The School Health Advisory Board accomplished the following items during the SY 2015-2016:

- Worked on health access outreach for uninsured families to increase participation in FAMIS and FAMIS Plus and use of local safety net providers. (See Attachment A. SHAB Health Outreach Access Report)

- Monitored ongoing programs, needs and implementation of school-based healthcare initiatives including general nursing care, oral health screenings, the Teen Wellness Center and the WOW Bus.

- Reviewed new Federal Food and Nutrition Services guidelines and Smart Snacks and drafted relevant policy.


- Monitored problems with substance abuse and reviewed Youth Risk Behavior Survey (YRBS) data. Oversaw coordination of results to various preventive programming for students. (See Attachment C. SAPCA Recommendations based on 2013-2014 YRBS Data)

- Reviewed Family Life Education (FLE) curriculum implementation process. (See Attachments D. and E. for FLE reports by Michael Humphreys)

- Research national best practices for required daily physical activity.

- Encouraged staff to incorporate exercise and movement into daily activities, including the support of bike and walk to school programs and movement during classes.

- Monitored ACPS strategic plan implementation of health and wellness goals. Advise pursuance of a federal grant for a School Based Health Center.

- Edited, approved, and updated SHAB By-Laws. (See Attachment F. SHAB Bylaws)
ATTACHMENT A.

SHAB Health Access Outreach Project
April 6, 2016

2016-17 Goals

- Prepare data summary on health coverage for Alexandria children including total number of uninsured and estimate of children eligible for coverage but not enrolled.
- Disseminate data summary to School Board, Administrators and School Support Teams
- Monitor ACPS efforts to identify uninsured students eligible for coverage and make referrals for enrollment assistance.

2015-16 Goals Completed

- Updated outreach flyer to prepare for fall 2015 federal marketplace open enrollment period.
- Ensured distribution of flyer through back-to-school packets.
- Prepared and disseminated data summary on health coverage for Alexandria children.
- Presented materials to PTAC and did outreach to PTAs.
- Posted updated materials on ACPS website.

2014-15 Goals Completed

- Updated technical assistance paper and outreach flyer to prepare for fall 2014 federal marketplace open enrollment period.
- Ensured distribution of flyer through back-to-school packets.
- Posted updated paper and flyer on ACPS website; worked with staff to improve navigability to make documents more accessible.
- Presented project update and materials to PTAC and interested WOW Bus schools.

2013-14 Goals Completed

- Finalized and distributed one-page flyer for families in four languages.
- Held informational forum for all School Support Teams.
- Held informational sessions for PTAC and WOW Bus schools.
- Coordinated outreach between WOW Bus provider and potential patients.
- Coordinated outreach to families with Virginia Health Insurance Exchange navigator.

2012-13 Goals Completed

- Reviewed ACPS health coverage outreach practices.
- Gathered and analyzed data available to show the number of uninsured children in Alexandria; also considered problem of families moving on and off coverage throughout the year.
- Gathered information about new federal health coverage options available in 2014 through Virginia health insurance exchange.
- Evaluated information currently used to identify needs to support increased outreach efforts.
- Prepared technical assistance document for use by all ACPS Nurses, Administrators, Counselors and Social Workers.
- Drafted summarized one-page outreach brief for families.
- Reported back to School Board on outreach education efforts.
- Held informational session for administrators.
ATTACHMENT B.

ALEXANDRIA CITY PUBLIC SCHOOLS:
2014-2015 INCOMING KINDERGARTENERS WEIGHT STATUS REPORT

Purpose

The purpose of this report is to assess weight status, utilizing the body mass index (BMI) measures of incoming kindergarteners to Alexandria City Public Schools (ACPS) during the 2014-2015 school year.

ACPS has measures of health and wellness from the Youth Risk Behavior Survey (YRBS) that indicate overweight and obesity may be an issue for our teens, but YRBS data is self-reported by students and may not provide an accurate measurement to inform prevention programs. To date, there has been no mechanism for assessing the weight status of Alexandria’s youth in elementary school years.

