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ABSTRACT

The statistical portrait of this Kids Count report is based on seven indicators of child health: (1) lead poisoning; (2) immunization; (3) hunger; (4) condom use; (5) tobacco use; (6) alcohol use; and (7) inhalant use. The first section of the report presents information on the health indicators. Findings indicate that Vermont immunization levels are getting closer to national goals; model clean indoor air legislation restricts exposure to environmental tobacco smoke; state laws address prevention, intervention, and treatment of childhood lead exposure; the Women Infants and Children Nutrition Program has very high participation and innovative services; most Vermont children have health insurance; and a new law offers the most comprehensive model of treating child and adult mental health and substance abuse conditions. However, children continue to be exposed to environmental toxins, experience hunger and are at risk for the effects of under-nutrition; school indoor air quality is not regulated; and youth substance use is rising. The report concludes by noting that continued support of state policies and programs to address child health issues and continued child advocacy are crucial. The appendix includes a resources section providing information on related legislation, program eligibility, and specific indicator information such as an immunization schedule, and childhood lead screening recommendations. Also appended are the study methodology, data sources, and acknowledgments. (KB)

The State of Our Children

1997 Data Book

kids count

Kids Count in Vermont Health Addendum

Prepared by
The Vermont Children's Forum

A report of Vermont KIDS COUNT,
a project of The Vermont Children's Forum,
funded by The Annie E. Casey Foundation.

Vermont KIDS COUNT is a collaborative effort with
Vermont's Agency of Human Services and Department of Education.

Additional Copies of
The State of Our Children: Kids Count in Vermont Health Addendum
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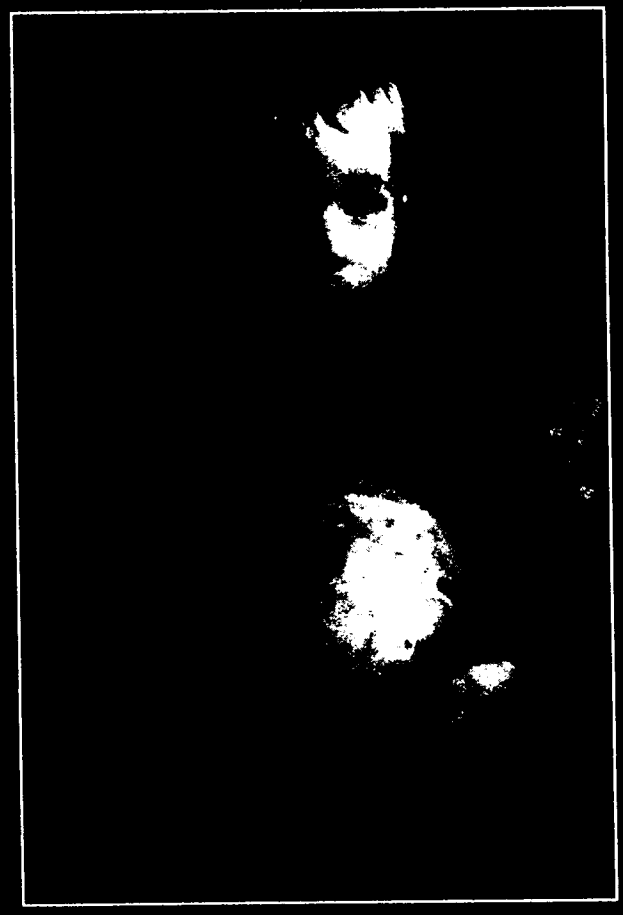
Being healthy feels like a brisk shower from a cold waterfall on a Summer's day.

Being healthy feels like running on a breezy day in a pine-smelling forest.



Introduction

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About Vermont Kids Count

Vermont KIDS COUNT is an ongoing project of the Vermont Children's Forum to collect and analyze state data on child welfare. It is funded by the Annie E. Casey Foundation, the nation's largest funding institution committed to support for disadvantaged children.

Vermont KIDS COUNT is a unique collaborative effort involving the Vermont Agency of Human Services and the Vermont Department of Education. In addition, volunteer committees have guided the selection of the indicators and the design and distribution of the data book. KIDS COUNT volunteers include representatives of private, non-profit, government and educational agencies, as well as business people and individuals.

Goals of Vermont Kids Count

The goals of Vermont KIDS COUNT include the creation of a KIDS COUNT database; publication of an annual report on child well-being issues; development of special reports and fact sheets, and regional workshops to increase public awareness of issues affecting child well-being; and participation in the Vermont Children's Forum's Annual Vermont Children's Campaign, which produces the Children's Campaign Agenda.

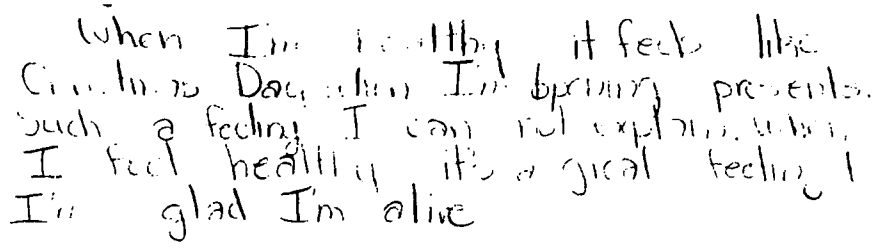
The State of Our Children offers an in-depth look at the needs of Vermont's children and families, through data reported on local and state levels.

Kids and Vermont Kids Count

Part of KIDS COUNT outreach includes working with children to get their perspectives and hear their voices. Thus, their art work, photography and words are throughout this book. In this publication, there are selections written by sixth graders describing health, and an article about teens written by a class of eighth graders.

The Fourth Edition of the Kids Count Report

The State of Our Children, Kids Count in Vermont 1997 Health Addendum is focused primarily on health-related issues affecting children and youth in Vermont. This edition highlights seven key child and adolescent health indicators not previously covered by Vermont Kids Count data books. An overview of the effects of environmental toxins on children and adolescents introduces the first section. A resource section provides information on some related legislation, program eligibility, and specific indicator information such as an immunization schedule, or childhood lead screening recommendations. The Appendix encompasses data methodology, sources and acknowledgments.



Foreword

The health of children is a vital indicator of the health of a nation. The World Health Organization defines health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. Nationwide, 24 percent of children are not fully immunized; exposures to known and unknown environmental toxins threaten children's health; and childhood hunger is a growing problem.

Vermont's commitment to children's health, through legislative, policy, and program initiatives is exemplary. Immunization levels are closing in on national goals; model clean indoor air legislation restricts exposure to environmental tobacco smoke; state laws address prevention, intervention and treatment of childhood lead exposure; WIC, the program for pregnant women and young children, boasts very high participation rates and innovative services; most Vermont children have health insurance; and a new Vermont law offers the most comprehensive model of treating child and adult mental health and substance abuse conditions, in a similar fashion to physical health.

Yet, children in Vermont still face many threats to their health. Children continue to be exposed to environmental toxins such as lead and pesticides, thousands of children are hungry and at risk for the immediate and potentially lifelong effects of undernutrition; school indoor air quality environments are not regulated; and substance use among Vermont youth is rising.

To address these and other complex child and adolescent health issues, it is critical that we continue to support state policies and programs that address child health issues and advocate to enhance services that help to ensure all children have opportunities to be physically, mentally, and socially healthy.

Being healthy is feeling like you could run faster than a cheetah or being ~~as~~ stronger than an elephant.

Environmental Toxins and Children's Health

It has long been recognized that environmental pollutants — from industrial wastes and pesticides to secondhand smoke — can be extremely harmful to human health. Yet, the serious, and potentially long-term impacts of environmental hazards on children and youth are not specifically considered in national studies or in our nation's environmental policy. "Most federal environmental regulations are based solely on data from adults and do not necessarily protect the health of children." (Children's Environmental Health Network 1996) Although considerable work has been done in recent years to reduce pollutants, the health of children and teens is still jeopardized by known preventable environmental hazards as well as by toxins yet to be identified. (Lewit & Baker 1995, 9)

Children's bodies are different from adults', constantly changing even through adolescence and distinctly susceptible to the "insults" of toxins, undernutrition, or disease. Throughout the first months and years of life, children's nervous, reproductive, respiratory and immune systems continue to develop and grow, and are particularly vulnerable to environmental toxins.

Young children breathe more rapidly, take in more air, have higher metabolic rates, and have a higher intake of food and liquids than do adults. Pound per pound, children are more likely to experience increased exposures to air, food or water pollutants. For example, an adult's body will absorb 10 percent of consumed lead, yet a one- to two-year-old child will absorb 50 percent of the consumed lead. (Bearer 1995, 20)

In addition to children's physiological and metabolic differences that increase the adverse impacts of environmental toxins, their living environments may also subject them to more or higher levels of toxins. Before birth, the fetus can be exposed to a variety of pollutants because many toxins, such as lead, can cross the placenta, directly affecting the growing fetus. Infants and young children often play near or on the ground, and are thus exposed to contaminants in dust, soil, and carpets as well as low-lying vapors from radon or pesticides. Adolescents may be inadvertently exposed to toxins at a job or through sports activities (see Children and Environmental Risk Factors During Different Stages of Development on page 31).

"Despite the known dangers to children's growth and development, American society has still not expressed a commitment to ensure that children will grow up in a safe environment and reach their full potential unhindered by toxins in air and food."

