THE HEALTH PROGRAM IN THE GRADE AND SECONDARY SCHOOLS IN THE UNITED STATES

VI.

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I wish to acknowledge my debt to
the large circle of authors whose work
has influenced my thinking and to whom
I owe whatever is valuable in this critical
study of the health program.

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AIMS

The objectives of health education as summarized by a report of the joint Committee on Health Education of the N. E. A. and the A. M. A are :-

(1) To instruct children and youth so that they may conserve and improve their own health.

(2) To establish in them the habits and principles of living which throughout their school life and in later life will assure abundant vigor and vitality which provides the basis for the greatest possible happiness and service in personal, family and community life.

(3) To influence parents and other adults through the health education program for children to better habits and attitudes, so that school may become an effective agency for the promotion of the social aspects of health education in the family and community as well as within the school itself.

(4) To improve the individual and community life of the future; to insure a better second generation, and a still better third, a healthier nation and race.

"I hope that the day will soon come when all the children of America will be given an unfettered start and a fair chance in the race of life."

Abraham Lincoln.

The truth of the axiom that no leader can go any farther than his followers are ready and willing to go with him, is proven by the slowness of this country in providing systematic care for the child health. Any country with a system of free education, nay even compulsory education would seem to be singularly short sighted in not presenting a knowledge of the means for conserving that treasure without which most other things of life prove a delusion and a snare.

HISTORY

In 1837 France, by royal edict, charged the school authorities with the health supervision of school children and the sanitation of school houses. Brussels in 1874 began a system of school inspection by a physician similar to the method in use today. 1894 saw medical inspection of school children introduced into the United States by Boston, Massachusetts.

To Miss Amy Hughes, Superintendent of London Queen's Nurses, Bloomsbury Square goes credit for introducing the nurse to the schools. She, herself answered a request for a nurse assistant in a survey being made of the nourishment of school children. Her discovery of the many ways in which a nurse might alleviate the bad health conditions in schools led to the establishment of London School Nurses Society in 1898. This was a voluntary society and never enlarged its scope or program very much as it was felt to be a public, rather than a private duty.

It was not until 1900 that the London school board experimentally provided one nurse to deal with a severe epidemic of ring worm . Little by little the value of the nurses' work became more apparent and in 1904 a staff of nurses, under a nurse superintendent, was appointed by the London County Council and financed by them.

Liverpool, long more health conscious than most cities, had started a program of school nursing service in 1893, financed by volunteer contributions.

In 1902, Miss Lillian Wald of the Henry Street Settlement while on a visit to England was interested in the school nursing program. Up to this time the method of school health protection was the exclusion by the teachers of any child who might seem to her to be unfit for contact with others. Miss Gardner in her "Public Health Nursing" cites an instance of a boy of twelve who had never been to school because of a small sore on his head. Many parents in the homes where conditions of this kind existed knew practically nothing of the ordinary rules of sanitation, moreover merely excluding the child from school did not interfere with his close association, not only with his family, but also with the very schoolmates his exclusion was designed to protect. Last but of primary importance there was little if any attempt at correction of defects and no health education program.

The Henry Street Settlement offered to place a nurse in four New York schools. One months demonstration sufficed to show the value of the work. The Municipality took the program over.

It is interesting to note that from this small entering wedge the importance of health as an objective in the school program has grown until now thirty-five years later it heads the list of those outlined by the N. E. A. as most desirable.

While exclusion still holds its place as a weapon of prevention, a wider and more comprehensive program has the ideal of a development of appropriate habits, skills and attitudes. The major aim of health education is the development of a health conscience, through a critical attitude toward health experience and problems. A condition of health should be normal and in the school program this is a positive goal, with emphasis on doing, rather than knowing.

It has been said of late that the child of today, who will be the adult of tomorrow, will confront a struggle in the economic world, such as we have never known. Every aid in this titanic struggle will help him to his place in the sun. Without physical and mental health, he is, if not lost, at least seriously handicapped.

METHOD What are some of the things necessary to obtain optimum results in the school health program ?