The lack of reliable, local data on the percentage of children overweight and obese in Alexandria makes it difficult to understand how to allocate resources toward decreasing childhood obesity in our city. This has motivated the School Health Advisory Board and the Partnership for a Healthier Alexandria to work with ACPS staff to begin to quantify childhood overweight and obesity using existing ACPS data for incoming kindergarteners.

The Incoming Kindergarteners Weight Status Report aligns with the Health and Wellness goal as outlined in the ACPS 2020 Strategic Plan and fills a need as outlined in the Alexandria Children and Youth Master Plan 2014 and in the Alexandria Community Health Improvement Plan 2014-2019. Additionally, legislation for body mass index (BMI) surveillance and screening programs has passed in 25 states (1). In collecting this information, we may also serve to fulfill future state legislation mandating the surveillance of obesity rates in youth at the local and state level, and we’ll also be able to inform future grant proposals toward acquiring funds for obesity prevention.

The data presented in this report will serve as a baseline for identifying the current magnitude of childhood overweight and obesity for incoming kindergarten students with an average age of 4 years old at the time of measurement.

Report Goals

- Inform and educate City of Alexandria stakeholders on weight status of incoming kindergarteners in the 2014/2015 school year
- Identify weight disparities that may exist by:
  - Gender
  - Race/Ethnicity
  - Zip-code
  - School
Background

National and state organizations such as the Centers for Disease Control and Prevention (CDC), the American Heart Association, the Institute of Medicine, Trust for America’s Health, American Associations of Pediatrics and Family Practitioners, the Virginia Department of Health, the Virginia Foundation for Healthy Youth, and many others, have all highlighted the risks of pediatric obesity in recent years.

Obesity is widely known for its negative effects on child health. These include, but are not limited to, cardiovascular disease, hypercholesterolemia, hypertension, pre-diabetes- which indicates off-balanced blood glucose levels that can result in diabetes-, bone and joint problems, including flat feet, sleep apnea, asthma, gallstones, and polycystic ovarian syndrome (2). In addition to those short-term health effects, obesity is associated with an increased risk for long-term health effects, including heart disease, type 2 diabetes, strokes, osteoarthritis, and many types of cancer (3,4).

In addition to the many physical consequences, obesity can also lead to social and psychological problems. As early as five years of age, overweight or obese children display lower self-esteem (5). A child that continues to stay overweight/obese may also run into problems later on in adolescence, where obese females have been found to have significantly lower levels of self-esteem, which has led to sadness, loneliness, and high-risk behaviors, such as smoking or alcohol consumption (6). Along with poor self-esteem and depression, childhood obesity is also linked with eating disorders (7).

Although significant in and of themselves, the effects of childhood obesity do not end with the noted physical and psychological outcomes in youth. Rather, research has shown obesity to be further linked with poorer academic performance in school. A student's performance in areas, such as mathematics, English or science, may also suffer. A decade ago, Dr. Susan K. Rhodes, a psychologist at the Medical University of South Carolina in Charleston found that obese adolescents may develop sleep disturbances that can cause learning disorders and a potential type of brain damage due to lack of oxygen to the brain. Among these obese adolescents studied with apnea, researchers found diminished performance "across the board," in visual and verbal learning and on standard I.Q. tests. (8)

According to the Children’s Defense Fund, obese students may not perform as well as their non-obese peers because they’re not in school as often. Excerpt below taken from webpage on 5/18/2014:

Even after controlling for numerous factors, overweight or obese children are more likely than children who are not overweight or obese to miss more than two weeks of school in a year and to repeat a grade in school. In one study, obese children had rates of school absenteeism that were 20 percent greater than those of their non-obese classmates.