(Lewit & Baker 1995, 9)

wagon to a star!!
When I'm healthy it feels like...
I could fly as high as a bird
I could go as far as a butterfly

Examples of Environmental Hazards

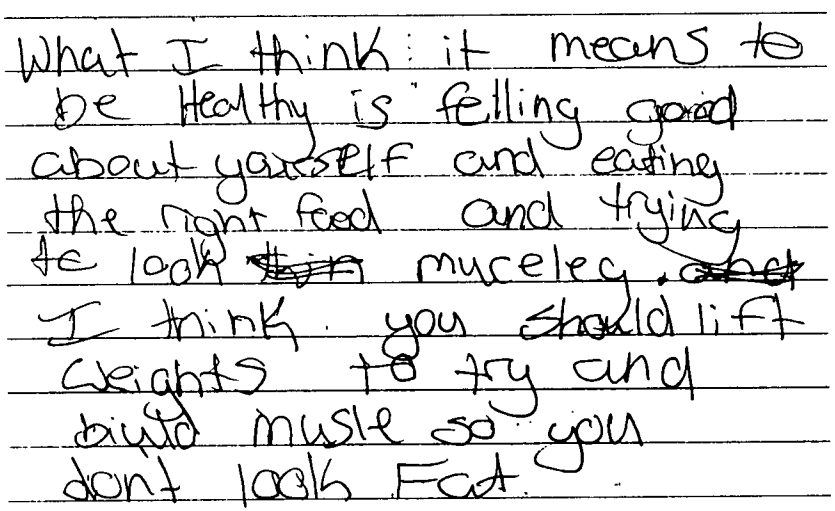
Indoor air quality provides one example of the potential impacts of environmental pollutants on children. Exposure to second hand smoke (environmental tobacco smoke or ETS) has been shown to increase the risk of lung cancer in non smokers. Exposure of children to ETS has been shown to increase respiratory infections and the severity of symptoms of children with asthma, and be a risk factor for new cases of childhood asthma. School indoor air quality can also affect children's health, yet many Vermont schools have inadequate ventilation, potentially exposing children to a variety of pollutants—from toxins and pesticides in cleaners, to the fumes from glues and paints. Currently, there are no public school air quality regulations in Vermont.

Outdoor air pollutants include ozone and particulate matter. As with second hand smoke, "exposure to ozone has been associated with increased asthma rates in children, as well as reduction in lung function."
(Children's Environmental Health Network, 1996)

National and State Policy

Research clearly demonstrates major differences between children and adults. It is critical that the nation commit to the development of a children's environmental health policy. And Vermont must take similar action and focus on the unique needs of children in all state environmental policies, regulations and legislation. Children must come first.

> *"For a variety of reasons, special consideration should be given to protecting children in formulating environmental policies: children are less able than adults to protect themselves, may be more vulnerable to particular toxins, and are not considered responsible for pollution. Crafting environmental policies responsive to the special needs of children requires a thorough consideration of these special needs and an understanding of how these needs may change as children grow and develop."* (Bearer 1995, 12)



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Childhood Lead Poisoning

Children with elevated blood lead levels are at risk for significant health problems. The effects can include behavior and learning problems, attention deficits, slowed growth, hearing problems, and headaches. Severe lead poisoning and long-term exposure can cause damage to the brain, kidneys, and nervous system. Extreme lead poisoning can lead to convulsions and death. Too-high blood lead levels in pregnant women may also impact the fetus because lead crosses the placenta. Studies have found that lead exposure can affect intrauterine growth and growth during the first year of life.

Nationally, it is estimated that 4.4 percent of children age five and under have lead in their blood at unsafe levels (approximately one million). In 1991, The United States Centers for Disease Control and Prevention (CDC), lowered the unsafe blood lead level threshold in children to 10 micrograms of lead per deciliter of blood (µg/dL). In the same year, as many as 10 million American children were at risk for blood lead poisoning.

In Vermont, a 1993 Vermont Department of Health (VDH) prevalence study reveals that at least nine percent of two-year-olds in Vermont may have unsafe blood lead levels.

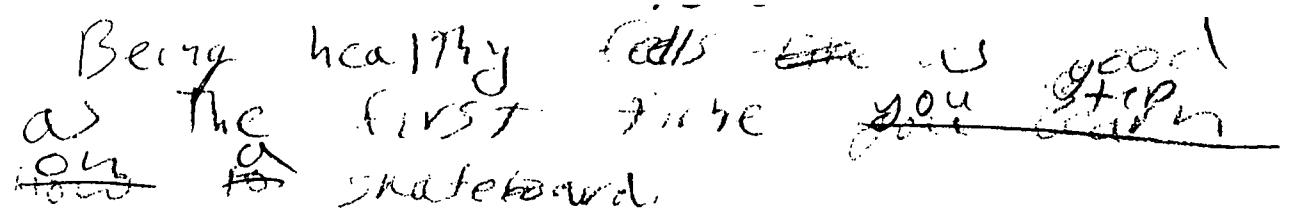
"Childhood lead poisoning is the number one environmental disease affecting young children today"
(Childhood Lead Poisoning Prevention:
1995 Progress Report. VT Department of Health)

The most common source of lead exposure in children is lead-based paint. Paint that is deteriorating or disturbed—a condition most commonly caused by the friction of opening and closing windows—settles as surface dust. Children breathe in or eat the contaminated surface dust that can get on their hands and toys. Children can also be exposed to lead in bare soil and less frequently through water.

Until 1978, when the U.S. banned the use of lead in residential paints, lead-based paint was routinely used for exterior and interior painting. According to a 1995 report of the U.S. Department of Housing and Urban Development, despite the marked decrease in blood lead levels over the past 15 years, unsafe lead levels continue to be a significant and preventable problem for children.

> *"The recent reductions in blood lead levels are attributable largely to removing lead from gasoline and food cans. By contrast, relatively little has been done to reduce hazards from lead-based paint in pre-1978 housing and from lead-contaminated soil."*
>
> (U.S. Department of Housing and Urban Development 1995, 3)

In Vermont, according to the 1990 Census, about one half of the housing stock was built before1978, increasing the likelihood that it contains lead-based paints.



What is a Toxic Dose of Lead?

Standards change over time, as new research reveals greater risks. In the 1960s, the definition of a toxic blood lead level was designated as 60 micrograms per deciliter of whole blood (µg/dL), this was decreased in 1972 to 40 µg/dL, to 30 µg/dL in 1978, and the threshold was lowered to 25µg/dL in 1985. A complete evaluation by the Centers for Disease Control and Prevention in 1991 found:

"New data indicate significant adverse effects of lead exposure in children with blood lead levels previously believed to be safe. Some adverse health effects have been documented at blood lead levels at least as low as 10 micrograms per deciliter of whole blood (µg/dl)."

(Needleman, 1992, pg. 11)

Between 1994 and 1996, 19,344 (duplicated counts) child blood lead levels tests were administered in Vermont. During the three year period, an average of 1.2 percent of the children tested had blood levels designated as severely lead poisoned by VDH standards.

According to VDH guidelines, children with blood lead levels of ≥ 20 µg/dL are severely lead poisoned and should be retested every 1-3 months. Public health outreach workers will do environmental testing to look for the source of the lead — paint, occupational exposure of adult(s), soil, and water. An outreach worker will also work with homeowners or landlords to address the problem.

Table 1

Lead Poisoned Children

*Vermont children screened for lead poisoning with unsafe blood lead levels**

µg/dL	1994 Number	1994 Rate	1995 Number	1995 Rate	1996 Number	1996 Rate
10-14	496	10.3	568	8.0	507	6.8
15-19	161	3.4	93	1.3	96	1.3
≥ 20	84	1.7	79	1.1	58	0.8

µg/dL = micrograms of lead per deciliter of whole blood
** 10µg/dL or above has been shown to negatively affect the health of children.*
Rate = the percent of all children tested who have designated elevated blood lead levels.
In 1994, 4,804 children were tested, in 1995, 7,078, and in 1996, 7452 children were tested.

For moderate blood lead levels of 10-14 or 15-19 µg/dL, cleaning and nutrition are critical in helping to reduce blood lead levels. Regular cleaning — washing hands and toys and cleaning window wells where contaminated dust settles — can help reduce the risk of lead ingestion. Insuring a diet rich in calcium and iron helps protect children from the harmful effects of lead in the blood.

Children with lead levels at or above 40 µg/dL need immediate medical intervention. At high levels, lead will accumulate in the soft tissues — the brain, kidneys, teeth, and bones.

Being healthy is like reliving the best day of your life over and over. Each day brings that feeling of happiness and hope; that nothing can go wrong.

Income is another factor that determines who is at risk for lead poisoning. Low-income children ages one through five are four times more likely than children in high-income families and three times more likely than those in moderate-income families to have unsafe blood lead levels, according to the Children's Defense Fund Report, *Wasting America's Future.* Lower income families are more likely to live in older housing or housing with deteriorating paint, increasing their risk for exposure. In addition, poor children experience a type of double jeopardy. They are at higher risk for lead poisoning and more likely to have iron deficiency caused by undernutrition. *"When these two consequences of poverty interact in the blood stream ... the combination of lead poisoning and iron deficiency is distinctly more harmful than the presence of either alone."* (Sherman 1994, 55)

In Vermont, the 1993 VDH prevalence survey reveals that 15 percent of two-year-olds with Medicaid coverage had unsafe lead levels, suggesting that in Vermont, as in the nation, lower income children are at increased risk for lead poisoning. Between 1991 and 1997, 276 children under age six tested as "severely lead poisoned" (≥20 µg/dL). Seventy-six percent lived in housing built before 1978.

"...the human body needs iron, and blood cells seek it out; when children lack sufficient iron, their blood cells instead grab hold of lead molecules that the child has ingested from paint dust, contaminated water, or other sources. These children therefore absorb more of the poisonous metal and it bonds more tightly to their blood cells. The result is more severe lead poisoning." (Sherman 1994, 55)

Preventing Childhood Lead Poisoning

Lead poisoning in children is:

1) the most common pediatric environmental disease;
2) a serious threat to their health and welfare; and
3) preventable.

Reducing and, ideally, eliminating childhood lead poisoning requires comprehensive public education, identification of risk, screening, and lead-hazard reduction strategies.

In Vermont, VDH has been designated the lead agency for lead poisoning prevention. VDH, parent advocates through the Vermont Lead Safety Project, health care providers, the Vermont Housing and Conservation Board, and Community Action programs coordinate lead poisoning prevention and early intervention efforts. In addition, two state laws specifically address the reduction of lead hazards in rental housing and day care homes and centers, and the development and implementation of child screening recommendations (see the Resource section, page 32).

Feeling healthy is like finding a crocus under an April snow.
Feeling healthy is like a flea on a plethora of poodles!
Good health is like a bottomless treasure.

Preventing Childhood Diseases

In developing nations, broad-based immunization is critical for improving the health conditions and life expectancies of children. Diseases such as measles, diphtheria, polio and whooping cough are still major causes of severe illness, disability or death.

