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Thesis
1963

STUDENT RECORD DATA USEFUL IN SECONDARY SCHOOL CURRICULUM IMPROVEMENT FOR HEALTH EDUCATION

By

Felisa I. Mopera

59336

A Thesis in Partial Fulfillment

of the Requirements for the Degree

Master of Science in the Field of Nursing

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I certify that I have read this thesis and that in my opinion it is adequate, in scope and quality, as a thesis for the degree of Master of Science.

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TABLE OF CONTENTS

CHAPTER	PAGE
I. OVERVIEW OF THE STUDY	1
Introduction to the Problem	1
The Problem	1
Need for the study	1
Statement of the problem	3
Assumptions	3
Limitations	4
Method of study	4
Definitions of Terms Used	5
Curriculum	5
Curriculum improvement	5
Health education	6
School health education	6
Record	6
Student record	6
II. REVIEW OF THE LITERATURE	8
Trends in School Health Education	8
Public health movement	9
Inclusion of health related subjects in the curriculum	9
Widened activities of the health services	10
Contributions of conferences and organizations	10
The child study movement	11
Meaning of Health Education	12
Curriculum Viewpoints	13

CHAPTER		PAGE
	Basic Principles and Approaches to Curriculum Improvement	15
	Understanding the Health of the Adolescent in the Secondary School	19
	Implications in the Literature for the Improvement of Health Teaching	25
	Students' Records, Values and Purposes	27
	Related Studies	30
	Summary	32
III.	METHOD OF STUDY AND COLLECTION OF DATA	34
	The Method of Study	34
	Selection of the research method	34
	Selection of facility	35
	Selection of the tools of research	36
	Collection of Data	40
	Summary	42
IV.	ANALYSIS AND INTERPRETATION	44
	Medical Examination Record	44
	The Mooney Problem Check List	50
	Health and physical development	52
	Social-Personal relations	58
	Personal-Psychological relations	63
	Summary	67
V.	SUMMARY, CONCLUSIONS AND RECOMMENDATIONS	69
	Summary	69
	Conclusions	73

CHAPTER PAGE

The medical examination records 73

The Mooney Problem Check Lists 74

Health and physical development 74

Social-Personal relations 75

Personal-Psychological relations 75

Recommendations 76

VI. BIBLIOGRAPHY 78

VII. APPENDIX 85

LIST OF TABLES

TABLE		PAGE
I.	Recorded Findings on Entrance Medical Examination Record by Private Physicians for 358 Secondary Students of a Selected Church-Sponsored School	45
II.	Relative Rank of Health and Physical Development Problems Checked by 358 Students on the Mooney Problem Check Lists on October 24, 1961	53
III.	Relative Rank of Social-Psychological Relations Problems Checked by 358 Students on the Mooney Problem Check Lists on Ocotber 24, 1961	60
IV.	Relative Rank of Personal-Psychological Relations Problems Checked by 358 Students on the Mooney Problem Check Lists on October 24, 1961	64

CHAPTER I

OVERVIEW OF THE STUDY

I. INTRODUCTION TO THE PROBLEM

The modern philosophy of education cites that the primary purpose of the school is to provide a comprehensive education involving the "whole person." This revolutionary concept of education has stimulated numerous studies on subject matter such as curriculum content, the psychology of learning, growth and development and many others. The study findings have been used to improve and broaden existing curriculums; they have fostered the development of improved methods of teaching; stimulated changes in the quality of learning experiences planned for boys and girls; and affected changes in individual educational goals. The study of students' records for research purposes has resulted in many findings pertinent to curriculum improvement and revision including the area of health education.

II. THE PROBLEM

Need for the study. A comprehensive system of students' records was observed in a well-organized school health service. The information on the records was classified and selectively distributed to the principals and teachers of the various schools of the college. However, these individuals did not know how to make use of this information as indicated by one of the high school teachers who remarked, "Of what use are the students' records to us? They just crowd the teacher's file!"

This remark aptly confirms Oberteuffer's comment, with regard to the medical examination records, "To conduct medical examinations, file the records in a locked compartment and do nothing with the data except arrange statistical tables is to expend money foolishly."[1]

From such remarks it is clear that a change of emphasis is needed from the traditional "keep safe" practice in the handling of records toward the utilization of the data recorded therein. This implication provided stimulus to undertake a study of records. The need for the study was also stimulated by reading Charlotte L. Ehling's[2] study on "School Health Records in Health Counseling Children and Parents." This three-year research study recommended the use of school health records for counseling purposes.

Further encouragement to undertake a study of this nature was fostered by a study of the report of the Expert Committee on School Health Services of the World Health Organization in which the committee explained the need for research of school health records in terms of their uses. These research suggestions were: "(1) Guidance of children and parents, (2) improving supervisory and administrative practices, and (3) providing basic research information for planned studies in child health."[3]

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[1]Delbert Oberteuffer, School Health Education (New York: Harper Brothers, 1954), p. 238.