More recently in a 2012 study, Yau and colleagues highlighted a connection between short-term impairments in metabolism and brain function. Adolescents with metabolic syndrome had lower cognitive performance than those studied without the syndrome. Specifically, they scored significantly lower on math, spelling, attention, and mental flexibility and showed a trend for lower overall intelligence. As the prevalence of the metabolic syndrome is high among obese children and adolescents, increasing with worsening obesity (9), these findings suggest that obesity-associated metabolic disease may play a role in lowering the academic potential of adolescents (10).
Nationally, the rates of obesity in children have tripled in the last two generations in the United States, with the Centers for Disease Control and Prevention’s national data from 2009-10 indicating obesity rates of 12.1% for children aged 2 – 5 and 18% for children aged 6 – 11. Childhood obesity rates remain high today, and although the 2014 & 2015 National Health and Nutrition Examination Study (NHANES) study report and data brief (11, 12) show a decrease in obesity rates for children 2-5 years, overall, obesity among our nation’s young people, aged 2 to 19 years, has not changed significantly since 2003-2004 and remains at about 17 percent. (12) Additionally, national and state data show that BMI tends to increase as children get older, which indicates a need for an aggregate assessment of children in older grades to better understand the path toward obesity for youth and the most beneficial ages to target for intervention.

Methodology

ACPS Health personnel accessed data from school registration documents for incoming ACPS kindergarteners for the 2014-2015 academic year to obtain the necessary measures for calculation of a Body Mass Index (BMI) for each child. These data are outlined below, and include: demographic information via parent report to the school; height and weight data as measured by the physician’s office completing the child’s school entrance health exam; and the date the exam measurements were taken.

- Demographic information
- Height measurement (inches)
- Weight measurement (pounds)
- Date of assessment (the date on which the height and weight measurements were taken)

Once a complete dataset was compiled, a new identity number was assigned to each student and identifying information, including the name, ACPS student ID, and street address were removed from the file.

The Alexandria Health Department calculated the BMI for each student to be able to assign each individual to the appropriate corresponding weight status category. BMI was calculated using the English formula \( \text{BMI} = \frac{\text{weight in pounds}}{(\text{height in inches})^2} \times 703 \) for each child. Each calculated BMI was then compared to the standard percentile distribution as defined by the gender-specific CDC growth charts\(^1\) and assigned to a weight status category (Table 1).

Data storage and analysis were completed using PowerSchool, Excel 2010, and ARC GIS.

Table 1: CDC Weight Status Categories for Children

<table>
<thead>
<tr>
<th>Weight Status Category</th>
<th>Percentile Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>Less than the 5th percentile</td>
</tr>
<tr>
<td>Healthy weight</td>
<td>5th percentile to less than the 85th percentile</td>
</tr>
<tr>
<td>Overweight</td>
<td>85th to less than the 95th percentile</td>
</tr>
<tr>
<td>Obese</td>
<td>Equal to or greater than the 95th percentile</td>
</tr>
</tbody>
</table>

Limitations of the data

Health data for incoming students, including measures such as height and weight, are not uniformly collected. Incoming students are seen by private healthcare providers whose tools for measuring height and weight are
uniquely calibrated. Each child’s measures used for BMI calculation cannot be verified given that they are gathered from a wide variety of private healthcare providers in the community.

Out of the 1,424 children initially registered as incoming ACPS kindergartners for the 2014-2015 school year, 1227 health records (86%) were available for analysis in the spring of 2015. The remaining 14% of students for whom records were not available may be missing for a number of reasons. Students may have initially registered but did not enter school in the fall or left the school system at some point during the school year. Differences in weight categories of the two populations – those for whom health records were available and those for whom they were not – cannot be measured.

Results

For children and teens, BMI is age- and sex-specific and is often referred to as BMI-for-age (13). Although BMI does not measure body fat directly, research has shown that it is correlated with direct measures of body fat (14, 15, 16). BMI is not a diagnostic tool, but serves as a useful screening tool to determine weight categories, including higher risk groups who may be overweight or obese, and at risk for health problems.

