interests, needs and problems.

23. Gearing research studies to school and college health problems on state and local levels.

24. Analyzing the health misconceptions which exist among students and teachers.

25. Developing increasingly valid and reliable evaluation instruments for functional use in the school and college health program.

26. Using the self-appraisal technique more continuously as a major type of health program evaluation.

27. Including representatives of the entire school or college faculty in health curriculum building and policy making.

28. Recognizing a need for school and community representatives to cooperatively develop and carry out school and college health policies.

29. Establishing inter-agency committees and health councils at state and local levels.

30. Pointing up the function, as opposed to the structure, of the advisory school and community health council in promoting cooperation in the school health program.

31. Sharing of responsibilities by state departments of education and state departments of health for the school health program.

32. Implementing the principles by which schools and voluntary agencies can cooperate to improve school and college health programs.

33. Utilizing the leadership of medical societies at state and local levels for school and college health programs.

34. Providing of leadership by professional health organizations in school and college health programs.
35. Increasing cooperation between medical and educational organizations as evidenced by their activities at state and local levels.

36. Organizing adult and community health education programs.

37. Upgrading standards for desirable athletic competition in schools and colleges.

38. Utilizing student values as a basis for planning the school and college health program.

II. School Health Services

39. Pointing up communication and public relations as the key factors in interpreting the school health program to parents, professional organizations and other community groups.

40. Developing standing orders and policies covering school emergency care and disaster procedures.

41. Organizing the school health program with the realization that the family has the primary responsibility for the health of the student.

42. Varying the school health services and policies according to locale, as influenced by community resources, customs and other factors.

43. Utilizing the many facets of the health service program containing opportunities for learning about health and its protection.

44. Increasing responsibility taken by boards of education for the administration of school health services.

45. Involving the classroom teacher to a greater degree as part of the health team in the health service program.

46. Recognizing the value of the continuous observation and appraisal of students by all teachers.

47. Utilizing parents and other non-school personnel in administering screening tests, such as those for vision and hearing.
48. Clarifying the professional roles of the nurse and physician as consultants in the school and college health program.

49. Promoting the concept of periodic health appraisal for well children from birth through high school.

50. Changing the philosophy related to the responsibility for medical and dental examinations from the educational institution to the family physician and dentist.

51. Releasing the student during school hours to obtain medical and dental treatment.

52. Using the cumulative health record effectively, i.e. as the focal point of communication between members of the school health team.

53. Emphasizing the use of the conference as a technique to promote effective follow-up and interpretation of health problems discovered by school personnel.

54. Promoting the concept of the health counseling role of the school health team.

55. Including psychological testing and other mental health services in the school program.

56. Developing effective follow-up programs via the team approach in the area of health services.

57. Providing health appraisal and medical services for the indigent student through increased community services.

58. Adjusting the school program to individual needs with particular reference to those students with special health problems.

59. Including the physically handicapped in regular classes in the public school or in special classes arranged for these students by the school system.

60. Making special provisions and adaptations for the mentally exceptional student in either regular or special classes in the school.

61. Recognizing the opportunities of the school to promote the control of communicable diseases and to educate concerning them.
III. Healthful School Living

62. Changing the case finding techniques for tuberculosis.

63. Increasing recognition that the emotional health of the teacher influences the emotional tone of the classroom.

64. Emphasizing the importance of the health of all school personnel.

65. Utilizing educational procedures for effective student-teacher planning and interaction.

66. Promoting the health and welfare of students by providing a school program organized and administered with these factors in mind.

67. Recognizing the school environment as providing for the enrichment of health instruction.

68. Accepting standards of safety, housekeeping procedures and sanitation as recognizable factors that affect learning.

69. Acknowledging that the physical factors of the school environment affect student health.

70. Including functional health suites and health service units in modern school-building construction.

71. Directing attention to the hazard of over-emphasis on perfect school attendance.

72. Emphasizing the educational, nutritional and sanitary aspects of the school food service.

IV. Health Instruction

73. Producing ACTION in health education through the functional approach to health instruction.

74. Accepting the purpose of health education as a process which favorably influences knowledge, attitudes and practices.
75. Stressing the emphasis on desirable student behavior and practices as the end product of the health instruction program.

76. Widening interest in the understanding of motivation as it is involved in the psychology of teaching health.

77. Implementing the students "need and interest" approach in curriculum planning.

78. Developing health curricula and policies by means of the team approach which includes parents and community groups as resource consultants.