[2]Charlotte L. Ehling, "School Health Records in Health Counseling Children and Parents" (unpublished Ed. D. Dissertation, Stanford University, Stanford, 1953).

[3]World Health Organization, Expert Committee on School Health Services (report of the First Session, Geneva, August 7-12, 1950, Technical Report Series, No. 30, Geneva: The Organization, 1951), p. 35.

A need for conducting the contemplated study in the secondary school was also provided by the literature, as expressed by Van der Slice:

> There are great gaps in our knowledge concerning a proper secondary school health program. There is a great need for trying new methods in an attempt to find out what works and what doesn't work under today's conditions.[4]

Wrinkle and others[5] also pointed out that there seems to have been, in too many schools, an unthinking acceptance of existing practices and an absence of challenging inquiry into why practices are being done the way they are.

Statement of the problem. It was the purpose of this study to obtain recorded information on students' records of a selected church-sponsored secondary school which could be of value to the administration and staff for curriculum improvement in health education.

Assumptions. It was assumed in this study that: (1) the data on records which the students filled in or checked indicated their true feelings as to what was a concern, problem or interest to them; (2) that this information had merit for use by administration and staff in curriculum improvement to vitalize health education geared to the adolescent; (3) that the student's personal signature on the Mooney Problem Check Lists did not influence his answers sufficiently to invalidate their use in this study.

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[4]David Van der Slice, "Today's Community Concept of School Health," California's Health, 8:65-67, November, 1950.

[5]William L. Wrinkle and others, Secondary Education for American Democracy, (Revised edition; New York: Rinehart and Company, 1957), p. 8.

Limitations. The collection of data was limited to: (1) The study of two types of recorded data--the Medical Examination Record of Academy Students and the Mooney Problem Check Lists; (2) those students (358) whose records of medical examination and Mooney Problem Check Lists were available; (3) use of the Mooney Problem Check Lists restricted arbitrarily to the categories on Health and Physical Development, Social and Personal Relations, and Personal Psychological Relations.

Method of study. The descriptive survey approach was selected as the method of research. The descriptive survey method is also known as "fact finding with adequate interpretation." It also "helps to focus attention on practical needs that might otherwise remain unobserved for sometime."

The literature was reviewed to gain knowledge and understanding pertinent to the improvement of the curriculum in health.

The tools of research used were the Medical Examination Record of Academy Students and the Mooney Problem Check Lists. These were the available records of health. They provided information pertaining to the physical and mental health of the students.

The school from which the students' records were surveyed is a 12-grade suburban Seventh-day Adventist church-sponsored school, located on the eastern edge of the attractive small city of L. The school upholds the philosophy of Christian education maintained by the Seventh-day Adventist denomination. This philosophy is "the harmonious development of the mental, the physical, and spiritual powers." There was a total enrollment of 396 for the school year 1960-1961. The

students ranged in ages from 13 to 18 years. Out of the total enrollment there were 358 available records of the medical examination. Each of those records was studied. The Mooney Problem Check Lists of the 358 students were then surveyed.

Analysis of data was made of the items checked on the records after it was tabulated on frequency tables. Tables of relative rank were devised for the Mooney Problem Check Lists in order to obtain the top ten per cent for the purposes of analysis and interpretation.

Analysis of data from the medical examination records was made from tabulations of the items checked by the family physician. A frequency table was also used, but the analysis and interpretation was based on a percentage of the findings for the group in each category listed in the medical records.

From the analysis and interpretation, conclusions were drawn and recommendations made.

II. DEFINITIONS OF TERMS USED

Curriculum. Curriculum is composed of "the experiences of learners--what they undergo, feel and react to--under the guidance of the school."[6]

Curriculum improvement. In this report, curriculum improvement connotes the betterment in the quality of learning experiences planned in the school, and to which the students are exposed that will bring

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[6]Gordon N. Mackenzie, The Work of the Curriculum Coordinator in Selected New Jersey School (report to the New Jersey Curriculum Coordinators; Teachers College, Columbia University, Bureau of Publications, 1955), p. 2.

about desirable changes in their behavior, or practices. The concept is more aptly expressed in the following statement:

> Curriculum improvement thus becomes more than a course of study development. Curriculum coordinators, supervisors, principals, and superintendents have a common task: the improvement of experiences of learners. These experiences will be improved as those who guide the learning process change their values and their skills of working. The process of curriculum thus becomes one in which individuals learn how to provide improved learning experiences for boys and girls, and to develop support for the improved program of the school and community.[7]

Health education. "Health education is the process of providing learning experiences for the purpose of influencing knowledge, attitudes, and conduct relating to individual and group health."[8]

School health education. Irwin stated:

> School health education is that part of the school health program that provides teaching and learning experiences and activities for the purposes of influencing knowledge, habits, attitudes, practices, appreciations, and conduct pertaining to individual and group health.[9]

Record. Record means "a continuing collection of tabulation of facts which can be thus preserved for present or future interpretation."[10]

Student record. In this study, student record means the collection or tabulation of facts pertaining to a student's health, physical

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[7] Ibid., pp. 2-3.