**Figure 1: Overall Weight Status of Incoming Kindergarteners at ACPS**

When BMI was used to assign weight status of the incoming kindergarteners, it was found that 31.1% of them were overweight or obese, with 15.7% of the students obese; and 15.4% were overweight (Figure 1).
When stratified by gender, differences in overweight and obesity were found to be statistically significantly higher in girls (17.1% overweight, 17.8% obese) than boys (13.7% overweight, 13.7% obese), $\chi^2(3,N=1227)=13, p=0.004$. A higher proportion of boys than girls were found to be underweight, at 5.5% vs. 2.6% (Figure 2).
Statistically significant differences were found among distinct racial/ethnic groups, with higher proportions of overweight and obesity measured among Hispanic students at 19.8% and 22.6%, respectively (Figure 3), $\chi^2(12, N=1227)=54.6, p<0.001$. More than 2 out of 5, or 42.4% of incoming Hispanic kindergartners to ACPS in the 2014-2015 school year were overweight or obese.
When stratified by zip code of student residence, the zip code with higher levels of overweight and obesity—and therefore, the lowest level of children at healthy weight—was 22305. Conversely, children at highest levels of healthy weight and lowest levels of overweight and obesity were observed to reside in 22301 (Figure 4). Results for analysis of weight category by zip code were not found to be statistically significant, $\chi^2(57,N=1227)=73.9$, $p=0.07$. 
Figure 5 shows weight category by the elementary school the students attend. Percentages represent the percent of each school’s sample that fall within a specific weight category. Schools are organized by the highest percentage of students who fall in the overweight or obese category to the lowest percentage. The results align with national data as reported by the CDC (17), which indicates a higher prevalence of obesity in pre-school children from lower-income families and in Hispanic and non-Hispanic black children than non-Hispanic White youth:

- Cora Kelly has a student body in which 80% qualify for free and reduced meals (FARM), 68% are Hispanic, 24% black and .06% are white. Students from the sample who attend Cora Kelly have the lowest percentage of healthy weight students and highest percentage of overweight or obese students.
- Students from the sample who attend Lyles-Crouch have the highest percentage of healthy weight students and no students who are considered underweight. The
demographics of this school show only 25% of students qualifying for FARM and a majority of children to be white (55%) with only .07% Hispanic.

• Students from the sample who attend Matthew Maury have the lowest percentage of overweight or obese students. Maury’s demographics are similar to Lyles Crouch with 56% of the population reported as white and 33% qualifying for FARM.
Overall, 15.7% of incoming kindergarten students were obese in the 2014-2015 school year. As shown in Figure 6, the national target set by Healthy People 2020 aims to lower the national measures of obesity in children aged 2-5 years to 9.4% by the year 2020. Healthy People is an effort put forth by the federal government to improve health outcomes and monitor progress across the country, and is updated every ten years. It identifies national priorities and provides measurable objectives and goals that can be used to compare baselines and set realistic targets at all levels of the community, be it local, state or beyond (18).
Figure 7: Alexandria City Public School BMI Analysis by Zip Code

GIS Data Source: Alexandria City GIS Data Layers, ACPS BMI Data

Figure 7 depicts student BMI rate by location. Please note that the grid generated colors the grid cell based on the average BMI of all students within that grid cell. The map shows that ACPS students who are classified as overweight or obese (red and green colors) reside throughout the City and are not centralized in one location.
Findings

More than 30 percent (31.1%) of 2014-15 incoming kindergarteners attending public school in the City of Alexandria were considered to be overweight or obese with the highest rate of overweight or obesity in Hispanic youth (42.4%).

There are a higher proportion of overweight and obese students residing in zip codes 22305, 22311, and 22304 (39.3%, 32.8%, and 32.0%, respectively) and attending Cora Kelly, Mount Vernon, and Patrick Henry elementary schools (47.17%, 37.59% and 35.63%, respectively). As Figure 7 depicts, however, overweight and obesity in youth is found throughout the city.

