AN ANALYSIS OF A FIRST YEAR OF PARTICIPATION
IN THE TEXAS HEALTH EDUCATION PROGRAM
BY THE SANGER SCHOOL

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TABLE OF CONTENTS

Chapter

I. INTRODUCTION .................................. 1

  Statement of Problem
  Source of Data and Limitations
  Statement of Philosophy

II. HEALTH EDUCATION PROGRAM AT WORK ....... 8

  Initiation of Health Program into the
  Sanger School
  Formulation of Community and School
  Health Council
  Survey of School and Cumulative Records
  The Immunization Program
  Screening for Visual Defects
  Screening for Loss of Hearing
  Daily Observation
  Lunchroom as an Aid in Teaching Nutrition
  In-Service Growth

III. EVALUATION OF HEALTH EDUCATION PROGRAM .... 29

  Physical Defects Remedied
  Emphasis upon Health Habits
  Improved Human Relations
  Improved Health Instruction

IV. CONCLUSIONS AND RECOMMENDATIONS ............ 44

  Conclusions
  Recommendations

APPENDIX ............................................. 51

BIBLIOGRAPHY ...................................... 52
CHAPTER I

INTRODUCTION

Statement of Problem

The main purpose of this study is to analyze the values and results of one year's participation of the Sanger School in a three-year Texas Health Education Program (Texas Extended School and Community Health Program) in order to determine an adequate basis for making recommendations for the further development of this program.

This study will attempt to formulate suggested recommendations that will promote a continuing and well-balanced program to improve human living by guiding living situations rather than instructing about health.

Source of Data and Limitation of This Study

The data for this study were obtained from actual experiences of teachers and pupils in the Sanger School. Books written by authorities in the area of health, personal interviews, cumulative records, observation reports, and surveys were also basic to this study.

Conclusions drawn from this study are limited in so far as the cumulative records, observation reports, and survey records have been accurately kept. It must be remembered
that all teachers are not skilled in keeping records and making reports. In spite of the limitations of these materials, it is believed that these data are the best means available for determining the values and results of this complex problem.

The Health Education Program to be evaluated is limited to the twelve-grade Independent School of Sanger, Texas, located in the north portion of Denton County, and operated for nine months in the year. There are fourteen teachers, and three hundred and eighty students. The building is new, having been built in 1948 and 1949.

The twelve grades are in one building, consisting of seventeen classrooms, a bookroom, two libraries, a gymnasium-auditorium, a cafeteria, and a teachers' lounge.

About one-half of the student body live in the small town of Sanger with a population of 1,500 people. The remainder of the students live in the country and commute on the school busses.

A Statement of Philosophy

The people of America have become vitally concerned about the health of their nation. They have been aroused by the need for a definite program of health education to be put into effect in every school.

The promotion of health through instruction related to real life situations constitutes a distinct challenge to present-day education. Although schools have unique opportunities for instructing large
numbers of young people, the health instruction should not be limited to school children. Adults have health interests and needs which should be met by a community-wide program of health instruction.  

The Health Education Program should be made an integral part of the total education program for better school and community relationships as it is an outstanding mechanism for education. Most health problems require some degree of community education for their solution and the community should want the help of the education leadership in promoting health activities.

Thus the schools have come to contribute to community health not only through their own planned program of health service and graded instruction, and through their own broadening program of adult education, but also through joining hands with health authorities and other agencies to study and seek the solution of community health problems as they arise.

Every school or college presents conditions which may be potentially good or bad for the health of the student and which may offer directly or indirectly source material for the health instruction of the student. Every institution is a potential clinical laboratory in this field and it is only as we make these practical tie-ups, drawing upon materials which are directly within the experiences of the student that we can hope to translate the study and its problems into student conduct.

Health education includes the actual experiences one has

1National Committee of School Health Policies, Suggested School Policies, p. 15.
in the home, school, and community utilized into an instructional program used to contribute to the child's understanding of facts that influence his health and growth. The school should guide the child to understand health education either by direct or indirect teaching. The major part of a child's knowledge may come incidentally but it can be made a vital part of the teaching program if taken from the child's own experiences. The desirable attitudes toward health habits may be established in the child at an early school age and then personal health practices extend throughout his school life.

The school should stress such fundamentals as preventive measures against communicable diseases, observation for new communicable controls, defects, classroom environment, wholesome mental and physical recreation, safety, personal hygiene, and social relationships. The program must symbolize the highest ideals of American living and standards of American Democracy.

The need for a health education program in the school should be determined by careful planning and counseling of teachers, pupils, parents, and doctors. It also involves the use of teacher observation, examinations, reports and careful screening. This should be done very carefully as each child's needs and interests are different. In general, there is always a need for an efficient state of health, a feeling of responsibility for others, a co-operative
understanding of community-school relation, and the health and professional services devoted to the community.

School, when adequately staffed and administered, provides experience in healthful living, an opportunity to become acquainted with good health services and to benefit from their advice and supervision, and a chance to learn something about the care of one's own body, the maintenance of health, and the prevention of disease. By direct instruction and, perhaps more importantly, through indirect learning, the modern school educates the nation toward healthful living, generation by generation. To this end, our best school systems are bringing together available experts in health and in education, from within and without the school personnel, to plan the best possible program for their respective communities.4

Everyone who associates with the child contributes to his health education. The teacher can do much in the role of the life of a child in helping him to use his experiences in developing understanding, attitudes, skills, and habits essential to living healthfully, and also help him to have a richer background of experiences.

To be sure, the teacher has help in many phases of her work through the assistance of the school administrator, various specialists in education and health, and from community resources outside of the school. The development of pupil health, as well as knowledge, personality, and power are to a large extent in the teacher's hands.

Teachers, school administrators, and school health personnel share with parents the responsibility for the education of children and youth in the maintenance of a quality of mental and physical health which will add zest to life, give strength to character, and help to produce vigorous self-reliant, courageous, and public-spirited citizens.5

4Turner, op. cit., p. 18. 5Ibid., p. 18.
Children differ greatly due to family background, home training, and community opportunities. These differences have a direct bearing upon the specific health needs and problems of the individuals. The development and maintenance of good health is always a very personal matter. Then it is the obligation of health programs to provide equal opportunities for all pupils to obtain information about health and to have good guidance in personal health matters.