[8] Ruth E. Grout, Health Teaching in Schools (third edition; Philadelphia and London: W. B. Saunders Company, 1959), p. 2.

[9] Leslie W. Irwin, et. al., Methods and Materials in School Health Education (St. Louis: The C. V. Mosby Company, 1956), p. 22.

[10] Carter V. Good, Dictionary of Education (New York: McGraw-Hill Book Company, 1959), p. 119.

and mental, which is preserved for present and future interpretation. In this study the terminology health record and student's record were interchangeably used.

CHAPTER II

REVIEW OF THE LITERATURE

By review of the literature it was hoped that a broader meaning of the term, "health education," might be acquired. It was also anticipated that present trends in the field of school health education would be found indicating current thinking on health in the curriculum. It was necessary also to discover the uses and value of students' records as well as how records have been used for improving curricular offerings of the school. Other purposes pursued in the survey of literature were to review various curriculum concepts, to understand better the principles and procedures of curriculum improvement, and to discover the kind of health education program most meaningful in the secondary school. Reports and studies dealing with health and health practices of the adolescent as well as the curriculum in health were used as sources by which to ascertain what had been done with recorded information on students' records.

I. TRENDS IN SCHOOL HEALTH EDUCATION

The increased health awareness that gathered impetus during the last half of the nineteenth century fostered a concern for school health education among educators. It was felt that background understanding of the trends in school health was essential in the consideration of curriculum improvement in health education, specifically in the secondary school.

1. Public health movement. The year 1850 marked the beginning of public health as an organized movement in this country. The significance of this movement in relation to school health rested in the published Report of the Sanitary Commission of Massachusetts prepared by Lemuel Shattuck. It stated:

> Every child should be taught, early in life, that to preserve his own life and his own health and the lives and health of others, is one of his most important and constantly abiding duties. Some measure is needed which shall impel children to make a sanitary examination of themselves and their associates, and thus elicit a practical application of the lessons of sanitary science in the every-day duties of life. The recommendation now under consideration is designed to furnish this measure. It is to be carried into operation in the use of a blank schedule, which is to be printed on a letter sheet, in the form prescribed in the appendix, and furnished to the teacher of each school. He is to appoint a sanitary committee of the scholars, at the commencement of the school, and on the first day of each month, to fill it out, under his superintendence. . . . Such a measure is simple, would take but a few minutes of the day, and cannot operate otherwise than usefully upon the children, in forming habits of exact observation, and in making a personal application to themselves. This is education of eminently practical character, and of the highest importance.[11]

2. Inclusion of health related subjects in the curriculum. In 1842 Horace Mann expressed the need for health instruction in schools. Physicians also, at this time, proffered their opinion for the teaching of physiology. The pooled ideas of educators and physicians resulted in the teaching of hygiene. In 1880 the teaching of physiology and hygiene became mandatory, due to the efforts of pressure groups--such as the Women's Christian Temperance Union. The purpose of this legislation was to require instruction on the effects of alcohol and narco-

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[11] Lemuel Shattuck, Report of the Sanitary Commission of Massachusetts, 1850, Facsimile edition (Cambridge: Harvard University Press, 1948), pp. 178-179.

tics. Between 1880 and 1890 physical education became another significant development. In the interest of promoting physical condition and efficiency, the stress was on calisthenics. By 1910 legislation for the inclusion of physical education in school curriculums was widespread. Furthermore, home economics, another health related subject, had its introduction in schools by 1885.

3. Widened activities of the health services. The health services were initiated as a system of medical inspection given to pupils. These were started in Boston in 1894, for the purpose of contagion control. This program gradually expanded and included health appraisal and counseling in which parents, teachers, nurses and other health workers could participate.

4. Contributions of conferences and organizations. The combined efforts of private, professional, governmental and industrial sponsored organizations helped to strengthen the place of health education in the school curriculum. The White House Conferences, initiated by the late Theodore Roosevelt, resulted in the Joint Committee on Health Problems in Education of the National Educational Association and the American Medical Association and "have influenced all phases of school health including health instruction."[12] Three specific organizations received special consideration in this study due to their pioneering work in health education. The first of these organizations

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[12]National Education Association and American Medical Association, Joint Committee on Health Problems in Education, Health Education (Washington, D. C.: The Association, 1961), p. 18.

was the American Child Hygiene Association which was founded in 1909 under the name of the American Association for the Study and Prevention of Infant Mortality. It made significant contributions through the educational programs it conducted for the better care of children. The second was the National Tuberculosis Association which initiated the "Modern Crusade" in 1915. This movement was the first to give recognition to the importance of enlisting child interests as an important factor in modifying child health behavior. The third organization was the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association. Under the able leadership of Dr. Thomas Wood, it pioneered in the formulation of plans, objectives, curriculum content, materials, teachers' training, and other requisites for adequate school health education. This committee is still one of the most powerful groups influencing the development of all phases of the school health program.