Next Steps

These data show a significant percentage of children at levels of overweight and obesity well above the Healthy 2020 goal, and is a public health concern for the City of Alexandria. By identifying demographic and geographic populations at risk for obesity, the data will be used to create an awareness of the problem for community groups and policymakers and inform stakeholders where to target prevention and treatment programs.

As indicated earlier in the report, support for BMI assessment for weight status surveillance is fairly robust (19, 20). SHAB recommends that ACPS continue to monitor incoming kindergartners in the future, as well as consider surveillance of obesity prevalence in students at one or more points in higher grades, e.g., entry to middle school and entry to high school, or adding the height and weight measurements to existing school exams for vision and hearing that take place in the 3rd, 7th and 10th grades. Research supports that taking BMI measurements at school entry only, when levels could be low compared with later on in childhood, may result in our underestimating the obesity epidemic in our city’s youth. (21)

The NHANES and the YRBS provide population-based, cross-sectional state and national samples, however the YRBS data are self-reported. Studies comparing the YRBS self-report data with measured heights and weights have demonstrated that the self-reported data typically underestimates the prevalence of child and adolescent overweight and obesity (22). There is a need to continue surveillance of childhood and adolescent BMI to track progression of the obesity epidemic and to evaluate existing interventions implemented by community organizations in order to best understand how to target resources.

Report Collaborators: This report was a collaborative effort by the School Health Advisory Board (SHAB), Partnership for a Healthier Alexandria, Alexandria City Public Schools and the Alexandria Health Department. Special thanks to the Arlington County Public Health Division of the Department of Human Services for consulting with SHAB on the development of the ACPS Kindergarten BMI data collection protocol and mapping plan.
References


3. Data pulled from CDC website 5/19/14: http://www.cdc.gov/obesity/childhood/basics.html


School Health Advisory Board Meeting  
March 17, 2015

Based on the 2013 - 2014 Youth Risk Behavior Survey the Substance Abuse Prevention Coalition of Alexandria recommends the following activities to address youth substance use among Alexandria youth:

YRBS Finding: The youth usage rate is highest among 12th grade students for all substances. Twelfth graders also have the lowest perception of risk from regular use of alcohol and marijuana than any other grade level. Substance abuse prevention curriculum and/or programming is currently delivered during health class which ends in tenth grade.

**Recommendation: Provide substance abuse prevention curriculum/programming to students through 12th grade.**

YRBS Finding: The perception of risk from marijuana use significantly declined among high school students since 2011. Youth lack the proper information and are unaware of the consequences of youth marijuana use.

**Recommendation: Increase education on the harms of youth marijuana use and the impact youth use will have on the adolescent brain.**

Based on the YRBS findings and the needs of the Alexandria’s youth, SAPCA recommends the following:

**Recommendation: Provide annual professional development opportunities for physical education and health teachers to improve their knowledge and understanding of youth substance use and the risks associated with use.** Health and physical education teachers lead the prevention efforts among Alexandria youth, educating youth on the harms of youth substance use. Teachers need support and professional development opportunities to learn about the harms of youth substance use and understand the latest research on the adolescent brain.
At present, only those teachers who have taken the Human Sexuality course—or are able to demonstrate an equivalent content base via undergraduate or graduate studies—are permitted to teach Family Life. Currently, the division offers one fall class and one spring class of Human Sexuality with plans to expand to a summer offering. While many PE teachers and traditional classroom teachers have taken the course, FLE content is almost exclusively delivered by classroom teachers.

The new curriculum at the elementary level is still in production. I have planned for a February 8th announcement that the new curriculum is on Blackboard and up for ACPS employee review—with adjustments and additions to be made over the summer and implemented fall of 2016. Members of this board will also be invited to review the new guides. This announcement will be supplemented by my visits to elementary school staff meetings to ensure teachers are aware of the release and review. At the middle school level, training in a new program entitled Draw the Line/Respect the Line will begin in March with implementation in two of our three middle schools to follow immediately. It is an evidenced-based curriculum with 6 - 8 modules offered to students in all three grades. At the 9th grade level, Human Growth & Development teachers have recently been trained in a similar program, Be Proud!, Be Responsible!, and are currently seeking methods of implementation in their classrooms.