79. Gearing of state and local curricula and teacher's guides to help meet students' health needs and interests more effectively.

80. Providing and requiring patterns of direct health instruction through specific, graded courses carrying academic credit for junior and senior high school students.

81. Organizing planned, flexible and sequential health curricula in the schools.

82. Implementing the concepts of correlation and integration of health with the majority of subjects in the school program.

83. Acknowledging the need of a variety of methods, group procedures and resources in teaching health.

84. Augmenting the variety of health instruction materials and resources available from official and voluntary health organizations.

85. Increasing number of acceptable health resources available from commercial organizations.

86. Increasing number of textbooks published for school and college health courses.

87. Utilizing of research methods to determine the accuracy and readability of health textbooks.

88. Growing acceptance of the problem-solving method as an approach to the consideration of health problems.
89. Incorporating the important special problem area of sex education into the course patterns centered around family living or family life education.

90. Spotlighting such special content areas as alcohol, tobacco and narcotics, consumer health and mental hygiene.

91. Including driver training and driver education in school health and health education programs.

V. The College Health Program

92. Enlarging and enriching the effectiveness of the basic college required course.

93. Accepting the basic health course as a part of a student's general education, particularly on the college level.

94. Accepting of greater responsibility by colleges and universities for the physical and emotional welfare of students.

95. Coordinating the many facets of health services and health education on the college campus which promote student health.

96. Recognizing the need for basic professional health courses for all prospective teachers.

97. Extending the health education requirements for certification of classroom teachers.

98. Increasing the opportunities for in-service education of professional personnel in the form of workshops and conferences.

99. Emerging of school and college health education as a recognized professional field of specialization with an established curriculum of professional preparation.

100. Recognizing the professional status of the field of health education.

101. Identifying the competencies and experiences which are needed by school and college health educators.
102. Offering of graduate curricula in health education by a greater number of colleges of education.

103. Emphasizing recruitment and the career aspects of school health education.

104. Increasing the number of health workshops and conferences at state and national levels to consider the school, college and teacher education programs.

Signed

Title

Address

Return to Mary K. Beyrer, Pomerene Hall 312, The Ohio State University, Columbus, Ohio.
APPENDIX C

Sex, Type of Employment and Geographical Location of 107 Respondents to Checklist
TABLE 18.—Sex, Type of Employment and Geographical Location of 107 Respondents to Checklist

<table>
<thead>
<tr>
<th>Sex:</th>
<th>School Health Educators</th>
<th>Public Health Educators</th>
<th>General Educators</th>
<th>Respondents Total</th>
<th>Percentage of Total</th>
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<tr>
<td>Male</td>
<td>30 (55)</td>
<td>11 (25)</td>
<td>19 (27)</td>
<td>60 (107)</td>
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<td>Female</td>
<td>25 (55)</td>
<td>14 (25)</td>
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<th>Public Health Educators</th>
<th>General Educators</th>
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<td></td>
<td>9 (6)</td>
<td>32 (43)</td>
<td>14 (35)</td>
<td>29 (26.2)</td>
<td>29 (26.2)</td>
<td>12 (31.8)</td>
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<td></td>
<td>8 (6)</td>
<td>11 (26.2)</td>
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<td>43 (39.8)</td>
<td>43 (39.8)</td>
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<th>E. South Central</th>
<th>W. South Central</th>
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<td>22 (24)</td>
<td>2 (2)</td>
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<td>2 (2)</td>
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<td>2 (13.1%)</td>
<td>5 (4.6)</td>
<td>3 (11.9%)</td>
<td>3 (11.9%)</td>
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<td>3 (11.9%)</td>
<td>5 (4.6)</td>
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*The nine geographical areas used in the 1956 edition of *The World Almanac* were selected for purposes of classification for this study.
APPENDIX D