(1) One of the most important is nurse-teacher- rapport

which means the spirit of team-work and fairplay that should be the core of the entire school program. It means the fine spirit of working for a common end, the willingness to teach and to be taught, the appreciation of what each is trying to accomplish in striving for a common goal, in short co-workers with all that the word implies.

It is generally accepted that the shared thinking of the group is most important. This sympathetic cooperation between nurse and teacher embraces many aspects of shared opinion and coordinated activity.

(a) There should be discussion and agreement between nurse, teacher and oral hygienist about health procedures and policies.

(b) There should be active records involving mutual recognition of needs of children.

(c) Classroom information should be included in nurses home visit preparation.

(d) There should be teacher initiative relative to the health of her pupils and reference to the nurse.

(e) The teacher should be present and participate in physical examinations and the nurse in classroom inspections at least occasionally.

(f) The nurse's home calls should be true visits about apersonality, rather than a mere check on defects.

This ideal of rapport is often difficult of realization because of lack of common background of discussion. Teachers are found with all degrees of health knowledge and nurses who vary from routine desk clerks to social case workers.

To secure and maintain this important coordination it is necessary that both nurse and teacher have the best personal and professional qualifications possible. Their professional preparation should include courses in personal and community health, methods in health education, practice teaching or its equivalent in experience, courses in fundamental sciences, biology, chemistry, physiology and bacteriology. Personal good health with a critical attitude toward their own health practices and a happy well balanced disposition inclines the students favorably toward health habits.

+ "With respect to health values, example is more important than knowledge; healthful attitude is more surely caught than taught." The more informal the school, the more the student reflects the habits, attitudes and appreciations of the teacher.

Prospective teachers and nurses should have a complete physical examination early enough for the applicants to have an opportunity to correct remediable defects. These examinations should be repeated annually.

Mental and emotional health or balance are of equal importance with physical, to teacher, nurse and student.

+ Williams & Shaw. "Methods and Materials of Health Education."

(2) Healthful School Environment.

The school environment may be divided roughly into two parts. First, physical or those items which affect the sanitary and aesthetic conditions of the school building itself and Second, the conditions governing the childs time

spent in the classroom.

It is needless to go into detail as to adequate construction requirements for a school building. As early as 1929 the office of education of the Department of the Interior had taken cognizance of the fact that something was radically wrong with our school plants. It is to be hoped that those engaged in fostering the health program will keep in mind the necessity of educating the public generally, and specifically that portion that handles the building funds to secure the best and most modern plans for school buildings. It is a rather tragic commentary on America that with the millions that have been spent, and are being spent, annually so many of our schools are almost hopelessly outmoded from a health point of view. The most cursory survey of the lighting situation will prove this.

The fact is that with the knowledge of correct lighting and how to obtain it available, schools are being built yearly that are not only inadequate but definitely bad. The minimum requirements of sufficient window space and proper construction, avoidance of glaring shiny walls and furnitdre and the provision of correct indirect artificial lighting is neglected.

After observing the benefits handicapped children derive from a school constructed as the Mills Open Air School, one wonders why in our moderate and equable climate our well children are not given the benefits of a similar environment even tho a modified regime.

The ventilation of the schoolroom, the type of desk used, the kind and position of blackboards, are all matters of utmost

importance not only to the physical needs of the child, but also to his emotional well being.

Nervousness, restlessness, eyestrain, unduefatigue with their resultant behaviour problems may and often are direct results of an unsatisfactory school environment.

The conditions of the lavatories and drinking fountains and the general cleanliness of the school calls attention to another member of the school personnel. The janitor, whether in schools large or small is a very important person. It is necessary that he be a man of worthy character with a general knowledge of hygienic principles and orderly work habits. If it is a fact that 80% of our learning is visual, the necessity for neat, sanitary and attractive surroundings need not be emphasized.

The inclusion of a sanitary inspector in the administrative set-up would not be amiss, particularly one trained in school hygiene.

The janitor should be given the benefit of the superior training of the nurse and teacher in regard to healthful school living without straining a pleasant co-operative relationship. I hope the time will come when courses of instruction in the city school systems will be available to these members of the staff.