The entire process of education may be considered health education since it is the growth and development of the whole child. Many of his experiences in healthful living are a part of his school experiences. Hence, there must be a need for health instruction material each school year. The teacher will find opportunities to use materials related to health.

Method of Procedure

A logical sequence is used in presenting this study. The introductory chapter states the purpose of this study, gives the source of data and limitations of study, statement of philosophy, and method of procedure.

Chapter II gives the setting of this problem. It describes how the "Texas Health Education Program" was put into the Sanger School, how the co-ordinating personnel was chosen, about the training in workshop techniques, and the approval of the program by the board of trustees. This
chapter also gives an overview of the program and how it functioned. These procedures, it is felt, are necessary in order to make the program understandable and to evaluate it in terms of service to the participating school and community.

Chapter III evaluates the Health Education Program in terms of values and results received by students, staff members, school, parents, and community. The evaluation is based on cumulative records, opinions of teachers, surveys, books written by authorities in the field of health, and personal interviews.

Chapter IV is the conclusions drawn from the study and recommendations made on that basis for the year 1949-1950.
CHAPTER II

HEALTH EDUCATION PROGRAM AT WORK

Initiation of the Health Program into the Sanger School

At the outset of this study, it became obvious that a definite description of this health education program at work would be necessary to determine the form of evaluation.

The establishment of Texas Health Education Program in the Public Schools of Denton County and also in the State of Texas is available through previous studies so this study will not attempt to go that far into the program.¹ This study is concerned with the entry of the Sanger School into a program under the direction of the State Department of Education, The W. K. Kellogg Foundation, and North Texas State College. The Texas Health Education Program functioned in the Rural Schools of Denton County one year before the Independent Schools became interested.


In May 1948, Mr. Charles Silk, Superintendent of the Denton County Rural Schools, called a meeting of all the Superintendents of the Independent Districts of Denton County. At this meeting, the Health Co-ordinator of North Texas State College explained the Texas Health Education Program, a three-year program of health improvement. The State Department of Education, W. K. Kellogg Foundation, and North Texas State College were cooperating in establishing a program of healthful living in Denton County similar to the programs in action in other counties over the State of Texas.

The Superintendents of the various schools were very enthusiastic over the prospects of such a program in their schools. These administrators immediately called their own local school boards. C. D. Allen, Superintendent of the Sanger Public School, joined the other superintendents of this county to increase school efficiency through better health in the school and the community. The superintendent called a meeting of the local Board of Trustees and related the plans to them as they had been presented to him by the Health Co-ordinator of North Texas State College. He also explained the assets of such a program to the school and community. The Board of Trustees for the Sanger Public School was much in favor of the plans set forth and voted to work with the Texas Health Education Program to begin September, 1948.
With these plans, the administrative and faculty members began to work to establish an adequate program and one that would stimulate people to assume leadership in a new health program to develop the child as a whole and improve living conditions within the school and community.

The Sanger School Board and Superintendent appointed a Health Co-ordinator for the school. Plans were formulated for the Co-ordinator to attend the Workshop in Health Education which was offered jointly by North Texas State College and Texas State College for Women the following summer. In this workshop, techniques and procedures for a beginning health program were stressed. The participants were given the privilege to work on problems that concerned their own particular situation. Plans were also worked out on the organization of the program within the school. Several excursions were taken to places where a health education program was already in operation to acquaint the workshop members with the program at work. Consultants were available to train the personnel in health education activities. The workshop exemplified this bit of philosophy of Nina B. Lamkin

Health education is a continuing and well-balanced program which has for its goals the improvement of human living. It is an integral part of the school curriculum and of the day-by-day life in any community.²

²Nina B. Lamkin, *Health Education in Rural Schools and Community*, p. 3.
With the superintendent very enthusiastic over the program, the school board's approval, a health co-ordinator trained in workshop techniques of health education, the Sanger Public School was ready to launch the Texas Health Education Program of 1948-49.

Formulation of Community and School Health Council

Orientation of this program in the school and community became the first big problem. Two weeks before the opening of the school term 1948-49, the staff members of the school met as a planning board to determine the procedure for participation. Two health councils were emphasized as a necessity in orienting, correlating, and co-ordinating a health education program in the school and community. This Community Health Council met four times during the year. The minutes of these meetings revealed that the first meeting was mainly the organization and studying of duties that concerned the Community Health Council. The second meeting resulted in definite plans to assist the school in carrying out the program for immunization, the clean-up campaign, and the arrangement of the elementary playground.

The third meeting was a dinner meeting held jointly with the School Health Council. From this meeting, evolved a recreational planning committee to plan the erection of a fifty thousand dollar recreational park for the Sanger community.
The fourth and last meeting of this council summarized the work done through the year and planned the representative for the next school year.

The faculty with the administrators and health co-ordinator held regular meetings throughout the school year. The first meeting was concerned mainly with the health education program. The effective functioning of such a program is possible only when every area of school life is sensitive to its responsibility for promoting healthful living and is sensitive to the unique contribution it can make.

This meeting was of a general nature where suggestions were offered and problems were discussed openly. The staff members planned and formulated cooperatively the following objectives:

To find and encourage correction of physical defects.

To observe and reduce communicable diseases.

To develop healthful living in the school.

To help the home and community to understand and interpret the health program.

To live the desirable health habits in order to establish these habits among the students.

To carry on a program which would develop the desired health knowledge which would evolve into health habits that can be used throughout a lifetime.
To develop desirable mental attitudes about health, health practices, and life situation problems.\textsuperscript{3}

The fostering of healthful living as a concern and responsibility of the entire school program was emphasized in these early faculty meetings. The above objectives are indicative of an existing relationship between staff members. These objectives also substantiate the working and planning together of staff members on problems of vital interest.