In the United States, immunization also is critical for protecting children's health but images of children dying, seriously ill, or disabled from childhood communicable diseases have all but vanished from our national psyche. Many Americans have not witnessed the serious impact that diphtheria, polio or pertussis once had in the U.S., and may believe it is no longer necessary to immunize their children. Many of these serious diseases have all but disappeared* or are infrequent because of wide-spread access to childhood vaccines. Yet, the American Academy of Pediatrics reports that 25 percent of pre-school children have not been completely immunized. Immunization levels for pre-schoolers range from 40-60 percent and in some inner-city areas the rate is as low as ten percent.

An epidemic of a particular disease is more likely to occur when children are not immunized or are inadequately immunized. Between 1989 and 1991, there was a major measles outbreak that affected over 55,000 people in the U.S.; approximately 11,000 were hospitalized and nearly 120 died. According to the United States Centers for Disease Control (CDC), this outbreak is largely attributed to a failure to immunize pre-school children on time.

By maintaining the recommended immunization schedule, young children are more likely to receive other vital preventive services or conversely, "Children who are under-immunized at 24 months of age are three to 12 times less likely to have been screened for anemia, tuberculosis, or lead. (Pediatrics 1994, 545) The CDC has set a national immunization goal of 90 percent of children to be fully immunized by age two. According to National Immunization Survey (NIS) data, Vermont's child immunization rate was 86 percent in 1996 (see table 2).

The national average, while still well below the year 2000 goal, reflects a significant increase over the past four years. Between 1991 and 1996, immunization levels increased from 55 percent to 78 percent.

Improving immunization levels, as with confronting childhood lead poisoning, requires coordinated partnerships. CDC Director Dr. David Satcher has stated, "While no single factor accounts for under-immunization, achieving and sustaining high coverage clearly requires coordinated and comprehensive action by health-care providers, parents and communities." Experts cite four main reasons for under-immunization: 1) The high cost of vaccines; 2) the confusing immunization schedule; 3) the lack of a standardized system to track and notify parents and health care providers when vaccines are due; and, 4) parent education about the need to fully immunize children.

Being healthy is like math. Healthy = happy. Being healthy is like the satisfaction of having no homework.

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** Smallpox has been eradicated, and in 1994, the World Health Organization declared the Western Hemisphere free of polio. In the 1920s, about 125,000 cases and 10,000 deaths were caused by diphtheria each year. Since 1980, fewer than five cases a year are reported in the United States.*

Children should be vaccinated for the bulk of the immunization series before the age of two. Additional immunization is recommended for most of the same diseases between four and fourteen years of age. In 1996, additional immunization goals were set to 1) include the Hib vaccine—a vaccine for a strain of influenza— within the original 90 percent goal; and 2) meet a 70 percent immunization rate for the hepatitis B vaccine (see page in the Resources Section for the recommended immunization schedule).

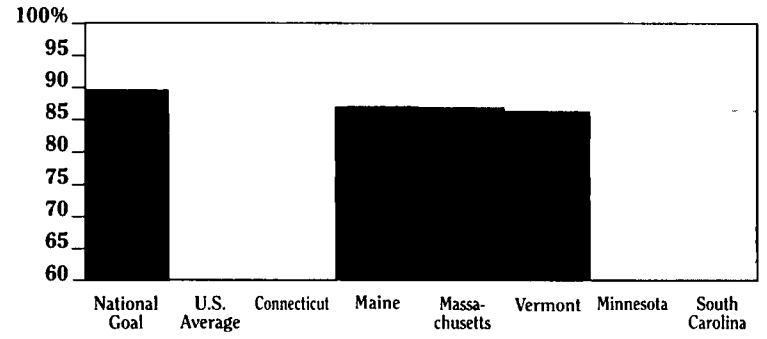
Table 2 provides data on the national child immunization goal and compares 1996 NIS national vaccine level data with the states that have vaccination levels at or above 86 percent in 1996. Vermont immunization levels have been above 85 percent since the NIS was initiated in 1994. The Vermont Department of Health coordinates immunization programs and services to help insure high vaccination levels (see page of Resources Section for more information on VDH immunization initiatives).

In Vermont, an outbreak of pertussis (whooping cough) occurred between 1996 and 1997 (outbreaks occurred in other states as well). It appears that under-immunization due to parental choice — concern over the vaccine's side-effects — and evidence of waning immunity in older children, may be the major reasons for the increase in cases in Vermont, and not the lack of access to vaccines. According to VDH, good access to medical care for diagnosis and treatment helped to identify cases occurring in the state, and Vermont's high immunization rates helped decrease the impact of this outbreak on young children. A new form of pertussis vaccine, which is less associated with side effects, is now available, and in the future may be approved as a booster dose to protect older children whose immunity has decreased.

Table 2

Immunization Coverage*

*States at or above 86 percent immunization rates of two-year-olds in 1996***



**The National Immunization Survey provides state estimates of vaccination coverage levels among children 19-35 months. This survey was implemented by the Centers for Disease Control beginning in 1994.*

*** Percent of two-year-olds with a complete 4:3:1 series Vaccines in the 4:3:1 series are four doses of DPT (diphtheria, tetanus and pertussis), three doses of polio, and one dose MMR (measles-mumps-rubella).*

The feeling of healthyness is like the feeling you get when you've just beat your big sister in a game of 1on1 basketball.

Childhood Hunger

Hunger, like lead poisoning, can be a silent health problem. Long before hunger's effects are severe enough to be detected, it can have a negative impact on children. Chronic undernutrition can affect children's growth, learning, and development.

In 1997, Vermont families, like families nationwide, face both hunger and a lack of food security*.

An estimated 12 million children in the U.S. have diets substantially lacking in the recommended allowances of nutrients. According to the most recent estimates by the Food Research and Action Center, a national anti-hunger organization, 21,000 Vermont children ages 12 and under are hungry or at risk for hunger. (FRAC 1995)**

There exists a strong association between family income and the growth and cognitive development of children.

Hunger

Hunger is a lack of regular, nutritious food that has sufficient amounts of calories, protein, and nutrients to meet the needs of children's growing bodies. It is also defined by Tufts University researchers as the "lack of adequate nutrition because of inadequate resources." And, as one child shared in a Vermont report on childhood hunger, "Hunger is when you go to the refrigerator and there's nothing there because it is not payday yet." (VTCECH 1996, 4)

Table 3 illustrates the percentage of eighth to twelfth grade students who reported going to bed hungry in 1995.

Inadequate nutrition in children can cause a variety of health problems such as extreme weight loss, stunted growth, anemia, headaches and weakened resistance to illness. It also can adversely impact brain and cognitive development, impair attention span, and cause developmental and behavioral disturbances.

**The Vermont Campaign to End Childhood Hunger describes food security as more than just alleviating hunger pangs. "Food security is earning a sufficient income to buy food, having access to safe food that is culturally appropriate, and possessing the knowledge, skills and resources to grow, purchase and prepare food that promotes health, makes us feel personally good, strengthens families and builds our communities." (VTCECH, "Food to Learn," Spring 1997)*

*** The Washington D.C. based group conducted the Community Childhood Hunger Identification Project in 1995.*

Q. What does it mean to be healthy
A. To enjoy your life at its full intent.

Undernourishment can be particularly harmful to very young children whose need for calories and nutrients is critical. It also appears that, while malnutrition in the first two years of life can slow down or stop normal brain development, improved diet at age three or four may help reverse earlier damage and aid further brain development.

Table 3

Hunger

Percent of 8th - 12th grade students who reported going to bed hungry because there was not enough to eat

Supervisory Union (SU)/ School District (SD)	Number Surveyed	Total Rate	Supervisory Union (SU)/ School District (SD)	Number Surveyed	Total Rate
Addison Central SU	686	8.0	Orange-Windsor SU	199	7.4
Addison Northeast SU	474	9.6	Orleans Central SU	NA	NA
Addison Northwest SU	NA	NA	Orleans-Essex North SU	962	8.5
Addison-Rutland SU	576	7.9	Orleans Southwest SU	266	8.4
Arlington SU	NA	NA	Rutland Central SU	238	4.3
Barre City SU	805	7.1	Rutland City SD	902	7.5
Barre Town SD	NA	NA	Rutland Northeast SU	492	10.5
Blue Mountain UHS #21	172	4.8	Rutland South SU	562	5.7
Burlington Public Schools	1007	14.8	Rutland Southwest SU	203	8.8
Caledonia Central SU	NA	NA	Rutland Windsor SU	NA	NA
Caledonia North SU	NA	NA	South Burlington DS	840	7.1
Chittenden Central SU	1036	7.5	Southwest Vermont SU	1055	10.8
Chittenden East SU	NA	NA	Springfield SD	567	8.8
Chittenden South SD	687	7.7	St. Albans Area	998	7.9
Colchester SD	728	8.2	St. Johnsbury SD	NA	NA
Dresden SD #22	NA	NA	Washington Central SU	608	9.8
Essex- Caledonia SU	NA	NA	Washington Northeast SU	221	8.8
Essex Town SD	NA	NA	Washington South SU	328	8.1
Franklin Northeast SU	208	6.3	Washington West SU	NA	NA
Franklin Northwest SU	660	6.8	Windham Central SU	275	8.6
Hartford SD	686	6.8	Windham Northeast SU	446	7.3
Lamoille North SU	446	7.7	Windham Southeast SU	622	10.3
Lamoille South SU	569	6.9	Windham Southwest SU	87	13.6
Manchester Area	339	8.4	Windsor Central SU	453	10.2
Milton SD	NA	NA	Windsor Northwest SU	70	4.8
Montpelier SD	450	9.2	Windsor Southeast SU	NA	NA
Orange East SU	336	9.0	Winooski SD	190	10.7
Orange North SU	189	7.7			
Orange Southwest SU	416	5.2	**Vermont**	**7165**	8.1

Hungry children and their families depend on anti-hunger programs to help bridge the gap in their income to meet their children's food and nutrition needs. School and child care meals programs help insure access to healthy and nutritious food; food stamp benefits provide critical financial assistance for purchasing food; and the Women, Infants and Children Program (WIC) provides individualized food packages, nutrition education, and health assessments.

According to the *Report on Childhood Hunger in Vermont; A Handbook for Action,* Vermont is credited nationally for its progress in child health issues. "Participation in the WIC program is second in the nation, and the numbers of schools participating in School Breakfast and Lunch Programs has been steadily rising." (VTCECH & VCF 1996, 8)

But, there are still thousands of children who do not have access to Vermont's school meals programs. (See table 4)

Unlike 21 other states in the nation, Vermont does not guarantee that all lower income children have access to these programs because there are no state laws mandating school participation.