In city as well as in rural areas even tho the children may be taught the principles of hygienic living, which they may or may not be able to practice at home, they all too frequently have no opportunity of practicing them in school. Only too frequently is the supply of towels, soap and hot water

for hand washing hopelessly inadequate.

Again the drinking fountain is such that the waste water falls back into the cup thus becoming a menace rather than an aid to good health. In many schools in the rural areas even the doubtful benefits of a poor drinking fountain are lacking and the water bucket with a common drinking cup still flourishes.

In the school cafeterias, with all the emphasis placed upon nutrition, are the dishes washed and scalded in the approved sanitary fashion ? I venture to say many times they are not, as flagrant violations of all these sanitary measures have come to my notice during this year.

In the practice of the skills and attitudes of the health program the participation of the children formulating the guiding principles should be sought and encouraged whenever possible. The development of the childs recognition of responsibility for his acts and acceptance of consequences, together with judgment and selection of courses of action unswayed by approval or disapproval is one of the major aims of any school program, and particularly of the health program.

NURSES' PART

(3) At present the Nurses' participation in the school health program is divided broadly into three parts, Education, Prevention and Correction.

The argument as to whether the school nurse shall be attached to the department of education or to the department of health has points on both sides. By being connected with the department of education, her work becomes part of the general

school plan and thus more easily correlated with other departments. The school system is thus made entirely responsible both for the physical and mental health of the child.

On the other hand, the better thought of late tends toward the school nurse connection with the Board of Health under the immediate direction of a nurse supervisor and of a medical director.

The growing feeling is that the school nursing service should be a generalized one, dealing with the child as a member of the family and seeking to supply his health needs as a part of the family needs. A more intelligent service can be given a community if the whole family rather than any one individual is treated.

Extensive studies show that in very few schools are studies of health conditions in the communities made in order that the school health program may serve the community needs. The fact that a close tieup in the home is essential to a successful program of health in the school is outstanding.

HEALTH TEACHERS

(4) What is the ideal ? The present setup requires for health teachers nothing more than an interest in and liking for the subject together with teacher requirements.

The normal training schools and teaching colleges until recently were making very little if any provision for preparation to teach health as such or correlated to other subjects in the curriculum in a scientific and authentic way.

In the city of Portland some of the health teachers are

affiliated with Christian Science and while as a philosophy of life that may be sufficient, it does not give a scientific background for a health teacher.

Until the teacher training schools handle this subject more authoritatively, generally speaking, nurses with teaching training or its equivalent, and their health background, would be more effective in the health teacher positions. On the other hand even public health nurses do not always have a health attitude. To quote an example given by Helen C. Peck, R.N. ex-Secretary of Infant Welfare, Minneapolis, Minn., a certain P.H.N. assisting at record work in a clinic said, "I suppose this means tabulating the defects", tho it was a clinic for well children. Very often the nurse is so busy and overburdened with routine work, she neglects the mental hygiene of the child.

The problem child may not be her charge but very often she has the only opportunity to gently direct the child out of poor mental channels into healthy normal ones. The early danger signals of future mental breakdown are easily observed by a trained person and the direction when necessary to a child guidance clinic, a psychiatrist or merely the application of principles of training and rest, will save untold suffering.

Faulty adjustments to normal life situations when continued over the formative years are dangerous to the future well being of the child, but very often may be corrected early if recognized as the danger signals that they are.

The Public Health Nurse should be able to recognize the symptoms of trouble in the incipient stage and she must know

where facilities for help are to be found. There are many forms of minor differences which families fail to recognize as other than "nervousness". The nurse should keep in touch with children whose histories show tendencies toward moodiness or exaggerated tendencies of any kind.

In the measuring and examining the ideal is correction of remedial defects. To begin with, what is a defect ? How severe must a condition be tobe considered a defect ? What do such expressions as 10% underweight mean ? 20/40 by the Snellen chart ? These are arbitrary selections and great care should be taken that the basis of selection of defects is clearly understood by all members of the group dealing with the child including the parent.

VISUAL

What are the principal reasons for failure of correction in visual defects ? The study made by the reaearch division of the A. C. H. Association in New York City shows that ;
(1) The classification of defects includes many more than there are adequate financial facilities to care for and
(2) that there is a noticable amount of inaccuracy of measurement.