There was a need for joint studies of problems devoted to healthful living in the school. There also needed to be a mobilizing force to get a better job done toward health education. Each home room teacher and pupils organized a health committee in his respective grade. This committee planned and decided on health matters that were devoted to his own particular room. The chairman from each of the home room committees was appointed to serve as a member on the school health council. This council was organized for the purpose of working with health problems that concerned the school as a whole. The chairman from each grade, three primary teachers, the superintendent, janitor, a bus driver, and health co-ordinator composed the council. The first meeting was concerned with the organization and relative function of a council in the school. They realized the need for

\textsuperscript{3}Taken from the minutes of the first faculty meeting, September, 1948.
stated goals to work toward. A committee was appointed to formulate objectives. These were the objectives worked out by the committee and approved by the School Health Council.

To act as a mechanism for determining and implementing health activities to be used in the school.

To suggest methods and ways by which each grade or group may work on problems that concern the school as a whole.

To assist the school in its responsibilities in the area of health, in that it should build or promote the health of the children. The council should also assist in protecting children from disease, ill-health, and urge prompt correction.

To keep each room informed of the progress made in each project committed to the school.

To give the assistance needed in carrying out health activities.

To act as a mediator in conveying messages to each grade or room in school. 4

A chairman, vice-chairman, secretary and reporter were elected to officiate at all meetings.

Survey of the School and Cumulative Records

In order to determine the health problems in the Sanger School, a survey form was needed. A committee of three school health council members and two faculty members formulated a form that gave the entire health picture of the child.

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As soon as survey forms were made available, copies were sent to the parents of all the pupils in school, along with an authorization for emergency treatment form. (See Appendix A and B). This survey was conceived and planned to provide information valuable for the establishment of cumulative record cards for each individual in the school. The County Superintendent, County Supervisor, a committee of three teachers formulated the cumulative health record card. These forms were in use by the common schools of Denton County. When the independent schools planned to join the common schools, the superintendents from the independent schools, the County Superintendent, County Health Committee, and County Supervisor standardized the Cumulative Health Record Card for the entire county.

This system of record keeping for each individual child was determined so that the teacher might go to the files to study valuable data about the pupil, and would be able to help the child much earlier than if such records had not been kept.

A study of data helps to locate causes of behavior changes and determine future methods of guidance. Any program of evaluation is poorly conceived if it is carried on without regard to a well-planned system of records and reports.  

Guidance of children in progressive schools demands a cumulative record for each child from

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the kindergarten through grade twelve. This developmental history should include such records as school achievements, psychological tests, social backgrounds, and experiences, personality pattern, or adaptibility. 

Record-keeping is in an evolving state in our modern schools but no true judgment of the worth of any record can be made until it is used through a period of time. It has been found that records give surprising insight to child growth and they have also enabled us to see that "our children are not living in a series of neat compartments, but are dealing with the whole range of life activities in a closely woven web." 

The Immunization Program

After information on survey forms had been transferred to the cumulative record card a check and tabulation was made to determine the exact need in the health education program. The data revealed among other things, that 81.0 per cent of the pupils needed smallpox vaccinations. Either they had not been vaccinated or the expiration date had passed. Thirty-eight children under nine years of age had not been immunized against diphtheria.

Upon this basis, an instructional program for all the

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grades began to centralize around the need for immunization. The community health council, school health council, staff members, and co-ordinator met in a committee to formulate plans for the program which was set for the early part of December. The school was fortunate in having two doctors in the town who were members of the community health council. These doctors, a nurse, and druggist gave their services to the school to administer the initial immunization, and to do all repeat shots.

The immunization was carried on according to schedule with a vaccination of two hundred and eighty-four or 92.8 per cent. Of these vaccinations, 1.05 per cent showed no reaction according to the cumulative health record card.

Toxoid for immunization against diphtheria was given to thirty-eight or 92.1 per cent needing immunization. This data was all recorded on cumulative health record cards and filed in a centralized place, accessible to the teachers.

During this program described in preceding paragraph, students, teachers, and parents cooperated to the best advantage to get a job done. The school health council worked willingly and cooperatively in giving the assistance needed in preparation, services to doctors and nurse, sterilization of equipment, and a number of other jobs essential to this type of program.

The cooperative spirit, active interest, and success of
the immunization program should provide a sound basis for the future development of the health education program to improve the living conditions of this community.

Screening for Visual Defects

Some of the teachers had observed that there were apparent visual difficulties in most grades. They suggested that a test for visual defects be made. Plans were made with E. F. Cambron, Co-ordinator of Health Education in North Texas State College, to arrange for the Massachusetts Vision Test to be given. The faculty members and health council decided it would be a better program if some class instruction was given before the screening began to acquaint the child with livable knowledge of eye impairment and also to help the child to gain the appreciation for visibility.

The care of the eyes, foods best suitable for growth, corrections and the protections for eyes were topics around which teachers and students worked.

Early in October, the graduate students in health education (Class Number 412), under the supervision of their instructor, E. F. Cambron, came to the Sanger School and administered the Massachusetts Vision Test to all the students. The children were ready and familiar with the test due to pre-study of the procedures of the test. The students also realized that they could not accomplish the best work under
the handicap of some eye defect. The students who could not read the chart satisfactorily were given a re-test with the Telebinocular Test. Then if some defect was apparent, a letter was sent to the parent asking that the child be taken to the family eye-specialist. The teacher or the health co-ordinator did not diagnose any case but she did attempt to get help through the parent.

The teacher is not supposed to be able to examine a child and make an exact diagnosis as to the nature of the visual disorder, but an attempt should be made to see that the child gets help from a competent eye physician.

Tests were given to 382 students. Records tabulated sixty-three with some type of visual defects. It must be emphasized that the teachers were aware that visual defects might be the results of many causes. Records also revealed that thirty-three had had a check-up with their family specialist and corrections made or were in the process of being made. Conferences had been held with the parents of the remaining who needed some correction. These parents had indicated they would have the child checked before the beginning of a new term. These figures show that 16.5 per cent of the students in the school needed some visual correction. Records show that 52.4 per cent of those who

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needed attention, received a correction before the end of the school term, while 47.6 per cent had not. Conferences had been held with the parents of the students who needed aid.