Research shows that low-income children receive between one-third and one-half of their daily nutritional intake from school lunches. Other studies indicate that attendance and achievement test results improve when youth have access to school breakfasts.

Table 4

National School Breakfast and Lunch Programs

Students without access to School Meal Programs in 1996

	Schools Not Participating in the School Lunch Program in 1996			Schools Not Participating in the School Breakfast Program in 1996		
County	Number of Schools	Enrolled Student	Rate*	Number of Schools	Enrolled Student	Rate*
Addison	5	952	16.2	10	1592	27.1
Bennington	5	800	12.7	9	2593	41.2
Caledonia	1	60	1.1	3	1621	29.3
Chittenden	0	0	0	26	12137	54.4
Essex	3	52	5.2	4	87	8.8
Franklin	0	0	0	1	287	3.2
Grand Isle	0	0	0	1	222	27.5
Lamoille	1	23	0.6	6	1855	46.7
Orange	1	148	2.7	4	1395	25.8
Orleans	1	100	2.0	4	1167	23.9
Rutland	2	76	0.7	9	3115	29.4
Washington	0	0	0	3	1082	10.6
Windham	12	1422	19.3	15	2000	27.5
Windsor	6	1142	11.1	15	4156	40.6
Vermont	37	4775	4.6	110	33309	32.2

** Rate = the percent of the total student population in each county or in Vermont without access to the School Lunch or Breakfast Programs.*

"Inadequate nutrition is a major cause of impaired cognitive development, and is associated with increased educational failure among impoverished children."

Tufts University: Statement on the Link Between Nutrition & Cognitive Development in Children.

Summer Food Service Programs (SFSP)

Hunger rates rise in the summer when school meals programs are often unavailable. In 1996, less than ten percent of eligible Vermont children had access to meals programs during the summer (see table 5). Vermont's rural communities face unique barriers to establishing SFSPs, including a lack of central meal locations and public transportation. Most public schools — which are ideal sites for meal services — are closed during the summer. Also, many Vermont communities are without children's recreation programs, which also can serve as meal sites. In addition, federal reimbursement rates for meals programs that serve a small amount of children (fewer than 150) are not always sufficient to cover program costs, making it more difficult to secure SFSP sponsors. In Vermont, the SFSP lost $16,800 in funding due to the 1996 Federal Welfare Reform Act. In 1997, the Vermont Legislature voted to allocate $16,800 in state monies to cover the lost funding.

Table 5

Summer Meals Program
Average Daily Participation

Year	Number	Rate*
1990	398	2.4
1991	454	1.8
1992	820	3.4
1993	1,903	7.4
1994	2,122	9.2
1995	2,289	9.1
1996	2,476	9.6

** Rate = the percentage of all Vermont students eligible for school meal programs (National School Breakfast and Lunch) who had access to a summer meals program.*

Healthy children are as important to humanity as a garbage can is to a racoon.

Child Care Food Program

Day care providers (registered homes and child care centers) can participate in the Child Care Food Program and receive meal reimbursements for eligible children (see table 6). It is unclear how many eligible children attend day care programs that do not or cannot participate in the Child Care Food Program.

The 1996 Federal Welfare Reform Act reduced the reimbursement rates for day care providers. It is estimated that two-thirds of providers would be affected by the reduction in reimbursement rates (amounting to approximately 1.1 million dollars). In 1997, the Vermont Legislature voted to fund $260,000, supplementing only the lunch rates.

Table 6

Child Care Food Program
1996 Participating Day Care Providers

Homes	Children Enrolled	Child Care Centers	Children Enrolled
950	8,585	95	3,345

Being healthy is like.....

When you are home alone and you can do anything you want to. you're free from anything, your free from sickness.

The Supplemental Food Program for Women, Infants and Children (WIC)

WIC — a major anti-hunger and health program — serves pregnant, post-partum and nursing women, and children under five. Sixty-two clinic sites throughout Vermont offer health and nutrition assessment, nutrition education, and provide access to other critical health services such as immunization clinics, lead screening and maternal and child health home visits.

The Vermont WIC food delivery system is unique. Local dairies make home deliveries to over 90 percent of WIC families — other families pick up their food packages at local dairies or grocery stores — helping to insure ready access to food packages and reduce the stigma often associated with receiving assistance.

Table 7 provides estimates of the number of eligible families participating in WIC. High participation rates can be credited, in part, to the food delivery system of Vermont's WIC Program. Also, eligibility for WIC services is based, in part, on mothers or children receiving Medicaid. In Vermont, Medicaid eligibility guidelines are above federal guidelines (For complete WIC eligibility guidelines see page 34 in the Resources section).

Children participating in WIC are better immunized and more likely to have a regular source of medical care. Also, WIC has a major impact on reducing anemia in children. The CDC's Pediatric Nutrition Surveillance data show a two-thirds decline in childhood anemia over a 10-year period. The study credits the WIC program for its important contribution to this substantial drop.

"At the end of the month, for some families, it means the difference between eating and not eating."

WIC worker referring to the WIC Program.
From the Vermont Health Department Report,
Food on the Table.

Table 7

Women, Infants and Children (WIC)

Program Participation

1985[1]		1990[2]		1995[3]	
Number	Rate*	Number	Rate*	Number	Rate*
16,246	82.3	15,347	77.3	15,982	101.3

[1]Three year average of 1984-1986, [2]Three year average of 1989-1991, [3]Three year average of 1994-1996
** Estimated percentage of potentially eligible participants.*
This data is for reference only, data may be statistically unreliable.

"One of the things for me was having my kids checked. That is something you're always worried about, because when your income is low you might put off going to the doctor until the kids are sick. My kids were always healthy.

(Former WIC program participant)

Youth Health Issues

The following article, written by a class of Barton eighth graders, introduces this section on youth health issues. It provides the much-needed perspectives of teenagers, drawing attention to not only their daily lives but to the heart of many teen issues—the adult society in which they live and grow.

Teens Defend Themselves Against Stereotypes

We present ourselves not as problems to society, but as we really are, 32 teens looking at themselves and society. Not statistics, but the real thing, us. We would like to present what we do that we are proud of, feel we have accomplished, and what we have given to others. We come from all social and economic backgrounds and come together each day in our town school. We have our ups and downs with each other, but get along more often than we do not. Life is not perfect, but neither is yours.

It you knew us, lived with us, celebrated and grieved with us there would be no need for this response. However, it is our experience that most adults simply ignore, disregard or fear teens. How many adults can you see in any given line at a movie even nod recognition of a teen's humanity, much less start a short conversation? We want to start that conversation.

Hey Mister, did you know that some of us do barn chores before we even go to school every morning. We do evening chores, too. In between, we go to school, make honor roll on occasion, play sports, participate in band and chorus and ride the roller coaster of adolescence.

Some of us have part-time jobs to earn the money we want for things. We shovel snow, mow lawns, baby-sit and clean houses for less than minimum wage. We've saved our money for a few years to get what we wanted. We also earn money to buy some of our own clothing, sports equipment and entertainment. Some of us even earn money to contribute to family necessities. Imagine that.

We have a sense of community. Who do you see picking up the trash along our roads and fields during Green Up Day? Who is collecting bottles for a class trip? Who are the crossing guards so younger children won't get hit by cars? Whose clothes have thoughtfully been gone through and chosen with care to give to clothing centers, or victims of fires? We have given our clothes, our bicycles, games, money and music to others in need just because we were asked.

We, the 32 teens of the eighth grade of Barton, have volunteered to carry elders' grocery bags just because we saw them struggling. We also volunteer to shovel out our grandparents' dooryards, and even accept the money they insist we take because we know it makes them feel good, too. We march and play our musical instruments in Memorial Day and Veterans Day parades in honor of those who served. Sometimes we go to local nursing homes and play our instruments or sing. Sometimes we go just to share and talk.

Most of us have family responsibilities that we honor. We split wood and stack it; and move it from one place to another. We trudge through snow and mud to gather sap and help sugar. We do the laundry for the family, set the table, cook some meals, and clean up afterward and empty the trash. We grumble, but we do the chores. We watch our younger brothers and sisters. For the most part, we think we are pretty helpful. Some of us were even responsible for bringing the possibility of recycling into our homes.

Did you know that teens in our community volunteer to tutor younger children? Some of the teens at Lake Region Union High School coach our junior hoop program and referee our games. Most of us would gladly lend a hand if we were asked.

Society says that our job is school. Mandatory. We do that, too. We go, learn, try to learn, and try to learn again. Sometimes we give up but not too often. The dropout rate at Lake Region Union High School is less than 2 percent, according to Lake Region Annual Report, Jan. 15, 1997. We might not be in the top 10 percent of the world's smartest kids, but do we really need to be? Society is a problem to us sometimes, too. If you want to separate society into parts, we, as teens and citizens, are not responsible for the pollution of the world, the genocide in most corners, poverty, houseless people, pornography, gridlock and the corruption of our national leaders. Drugs are everywhere. Do we manufacture them or smuggle them into the country? Society has taught us from the first time we viewed a sporting event that beer is where it's at. How are we to sort out the mixed messages we are bombarded with? We listen weekly to the adults in the news who compare us unfavorably with the test scores of other countries. We do not make the movies rated PG-13 that include more profanity than we would ever think of using. Where are the everyday role models that you would like us to emulate?

Our advice — get to know a teen up front and personal. We don't like the word scapegoat for anyone. It makes it too easy to cast the first stone.

This article was reprinted with permission of the eighth grade class of Barton Academy and their teacher. Their names are listed on the inside back cover.

Youth Health Factors

The following four indicators provide information from the 1995 Vermont Youth Risk Behavior Survey about eighth through twelfth grade students. The measures of well-being offer insight into the challenges and issues facing children and teens. As you read about teen behaviors, please keep in mind these key questions and issues:

What can help kids navigate their middle school and high school years and how can adults help?

How do we acknowledge and address the profound impacts of adult behaviors and societal messages on our children and youth?

What do we know about adults' behaviors? Consider these facts and thought-provoking questions: Three-quarters of all new sexually transmitted diseases (STDs) occur in U.S. adults each year. We also know that some adults have sexual relationships with children and teenagers. What percentage of these adults transmit STDs to their teen partners? How many of these adults are the fathers of children born to teen moms?