Care should be taken to explain the use and factors contributing to as accurate a test as possible to all persons giving the test as well as the fact that there are many eye conditions needing attention which this testing does not pick up.
(3) The parent knowledge of the corrective facilities available are often inadequate. This shows the lack of constructive follow-up work.

DENTAL

The criterion for selection in this study was decay involving one third of the occlusal area of at least two first permanent molars, or such a condition in one first permanent molar with one of the other three extracted. Defects of this severity occur in about 14% of all the school children.

The recommendations made were - (1) Attention devoted to preventive work, i e., (1) diet and dental attention. (2) Facilities for correction appraised. (3) Discriminating recording of dental defects so that proper selection of cases for follow up be made.

HEARING

(1) Classroom detection of such obvious defects as running ears.

(2) There are so many factors which make or mar an audiometer record that the results are not very accurate.

NUTRITION

The use of the word underweight as synonymous with malnourished makes for confusion. Underweight for age and height is not the same as underweight for skeletal build. Undernourishment is indicated by (1) a small amount of musculature shown by girth of upper arm, (2) by small amount of subcutaneous tissue shown by measurement over biceps and (3) low weight in relation to body build, i.e., height, width and depth of chest and width of hips.

TONSILS

It was suggested by this study that (1) the recommendations be carefully made with particular reference to childs history, general health and proveners to sorethroats etc., and (2) Nurses give followup consideration to other defects instead of preferential attention to tonsils.

PEDICULOSIS Recommended uniform method of eradicating with exclusion of cases if necessary and acquainting of parents with means of eradicating.

HEALTH The last recommendation was that any measurements be made by specialists in educational measurements . Health programs include much more than health examinations and health instruction. Health habits are fundamental. Actual health cannot be taught, it can be developed only by participating in healthful activities.

TEACHERS PART In the health program the classroom teacher has been called the keynote of the arch. She is the link thru which the children develop habit, knowledge and attitude. She alone can weld the results of the health examinations into habits and attitudes which mean prevention and correction. She alone can build safeguards, and respect for professional advice as well as build up a criteria for selection of professional advice and expose the fear and ignorance upon which quacks flourish.

Summing up the factors in a satisfactory program we have

(1) Adequate examination

(2) Persistent followup

(3) Teacher participation and responsibility in all parts of program.

(4) Live records

(5) Rapport amongst the staff.

What might be done and what is done in the light of our knowledge are two different things. Administration lags far behind our philosophy . There is a wide range of practice in regard to all phases of the program from the extent of medical inspection to the

amount and kind of health education.

Schools exist primarily for the purpose of supplying experiences that will insure the greatest amount of physical, mental and spiritual growth in order that the child may become a happy participating member of an everchanging dynamic society. One of our aims of health education being to supply pupils with satisfying experiences in healthful living during school life. It seeks its goal through the development of appropriate habits, skills, attitudes and ideals.

The essential steps of habit formation includes these points;

(1) A clear idea of the habit to be formed including what to do, how to do it and where to do it.

(2) Ample opportunity to practice, for this all the facilities of the school should be utilized, i.e., the washroom, drinking fountain, cafeteria, etc.,

(3) The avoidance of exceptions to the rule.

The motive for the lesson should be found in the class. The ideal sought is the correlation of health with all subjects taught and an integration of the whole with the life of the home and the community.

In a study made in 1932 by the office of education, Department of Interior, Monograph 28 it was found that of 460 secondary city schools which returned reports most of the courses of study (health) were dated 1929 or later. Of 24 announced objectives the teaching of exercises which would furnish proper and enjoyable recreation for living in later life was mentioned most often. The trend in physical education is away from formal drill to games and

free play, with less emphasis on gym equipment and more on space for both in and out door games and on pupil leaders.

USE OF LEISURE

There is a move in the direction of testing students for physical capacity with a classification into groups for instruction. Example - "Rogers tests for physical capacity." There is an increasing interest in the activities of pupils in out of school hours. With the signs of the times showing that the future of these boys and girls will probably hold a good deal of leisure time, it behooves them to be prepared to spend it wisely and happily. The new leisure has been the subject of some scholarly studies and the objective of making healthful recreation habitual, of developing desirable character traits and of learning games and acquiring avocations which will carry over to adult life has led schools in increasing numbers to supply playground supervisors after school, in the evening, on Saturdays and in the summer.