5. The child study movement. Just before the turn of the century, the school child was regarded as a passive individual, and learning was a "pouring in" process with the training of the faculties as the expected outcome.[13] But the studies made on child development became instrumental in drawing attention to the emotional, social and physical needs of the school child or the "whole child."

Concurrently, with the growth and development of the school health movement there have been many developments in education which have influenced the viewpoints of educators. The child study movement

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[13] Harold Alberty, Reorganizing the High School Curriculum (New York: The Macmillan Company, 1950), p. 65.

was initiated in Europe and was introduced and pioneered in the United States by G. Stanley Hall and associates.[14]

II. MEANING OF HEALTH EDUCATION

In the review of the literature, there seemed to be a generally accepted definition of health education as given in this study under the section, Definition of Terms, page 6. However, as brought out by Grout, there is a difference in the interpretation of the term, health education. She stated:

> The term health education means many things to many people. Numerous people have tried to define it. For some, it means an educational force, or a process by which agents of education-teachers, nurses, parent or community health workers exert their influence in such a way as to affect health behavior. This group would define health education as "the process of providing learning experiences for the purpose of influencing knowledge, attitudes and conduct relating to health. Health teaching (health instruction) in schools fall under this definition.[15]

More precisely Nemir stated that this meaning can be pertinently expressed in terms of information (what is known), conduct (desirable behavior patterns), who is involved (individual and community), and the educational process (instruction), all of which must be combined to achieve effective health education.[16]

In a simpler way, the term, health education, was viewed by one

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[14]National Education Association and American Medical Association, Joint Committee on Health Problems in Education, Health Education (Washington, D.C.: National Education Association, 1961), p. 16.

[15]Ruth E. Grout, Health Teachings in Schools, Third edition, (Philadelphia: W. B. Saunders Company, 1958), p. 2.

[16]Alma Nemir, The School Health Program (Philadelphia: W. B. Saunders Company, 1959), p. 325.

study group, the School Health Education Evaluative Study,[17] as "education for health," where the integration of health and education provides an educational field whereby information toward healthful living is afforded. Health determines the content and education the process. The health content is the information drawn from many behavioral sciences and is applied to an individual or group to achieve healthful living. The educational process determines the learning that takes place.

Recognition of all of these meanings were considered essential to the study of recorded data for the improvement of the curriculum in health education and the broader understanding of health education. Any venture for the improvement of the curriculum would therefore take into consideration the content and the process of health education as well as its end results which are according to Williams and Abernathy "the sum of all experiences which favorably influence attitudes, habit, knowledge, and conduct relating to health."[18]

III. CURRICULUM VIEWPOINTS

In the survey of literature different viewpoints of the curriculum were discovered. The word, "curriculum," is derived from the Latin meaning, a "racetrack." For a long time the word has been associated with schooling and has come to mean something planned for a somewhat limited segment of life but not for all of it.

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[17]Report of an Evaluation Research Study, School Health Education Evaluative Study--Los Angeles Area 1954-1959 (Berkeley: University of California Press, 1960), p. 13.

[18]Jessie Feiring Williams and Ruth Abernathy, Health Education in Schools, (New York: The Ronald Press, 1949), p. 8.

One of the older curriculum viewpoints pictures it as the particular sequential arrangement of a group of studies for instruction. This meaning is still in use by elementary and some high schools by whom reference is made to the total program of studies.[19]

The word, curriculum, is also used in a much narrower sense by secondary schools and colleges. In this setting curriculums mean a group of courses designed to meet a particular purpose, and not the total number of courses offered by the institution. Examples are pre-medical, pre-dentistry or college preparatory courses of study in a subject area such as the curriculum in English or Mathematics.

While the more restricted viewpoints of curriculum are still in use by schools, additions and modifications have been made. These have influenced a shift in emphasis from subject-matter content to a more comprehensive view, which is basically, a pupil-centered curriculum. The philosophy underlying this broader viewpoint is the belief that learning depends on what has gone on within the learner and that which has effected a change in his behavior. The word, curriculum, thus means that recognition is given to all the experiences which students have within and without the four walls of the classroom and for which the school has assumed responsibility. This viewpoint of the curriculum is more aptly stated in these words:

> It is now generally recognized that what is learned depends on what goes on within the learner, how he responds to the activities in which he takes part or how he reacts to the environment in which he lives. Today's writer on the curriculum as well as curriculum leaders in school systems rather generally use the meaning of the curriculum: the experiences

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[19] Mackenzie, op. cit., p. 1.

of learners — what they undergo, feel and react to under the guidance of the school.[20]

A consideration of this broader concept of curriculum became the concern of this study. Curriculum improvement is, therefore, more than a rearrangement of a program. It involves changes in human relationships among administrators, teachers, parents and the community concerned with the education of the learner. It involves changes in teaching-learning situations, pupil behavior, methods of teaching and in materials for improving the quality of learning experiences in order to achieve desirable behaviors on the part of the learner. Health education must become an integral part of any school curriculum.