Respondents to Checklist to Determine the Significance of Current Trends in School and College Health Programs, June, 1958
<table>
<thead>
<tr>
<th>School Health Educators</th>
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<tbody>
<tr>
<td>Anderson, Carl L.</td>
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<tr>
<td>Bechtel, P. C.</td>
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<td>Boydston, Donald N.</td>
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<td>Byrd, Oliver E., M.D.</td>
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<td>Creswell, William H., Jr.</td>
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<td>Cushman, Wesley P.</td>
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<tr>
<td>DeWeese, A. O., M.D.</td>
</tr>
<tr>
<td>Dilworth, Lula P.</td>
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<tr>
<td>Fogle, Florence L.</td>
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<td>Foster, Julia C.</td>
</tr>
<tr>
<td>Name</td>
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<tr>
<td>Garrison, Joy</td>
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<td>Haag, Jessie Helen</td>
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<td>Hein, Fred V.</td>
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<td>Hoyman, Howard S.</td>
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<td>Humphrey, James H.</td>
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<td>Irwin, Leslie W.</td>
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<td>Johns, Edward B.</td>
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<td>Johnson, Warren R.</td>
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<td>Jones, Edwina</td>
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</table>
Kelly, Ellen
Professor and Head, Department of Health and Physical Education for Women, Illinois State Normal University, Normal, Illinois.

Kilander, H. Frederick

Lantagne, Joseph
Chairman, Department of Physical and Health Education, University of California, Santa Barbara College, Goleta, California.

LaSalle, Dorothy
Professor, Physical and Health Education, Wayne State University, Detroit 2, Michigan.

Ludwig, Donald J.
Assistant Professor of Health and Safety, Indiana University, Bloomington, Indiana.

Manley, Helen
Director of Health, Physical Education, and Safety, University City Public Schools, University City 5, Missouri.

Mays, Frances A.

McNiff, Louise
Supervisor, Denver Public Schools, Denver 2, Colorado.

Moriarty, Mary J.
Professor of Health Education, Bridgewater State Teachers College, Bridgewater, Massachusetts.

Moss, Bernice

Neilson, Elizabeth A.
Chairman of Health and Physical Education, State Teachers College, Lowell, Massachusetts.

Nolte, Ann E.
Chairman, Girls' Physical Education Department, Wakefield High School, Arlington, Virginia.
<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oberteuffer, Delbert</td>
<td>Professor of Physical Education, The Ohio State University, Columbus 10, Ohio.</td>
</tr>
<tr>
<td>O'Keefe, Patric Ruth</td>
<td>Director of Health and Physical Education, Public Schools, Kansas City, Missouri.</td>
</tr>
<tr>
<td>Rappaport, Mary B.</td>
<td>Supervisor of Health Education, State Education Department, Albany, New York.</td>
</tr>
<tr>
<td>Rash, J. Keogh</td>
<td>Chairman, Department of Health and Safety, Indiana University, Bloomington, Indiana.</td>
</tr>
<tr>
<td>Shaffer, Thomas E., M.D.</td>
<td>Professor, Pediatrics, The Ohio State University, Columbus 10, Ohio.</td>
</tr>
<tr>
<td>Shaw, John H.</td>
<td>Professor of Health and Physical Education, Syracuse University, Syracuse, New York.</td>
</tr>
<tr>
<td>Sirnio, George J.</td>
<td>Director of Health and Physical Education, State Department of Education, Salem, Oregon.</td>
</tr>
<tr>
<td>Slipecevich, Elena M.</td>
<td>Professor of Health Education, The Ohio State University, Columbus 10, Ohio.</td>
</tr>
<tr>
<td>Southworth, Warren H.</td>
<td>Professor of Health Education, School of Education, University of Wisconsin, Madison 6, Wisconsin.</td>
</tr>
<tr>
<td>Spears, Lewis</td>
<td>Consultant, Health and Physical Education, Texas Education Agency, Austin, Texas.</td>
</tr>
<tr>
<td>Staton, Wesley M.</td>
<td>Associate Professor of Health Education, Wayne State University, Detroit 2, Michigan.</td>
</tr>
<tr>
<td>Streit, William K.</td>
<td>Director of Health and Hygiene, Cincinnati Public Schools, Cincinnati, Ohio.</td>
</tr>
<tr>
<td>Name</td>
<td>Title and Affiliation</td>
</tr>
<tr>
<td>---------------------------</td>
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</tr>
<tr>
<td>Wakefield, Ora</td>
<td>Health Education Coordinator, Nashville Public Schools, Nashville, Tennessee.</td>
</tr>
<tr>
<td>Warren, Ned L.</td>
<td>Associate Professor of Physical Education, George Peabody College, Nashville, Tennessee.</td>
</tr>
<tr>
<td>Wesley, Wallace</td>
<td>Consultant in Health and Fitness, American Medical Association, Chicago, Illinois.</td>
</tr>
<tr>
<td>Wilson, Charles C., M.D.</td>
<td>Professor, Education and Public Health, Yale University, New Haven, Connecticut.</td>
</tr>
<tr>
<td>Wilson, Elizabeth Avery</td>
<td>Consultant in Health Education, American Association for Health, Physical Education and Recreation, Washington 6, D.C.</td>
</tr>
<tr>
<td>Wilson, Joyce</td>
<td>Director, Health Education, General Conference of Seventh-Day Adventists, Washington 12, D.C.</td>
</tr>
<tr>
<td><strong>Public Health Educators</strong></td>
<td></td>
</tr>
<tr>
<td>Boatman, Ralph H.</td>
<td>Director, Health Education, Chicago and Cook County Tuberculosis Institute, 1412 W. Washington Blvd., Chicago 7, Illinois.</td>
</tr>
<tr>
<td>Craig, Marjorie L.</td>
<td>Director, School Health Bureau, Metropolitan Life Insurance Company, 1 Madison Avenue, New York 10, New York.</td>
</tr>
<tr>
<td>Derryberry, Mayhew</td>
<td>Chief, Health Education Services, U.S. Public Health Service, Washington 25, D.C.</td>
</tr>
<tr>
<td>Name</td>
<td>Position/Institution</td>
</tr>
<tr>
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<tr>
<td>Eastabrooks, Marjorie</td>
<td>Health Education Director, Anti-Tuberculosis League of King County, 612½ Arcade Building, Seattle 1, Washington.</td>
</tr>
<tr>
<td>Griffiths, William</td>
<td>Associate Professor of Public Health, School of Public Health, University of California, Berkeley 4, California.</td>
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<tr>
<td>Haynes, Ann W.</td>
<td>Chief, Bureau of Health Education, California State Department of Public Health, Berkeley 4, California.</td>
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<tr>
<td>Kessler, Alfred E.</td>
<td>Executive Secretary, Marion County Tuberculosis Association, 615 North Alabama Street, Room 335, Indianapolis 5, Indiana.</td>
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<tr>
<td>Lindsay, Edith M.</td>
<td>Associate Professor, School of Public Health, University of California, Berkeley 4, California.</td>
</tr>
<tr>
<td>Massengale, Helen</td>
<td>Chief, Division of Public Health Education, Ohio Department of Health, 65 South Front Street, Columbus, Ohio.</td>
</tr>
<tr>
<td>McKeever, Nell</td>
<td>Health Educator, Box 27, Fort Duchesne, Utah.</td>
</tr>
</tbody>
</table>
Morgan, Lucy S.  Professor, School of Public Health, University of North Carolina, Chapel Hill, North Carolina.