Within a period of thirty years high school enrollment has increased from a little over 10% of the population of hi-school age to more than 50% of that age. In Europe only 8-10% of that age attend school.

While health is supposed to be of first importance, practically nothing has been done to incorporate it in the high school program. High School teachers are specialists who are apt to think of their own subjects largely without reference to the whole of the child. The needs of the child are sometimes overlooked.

The success of any program depends upon the attitude and

and continued interest of the school executive and the teaching staff.

In an interesting experiment with an elective health course in a secondary school in Syracuse, N. Y., the term began with a study of background. Had they had health education in grades ? home economics ? general science ? sociology ? They decided that while they had considerable general information, they hadmany questions in their minds.

These proved to be the beginning of a cumulative list which lead to research committees, class reports, excursions to observe and procure first hand information and individual and group conferences. (Very few old type recitations.)

One of the findings most important was that they apply very little of what they know. This developed into the aim to live healthfully - based on the principle that knowledge does not necessarily influence behaviour.

An early project in this class of twelve girls was the care of the skin. This class should have been beautiful if "knowledge functions most effectively in influencing behaviour where we go out and seek it to show us how to do something."

Face powder was studied under the microscope. There was a demonstration of correct makeup. The need of health examinations became evident and this is now given early in the term.

Talks were given by the school physician. The students health records were gone over so that each item was understood.

The Doctor is very careful and takes into consideration emotional reactions, particularly the possible harm to over imaginative or those who do not understand the findings or exaggerate their importance.

In a project of this kind it is well to remember that the practice of lecturing is not adequate. The student must be prepared for discussion and not be merely a passive listener. On the other hand, discussion without authentic information is likely to result in uncritical expression of opinion in the absence of knowledge.

Williams and Shaw in Methods of Health Education say ; "Correlated teaching when well done leads to integrated learning,"and integrated learning enables one to see the whole. One may be in possession of a great many facts but unless one is able to relate them to one another and apply them to a whole situation they are useless.

Quoting from the Committee on Definition of Terms (Journal of Health and Physical Education);-

"Generally, health instruction is a class room procedure presenting factual information important for children to know in order to maintain a high level of individual functioning. Actually, of course, children learn about health in the other aspects of health education, in health service and in healthful school living, but the term health instruction is used to define that special effort in the class exercise to promote understanding and practice in health. Indeed, the practice is so essential that health instruction seeks to integrate health knowledge with actual living in home, school and community."

As in any other subject new material and fresh approach to health education is essential for each grade level. Adequate time arrangements must be made.

In"Principles and Practices in Health Education" - American Child Health Association 1931 - six ways of securing interest in health are considered justifiable.

(1) Incentives which lead to new activities are permitted.

(2) Knowledge of results and realization of progress.

(3) Group rewards.

(4) Approval of the group.

(5) Praise which is specific and spontaneous.

(6) Rewards which any one of group may attain by effort.

To motivate a child improvement must be the basis for satisfying some want.

+ In preparing lesson plans for each grade level the psychological law that in acquiring information the more history, psychology, mathematics or what you will, one already knows the easier to learn a new lesson.

"The physiological limit is that degree of ability which a particular person cannot surpass because of absolute limits in the speed or complexity of motor or mutual response".

In acquiring information in any field, law, medicine, etc., there is no physiological limit; there is always a possibility of learning more altho there is a limit to the speed with which the items may be acquired.

Again it is well to recall ;-

+Gates - Elementary Psychology, Chapt. 10.

(1) The law of frequency -

Other things being equal, the more frequently a connection has been exercised the stronger the connection - or more simply, whenever a modifiable connection between a situation and a response is exercised, other things being equal, the strength of that connection is increased.

This modifiability of nervous structure is a native capacity, but these modifications are not retained for an unlimited time. The changes of disuse are similar, roughly speaking, to the effect of disuse on a muscle. This gradual forgetting of information ---- leads to the "Law of Disuse." When a modifiable connection between a situation and a response is not exercised during a length of time, the strength of the connection is decreased.