IV. BASIC PRINCIPLES AND APPROACHES TO CURRICULUM IMPROVEMENT

A summary of recent literature dealing with problems in the process of implementing curriculum improvement indicated a wide range of considerations.[21]

1. Curriculum improvement is a process which involves a plan of action for the continuous use by curriculum workers and others who are concerned with the improvement of the learners. The experiences will be improved as those who guide the learning process change their values and their skills of working. The process of curriculum improvement will thus

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[20] Mackenzie, *Ibid.*

[21] Harold Alberty, *Reorganizing the High School Curriculum* Rev. ed. (New York: The Macmillan Company, 1953), pp. 536-565; Association for Supervision and Curriculum Development, *Action for Improvement 1951 Yearbook* (Washington, D. C.: The Association, 1951), pp. 39-41; Vernon E. Anderson, *Principles and Procedures for Curriculum Improvement* (New York: The Ronald Press, 1956), p. 17; Mackenzie, *op. cit.*, p. 3.

become one in which individuals learn how to provide improved learning experiences for boys and girls and to develop support for the improved program for the school.

2. There are numerous blocks and fears that bar the way to curriculum improvement. These are in the nature of belief in traditional content and approach; failure to recognize the need for in-service education; belief in rugged individualism; fear of community criticisms; lack of "know how;" fear of experimentation; and indifference to research.

3. Because of various barriers, many schools have been confined to revising the courses of study to the reorganization of the same subject content which has been handed down from generation to generation, and merely rearrange and manipulate it so as to appear different. Content is assigned to subjects and to grade levels and standards of achievement are determined. Little attention is given to the needs, problems, and concerns of boys and girls or to the democratic processes involved in helping students to meet life successfully. The curriculum becomes static and education is no longer an integral part of meaningful preparation for living. The process of curriculum improvement must include a plan for program evaluation which is based on the democratic values and the purposes for which the school exists. A continuous appraisal of the curriculum is necessary.

4. The process of curriculum improvement involves the formulation of a philosophy of the school to guide its course of action toward attainable purposes and goals. This philosophy would encompass good human relationships and the recognition of the dignity of each individual.

5. The process of curriculum improvement in a secondary school gives primary consideration to the study of the adolescent through the study of literature and the study of the students. This type of study may result in a formulation of statements of basic needs, problems and interest; and a plan for improving the schools' systems of recording student data pertinent to health.

6. The process of curriculum improvement depends to a degree upon the concept of classroom procedure. It includes development of a structure by which student participation in the planning, executing and judging of learning activities is possible.

A study of the various curriculum viewpoints and the plans that have been proposed seems to indicate two approaches for curriculum improvement. The first is called the subject matter approach. This plan is said to be widely used in secondary schools and is based on a preconceived idea of content to be covered. The second approach is based on the assumption that the individual or group has needs that should be recognized by the school.

In an article dealing with these two approaches Odell stated:

> It seems clear, however, that the ultimate senior high school program cannot be revised through the subject matter approach alone, no matter how stream-lined and disguised it may be. It is equally clear that the individual or group need approach could not be used by itself. Some of the present high school's program is not based on either individual or group needs determinable from an examination of students alone, but instead is based upon external factors such as college entrance requirements, vocational standards, social and civic mores, etc. It is obvious therefore, that we seek a happy combination of the two approaches.[22]

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[22]William R. Odell, "Two Approaches to High School Curriculum Revision," Curriculum Journal, 11:118, March, 1940.

The Commission on the Secondary-School Curriculum of Progressive Education made it clear that courses may be improved to meet the needs of the students, as aptly stated here:

> It is now almost universally granted that the intellectual content of subjects under study or projects undertaken must link with the personal concerns of the learner as well as with the social scene into which he is finding way. Far less often are these very personal concerns recognized in terms of their origins in the life histories of individuals. The individual's understandings are not only colored by his emotional bias; he responds to the subjects of instruction with his whole being and not with his mind alone.[23]

This point of view has been implemented in such courses as language arts, science, social studies, and health.

1. Language arts. The trend has been to move away from the formalism of dreary drill on grammatical construction and meaningless compositions that are external to the learner toward the development of techniques in group discussions.

2. Science. The present concept is to organize the study around the needs of the individual in the basic aspects of living.

3. Social studies. The trend in the social studies field is moving away from the traditional subject-matter lines. The emphasis is placed upon the "impact of culture on the individual, how he learns, how he creates and uses tools to serve his ends, how he uses biology and the physical sciences to solve his problems."[24]

4. Health. Emphasis is placed upon periodical examinations,

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[23] V. T. Thayer, Caroline Zachary, and Ruth Kotinsky, Reorganizing Secondary Education (New York: D. Appleton-Century Company, 1939), p. 373.