Screening for Loss of Hearing

Loss of hearing may cause many upsets in the school life of a student. Hearing is just as important to human beings as vision in the process of learning. The teacher and school council emphasized the need of a test to determine the amount of loss of hearing. The Group Audiometer Test was given to all students above the second grade by the graduate class in Health Education of North Texas State College, Number 412, under the supervision of E. F. Cambron. The tests were given to those above the second grade due to the nature of the test. Plans were made to give individual tests to grades one and two, but due to the limit of trained personnel in using these tests, these two grades had no tests administered to them. Teacher observation was the only means to determine loss of hearing in grades one and two. The tests were administered to thirty-five students at one time. A re-test was given to those who showed a sign of loss of hearing. After the screening process had been finished, there were four who had a loss of hearing in one ear. Letters were sent to these parents
Appendix) and stated that the teacher was incapable of diagnosing the ear trouble, but the student needed the attention of the ear-specialist. Three of these four received treatment which resulted in one tonsillectomy.

Daily Observation

Observation in the previous paragraph has been indicative to finding loss of hearing in grades one and two. There are many daily observations which teachers can make to determine deviation from the normal. Some of these may be made to detect some defect such as hearing and vision but most important is the daily observation for communicable diseases. The teachers and health committees within the homeroom used this list of symptoms sent out by the State Department of Health.

<table>
<thead>
<tr>
<th>Flushed cheeks</th>
<th>Sneezing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unusual pallor</td>
<td>Coughing</td>
</tr>
<tr>
<td>Blueness of lips</td>
<td>Noisy breathing</td>
</tr>
<tr>
<td>Watery eyes</td>
<td>Vomiting</td>
</tr>
<tr>
<td>Redness of eyes</td>
<td>Skin eruptions</td>
</tr>
<tr>
<td>Running nose</td>
<td>Rash</td>
</tr>
<tr>
<td>Complains of sore throat</td>
<td>Stiff neck</td>
</tr>
<tr>
<td>Complains of being cold</td>
<td>Headache</td>
</tr>
<tr>
<td>Drowsiness</td>
<td>Fever</td>
</tr>
<tr>
<td>Tired feeling</td>
<td>Backache</td>
</tr>
</tbody>
</table>

The teacher did not limit the daily observation to just a single morning inspection. The faculty decided not to encourage perfect attendance as had been done previously.

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\[9\text{Daily Observation, State Department of Health, Austin, Texas, p. 2.}\]
The school sought to approve the child who thought of protecting his classmates by remaining at home when signs of illness occurred. Many activities were used to stress the control of communicable disease and carry from the school into the home the importance of such a program. The cumulative record cards helped to keep a check on the child's weight and height. In this way, the teacher could observe the physical growth of the child which is quite noticeable in the elementary school. This routine activity offered new experiences for the homeroom health committees. Here was also a basis for teaching nutrition, posture, and also gave experiences in reading scales and tabulating records.

Lunchroom as an Aid in Teaching Nutrition

One of the direct causes of malnutrition among students, is insufficient diets. This may be caused by poverty, lack of knowledge of foods or lack of home control. Lunch eating is a part of healthful school living. The teachers made "Good nutrition" a basic part of the instructional program. Such activities as menu making, actual preparation of foods, using of proper table manners, preparation of food for cooking and many others were indicative to living the health program. Many activities were also utilized in establishing the values of foods eaten in the lunchroom, such as, checking food by Basic Seven Food Charts, determining the number
of calories in the lunch that day, how well the meal was balanced, attractive arrangement of food and many other practical techniques.

The lunchroom program was adequately supervised by the homemaking department under the direction of the homemaking teacher. This service fully utilized many educational opportunities in developing good eating habits among children and devoted some time in developing a deep appreciation of social relationship. The homemaking teacher was responsible for adequate food service, including menus which provided nutritious, wholesome, balanced, and attractive lunches.

The large, pleasant and very attractive lunchroom permitted many opportunities for the leisurely eating with friends and teachers, creating a close relationship between students and students and teachers and students. Approximately one hundred and fifty students each day ate the noon meal in the lunchroom. A mid-afternoon snack was provided for the grades one and two which consisted of some kinds of juices, (tomato or orange), raisins or milk with crackers. This snack was especially good for the child who rode the school bus.

Many values were received in checking the "Basic Seven Food Chart" such as an understanding of the daily food needs, the intake of food for the day, the assimilation of foods in the body, table manners, and etiquette of getting in and out of a lunchroom.
Campaigns were carried on within the rooms to learn new foods also to prevent the waste of foods.

**In-Service Growth**

The administrator, co-ordinator, teachers, and council members found that in-service growth was essential in setting up the development of a health program in the Sanger School. A workshop program on techniques and procedures was formed around suggestions that were offered by the group. The members, previously named, desired a better understanding of the program in general. The first of a series of in-service training of staff and council members began one week before the opening of school. Three members from the State Department of Health, Lustin, Texas, came as consultants in their field of health service. These three were: A. F. Blaebaum who discussed "Control of Communicable Disease"; D. B. Knudson who explained "Environmental Effects on Child's Health"; and U. A. Duckner who discussed "Dental Hygiene and Dental Care". These consultants helped in implementing the program and also assisted in solving existing problems. The Denton County Supervisor, was also available at all times for personal conferences and consultation. North Texas State College gave many capable and willing consultants who did much in helping and encouraging the program. The American Red Cross sent Harris Burton, a field
representative, to work out a program of water safety, first aid, and accident prevention with staff and community council members. Harris Burton worked two successive days directing workshop techniques used in presenting these materials.

North Texas State College extended a problem course to the teachers of the Sanger School as credit or non-credit course in which three took advantage of this offer. Many meetings were conducted in which faculty members and the health councils met jointly to discuss and solve immediate problems. The teachers were aware that the success of this program depended upon the relationship of parents, school health council, community health council and co-ordinator.