The law of recency - other things being equal, the more recent the exercise, the stronger the connection between the situation and response.

Again on Page 319, Chap XI in paragraph dealing with learning by observation, we have -"During the progress of learning changes in the combination of connections are constantly going on. The final proficiency is not merely the performance at the beginning done more rapidly; It is a new performance."

Health teaching should be part of the actual life of the child. As the whole child goes to school the enrichment of his daily experience is most desirable.

In the pre-school or kindergarden period, the child

should be able to converse intelligently on a desirable bed hour, a good breakfast, cleanliness, toilet habits and rest.

In the elementary grades the purpose of the program is to develop personal health habits without holding the child responsible for health information.

Grades I to IV;

(a) Growth in general.

(b) Personal cleanliness, i.e. care of teeth, mouth, eyes, etc.

(c) Fresh air and sunshine.

(d) Exercise and Play, (Posture)

(e) Rest and sleep.

(f) Food - Selecting an ideal diet.

(g) Elimination of wastes.

In the intermediate grades the personal habits are continued and the community aspect introduced .

Grades IV to VIII.

(a) The nervous system.

(b) Stimulants and narcotics.

(c) Mental health.

(d) Healthy individual in healthy community.

(e) Safe water supply.

(f) Insects and disease.

(g) Home, school and community cleanliness.

(h) Wearing of proper clothing.

(i) Accident prevention and first aid.

(j) Food cleanliness and preservation.

The following specific aims are presented as the base

for the health education program in the secondary schools:

(1) Appropriate habits related to the different aspects of health, racial, home and community, mental, emotional and social.

(2) Ability to adapt health practices to meet the demands of a given situation.

(3) Appropriate attitudes related to all aspects of health.

(4) A social conscience -,an attitude of social responsibility for a personal part in maintaining and improving the healthful condition of his surroundings, for protecting other persons from unnecessary exposure to infectious diseases and for maintaining a high standard of personal health.

(5) A high standard of health ideals.

(6) An awareness to the point of recognition of the qualities of a situation or activity which are unfavorable to health.

(7) A body of scientific knowledge related to health in all its aspects.

(8) A reading and speaking vocabulary related to the different aspects of health.

(9) An appreciation for the need of high standards of personal, racial, home and community, mental and emotional and social health.

(10) Discrimination in the choice and evaluation of certain materials, practices or activities.

Examples of time allotment in secondary schools;

(1) Two periods of physical education and one period of health instruction each week are required of all pupils throughout secondary school course.

(2) Extensive plan of one period a week per student thruout secondary school course.

or

Concentrated plan ;

(1) A minimum of three periods a week in the entrance year to senior high, in addition to this time allotment correlation of health education work with other subjects is essential.

The following suggestions are offered as possible adjustments in providing time for health education in a crowded schedule. Since the requirement for most subjects is on a basis of 120 clock hours (Carnegie unit) it is often possible to release time from a five period week of 45 minute class periods by extending the period to 50 minutes or more and operating on a four period week. This will release one period a week for health education.

In some situations this may mean the elimination of certain elective subjects. Many schedules are complicated by attempting to include too many electives in a small school (a core curriculum must be set up before electives.)

In the organization of the program -

Required subjects scheduled first. There should be a progression of materials based on the following principles;

(1) The topics should coordinate with thematerial presented in the natural and social sciences and other subjects in the same year.

(2) The essential material should be placed in the lower levels, so as to serve the boys and girls who discontinue school attendance in the earlier years.

(3) The material should be graded to the responsibility of the child for self determination.

(4) The material should be increasingly more difficult and compare favorably with science courses.

(5) Material should coordinate with specific community or national activities.

The program in the Rural School.

The rural school more than any other offers an ideal situation for the correlation and integration of the school program with the home situation. The school itself is simpler in organization and more nearly on a plane with the home. The children of rural homes are apt to have a more direct participation in the sanitary problems of the home, in helping with the care of the pets and animals, in gardening and beautifying the grounds, in helping to care for younger members of the family.