Implementation at the elementary level should take place at all schools beginning at the end of this year at the beginning of next. With hopes of creating a summer “certification” class, more teachers should be qualified to teach FLE. And beginning next year, once a curriculum is in place at the elementary level, schools will be more accountable as to how each grade level is receiving FLE instruction. I will lead discussions with principals and create a matrix that allows for the tracking of content delivery in each building. At the middle school level, I will work with several teachers in the late spring or over the summer to revamp the existing curriculum including the Draw the Line program.

I have developed a school-by-school spreadsheet that shows which teachers, according to our records, have either taken the course or are exempt based on background. I sent that list to the principals at the beginning of the school year and plan to do so annually moving forward.

I would be very interested in developing a plan—especially at the younger grades—to measure the impact of the curriculum. Beyond the current survey data that exists, I don’t believe anything in place to measure effectiveness.

Summing up, my biggest concern is implementation at each school and in each classroom (at the elementary level). The aforementioned matrix to keep track of who is providing the specific teaching at each school will be a nice step in this direction.
ATTACHMENT E.

FLE Questions and Answers
March 17, 2016 SHAB Meeting

1. Are classroom or PE teachers being trained and teaching the new curriculum? If/where PE teachers are being trained instead of classroom teachers, please explain why. One elementary school reports that letters for parents of fourth grade students indicate that physical education teachers will teach content. Have Physical Education staff been included/informed of this decision?

The model in development will be for classroom teachers (with possible assistance from other student service employees) to implement the curriculum. In one school the PE teachers are implementing the curriculum presently, so letters home might be tailored in that fashion. A full curriculum rewrite is still in production with an end goal of May of this school year, a June – August vetting, and an implementation beginning next school year.

2. Is PE space, specifically elementary school gyms, the proper setting for this curriculum to be taught?

Not in most cases. As stated above, this is not the design of the curriculum implementation.

3. Have parent concerns been addressed regarding the fact that FLE classes will take the place of physical activity day during PE.

This is not the case.

4. Dissemination of information: Will everything come from you, Mike, regarding communicating the changes for implementation or are other staff involved as well? If it’s the latter, how is it coordinated/standardized across all schools?

Initially, I will be the one communicating the messages. I will go through Dr. Piehota, Executive Director of Elementary Instruction, to reach the principals and other building-based administrators, but I will be the primary point of contact. Messaging is currently in place around the division that a new curriculum is in development and is expected to be implemented next year.

5. Schedule for teaching the content: Is there a template for a schedule for classroom teachers to follow instead of waiting until the end of the year to implement the curriculum?

Yes. There will be two models of implementation from which each building can choose. One will be through a regularly occurring weekly or bi-weekly FLE “period,” and one will be with multiple lessons occurring in the same week, happening several times per year.

6. There are inconsistencies in the FLE parent letter on Bb in regards to opt-out procedures: one option is a yes/no choice which makes it easier for families to "opt out" of the program.

I am in the process of updating all FLE-related material on the website.

7. Please provide data on the number of families opting-out of FLE in ES, MS & HS and explain how ACPS ensures opt-outs are strictly for religious and other allowed reasons. (There is concern opt-out numbers increase at HS simply because of course-load management. If families are opting-out for the allowed reasons, there should not be an increase in percentage of opt-outs as students age.)

I know that for the elementary school and middle school levels, opt-out is low (I am in the process of trying to collect specific data at those levels). I have heard as many 40% opt out in 9th grade, and the thought is that most of it is because of competing classes (band, foreign language, STEM Academy, etc.).
ATTACHMENT F.