The culminating activity for the school as a whole took place in the early part of February. Every student in school, faculty members and members from both councils took an active part in this project. The new school plant was completed the first of February. The school grounds were left piled high with lumber, brick, glass, cement, concrete, nails, tin cans, and debris. The students were conscious of the effect this had on the beautiful new building. They began to want to do something about this condition. A council meeting was called and suggestions made on the best procedures. Finally, each council member was asked to go back to his respective room and discuss what that room could contribute to a clean-up campaign where the whole school was involved.
This took two days and then the council was called together again to work out the suggestion that each member had received from his own room. A committee was formed to work out these suggestions so that each room would be directly responsible for certain tasks. This took about five days and then each council member took back to his room the responsibilities for his respective room. The health council within the room organized these duties so that each person in the room would be responsible for certain tasks that existed with the allotted duty of his room. The council member of each room and the teachers acted as mediators in organizing the work within the room. The superintendent and health co-ordinator acted as mediators for the school as a whole. Each grade was responsible for getting extra help, equipment and facilities necessary for carrying out their part of the project. The council was called together the day before the project was to be launched to see if all detailed plans had been worked out. Every room reported complete plans and everyone eager to get started. Work began early on the day designated as "Clean-up Campaign Day". The accomplishments of the day, interest everyone showed in the project, and the smoothness with which this enormous sized job was done were sufficient proof that actual living experiences are conducive to good teaching. Many activities
such as safety, beautification, cleanliness, attractiveness, and others evolved from this one day's work. The values of cooperative planning were exemplified in getting the job done well and orderly.

Here is a list of jobs completed as compiled by the School Health Council:

1. Pick up nails, glass, small rocks, wire and sticks.
2. Lay off diamond in northwest corner and build bases that will last.
3. Gravel walks at all exits around building.
4. Repair and paint benches for ball grounds.
5. Cut heads out of barrels for garbage and trash cans.
6. Remove lumber and plumbing fixtures by truck to a designated place.
7. Build back stops for all baseball diamonds. (3)
8. Trim trees and remove from school ground by truck.
9. Build fence on school ground near highway.
10. Make sand pile--using 8" by 8" boards nailed together and put in ground to make the wall.
11. Remove all debris.
12. Haul sand for sand pile.
13. Construct goals for an outside basketball court.
14. Lay off court and clean ground.
15. Haul leaf mold for flower boxes.
16. Put up playground equipment.
17. Repair broken equipment.
18. Dig up dead shrubs and replace with new.\textsuperscript{10}

\textsuperscript{10}"The Sanger School and Community Health Report," p. 20.
CHAPTER III

EVALUATION OF HEALTH EDUCATION PROGRAM

The evaluation of any learning activity is actually a part of the activity itself. Since the functional value of any experience is not necessarily always an immediate result but rather a cumulative and far-reaching matter in its influence on learning and behavior, it is difficult at times to make any immediate evaluation. Health education authorities agree that the proper evaluation and measurements of a health education program are very difficult.

Different school systems have different problems and need different health emphasis. Even if schools were more similar than they are, it would not be easy to agree upon a standard of perfect practices.1

Obviously, scientific factors in healthful living is a complicated process, impossible under vigorously controlled conditions. There is however, a practical kind of evaluation of the healthful living which result from health education conceived as the total pattern of influences that affect the health of the individuals and communities.2

Since this study is concerned with only the first year, it is very difficult to determine the values and results.

1C. E. Turner, School Health and Health Education, P. 425.

In the previous chapter, the progress pictured forms the basis for an evaluation. Such a tremendous effort was made to develop the proper type of functional program, no attempt was made to administer specific tests to measure the effectiveness of the activities concerning health education. The evaluation is made by means of personal interviews, opinions of teachers, reports by teachers, cumulative records, survey forms, and observation. The values and results are determined in the light of the objectives set forth in the beginning of the Sanger School Health Program.

The role of a teacher is more important in the health program than any other factor because of the close interrelationship with students and the contacts with parents. Therefore, the opinions and interviews with teachers go along way in substantiating the values and results of this program.

Physical Defects Remedied

The justification for health education is in improved health—physical, mental, emotional, and social—of the individual and the community. The Sanger Health Program did attempt to find and encourage the correction of physical defects through careful screening for vision and hearing impairment, indicated in the previous chapter. Tabulations from the cumulative records indicate that thirty-three out of sixty-three, found in the school to have some visual
defects, received the attention of their family physician. Three out of the four found to have a loss of hearing in one ear, were carried to a specialist. These activities just mentioned are indicative of improved health conditions and also provides the opportunity for children to cope with immediate and future needs. Figures from the record cards show that thirty did not receive any correction in visual defects and one did not receive attention for the loss of hearing. However, conferences had been held with parents and arrangements had been made to have this done before the opening of another school term. This indicates a weakness in the follow-up program in health education. This weakness was emphasized in a personal interview with the fifth grade teacher. She said:

The health program has many good qualities but it seems a waste of time not to do something about the ones who need attention. Our follow-up program needs to be more forceful and more time needs to be spent with the pupil who needs help and also with his parent. If the parents are not able or interested, some means of taking care of the child should be established through the school and the community.3

As previously stated in Chapter II, the health instruction program included many varied and direct experiences which did contribute to the individual's total development. As a part of each health activity, the school provided a

3 Statement by Cathlene Gentle, personal interview.
program of instruction to enlighten the child, to develop a close relationship between students and teachers, and to increase their responsibility for the identification and solution of present and potential health problems.

This is a statement made by the homemaking teacher who assisted in the screening for hearing and vision defects.

Screening for vision and hearing defects is an important program for the children of the Sanger School. Many of the children who needed attention did not know that they had a defect. They all seem to be interested in getting something done. I am sure that this is due to the instructional health program carried on within the classrooms. It is important to know whether the child's lack of success is due to physical handicaps or some other difficulty. It also gives the teacher a basis on which to know the child and his problem.  

Emphasis Upon Health Habits

Daily observation provided an opportunity for the student to participate in the recognition of health variances. Daily observation helped the student to recognize physical signs which did indicate disease and health variances such as paleness, flushed hot face, watery eyes, coughing and sneezing as indicated in Chapter II. This was all important in observing and reducing communicable diseases within the school and community.

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4Statement by Edith Lindley, personal interview.
The Health Education Program emphasized the value of living desirable habits in order to establish these habits among students. Some evidences that proper habit formation for the ability of the students to assume responsibility of his own health is indicative in this statement from the first grade teacher.

Since this is our first year in school emphasis is placed on habit formation. However, no set schedule or routine is used. The work consists of informal activities for habit and attitude formation without the presentation of any appreciable amount of subject matter, with the exception of health readers in the last part of the year.

We have a definite time in the schedule when such habit formations as washing hands before mealtime, proper methods of brushing teeth, cleanliness inspection, etc., are discussed.5

Further emphasis of the importance of desirable habit formation is indicated in a report from the second grade teacher.