Furthermore, consider these facts and their potential impact on children and teens. A recent study of Vermonters' substance use indicates that 37 percent of adults who need intervention or treatment for substance use have one child or more living in their household. The majority of motor vehicle crashes involving substance use, particularly alcohol, are caused by adults. Retailers (adults) are paid by tobacco companies (other adults) to attractively display tobacco products on store counters.

As the Barton students point out, "We, as teens and citizens, are not responsible for the pollution of the world, the genocide in most corners, poverty, houseless people, pornography, gridlock and the corruption of our national leaders. Drugs are everywhere. Do we manufacture them or smuggle them into the country?"

And, according to Tom Perras, Director of Vermont's Office of Alcohol and Drug Abuse Programs, while we have been focusing primarily on children and youth in the prevention of youth substance abuse, it is also necessary to look at adult behaviors and to consider how they contribute to young people's risky behaviors and problems. Adult and societal messages clearly impact children and youth.

Finally, it is important to keep in mind these questions asked by the Barton eighth graders. "How are we to sort out the mixed messages we are bombarded with? Where are the everyday role models that you would like us to emulate?"

Index of Schools in Supervisory Unions or School Districts:

Union/District	School
Addison Central SU	Middlebury Union High School Middlebury Union Jr. High School Bridport Central School
Addison Northeast SU	Mt Abraham Union High School
Addison-Rutland SU	Fair Haven Union High School Benson Village School Fair Haven Graded School Castleton Village School
Barre City SU	Spaulding High School Spaulding Graded School
Blue Mountain UHS #21	Blue Mountain Union High School
Burlington Public Schools	Burlington High School Edmunds Middle School Hunt Middle School
Chittenden Central SU	Essex Junction High School Albert D. Lawton Middle School
Chittenden South SU	Champlain Valley Union High School (No 8th grade)
Colchester SD	Colchester High School Colchester Middle School
Franklin Northeast SU	Richford High School
Franklin Northwest SU (includes Grand Isle SU)	Missisquoi Valley Union High School Alburg Community Educational Center
Hartford SD	Hartford High School Hartford Memorial Middle School
St. Albans Area (Franklin Central &) Franklin West SU	Bellows Free Academy - St. Albans Georgia Middle School St. Albans City Elementary School St. Albans Town Central School
Manchester Area (Bennington-Rutland & Windsor Southwest SU)	Burr & Burton Seminary Dorset Elementary School Manchester Elementary School Flood Brook Union School
Lamoille North SU	Lamoille Union High School
Lamoille South SU	Stowe Jr./Sr. High School People's Academy
Montpelier SD	Montpelier High School Main Street Middle School
Orange East SU	Oxbow High School
Orange North SU	Williamstown Senior High School Williamstown Middle School
Orange Southwest SU	Randolph Union High School
Orange-Windsor SU	South Royalton School Tunbridge Elementary School
Orleans-Essex North SU (includes Essex North SU)	No. Country Union High School Coventry Village School Lowell School Newport Town School Troy School Canaan School
Orleans Southwest SU	Hazen Union High School
Rutland Central SU	Proctor Jr./Sr. High School West Rutland School
Rutland City SD	Rutland High School Rutland Town School Rutland Jr. High School
Rutland Northeast SU	Otter Valley Union High School
Rutland South SU	Mill River Union High School
Rutland Southwest SU	Poultney High School
S. Burlington SD	South Burlington High School F.H. Tuttle Middle School Folsom Education & Community Center North Hero Elementary School
Southwest Vermont SU	Mt. Anthony High School Mt. Anthony Middle School
Springfield SD	Springfield High School Riverside Middle School
Washington Central SU	U-32 Jr./Sr. High School
Washington Northeast	Twinfield Union High School Cabot School
Washington South SU	Northfield High School & Middle School
Windham Central SU	Leland & Gray Union High School
Windham Northeast SU	Bellows Falls Union High School Bellows Falls Middle School
Windham Southeast SU	Brattleboro Union High School (No 8th grade)
Windham Southwest SU	Whitingham School
Windsor Central SU	Woodstock Union High School
Windsor Northwest SU	Rochester Schools
Winooski SD	Winooski High School & Middle School

Condom Use

Early sexual activity, specifically intercourse, is associated with a number of problems for young people including increased risks of sexually transmitted diseases (STDs) and teenage pregnancy. Alcohol and other drug use may also contribute to early sexual initiation and unprotected sexual intercourse. (Hofferth, & Huges, 1987) According to the Vermont YRBS, in 1995, 31 percent of males and 30 percent of females had sexual intercourse in the prior three months.

The use of condoms reduces the risks of unwanted pregnancy and exposure to STDs. Table 8 reveals that overall, 55 percent of students surveyed used condoms in their most recent sexual experience.

Education and health services are critical components of any strategy to reduce teenagers' risks for pregnancy and STDs. Research indicates that "Comprehensive sexuality curricula — curricula that promotes abstinence as the most effective method for preventing STDs (and pregnancy), and teaches strategies for sexually active youth, including condom use — has succeeded in both delaying initiation of intercourse and reducing risky behaviors among sexually active teens." (Center for Health Policy Research 1996, 2 -3)

The Healthy Vermonters 2000 objective for STD prevention is to increase to 100 percent, schools that offer education programs on sexually transmitted diseases. In Vermont, school-based Student Assistance Programs (SAPs) have been shown to help reduce pregnancy among teens.

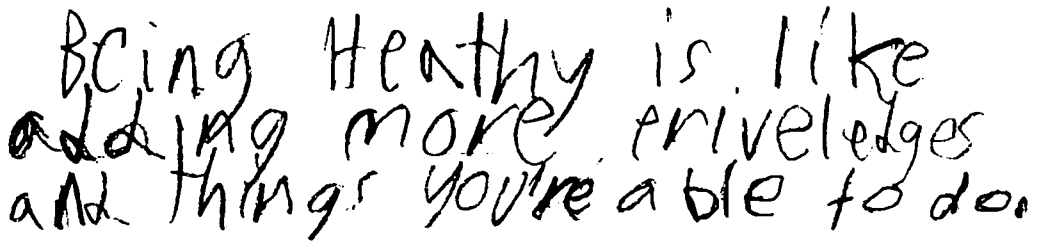


Table 8

Condom Use

Percent of 8th-12th grade students who used condoms during their most recent sexual experience, 1995 YRBS

Supervisory Union (SU)/ School District (SD)	Number Surveyed	Number Had Sex	Total Rate*
Addison Central SU	686	236	58.3
Addison Northeast SU	474	177	67.9
Addison Northwest SU	NA	NA	NA
Addison-Rutland SU	576	247	52.3
Arlington SU	NA	NA	NA
Barre City SU	805	357	65.6
Barre Town SD	NA	NA	NA
Blue Mountain UHS #21	172	79	41.6
Burlington Public Schools	1,007	448	56.1
Caledonia Central SU	NA	NA	NA
Caledonia North SU	NA	NA	NA
Chittenden Central SU	1,036	353	54.6
Chittenden East SU	NA	NA	NA
Chittenden South SD	687	253	58.7
Colchester SD	728	305	50.7
Dresden SD #22	NA	NA	NA
Essex- Caledonia SU	NA	NA	NA
Essex Town SD	NA	NA	NA
Franklin Northeast SU	208	110	50.9
Franklin Northwest SU	660	329	47.6
Hartford SD	686	305	56.9
Lamoille North SU	446	207	49.7
Lamoille South SU	569	224	53.1
Manchester Area	339	105	60.6
Milton SD	NA	NA	NA
Montpelier SD	450	155	65.1
Orange East SU	336	174	59.7
Orange North SU	189	82	49.3
Orange Southwest SU	416	128	50.9
Orange-Windsor SU	199	87	54.3
Orleans Central SU	NA	NA	NA
Orleans-Essex North Orleans	962	452	45.9
Southwest SU	266	133	60.2
Rutland Central SU	238	98	62.8
Rutland City SD	902	373	51.5
Rutland Northeast SU	492	217	51.1
Rutland South SU	562	257	55.6
Rutland Southwest SU	203	92	61.9
Rutland Windsor SU	NA	NA	NA
South Burlington DS	840	278	52.7
Southwest Vermont SU	1,055	512	54.1
Springfield SD	567	235	56.7
St. Albans Area	998	479	56.5
St. Johnsbury SD	NA	NA	NA
Washington Central SU	608	218	61.5
Washington Northeast SU	221	76	55.1
Washington South SU	328	137	51.9
Washington West SU	NA	NA	NA
Windham Central SU	275	138	54.0
Windham Northeast SU	446	215	56.1
Windham Southeast SU	622	280	57.7
Windham Southwest SU	87	38	50.0
Windsor Central SU	453	169	53.7
Windsor Northwest SU	70	29	62.5
Windsor Southeast SU	NA	NA	NA
Winooski SD	190	90	65.1
Vermont	**7,165**		**54.8**

**Includes only students who said they have had sexual intercourse.*

Tobacco Use

In the U.S. alone, tobacco use is the cause of over 400,000 deaths annually; deaths that, in large part, are preventable. And, according to the U.S. Department of Health and Human Services, because tobacco use most often begins in childhood and early adolescence, "nicotine addiction, is, consequently, a pediatric disease." Every year, one million youths become regular smokers and studies suggest that most people who did not smoke as adolescents will not begin as adults. Eighty percent of current Vermont smokers started before the age of 21.

In Vermont (see table 9), 15 percent of Vermont students are daily smokers compared to 22 percent of adults. **Among younger students, regular smokers have increased from four percent of eighth graders in 1993 to eight percent in 1995, and ninth grade smokers increased from eight percent to 14 percent.**

Information from the Vermont Chapter of the American Lung Association supports national data. In Vermont, smoking is the most preventable cause of death and lung disease. It is estimated that about 1,100 Vermont high school students begin smoking each year. Smoking causes harm almost immediately, reducing lung function, and causing coughing and other respiratory difficulties.

Federal law outlaws the sale of cigarettes and smokeless tobacco to children and adolescents younger than age 18. Summary information from the federal Tobacco Rule indicates that young children are susceptible to advertising. Because of this, the law restricts free sampling of cigarettes, bans outdoor advertising within 1,000 feet of schools and playgrounds, and prohibits tobacco logos on unrelated merchandise.

Being healthy is like canoeing down a calm glistening lake without a care in the world.