The environment furnishes a testing ground. Because of the relatively intimate acquaintanceship between the pupils, teachers and other members of the community the possibilities of socialization of the school health program is unlimited.

The teacher in the rural school should know the value of daily inspection both as a preventive and educational measure.

If practiced constantly it may be rapid and unobtrusive and yet furnish an incentive for improvement.

The discussion with the nurse and physician of the physical findings following the examination should clarify the individual problems with a view to a possible plan for correction.

Teachers should be familiar with the local health department regulations for the control of communicable disease and make herself responsible for her share.

In the rural community the nurse visits homes and schools and links the problems of both into an understandable whole.

The aim of all education being the enrichment of experience, that experience will be more truly educational if it springs from the interests and problems of the students.

These problems come to light naturally in informal discussion with both students and parents. A simple questionaire is often valuable.

In the lower grades there is little formal health teaching.

In a one or two teacher school where the older and younger pupils mingle, many projects become of interest to the entire school. The essential difference between the aims for the lower and upper grades is that the aims for the lower grades emphasis is on habit formation without more than a slight understanding of the principle involved. In the upper grade the aim is for student understanding, judgment and responsibility.

The use of a school health inventory kept by the teachers and checked at the beginning and end of each school year is of great value in measuring progress and keeping general trends in mind.

The outline should contain such divisions as :

School Equipment.

(1) Water supply -

Has it been tested this year ?

(a) Drinking -

If water is carried into school.

(1) Is covered pail used.

(2) Is pail washed often with soap and water and then rinsed and aired ?

(3) Is water kept in covered container with faucet ?

(4) Is there a sink or lavatory near container ?

(5) Are paper cups used ?

(a) Are there sufficient cups to prevent reuse ?

(b) Are there always plenty of paper towels ?

(c) Is either liquid soap or soap powder used for hand washing ?

(d) Are toilets clean - free from marks and well ventilated, etc. etc. etc.

(1) Heating, ventilating, lighting.

(2) Room arrangement and seating.

(3) Safety.

(4) School lunch, weighing and measuring.

(5) School program and health. i.e., Rest periods, freedom from strain, supervised play out of doors, morning inspection, drying wet clothes, isolating pupils with colds, participation in community projects, reading heath books.

(6) Individual health behaviour at home and in school.

(7) Home environment.

Immediately after fall check teacher may list one or more

problems she and children have decided to work on that year and at the end of the year make evaluation of progress.

Illustrations of typical units chosen and developed by students are :-

A Grocery store, a farm unit, a study of state,local and national parks, a school newspaper, a study of milk, a safe water supply, the relation of animals to human disease, etc.,

In conclusion it is obvious that in order to attain these positive aims in all divisions of school life, everyone in the school system should be actively interested in the subject of health, since the success in the work comes from concerted action of all.

The achievement of positive health means the prevention of many of the diseases and defects from which pupils suffer because these handicaps are often the results of malnutrition, neglected physical defects and poor health practices.

In gathering material for a paper on this subject, one is struck at once by two things; First, that the idea of a generalized health program, with the aims embodied in "The Childrens Charter" issued by the members of the White House Conference on Child Health and Protection is generally accepted by educators, and second, that the interpretation of the means to secure these aims is varied, and the practice moreso.

The ideal is the correlation of health with all other subjects, a way of teaching to which health lends itself readily.

Until the curriculum is revised to permit of units of work embodying learning by centering all subjects about a center of interest, and until classroom teachers are trained in this method and have a scientific background, I believe a definite period should be assigned in the daily program of health instruction. Correlation and integration in the general program should be constantly worked for.

Over and over again we see people, young and old, practicing health habits which they know to be bad. Until we have embodied health habits and more important still critical health judgment in the daily life of the individual so completely that automatically he makes the right response, we have failed in our objectives. They say that a person does not know a language until he is able to think in that language automatically. The same is true of health teaching.