[24] Harold Alberty, Reorganizing the High School Curriculum (New York: The Macmillan Company, 1950), p. 390.

mental hygiene and remedial instruction. Alberty stated that the field of health is frequently neglected while there are significant possibilities in helping youth solve their problems through health and physical education.[25]

Such concepts have stimulated this study on recorded data in students' records in an effort to implement the newer curriculum approach to improving the health education curriculum.

V. UNDERSTANDING THE HEALTH OF THE ADOLESCENT IN THE SECONDARY SCHOOL

In the early years of the school health movement, health education did not receive the same degree of emphasis in the secondary school as it did in the elementary school.

Some generalizations concerning this lack of interest for adolescents of the secondary school might be given from literature as follows:

1. Belief that the age of adolescence was the healthiest, with a low mortality rate from disease.[26]

2. Belief that the extreme volatile emotions of adolescents are due to the physical changes going on as normal processes of growth, and that nothing need be done about them.[27]

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[25] *Ibid.*, p. 391.

[26] Metropolitan Insurance Company, "Health of the Teen Agers," *Statistical Bulletin*, 34:6-8, August, 1953.

[27] G. Stanley Hall, *Adolescence*, Vol. II (New York: D. Appleton-Century Company, Inc., 1904), pp. 44-45.

3. Belief that the behavior of the adolescent is the result of innate inherited and cultivated tendencies which cause him to "recapitulate" to the experiences of the human race and held that nothing can be done about it.[28]

4. Belief that the age of adolescence is a typical "stress and storm" interval that would automatically come to normalcy as the period of adulthood is reached.[29]

A somewhat contrasting picture of adolescent years may also be gathered from literature. Williams stated:

> Physical defects are abundant during the high school years. Nose, throat, and teeth need expert attention. Orthopedic defects improve over the elementary school years for boys but get worse with girls. Defects of hearing grow somewhat worse during the high school period, and visual defects increase by leaps and bounds. Skin diseases and glandular disturbances are much more common among high school youth than among younger children. The high school health program has to take this matter into account if it is to meet the students needs.[30]

One disease that is gaining rapid prevalence among even teen age individuals is venereal disease. Baumgartner reported that the increase of syphilis alone among teenagers is up fifty-six per cent between 1960 to 1961.[31]

However, Cole indicated that the greatest single threat to the

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[28] *Ibid.*, pp. 555-589.

[29] Ibid., pp. 40 *et. seq.*

[30] L. A. Williams, *Secondary School for American Youth* (New York: American Book Company, 1944), p. 374.

[31] Leona Baumgartner, "What Parents Must Know About Teen-agers and V. D.," *McCall's*, XC:44, 118, January, 1963.

life of the adolescent comes from a largely preventable source--accidents.[32] According to this author, the primary causes of death in this age group were due to: (1) accidents, (2) cancer and leukemia, (3) heart disease and rheumatic fever, (4) tuberculosis, pneumonia and influenza, (5) kidney disease, (6) poliomyelitis, (7) congenital malformations, (8) suicide, and (9) homicide.[33]

Regarding mental and emotional health, Williams further stated that "adolescents are plagued with periods of brooding, shyness and indifference."[34]

Evidences of ill-health among the youth of the nation was demonstrated by the large number of draftees who were rejected by the military services during the two world wars because of mental and physical ill-health. The large number of rejectees aroused interest in the health of youth. Many leaders in the country became concerned about the physical stamina and emotional stability of youth. Educators have long recognized that the school has a responsibility in educating the "whole adolescent."

Alberty wrote:

> The secondary school is charged with the primary responsibility of providing and maintaining optimal physical and mental health for its students. This means that adequate medical examination and appropriate remedial treatment should be provided for all students at the starting period. But this is not enough. Health education should be made a part of the

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[32] Luella Cole, Psychology of Adolescence (New York: Rinehart and Company, 1959), p. 86.

[33] Ibid.

[34] Williams, op. cit., p. 375.

program. Before this can be done effectively the school needs to clarify its conception of the meaning of health. Clearly, it must embrace both the physical and mental aspects which are so closely related that one cannot be considered without giving attention to the other.[35]

The interrelatedness of the physical, mental and emotional health have been aptly stated by White:

Since the mind and the soul find expression through the body, both the mental and spiritual vigor are in a great degree dependent upon the physical strength and activity; whatever promotes physical health, promotes the development of a strong mind and well-balanced character.[36]

Jersild contended that the emotional life of the adolescent may be grouped into three broad headings although there is some overlapping. These are:

1. The concerns that arise in the adolescent's private life with himself. From here may be grouped feelings of inferiority or the opposite, feelings of guilt and of pride with respect to the past and present, feelings of apprehension or of pleasant anticipation concerning the future, feelings involved in self discovery and in the experience in one's physical change, mental and emotional make up.[37]

2. The feelings that relate to the young person's relations with other people. Here fall the strains and satisfactions that are involved in his relations with his parents; the stresses, resentments, fears, and joys that arise in dealings with his peers and his heterosexual interests.