In Vermont, the Legislature stiffened its regulations in 1997, making it illegal for minors to possess tobacco and fining teens $25. However, there is no provision in the bill to help young people quit smoking, despite the fact that the most damaging consequence of smoking in young people is the potential of lifelong addiction. According to Healthy Vermonters 2000, "The earlier a person starts smoking, the more difficult it is to quit later in life." (Vermont Department of Health 1992, 20.)

Additionally, the law phases out cigarette vending machines by the year 2000, and requires that all tobacco products be displayed behind the counter or in a locked cabinet, thus reducing young people's access, eliminating attractive displays and requiring significant interaction with the retailers. By federal law, retailers are already required to request identification and are subject to fines for selling tobacco products to minors.

Being healthy is as important as, the hole in the ozone layer.

Table 9

Regular Tobacco Use

Percent of 8th-12th grade students who smoked every day during the past 30 days, 1995 YRBS

Supervisory Union (SU)/ School District (SD)	Number Surveyed	Total Rate
Addison Central SU	686	14.5
Addison Northeast SU	474	18.2
Addison Northwest SU	NA	NA
Addison-Rutland SU	576	11.7
Arlington SU	NA	NA
Barre City SU	805	15.1
Barre Town SD	NA	NA
Blue Mountain UHS #21	172	13.4
Burlington Public Schools	1,007	16.4
Caledonia Central SU	NA	NA
Caledonia North SU	NA	NA
Chittenden Central SU	1,036	13.2
Chittenden East SU	NA	NA
Chittenden South SD	687	12.3
Colchester SD	728	14.0
Dresden SD #22	NA	NA
Essex- Caledonia SU	NA	NA
Essex Town SD	NA	NA
Franklin Northeast SU	208	15.4
Franklin Northwest SU	660	19.2
Hartford SD	686	10.1
Lamoille North SU	446	11.6
Lamoille South SU	569	14.3
Manchester Area	339	7.8
Milton SD	NA	NA
Montpelier SD	450	14.7
Orange East SU	336	9.7
Orange North SU	189	10.8
Orange Southwest SU	416	9.9
Orange-Windsor SU	199	6.7
Orleans Central SU	NA	NA
Orleans-Essex North Orleans	962	18.8
Southwest SU	266	12.3
Rutland Central SU	238	16.4
Rutland City SD	902	13.8
Rutland Northeast SU	492	14.9
Rutland South SU	562	14.7
Rutland Southwest SU	203	10.6
Rutland Windsor SU	NA	NA
South Burlington DS	840	10.4
Southwest Vermont SU	1,055	17.3
Springfield SD	567	14.5
St. Albans Area	998	15.3
St. Johnsbury SD	NA	NA
Washington Central SU	608	13.4
Washington Northeast SU	221	6.0
Washington South SU	328	18.8
Washington West SU	NA	NA
Windham Central SU	275	13.2
Windham Northeast SU	446	15.2
Windham Southeast SU	622	17.1
Windham Southwest SU	87	16.5
Windsor Central SU	453	8.4
Windsor Northwest SU	70	4.3
Windsor Southeast SU	NA	NA
Winooski SD	190	23.1
Vermont	**7,165**	**15.1**

Alcohol Use

Data from the Vermont YRBS reveals that in 1995, 18 percent of eighth to twelfth graders were drinking on a regular basis (6-30 times during the last 30 days). Additionally, 91 percent of these regular drinkers had also binged on alcohol (five or more drinks in a row).

The use of alcohol can threaten the physical, mental and social development and well-being of young people. Alcohol use has been linked to physical fights, vandalism, academic and occupational problems, and trouble with law enforcement officials. (Blanken 1993, 25)

Alcohol also contributes to a leading cause of preventable deaths in Vermont—motor vehicle accidents. Alcohol and other substance use are related to one-third to one-half of these deaths. Among teens and young adults in Vermont, motor vehicle crashes are the leading cause of death.

Adolescents not only face tremendous pressures — from peers to advertising that promotes drinking — but they receive mixed messages from society about alcohol use. "Our society considers the use of alcohol socially acceptable. It should not surprise us that the majority of our adolescent population consumes alcohol... usually motivated by the same reasons provided for most adult drinking." (Males, 1996, 185) Or as the Barton teens observe in their article (page 19), "Society has taught us from the first time we viewed a sporting event that beer is where it's at."

In Vermont, there is a high percentage of adults with alcohol abuse problems. State and community efforts need to focus not only on prevention of and intervention for teen alcohol use, but also to recognize the effects of societal messages about substance use and the impact of adult use and abuse behaviors on children's and youth's behaviors.

3. Eating healthy is like walking on a high wire, you have to be balenced.

School-based substance abuse prevention and early intervention programs have been shown to be effective when they are comprehensive—involving peer groups, families, and schools and communities.

In Vermont, an effective program that addresses substance use among teens is the Student Assistance Program (SAP). SAPs counselors and/or teams whose role is to identify youth with substance use problems, intervene, and when necessary, refer to community treatment. (Downey 1996, 18) According to Vermont school staff, schools with an SAP program are associated with 13 times fewer physical assaults, four times more student self-referrals, and almost half the suspensions for drug use and sales by students.

Being healthy is like the first time you get your way

Table 10

Alcohol Use

Percent of 8th-12th grade students who drank alcohol during six or more days during the past 30 days, 1995 YRBS

Supervisory Union (SU)/ School District (SD)	Number Surveyed	Total Rate	Supervisory Union (SU)/ School District (SD)	Number Surveyed	Total Rate
Addison Central SU	686	17.1	Orange-Windsor SU	199	13.7
Addison Northeast SU	474	21.4	Orleans Central SU	NA	NA
Addison Northwest SU	NA	NA	Orleans-Essex North Orleans	962	22.1
Addison-Rutland SU	576	21.7	Southwest SU	266	19.2
Arlington SU	NA	NA	Rutland Central SU	238	15.9
Barre City SU	805	15.1	Rutland City SD	902	15.6
Barre Town SD	NA	NA	Rutland Northeast SU	492	18.8
Blue Mountain UHS #21	172	20.2	Rutland South SU	562	17.2
Burlington Public Schools	1,007	18.1	Rutland Southwest SU	203	13.7
Caledonia Central SU	NA	NA	Rutland Windsor SU	NA	NA
Caledonia North SU	NA	NA	South Burlington DS	840	12.9
Chittenden Central SU	1,036	15.8	Southwest Vermont SU	1055	20.4
Chittenden East SU	NA	NA	Springfield SD	567	13.8
Chittenden South SD	687	14.6	St. Albans Area	998	23.5
Colchester SD	728	14.8	St. Johnsbury SD	NA	NA
Dresden SD #22	NA	NA	Washington Central SU	608	15.3
Essex- Caledonia SU	NA	NA	Washington Northeast SU	221	13.8
Essex Town SD	NA	NA	Washington South SU	328	17.7
Franklin Northeast SU	208	27.1	Washington West SU	NA	NA
Franklin Northwest SU	660	21.2	Windham Central SU	275	18.1
Hartford SD	686	16.3	Windham Northeast SU	446	19.7
Lamoille North SU	446	18.4	Windham Southeast SU	622	15.1
Lamoille South SU	569	23.5	Windham Southwest SU	87	25.3
Manchester Area	339	11.0	Windsor Central SU	453	16.9
Milton SD	NA	NA	Windsor Northwest SU	70	22.4
Montpelier SD	450	14.4	Windsor Southeast SU	NA	NA
Orange East SU	336	13.6	Winooski SD	190	34.6
Orange North SU	189	12.1			
Orange Southwest SU	416	11.6	**Vermont**	**7,165**	**18.0**

Inhalant Use

Labeled a silent epidemic by the National Inhalant Prevention Coalition (NIPC), inhalant use is a significant form of drug abuse among youth. Inhalant use is is the deliberate inhalation or sniffing of common products found in homes and schools, like glue and cleaners, to obtain a "high". It can cause short term memory loss, brain, liver and bone marrow damage, or even sudden death. Inhalants are legal, easy to get, inexpensive and difficult to detect. Experimentation typically begins in the pre-teen years.

Between 1980 and 1990, inhalant use escalated, the only drug abuse problem monitored by the National Institute on Drug and Alcohol Abuse to show an overall increase.

According to the NIPC, one in five students have tried inhalants. Nationally, a 1996 survey of students reveals that 21.1 percent of eighth graders have used inhalants compared to 30 percent of Vermont eighth graders in 1995.

Table 11 indicates that in 1995, nearly 27 percent of Vermont eighth to twelfth grade students had tried inhalants at least once.

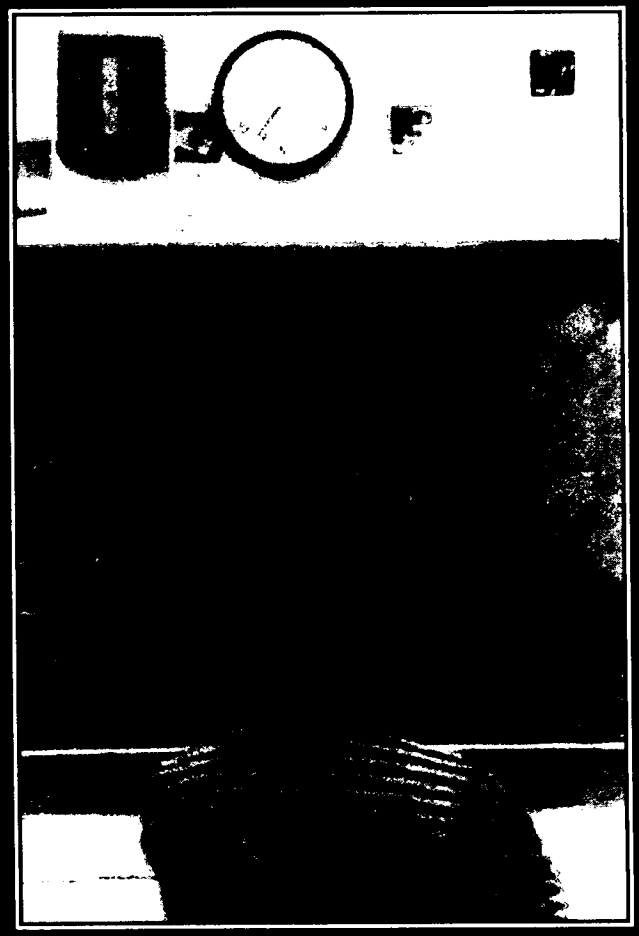
Children and teens have easy access to inhalants - they are common household and school products.