The second grade has worked on good habit formation and needs through pupil behavior in daily situations. We have had many types of activities and projects which the children have planned and carried out. For example, a doctor and nurse were chosen each day by the pupils for their morning inspection to encourage cleanliness and neatness. Out-of-school environment for some pupils are not conducive to healthful living. Therefore, demonstrations of desirable practices were made by the children.

5Alyne Seals, Taken from the "Community and School Health Report," 1948-1949.
We used health plays and dramatizations of stories. Proper foods, clothes, sleep eating habits, safety habits, and good manners are some of the units centered around habit formation.  

Improved Human Relations

The home and school had a more vital interrelationship through the findings in the immunization program discussed on pages 16-17 of this study. This discussion points out certain practices in democracy carried on by the teacher and pupil through class discussion and planning. Films used in this program presented to the student and parents the importance of protecting himself and others. The pre-study of the immunization program brought about a desirable mental attitude concerning health practices. Instructional materials used in this study provoked thinking and organization by students, parents and teachers. This statement from the superintendent of the Sanger School in his comment for the annual report of the Community and School Health Program exemplified this viewpoint. "There has been much progress made in the thinking of the community regarding the health of their children."  

The various meetings held for the purpose of planning and studying the problems concerned in the health program

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6 Virgie George, Taken from the "Community and School Health Education Report, 1948-1949.

7 C.D. Allen, Taken from the Community and School Health Education Report, 1948-1949.
throughout the year exemplified a relationship among the administrators, health co-ordinator, and teaching personnel. The work was studied, planned, and organized by the councils, teachers, pupils, and administrators as discussed in Chapter II. The fostering of healthful living was seen as a concern and responsibility for the entire school and community during the meetings of staff and community council members. Especially was this true in the meeting where plans were made for inaugurating the health program in the community, discussed on page 11 in this study. The establishment of the community council and the cooperation which this council gave the school, are indicative of improved school and community relationships. The effective functioning of this program was possible when every area of school and community life were sensitive to the responsibility for promoting healthful living, and were sensitive to the unique contributions.

The general organization of the administration and staff members of the Sanger School did facilitate a gradual and continuous growth in healthful living by providing for an environment in which students did feel at ease, where the work was a challenge, and where each had the opportunity to succeed as far as his capacity and ability permitted.

The report given by the homemaking teacher, who cooperated with the entire school in setting forth a program of healthful living among the students, emphasizes these principles;
The Homemaking Department has participated in the program of health education during the year 1943-1949 in many ways. Each of the three classes have had a six to eight week food unit centered around healthful living. During this unit the class planned its own diet for one day using the Daily Food Requirement Chart. Each individual was allowed one dollar per day to buy the food used in preparing this meal. The students not only cooked the meal, but they made menus, planned and did their own marketing, and evaluated the meal.

The students saw the overall picture of food values, cost preparation, table service, and menu-making values. Students were not only learning health, but learning to get along with others. This is an example of improved human relations through working and planning together.

In the home nursing unit, the students learned the procedures for bathing a sick person. They also learned first aid during emergencies, the contents and precautions of a medicine cabinet in the home. The students worked with the immunization program in learning to protect themselves and others against contagious diseases. This is evidence of improved health behavior in students.

Some of the girls assisted in the lunchroom by serving and preparing the food. This helped the student to have a feeling of ease and security in preparation and meal service. It also helped them to visualize quantitative food preparation.

Units on personal appearance made the students more conscious of their own health habits and also caused an improved personal appearance. Every day during these units a chart was checked to see if they had good health habits.

The outcomes for these units were: students stopped the exchange of powder puffs and combs. Students began to shine their shoes before coming to school. Students began pressing their clothes. Students began eating breakfast. Students began taking a bath more often. Students began using deodorants.
The health program has created much interest in each of the units we have worked with in the homemaking classes. When students are health conscious, they are all interested in correlation of units.  

The School Health Council encouraged leadership in that each member was a representative from his homeroom. The members were to act as mechanics for determining and implementing health activities to be used in the school. The council members planned the health education problems that concerned the school as a whole. Such responsibilities as giving information, giving assistance on specific problems, the role of a mediator, and planning for the development of leadership. Contributions from each student in the school was handled through the committees in each room. Leadership was improved by providing leadership opportunities. The seventh grade teacher emphasized the improvement of leadership through council work in health education.

The Health Education Program is an asset to this school. There has been much planning and coordinating among teachers and pupils. There are opportunities for leadership for the students when acting as chairmen of the various rooms in the school health council, and other official places. The program has trained students to assume responsibility for their own health and the health of the school and the community.  

The community council, the school health council, and staff members working together in organizing, planning and

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8 Edith Lindley, Taken from the "Community and School Health Education Report," 1948-1949.

9 Statement by Grace Brown, personal interview.
participating in the health program in various ways, emphasized the techniques of democratic living. These techniques were described in the chapter on "Health Education at Work". The working and planning together of people for a common good indicate an improved human relations.

Some of the areas in which the community health council invested its efforts for community improvement with the cooperation of the school were in public health protection, cleanliness and beauty, safety, public services, and recreational opportunities discussed in the previous chapter. The evolving of the Community Planning Committee from the Community Health Council is illustrative that a council is a means to an end, rather than an end in itself. Many values and results, as shown previously, have evolved from the work of these councils. Many proposed values of the councils which will be recognized later, will have a bearing upon the community and school in time to come. The council members served as individuals with certain skills, knowledge, points of view and connections which made them valuable in the planning and organizing processes. The working and planning together of the councils and staff members expressed a trend toward better human relations between the school and the community. Constant attention was given to the value of improving the school-community relationships in developing a sound and practical attitude toward healthful living.
Improved Health Instruction

A functional health curriculum is based upon organized instruction in health, utilizing the school, home and community experiences which aid the child in understanding factors that influence health and growth. The teaching personnel realized that effective learning is the result of experiences in facing and satisfactorily solving personal problems in health whether they be in the home, the school, or the community. Reports and opinions of faculty members given in the previous part of this chapter indicate that developing the child as a whole is of paramount importance.