3. The feelings that are involved in the vast range of frustrations and satisfactions encountered in the exercise of his mental, motor and physical capacities, in work and in play, in reading, radio listening, and the like, in coping with the physical environment, in mastering subject matter at school, in

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[35]Alberty, op. cit., p. 45.

[36]Ellen G. White, Education (Mountain View: Pacific Press Publishing Association, 1942 by the Ellen G. White Publications), p. 195.

[37]Arthur T. Jersild, Child Development and the Curriculum (New York: Bureau of Publications, Teachers College, Columbia University, 1946), p. 211.

learning new skills, in earning money, in exercising new liberties and powers.

In the pursuit of helping adolescent students to achieve total health, an understanding of their mental and emotional health problems is required. This was emphasized by Lesser who stated:

> The problems of adolescence are especially pertinent to the health of the secondary schools. There is a greater interest in adolescence than ever before. In fact some people state that just as the period of infancy and early childhood formerly received a concentration of attention in pediatrics and in public health, so we are now moving toward the adolescent and devoting more time to his problem of growing up and in seeking independence in our ever complex society.[38]

An understanding of the adolescent's emotional and mental health problems requires self-expression of their thoughts and feelings which are difficult to detect. Wickman stated that problems of the adolescent are not always seen as overt aggressive behavior and are often times missed by teachers in their estimation of problem children.[39]

The role of the school in the realization of goals that contribute to the development of a well-adjusted person was aptly stated by the American Association for Health, Physical Education and Recreation:

> Our functions as teachers is to help to provide the goal resources in the forms of conditions, materials, experiences and opportunities which shall make desirable satisfactions possible for adolescents.[40]

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[38] Arthur J. Lesser, "Changing Emphasis in School Health Program," Children, 5:9-14, January-February, 1958.

[39] E. K. Wickman, Children's Behavior and Teacher's Attitudes (New York: The Commonwealth Fund, 1928), pp. 60-62.

[40] American Association for Health, Physical Education and Recreation, Developing Democratic Human Relations Through Health Education, Physical Education and Recreation, First Yearbook (Washington 6, D. C.: American Association for Health, Physical Education and Recreation, 1951), p. 244.

Health education of the adolescent should be a required part of the over-all school program, as it aims toward the development of the whole adolescent. Cole believes that "the curriculum of today and tomorrow should try to develop the 'whole adolescent' just as a few decades ago, when the elementary school was dedicated to the development of the 'whole child.'"[41]

The development of the whole person results in a well-adjusted individual. It is this kind of person that educators hope the adolescent will become. Symonds described the characteristics of a well-adjusted person which was paraphrased by Kuhlen.[42] The well-adjusted person

1. is free from inner conflicts.

2. is able to apply his intelligence to the effective solution of the problems of living.

3. recognizes reality and the inevitability of the conditions to which he has to adjust.

4. has, in addition to his capacity for self-control, a certain freedom for emotional expression and is able to:
   a. relax, laugh and smile freely,
   b. love and accept love,
   c. achieve adequate gratification of bodily desires while not being overly interested in or preoccupied with his body,
   d. show anger when injured or show hostility and aggression whenever necessary or desirable.

5. enjoys social contacts and interests and perceives his world as a warm and friendly place inhabited by pleasant, friendly people. He is not too unlike the group in which he lives, and is able to recognize ability and merit in others,

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[41]Luella Cole, _op. cit._, p. 661.

[42]P. M. Symonds, _The Dynamics of Human Adjustments_ (New York: Appleton-Century Crofts, 1946), p. 569.

even when they surpass him in respects that are important to him.

6. is characterized by consistency of personality, in that he is not a flighty dilettante, a person of shifting goals and unpredictable behavior, yet is to a degree flexible, plastic and suggestible; he does not, for example, hold rigidly and inflexibility to a course in the face of insurmountable difficulties.

7. adopts goals that are reasonable and achievable in the light of his talents and capacities; recognizes his strengths and limitations; neither markedly over estimates or underestimates his talents.

8. has adequate drive based on physical vigor and talents.[43]

VI. IMPLICATIONS IN THE LITERATURE FOR THE IMPROVEMENT OF HEALTH TEACHING

The literature seems to indicate that the need for improved methods of teaching is equally as great as the need for improved content of health teaching. Strang and Smiley reported that surveys have shown that pupils of all ages have poor health habits. Yet teachers are confronted with a blase attitude toward health subjects by their pupils.[44]

The following quotations gathered by Strang and Smiley were made by high school students:

> Some of these things we learned before and some we could use our heads about.
>
> To be truthful, I really do not really care for the course. I found it helpful in many ways but it took two study periods a week and I think we could do without the course. If we had

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[43] Kuhlen, *op. cit.*, p. 284.

[44] Ruth Strang and Dean Smiley, *The Role of the Teacher in Health Education* (New York: The Macmillan Company, 1941), p. 103.

the time, I wouldn't mind.