Table 11

Inhalant Use

Percent of 8th-12th grade students who used inhalants to get high one or more times during their lifetime, 1995 YRBS

Supervisory Union (SU)/ School District (SD)	Number Surveyed	Total Rate	Supervisory Union (SU)/ School District (SD)	Number Surveyed	Total Rate
Addison Central SU	686	23.8	Orange-Windsor SU	199	20.6
Addison Northeast SU	474	27.4	Orleans Central SU	NA	NA
Addison Northwest SU	NA	NA	Orleans-Essex North Orleans	962	28.0
Addison-Rutland SU	576	30.7	Southwest SU	266	24.8
Arlington SU	NA	NA	Rutland Central SU	238	28.5
Barre City SU	805	26.3	Rutland City SD	902	31.0
Barre Town SD	NA	NA	Rutland Northeast SU	492	32.8
Blue Mountain UHS #21	172	24.1	Rutland South SU	562	28.9
Burlington Public Schools	1,007	33.4	Rutland Southwest SU	203	22.5
Caledonia Central SU	NA	NA	Rutland Windsor SU	NA	NA
Caledonia North SU	NA	NA	South Burlington DS	840	27.2
Chittenden Central SU	1,036	28.9	Southwest Vermont SU	1055	32.9
Chittenden East SU	NA	NA	Springfield SD	567	22.8
Chittenden South SD	687	27.3	St. Albans Area	998	33.2
Colchester SD	728	24.0	St. Johnsbury SD	NA	NA
Dresden SD #22	NA	NA	Washington Central SU	608	21.1
Essex- Caledonia SU	NA	NA	Washington Northeast SU	221	21.2
Essex Town SD	NA	NA	Washington South SU	328	33.4
Franklin Northeast SU	208	22.9	Washington West SU	NA	NA
Franklin Northwest SU	660	32.7	Windham Central SU	275	31.0
Hartford SD	686	25.1	Windham Northeast SU	446	35.5
Lamoille North SU	446	30.1	Windham Southeast SU	622	24.5
Lamoille South SU	569	34.2	Windham Southwest SU	87	25.0
Manchester Area	339	21.6	Windsor Central SU	453	23.3
Milton SD	NA	NA	Windsor Northwest SU	70	30.0
Montpelier SD	450	18.8	Windsor Southeast SU	NA	NA
Orange East SU	336	23.6	Winooski SD	190	28.7
Orange North SU	189	28.7			
Orange Southwest SU	416	21.4	**Vermont**	**7,165**	**26.9**



Appendix

Resources

Vermont Immunization Initiatives

(1) Vermont is one of only twelve states that already has in place a Universal Distribution Program. Vaccines are distributed free of charge to private practitioners, thus reducing high immunization costs for families.

(2) VDH holds free vaccine clinics at all 12 district offices for individuals who are unable to access a private practitioner in a timely manner, and coordinates immunization services with the Women, Infant and Children Program's health and nutrition clinics, and other VDH programs like Healthy Babies and Early Periodic Screening, Diagnosis and Treatment (EPSDT).

(3) VDH is working with the Vermont Chapter of the American Academy of Pediatrics, family practitioners and school nurses to design a single immunization registry system in Vermont. VDH already has a registry to monitor diseases.

(4) VDH works with child care providers and the Social and Rehabilitative Services Child Care Services Division to assure that children in regulated child care programs have up-to-date immunization records on file. Public Health Nurses provide education to child care providers and parents and on-site technical assistance to child care programs.

(5) VDH works closely with school nurses and the state's Social and Rehabilitative Services division to improve vaccine levels for 11- to -12 year olds and adolescents (MMR booster and Hepatitis B vaccine, respectively).

(6) VDH staff participate in the statewide Early Childhood Work Group to develop health, including immunization, communicable disease and safety standards, and to provide technical support to early childhood programs, such as Head Start and Early Education settings, to insure that participating children are immunized.

Vermont Immunization Schedule

	At Birth	2 Months	4 Months	6 Months	12-15 Months	15-18 Months	4-6 Years	11-12 Years	14-16 Years
DPT diphtheria, tetanus, pertussis							(Before school)	Tetanus/diphtheria and every 10 years for life	
MMR measles, mumps rubella							MMR (4-6 years *or* 11-12 years)		
Hepatitis B	Two doses by 4 months							Ask your doctor	
Polio									
Hib haemophilus influenza b				Ask your doctor					

Environmental Risk Factors for Children at Different Stages of Development*

Developmental Stage	Developmental Characteristics	Exposure Pathways (Physical Environment)	Biological Vulnerabilities	Appropriate Responses in the Social Environment
Newborn (0 to 2 months)	Nonambulatory Restricted environment High calorie/water intake High air intake Highly permeable skin Alkaline gastric secretions (low gastric acidity)	Food Breast milk Infant formula Indoor air Tap/well water in home	Brain Cell migration Neuron myelination Creation of neuron synapses Lungs Developing alveoli Bones Rapid growth and hardening	Need for newborn-sensitive programs and regulations regarding: Polychlorinated biphenyls (PCBs) Lead in drinking water Environmental tobacco smoke Need to educate parents and policymakers concerning environmental hazards
Infant/Toddler (2 months to 2 years)	Beginning to walk Oral exploration Restricted environment increased time away from parents Minimal variation in diet	Food Baby food Milk and milk products Air Indoor, Layering effects Tap/well water in home and day care Surfaces Rugs, Floors, Lawns	Brain Creation of synapses Lungs Developing alveoli	Need for child-sensitive programs and regulations regarding: Radon in the home Residential pesticide use Lead abatement Environmental tobacco smoke Need to educate parents and policymakers oncerning environmental hazards
Preschool Child (2 to 6 years)	Language acquisition Group and individual play Growing independence Increased intake of fruits and vegetables	Food Fruits and vegetables Milk and milk products Air Day care/ preschool, Outdoor Water Tap/well, Water fountains	Brain Dendritic trimming Lungs Developing alveoli Increasing lung volume	Need for child-sensitive programs and regulations regarding: Food pesticides Environmental tobacco smoke at home and at preschool Need to educate parents and policymakers oncerning environmental hazards
School-Aged Children (6 to 12 years)	Beginning of school Playground activities increased involvement in school activities	Food At home and school Air School air, Outdoor air Water School water fountains Tap/well Other Arts and crafts supplies	Brain Specific synapse formation Dendritic trimming Lung Volume expansion	Need for child-sensitive programs and regulations regarding: Asbestos abatement Lead in school drinking water Hazards in arts and crafts materials Need to educate parents and policymakers oncerning environmental hazards
Adolescent (12 to 18 years)	Development of abstract thinking Puberty Growth spurt	Food Air Water Other Occupation Self-determination	Brain Continued synapse formation Lung Volume expansion Gonad maturation Ova and sperm maturation Breast development	Need for adolescent-sensitive programs and regulations on child labor and other issues Need to educate parents and policymakers oncerning environmental hazards

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Environmental Health Hazards: How Children Are Different From Adults. The Future of Children, S. Bearer, 1996, p.17

Vermont Childhood Lead Poisoning Information

The Vermont Department of Health's Childhood Lead Poisoning Prevention Program (CLPPP)

CLPPP is responsible for:

- Education: Develops and distributes materials on lead poisoning to parents, day care providers and the public; gives presentations to professional and community groups; staffs the Lead Hotline; and provides education on lead issues to health care providers and offers guidance to physicians on treatment for lead-poisoned children.
- Screening: Offers free blood lead level testing for children under age six. Monitors and encourages follow-up testing with physician for children with elevated blood lead levels.
- Assessment: Performs environmental testing on the homes and day care programs of severely lead-poisoned children; and monitors related lead hazard reduction activities.
- Advocacy: Works with the Legislature to initiate lead legislation, and is involved in policy-making decisions for lead poisoning prevention.

Vermont Lead Poisoning Legislation

Act 94, An Act Relating to Childhood Lead Poisoning; Screening; and Lead Hazard Abatement: Enacted 1993

According to the Vermont Department of Health's *1995 Progress Report: Childhood Lead Poisoning Prevention*, Act 94 requires that "individuals performing lead based paint activities be licensed by the Department; that the Department develop a public education campaign and blood lead screening recommendations for Vermont children; and that the Department adopt rules for intervening in cases where children have been diagnosed as severely lead poisoned." Lead screening recommendations are a critical part of child lead poisoning prevention and intervention because, in most cases, children with unsafe blood lead levels do not exhibit identifiable symptoms (see page 33 for VDH screening guidelines). VDH has a blood lead level registry to ensure that children who have tested at or above 10 µg/dL are provided the services recommended by the Department.

ACT 165, An Act to Prevent Childhood Lead Poisoning in Rental Housing and Child Care Facilities: Enacted 1996

This law requires property owners of pre-1978 rental housing to:

- provide written information on lead paint hazards to tenants
- post a notice in rental housing asking occupants to let owners or agents know about any deteriorating paint
- complete a VDH training course—to learn and perform Essential Maintenance Practices (EMP) listed below:
  - * installing window well inserts
  - * stabilizing deteriorating paint
  - * taking reasonable precautions when disturbing paint, and using safety precautions to prevent the spread of dust
  - * annual specialized cleaning, and as a unit turns over

For more information about any lead poisoning issue, call 1-800-439-8550

Lead Poisoning Screening Guidelines

Vermont Department of Health Lead Screening Guidelines

- All children should be screened by age one.
- All children not screened at age one should be screened by age two.
- All children ages three to five who have never been screened may be screened at the discretion of the child's parents and health care provider, based on risk status (see below) and CDC guidelines.

Guidelines are based on the results of a 1993 VDH study of lead poisoning among two-year-olds in Vermont and the recommendations of the CDC and the American Academy of Pediatrics.