Health instruction was given in carefully organized courses at a specific time as well as incidentally or as a type of supplementary health instruction given in related subjects. The materials were adapted to needs, interests and capacity of the students as indicated in the first and second grade reports. Health instruction did stress the development of good habits and attitudes. In these reports just mentioned, emphasis was placed on the activity rather than reading about it. The bases for health instruction were needs and interests discussed in Chapter II. In the primary grades, emphasis was placed on healthful living to the end that desirable habits and proper attitudes were to be developed. The method for giving this emphasis were through utilization of every day life experiences and
through planned activities that are of interest and have meaning for children. Such planned experiences are: use of handwashing facilities, lunch period, weighing and measuring, housekeeping, ventilation of the classroom, and many others.

In the intermediate grades emphasis was placed on the development of safety, health and attitudes toward daily living in the home, the school, and community.

Specific and desirable health experiences were provided in the high school. Certain needs, interests, and understandings were basic to the instructional program as indicated in the report given by the homemaking teacher previously in this chapter. Many opportunities were given for the individual to assume increasing responsibility for his own health. Teachers, in previous reports, mentioned balanced menu, leisurely manner of eating in the lunchroom, safety precautions, proper selection of clothing, and good grooming as responsibilities of the student.

Most of the health instruction in the high school was in coordination with other subjects, such as homemaking, science, civics and safety. For an effective health program in the secondary school, special health courses seemed necessary. Teachers are not fully trained for health instruction, especially in courses where health correlation is made with unrelated subjects. Indications are that a
more adequate in-service training program was needed in order to improve the proper health instruction for high school students.

Many of the health activities were vitalized to encourage the student in this program of health education. Since the goal of the school health program is to maintain and improve health, it is imperative that this program be endowed with life. The seventh grade teacher expressed this factor in a personal interview.

This is the type of program we have been needing in our school. Students enjoy doing things rather than reading about them. We need to work with more desirable problems so that we may eliminate the undesirable problems. It seems necessary that we keep this in mind when we set up our objectives and make them practical and livable.10

A variety of instructional materials were made available through the health co-ordinator, for all grade levels. The materials were from different companies and most of them were free or inexpensive. Films, teaching units in different areas of health, posters, and many other types of materials were filed in accessible places for teachers.

The Health Education Program of the Sanger School began a trend from factual instruction to one of the work experience type of program. Girls cooking in the lunchroom, planning menus for lunchroom, clean-up campaign, assisting in the

10 Statement by Grace Brown, personal interview.
screening programs, serving on councils and committees, designing playground, and typing letters, forms and reports are indicative of some of the experiences offered by the health program. An interview with the typing teacher substantiates the value of the health program to the commercial department.

A practical and livable program provides opportunities for students and teacher planning. The typing class has shown great interest in doing worthwhile things concerned with the health education program. Letter writing, making of forms, report blanks, and many other experiences have proved very instructive to this class. The members of the class took special pride in the work of local interest rather than textbook materials. Health education materials were substituted for the textbook and credit was given to those of students who worked with the health program.11

The health instruction for the Sanger School Program included many varied and direct experiences which did contribute to the individual's total development. These experiences have overlapped in some of the grade levels. Some means of over-all planning of instructional materials are indicated.

Many of the students changing schools in the county had not had the health experiences and services given to the students in the Sanger School. This indicated that a

11 Statement by Callie Miller, personal interview.
county-wide program should be undertaken. This would necessi-
sitate a county-wide council to formulate plans and coordinate
health activities and services.

Since the evaluation of this health program has been
so difficult, a criteria for evaluation of the health
programs in this county seems important. This criteria could
act as a motivating force in promoting better healthful liv-
ing in Denton County.

Some emphasis has been given to the mental hygiene of
the child such as, providing a wholesome environment for
working, living with others, feeling of security, and the
feeling of achievement. This study reveals that not
enough emphasis has been placed on this phase of child de-
velopment.

This chapter emphasizes some of the values and results
found in one year's participation of the Sanger School in
the Community and School Health Education Program under the
direction of the W. K. Kellogg Foundation, Department of Edu-
cation, and North Texas State Teachers College.
CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The problem of this study, as stated in the introduction, was to analyze the values and results of one year's participation in a three year program in order to determine an adequate basis for making recommendations for the further development of this program.

In the light of the data analyzed in this study, the conclusions are made as follows:

1. The Health Education Program, in the main, did seek to unite the home, school, and community in an effort to provide for the total development of the child and to improve the local environment in the interest of both children and adults.

2. Many individuals were given status and opportunities for leadership in group work. This program seemingly stressed the importance of individual contribution.

3. This health program tends, if this analysis can be taken as indicative, to bring about a democratic setting for planning, cooperating, and participating of pupils, staff members, and parents.
4. There is a trend toward community-school participation as shown in the planning and execution of the health program.

5. There is a definite trend toward the practice of coordinating health education with other phases of the entire school program.

6. Cooperative group planning which enlists the participation of pupils, staff members, parents, and service agencies of the community has probably improved human relations.

7. The evaluations of those participating were made in the light of the effectiveness of service rendered to the child.

8. The fostering of the exchange of ideas, the developing of means of meeting individual and group needs, and the improving of certain conditions in the environment were conducive to improved human relations.

9. It is concluded that the health survey was a vital factor in finding the health needs of the child in order to determine the basis for a health program.

10. This study indicates that the health program was well-rounded. It gave many opportunities for students to establish and develop good habits and attitudes.

11. The immunization and screening program proved to be important factors in bringing the students, parents, and classroom teachers into a closer relationship.
12. It is assumed that the work-experience type of program was more evident in health education than it was in any other phase of school instruction.

13. It is believed that democratic procedures permeated most of the health activities used in this study.

14. It is assumed that the flexibility of the health instructional program promoted a trend toward the improvement of leadership. Leadership was improved by providing situations for leadership.

15. It was found that the Health Education Program was flexible enough to include community and school cooperation.

16. The contents of this study reveal that a definite health criteria is needed for evaluating the schools of this county.

17. This study described a program of in-service-training for staff and council members but it also indicates that there is a definite need for a more adequate program of growth as many teachers are not trained in the area of functional health education.