ADVISORY COMMITTEES TO THE ALEXANDRIA SCHOOL BOARD
SCHOOL HEALTH ADVISORY BOARD

BY-LAWS

REGULATIONS GOVERNING SCHOOL HEALTH SERVICES

The School Health Services Program seeks to strengthen and facilitate the educational process by improving and protecting the health of children and by identification and assistance in the removal or modification of health related barriers to the learning process for individual children. The major focus of school health services is the prevention of illness and disability, and the early detection and correction of health related problems.

MISSION

The mission of the School Health Advisory Board (SHAB) is to assist with the development of health policies in the school division and the evaluation of the status of school health, health education, the school environment and health services.

PREFACE

The Advisory Committee By-Laws have been created to assist the staff, parents and community members of Alexandria City Public Schools in their roles and interactions with the School Health Services Program.

Section 22.1-275.1 of the Code of Virginia provides guidance to school divisions about establishing SHABs to assist with the development of health policies and with the evaluation of school health programs and services. It is intended that the local school board receive recommendations of the school health advisory board procedures relating to children with acute or chronic illnesses or conditions, including, but not limited to, appropriate emergency procedures for any life threatening conditions and designation of school personnel to implement the appropriate emergency procedures. The procedures relating to children with acute or chronic illnesses or conditions shall be developed with due consideration of the size and staffing off the schools within the jurisdiction.

MEMBERSHIP

1) The Code of Virginia establishes specific requirements for the number of the SHAB members, which shall consist of no more than twenty members to include broad-based community representation including but not limited to, parents, students, health professionals, educators and others. Membership in Alexandria City Public Schools' SHAB continues to be diverse among parents, students, health professionals and community groups. Members shall be appointed by the Alexandria City Public School Board.
2) Members must attend 75% of meetings held to maintain active membership status.

**BOARD OFFICERS**

1) Chairperson  
2) School Board Liaison

**MEETINGS**

1) The School Health Advisory Board shall meet at least semi-annually between September and June. A schedule of meeting dates and times are determined no later then the first SHAB meeting of each school year.  
2) The first meeting shall be convened no later than October of each school year.

**OPERATIONS AND PROCEDURES**

1) Topics explored and discussed by the School Health Advisory Board shall reflect current conditions and latest research findings on various school health-related issues.  
2) Coordinate presentations and consult with local and regional agencies that may have an impact on the School Health Services Program.  
3) Facilitate committee discussions and serve on subcommittees when recommendations come before the advisory committee.  
4) The School Health Advisory Board shall forward to the School Board a report of committee activities and recommendation with supporting documents no later than July 1st of each year.

**EXCEPTIONS**

The School Board may make exceptions to these practices and procedures as it deems appropriate.

*Adopted: March 17th, 2016*
Date: July 5, 2016

For ACTION  
For Information  X

FROM: Julie A. Crawford, Ed.D., Chief Student Services Officer

THROUGH: Alvin L. Crawley, Ed.D., Superintendent of Schools

TO: The Honorable Karen Graf, Chair, and Members of the Alexandria City School Board

TOPIC: Staff Response to School Health Advisory Board 2015-16 End of Year Report

The Department of Student Services, Alternative Programs and Equity completed a successful year of partnership with the School Health Advisory Board (SHAB). The group convened regularly throughout the year and had consistent membership and regular representation from parents, Alexandria City Public Schools (ACPS) staff and community stakeholders. SHAB’s activities for the school year provided support and oversight to the ACPS Strategic Plan Goal 5 of Health and Wellness by promoting efforts to enable students to be healthy and ready to learn.

ACPS staff thanks the members of SHAB, including SHAB Chair Candace Hill, for their commitment to the work. The group is responsive and well-organized which enables them to complete the many work assignments.

We look forward to the continued partnership to address the wellness needs specified in ACPS 2020, the Alexandria City Children Youth Master Plan, Youth Risk Behavior Survey and Developmental Assets Survey results.

CONTACT: Dr. Julie A. Crawford, 703-619-8034