Lead Screening Recommendations for Children Receiving Medicaid/ Dr. Dynasaur Health Benefits

All children age six months to 72 months are considered at risk for lead poisoning, and must be screened. Beginning at six months of age, and at each visit thereafter, the provider must discuss lead poisoning interventions with the child's parents or guardian, and assess the child's risk for exposure.
At a minimum, the following questions must be asked:

- Does the child live in or regularly visit an old house built before 1960?
- Was the child's day care center, preschool or babysitter's home built before 1960? Does the house have peeling or chipping paint?
- Does the child live in a house built before 1960 with recent, current, or planned renovation or remodeling?
- Have any of your children or their playmates had lead poisoning?
- Does your child frequently come in contact with an adult who works with lead? (Examples are construction, welding, pottery, or other trades practiced in your community.)
- Does your child live near a lead smelter, battery recycling plant, or other industry that would likely to release lead into the environment (such as an autobody shop or a firing range)?
- Do you give the child any home or folk remedies that may contain lead?
- Does the child live near a heavily travelled major highway where soil/dust may be contaminated with lead?
- Does your home plumbing include lead pipe, or copper pipe with lead solder joints?

If the answer to all such questions is NO... the child is considered to be at low risk for lead poisoning. A blood lead test is required at ages one and two. If the child is age three, four or five and has never been screened, then screen regardless of risk status.

If the answer to any such question is YES... the child is considered to be at high risk for lead poisoning. A blood lead test is required, beginning at six months of age. even if the child's initial blood lead test result is less than 10 µg/dL, so long as the child remains in the high risk category a blood lead test is required at every routine visit through age six - unless the child has already had a blood lead test within the past six months of the visit.

For children with elevated blood lead levels, see the VDH's Guidelines for Managing Children with Elevated Lead Levels (> 10µg/dL) for follow-up testing guidelines and treatment considerations.

Being healthy feels like a cold glass of lemonade in 100°F weather.

Women, Infants and Children Program's Eligibility Requirements

To be eligible for Vermont WIC Services, an applicant must meet all of the following criteria:

- Live in Vermont
- Have a household income of less than 185 percent of the federal poverty threshold, or be receiving ANFC or Food Stamp Benefits, or Medicaid. Vermont Medicaid guidelines are 200 percent of poverty for pregnant women and 225 percent of poverty for children.
- Be pregnant, or breastfeeding, or a mother of an infant less than six months old, or a child under the age of five.
- Be at medical or nutritional risk—determined by health and diet history and height, weight and anemia screening.

Being healthy is like you have, it popped a breath mint into your mouth.

Sources

Ashikaga, T. & Carpenter, J. 1990-1992 Impact of Smoking in Vermont. University of Vermont Biometry Facility. 1993.

Bearer, C. "Environmental Health Hazards." in The Future of Children.Vol..5. No.2 - Summer/Fall 1995. The Center for the Future of Children. CA.

Blanken, A. Measuring Use of Alcohol and Other Drugs Among Adolescents. Public Health Reports. Vol. 108, Supplement 1, U.S. Department of Health and Human Services, 1993.

Brown, L. & Pollitt E. "Malnutrition, Poverty and Intellectual Development." Scientific American. February 1996.

Center for Health Policy Research. "Adolescents and STDs: Education, Services Raise Difficult Issues for Policy Makers." in Health Policy and Child Health. George Washington University Medical Center. Winter 1996.

Centers for Disease Control. Morbidity and Mortality Weekly Report. Department of Health and Human Services. February 4, 1997.

Children's Environmental Health Network. "What is Pediatric Environmental Health?" June 1996.

Cortnie Lowe, Editor. City Health Information. New York City Department of Health. N.Y.. Jan - March 1995. Vol. 14 No.1.

Department of Health and Human Services. Executive Summary: The Regulations Restricting the Sale and Distribution of Cigarettes and Smokeless Tobacco To Protect Children and Adolescents. U.S. Food and Drug Administration. 1996.

Downey, K. Vermont Student Assistance Programs: Bridging the Gap between Prevention and Treatment. Vermont Office of Alcohol and Drug Abuse Programs. VT 1996.

Hofferth, S. & Huges, C. (eds). Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing. Committee on Child Development Research and Public Policy, Commission on Behavioral & Social Sciences and Education, National Research Council. Washington D.C. National Academy Press, 1987.

Lewit, E.. & Baker, L. "Children's Health and the Environment." in The Future of Children. Vol..5. No.2 - Summer/Fall 1995. The Center for the Future of Children. CA.

Males, M.. The Scapegoat Generation. Common Courage Press. ME 1996.

Needleman, H. The Poisoning of America's Children:Lead Exposure, Children's Brains, and the Ability to Learn. Occasional Paper #6. National Health/Education Consortium. November 1992.

Pediatrics. Vol. 94. No. 4, Oct 1994.

Sherman, Arloc. Wasting America's Future. Beacon Press, MA. 1994.

The Alan Guttmacher Institute. Sex and the America's Teenagers. New York & Washington DC, 1994.

The Center for the Future of Children. The Future of Children. Vol. 5. No. 2, Summer/Fall 1995. CA.

Tufts University School of Nutrition. The Link Between Nutrition and Cognitive Development in Children. Center on Hunger, Poverty and Nutrition Policy. MA., 1995.

U.S. Department of Housing and Urban Development. Putting the Pieces Together: Controlling Lead Hazards in the Nation's Housing. Report of the Lead-Based Paint Hazard Reduction and Financing Task Force. July 1995.

Vermont Campaign to End Childhood Hunger and the Vermont Children's Forum. Report on Childhood Hunger: A Handbook For Action. 1996.

Vermont Department of Health. "Behavioral Risk Factor Survey: Vermont Highlights". 1994 & 1995.

Notes on Statistics and Methodology

Child Nutrition Programs

Child Care, School, and Summer Meal programs' figures are provided by the Vermont Department of Education's Child Nutrition Programs.

Lead Poisoning

Data for blood lead levels were compiled using Vermont Department of Health, Division of Public Health Analysis and Policy vital statistics.

Immunization

Immunization Coverage Levels data are taken from the National Immunization Survey (NIS). The data used in this edition of Kids Count is for 1996.

NIS is an ongoing survey to provide estimates of vaccination coverage level among children aged 19-35 months, in all 50 states, selected urban areas and for a U.S average. The United States Center for Disease Control and Prevention implemented the NIS in April 1994 as one element of the five-part Childhood Immunization Initiative.

NIS uses a two-phase sample design. The first phase uses a quarterly random sample of telephone numbers for each survey area and includes administration of a screening questionnaire to respondents aged > 18 years to locate households with one or more children aged 19-35 months. Vaccination information is collected for all age-eligible children. All respondents are asked to refer to written records; however, reports from recall are also accepted.

In the second phase, vaccination information is requested from the health-care providers for children in surveyed households.

1995 Vermont Youth Risk Behavior Survey

Data from the 1995 Vermont Youth Risk Behavior Survey were provided by the Office of Alcohol and Drug Abuse Programs of the Vermont Department of Health.

In order to obtain a representative sample of Vermont students, 20 high schools of varying sizes, along with their 26 associated middle schools, were randomly selected for the state sample (1:3 systematic sample after sorting by enrollments). Thirty-four of the forty-six sample schools participated. Out of the 8,474 sampled students, 7,165 completed usable questionnaires. The state sample results were weighted in order to compensate for differences between the sample and the population of all 8th to 12th grade students in Vermont. The weighting procedure ensures that the sample is representative of the population. This permits us to draw inferences about the entire student population based on the results of the sample. Individual supervisory union results were not weighted; therefore, we urge caution when comparing these results with the results of the state sample.

Women, Infant and Children Program

Figures provided on WIC participation are estimates of the percentage of eligible women and children served by the WIC program. The estimates are based on three assumptions:

1. The number of women 3-9 months pregnant, plus those 0-6 months postpartum, is equal to the number of births in any given year.
2. The percent of pregnant and postpartum women with incomes less than 185 percent of poverty is the same as the percent of children with incomes below 185 percent of poverty.
3. Approximately 50 percent of women initiate breastfeeding and 25 percent of those continue for 12 months postpartum. This represents 12.5 percent of all births or about 10 percent of births to women eligible for WIC.

The error factor in these calculations may be +/- 5 percent.

Cautions: This data may be unreliable for several reasons:

1. Data covers different time periods and is from different sources.
2. Due to the low population, there are statistical problems commonly associated with small numbers.
3. Estimates are based on income levels only, and do not include those who may have incomes above 185 percent of poverty but who are deemed financially eligible due to participation in the Medicaid program Also, estimates are not available of how many people might be eligible for Medicaid but are not yet enrolled.
4. Estimates based on 1990 census data may underrepresent the number of children living in low-income households in 1986-1996. The regional recession did not manifest itself until after 1989, and recovery has been slow.

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Credits

Data Collection and Analysis
Carlen Finn

Writer
Carlen Finn

Editoral Services
Beth Burgess

Design
Tim Newcomb, Editing and Design
Publication Services

Student Contributions
Montpelier's Main Street Middle School; Charlie Catlin's Sixth Grade Class:
Christine Aldrich, Mary Campo, Eli Chalmer, Emily Cykon, Megan Duplessis, Jennie Ferris, Carrie Goldberg, Kathryn Hansen, April Jones, Rebecca Jordan, Zoe Lawrence, Nina Loverin, Julia McLaughlin, Jean Opel, Celeste Parke, Kalinda Philibert, John Robinson, Erin Sollace, Jake Volz, Grant Weisel

Barton Academy's Eighth Grade Class; Vicki Gentler - Teacher
Students: Chad Aldrich, Tabitha Blake, Margo Blanchard, Miles Blanco, Raymond Boutin, Lee Brown, Jillian Charles, Alexis Chernovetz, Deveney Choquette, Karl Cloney, Nicole Conley, Doug Devost, Katherine Doyon, David Dwyer, Ryan Gage, Chance Griffin, Lee Hale, William Hansen Jr., Benjamin Henchel, Amanda Henderson, Justin Kipp, Cole Labrecque, John Powell, William Powell, Kevin Riendeau, Ryan Robitaille, Robert Russell, Eben Sargent, Keith Stone, Derek Thompson, Amanda Young

Cover art: Lydia Newcomb, Worcester

Student Photographers
Students of Carley Stevens-McLaughlin
Montpelier High School

Being healty is like being a movie star who plays in a nice part.

Being healthy means that you are in a caring, loving home. That you have an equal chance in this world. Being healthy is living in this world with the safety, love, and care you deserve.

kids count

The Vermont
Children's Forum
P.O. Box 261
Montpelier, Vermont 05601
Telephone: 802-229-6377
Fax: 802-229-4929

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