In the "Teachers' Hand Book on Health Teaching and Health Services" issued by the Department of Education of the Province of Ontario in 1934, is the following statement: "More and more does the worthwhile teacher appreciate the physical, intellectual and emotional limitations and capabilities of the pupils under his or her care. That the teacher should be familiar with the social background and the emotional environment of the child and the health attitude of the home is equally important. But their importance is equally shared by the childs physical make-up, his ability to attend regularly, to hear and see to advantage, to participate fully in the ordinary physical

activities associated with school attendance, to profit generally by his school opportunities."

In other words, the success of the school program to a great degree depends on recognition of the child as an individual as well as a member of a group and treatment as such.

We emphasize the importance of experience of doing in relation to teaching. The old adage -"Experience is the best teacher" - continues to be true even tho a literary cliche. In health practice as in all our actions we are apt to take chances because the possible result does not inevitably follow. If drinking from a common cup was always followed by Vincent's Angina, the common cup would soon disappear. If drinking un-pasteurized milk was always followed by typhoid or strep sore throat, or some other loathsome disease, our pasteurization of milk would be 100%, but because only occasionally do the tragedies occur we are willing to take chances. None of us want to be taught by experiences such as these but the opportunity to learn why it is mere chance to a large extent which prevents such results from bad practice should be given to all children. In short, they should know why one line of action is right and logical, and another apt to lead to disastrous results.

The outmoded method of teaching mere subject matter has been superceded by the wish to live richly and worthily both for the individual and for society.

If the emphasis placed on health seems to unbalance the picture of the child as a whole, I have failed in my thesis.

Again I remind the reader that without physical and mental health all the wealth of the Indies would not compensate. The mental health of the individual should be such as to develop a philosophy of life which in these days of strain and turmoil will stabilize while allowing adaptability to the dynamic conditions of social life.

Fredrick G. Bouser in "An Educational Perspective on Health Teaching" says, "Work, citizenship and play are all conditioned by the quality of functioning of body and mind." and Bader in "Advances in Health Education" says "Education is not an end in itself but a way of life, and Health is not an end in itself but is that way of living which produces at each stage an important, wholesome type of living."

BIBLIOGRAPHY

1934 Health Course of Study for First to Eighth Grades, incl.
Burkhard- Chambers-Maroney.

1935 Public Health Nursing.
Mary Sewall Gardner, R.N.A.M.

1929 Changing Conceptions of the School Building Problem-
Bulletin No.20
Office of Education, Department of Interior.

1936 How the Nurse can Coordinate and Promote School Health Program.
Journal of Educational Psychology, Vol 10, No.4-P.194 Dec.
Helen Mauzer.

1937 Health Teaching in a Secondary School.
Public Health Nursing, May Vol. 29 No.5
Mary E. Bowen.

1934 Handbook of Health Education.
Grout.

1933 School Health Study of children in New York City conducted
by research division of A.C.H. Association in co-operation
with Department of Health and Department of Education.
Financed by Medical Life.

1934 Conference "Advances in Health Education"
Held at University of Michigan, Ann Arbor.

1933 Evaluation of School Health Procedures.
School Health Research Monograph.
American Child Health Association. V

May 1935 Health Teaching in Secondary School"
Public Health Magazine.
Mary E. Bowen, Health Teaching Supervisor, School Health Service, Syracuse, N. Y.,

1931 Principles and Practices in Health Education.
American Child Health Association.
GATES "Elementary Psychology."

1935 1936 Annual Report of Health Department.
Pasadena City Schools.

1933 Teaching Health in Fargo.
Maud E. Brown.

1936 The Custodian and the School Child.
Metropolitan Life Insurance Co.

1936 Monograph - Teaching Health to Student Teachers.
Dr. George H. Black.

1931 Discovering Ourselves.
Edward A. Strecker. A.M.M.D.

1934 The Challenge of Leisure.

Arthur N. Pack.

1936 Leisure and Recreation.

M. S & E. E. Newmeyer.

1926 Subject Matter in Health Education.

Ruth Strang.

1927 Health Trends in Secondary Education.

American Child Health Association.

1930 An Educational Perspective on Health Teaching.

American Child Health Association.

Fredrick G. Bonser.

1935 Secondary Education.

Thos. L. Briggs.

1936 Mental Hygiene of a Family.

Family Magazine, April, May & June.

Dr. Plant.