Reeves, G. Spencer  Associate Professor of Health and Physical Education and Public Health and Preventive Medicine, University of Washington, Seattle, Washington.

Rugen, Mabel E.  Professor of Health Education, School of Public Health, University of Michigan, Ann Arbor, Michigan.


Vavra, Catherine E.  Lecturer in Public Health, University of Washington, University of Washington Medical School, Seattle, Washington.

Yoho, Robert  Director, Division of Health and Physical Education, State Board of Health, Indianapolis, Indiana.

Young, Marjorie A. C.  Assistant Professor of Health Education, Harvard University School of Public Health, Boston, Massachusetts.
General Educators

Anderson, Earl W.  Chairman, Department of Education, The Ohio State University, Columbus 10, Ohio.

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I, Mary Katherine Beyrer, was born in South Bend, Indiana, March 3, 1922. I received my secondary school education in the public schools of South Bend, Indiana, and St. Paul, Minnesota. My undergraduate training was taken at Macalester College, St. Paul, Minnesota, from which I was granted the B.A. degree in 1944. Following three years of teaching health and physical education in the Buffalo Public Schools, Buffalo, Minnesota, I was in residence at MacMurray College, Jacksonville, Illinois. During that year of residency, 1947-1948, I was a Graduate Assistant in the Women's Physical Education Department; in 1950 I was awarded the degree of M.S. in P.E. degree from that institution. From 1948 - 1956, I was an Assistant Professor at Madison College, Harrisonburg, Virginia. For the first three years of that period, I held the dual position of Director of Girls' Physical Education at the Harrisonburg High School and Supervisor of Student Teaching in Physical Education at Madison College. After 1952, I devoted full time to teaching courses on the Madison College campus. In 1956, I became a Graduate Assistant in the Women's Physical Education Department, The Ohio State University, and in 1957 was appointed an Instructor in the same department. I held these positions for the three years while completing the requirements for the degree Doctor of Philosophy.