18. These data reveal that much time was used in the instruction program to promote good habits and attitudes.

19. It is concluded in this study that the health instruction program did provoke thinking and organization among teachers, students and parents.
20. This study concluded that the program evolved from the needs and interests of parents, teachers, students, and patrons of the community.

21. The health program promoted among students a feeling of ease and security by planning and working with their own problems.

22. It is believed that the health councils were coordinating forces that motivated the health education program.

23. It is concluded in this study that the health program is a gradual and long-ranged process extending throughout the school year.

24. It is believed that the health council members had a definite contribution to make toward the development of the health program in that their skills, knowledge, points of view and connections offered an adequate means for improvement.

25. Cumulative health records are instrumental in the problem-solving aspect of the total program of education.

26. In many of the activities, the student not only learned health, but they learned to work and plan with others.

27. The evidence presented in this study indicates that the Sanger School and Community have been improved by the one year's participation in the Texas Health Education Program.
There are indications that the program has established a sound basis for the further development of healthful living by continuing and increasing the guidance and cooperative efforts presented thus far in the program.

Recommendations

In view of the data analyzed in this study and in the light of the conclusions previously listed, the following recommendations will promote a continuing and well-balanced program to improve human living by attempting to solve real problems in the life of the school and community. The following recommendations are:

1. That a continuing effort be made to carefully study the offerings included in the health instructional program in view of determining their suitability in meeting the health needs of the students.

2. That the staff members of the Sanger School continue to strive for improvement of a vitalized program of health in the school by increasing democratic techniques.

3. That a thorough program of in-service training for all the school personnel be provided to the end that each participant will have the opportunity to grow continuously in his ability to make a worthy contribution to the health education program.
4. That real effort be made to enlist the interest and participation of all schools in a county-wide health council to coordinate the health problems of the county.

5. That more opportunities be given for the use of community resources in health education.

6. That an effort be made to make the health education program such a meaningful part of the school and the community life that it will enlist further the interest and cooperation of the entire community.

7. That more provisions be made in the program for the development of mental hygiene.

8. That a more adequate follow-up program be used in securing the correction of physical defects found among students.

9. That an intelligent over-all planning of health instruction on all grade levels be made to prevent the overlapping of instructional activities.

10. That a health education criteria of evaluation be formulated to appraise all the schools in the county.

11. That the program of health will be extended so that dental and physical examinations will be given to each student in the school.

12. That a full-time health co-ordinator be provided in the school to promote better coordination and healthful living within the school.
13. That an effort be made to increase the trend from factual instruction to work-experience type of program.

14. That special courses in health education be offered in high school.
APPENDIX
Dear Parent or Guardian:

We are making a physical health record for each child in our school. This record will be kept in our confidential files at school, and we shall add to it each year. Will you please assist us by giving the information requested in the forms below. We appreciate your cooperation and assistance which you are giving and have given to our health program.

Thanking you, we are

Yours truly,

Superintendent: C. D. Allen
Health Coordinator: Cleo Lockhart
Home Room Teacher:

Name .......................................................... Guardian’s Name ..........................................................
Address .......................................................... School ..........................................................
Address .......................................................... Grade ..........................................................
Address .......................................................... Family Physician ..........................................................
Date of Birth: Year .......... Month ........ Day ........ Sex ........ Race ........

___________________________

GIVE DATE AT WHICH CHILD LAST HAD:

Measles .......................................................... Infantile Paralysis .......................................................... Conclusions ..........................................................
Malaria .......................................................... Mumps .......................................................... Chorea ..........................................................
Whooping Cough .......................................................... Pneumonia .......................................................... C. S. Meningitis ..........................................................
Asthma .......................................................... Diphtheria .......................................................... Tuberculosis ..........................................................
Rheumatism .......................................................... Hay Fever .......................................................... T. B. Contact ..........................................................
Typhoid .......................................................... Bronchitis .......................................................... Tuberculosis ..........................................................
Chicken Pox .......................................................... Influenza .......................................................... T. B. X-Ray ..........................................................
Tonsillitis .......................................................... Scarlet Fever ..........................................................
Frequent Colds .......................................................... Heart Disease ..........................................................
Smallpox .......................................................... Discharging Ears ..........................................................

___________________________

GIVE DATES OF IMMUNIZATION AGAINST:

Smallpox .......................................................... Scarlet Fever ..........................................................
.......................................................... Hay Fever ..........................................................
Diphtheria .......................................................... ..........................................................
Typhoid .......................................................... Whooping Cough ..........................................................
Tetanus .......................................................... ..........................................................
SANGER PUBLIC SCHOOL
Authorization for Emergency Treatment

To the parents of ______________________________

We believe that the information herein requested would be of invaluable assistance to us in case of an emergency. Will you please fill in the blank and return as soon as possible?

Thanking you, we are

Yours truly,
Superintendent: C. D. Allen
Health Coordinator: Cleo Lockhart

Home Room Teacher:

Name of Parent or Guardian ______________________________
Address ____________________ Telephone ____________________
Mother's business _______________ Telephone ____________________
Give directions for reaching your home from School _______________

If your family physician cannot be located, what other doctor do you authorize us to use? ______________________________

In case hospital treatment is necessary, do you authorize us to proceed as advised by physician? __________________________

Which hospital do you prefer? ____________________________

Any other information? ________________________________
To the Parents or Guardian of__________________________

Since parents are always directly interested in the health of their children, and since the condition of a child's_______ is important to his health and school work, you will be interested to know that an inspection of your child's___________ show that they need the attention of a ________________.

We suggest that you see the doctor of your choice. If this is not possible, we suggest that you consult the home room teacher. We are very anxious to help your child.

In order that we may know that you have received this notice, and that our records may be complete, we request that you fill in the form below and return the notice to the home room teacher.

Thanking you for your cooperation, I am

Yours truly,

______________________________
I will take my child to the doctor____________

______________________________
Home Room Teacher

______________________________
I wish to have a consultation with the home room teacher__________

______________________________
(Mrs.) Cleo Lockhart
Health Co-ordinator

______________________________
C. D. Allen
Superintendent
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Personal Interviews

Statement by Grace Brown
Statement by Cathlene Gentle
Statement by Edith Lindley
Statement by Callie Miller