> Personally I have received nothing from the course because I have had all the information before, either at home or in the hospital. I do think the course is necessary for girls who don't have parents to inform them.
>
> Much of the work is too juvenile. I feel we spent too much time on topics we know about.
>
> I think that Health Class is a waste of time and of a good study period. Anybody who doesn't know enough to wash his hands and hang up his clothes is too far gone to correct now. If we studied sports or something we did not know about we might learn something. Cleanliness is an important subject but we should study parts of it we don't know. A three-year old child knows enough to wash his hands if they are dirty, but he doesn't know why he should get the dirt out except that it does not look well.[45]

These and perhaps some other frank criticisms suggest certain definite points for improvement of the health curriculum. An apparent implication for improvement of teaching health is the lack of "know how" among teachers. This was revealed by the School Health Evaluative Study in which sixty-one per cent of the secondary school teachers felt a need for more adequate preparation in the health field.[46] According to this study, the picture was even more appalling when it was revealed that none of the administrators and only eight per cent of the supervisors had taken any kind of a course in health education.[47] From these stated findings, inference could be made that the focus of curriculum improvement should be first toward an in-service education of teachers.

It is only when the school is able to obtain teachers equipped

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[45] *Ibid.*

[46] Report of the School Health Evaluative Study, *op. cit.*, p. 61-63.

[47] *Ibid.*

with a trained understanding of adolescents, that the administrator and faculty staff are able to consider the problems of concern to the adolescent and decide which problems need the most attention. Haag advanced the thought that when the problems, needs, or interests are studied, the one that receives the highest frequency becomes the basis of instruction.[48] Cronbach felt that each problem of concern suggested the area of possible solution, whether it be in the proximity of the school, home or community, and that each problem merited an attempt to solution.[49]

VII. STUDENTS' RECORDS, VALUES AND PURPOSES

It is significant to note that the school has accepted obligations regarding the health of its students. Oberteuffer pointed out that the first concern of educators is to find ways by which school personnel might discover the needs and problems of youth.[50] Irwin has suggested, with others, ways whereby the school age population needs might be revealed. One of these suggestions is record keeping.[51] The Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association consider record

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[48] Jessie Helen Haag, "Discovering Needs and Interests for Health Instruction," Journal for Health, Physical Education and Recreation, 23:24, January, 1953.

[49] Lee J. Cronbach, Educational Psychology (New York: Harcourt, Brace and Company, 1954), p. 165.

[50] Delbert Oberteuffer, School Health Education (New York: Harper Brothers, 1954), p. 226.

[51] Leslie Irwin, W. James Humphrey and R. Warren, Methods and Materials in School Health Education (St. Louis: The C. V. Mosby Company, 1956), pp. 58-59.

keeping as an "essential part of child study."[52]

The literature on students' records and their use revealed similarities to this study. The following uses of records are pertinent:

1. Records tell a story of progress and give warnings of new dangers.
2. Records are invaluable tools in health education because they suggest places of emphasis and indicate at which point teaching efforts might bring the greatest return.
3. They are useful tools in research purposes.
4. Cumulative records become a tool in the hands of a teacher which he may use to effectively help particular boys and girls.
5. They are valuable tools for screening those children who are in need of special emphasis in the health instruction program. The data thus secured can be used for curriculum planning to provide a more functional health education for the individual school.
6. When considered collectively, records provide a basis for guidance of parent-teacher groups in planning their health education program for the unit.
7. Students' records provide a basis for counseling parents and students.

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[52] National Education Association and American Medical Association, A Report of the Joint Committee on Health Problems in Education, <u>Health Education</u> (third edition; Washington, D. C.: The Association, 1941), p. 182.

8. Records are effective instruments for evaluating pupil behavior and progress. Records play an essential role in understanding the adolescent. In giving emphasis to the importance of records Lefever stated, "By the record ye shall know them."[53]

9. Records are tools which help implement a program. Their importance is measured by their usefulness in aiding and maintaining a maximum health potential for each pupil.

10. Records act as guideposts indicating a change of direction along the way toward effective health promotion.

11. Records give information of the students' health needs, interests, and problems.

There are apparent tendencies on the part of some administrators and educators to overlook the value of records so that the information that could be obtained from this source is not being used to the best advantage. To cite an example, Irwin stated:

> If the pupils are given physical examinations and the results are not used to advantage, the value of obtaining them is questionable. Too often fairly complete physical examinations have been made in the school only to have the record filed.[54]

There are also records of students that are lacking in certain essentials. Hence, they lose the purpose for which they were intended. Nyswander observed that such records are "only a time consuming adminis-

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[53]Welty D. Lefever, Archie M. Turrell, and Henry Weitzel, Principles and Techniques of Guidance (New York: The Ronald Press, 1950), p. 131.

[54]Leslie Irwin, The Curriculum in Health and Physical Education (Iowa: William C. Brown Publishers, 1960), p. 632.

trative device to acquire statistics for running the service."[55]

VIII. RELATED STUDIES

A search of the literature was made to find if any study had been undertaken which specifically used students' records for curriculum improvement. Three studies were found but were instituted for a different purpose.

The first study was by Ehling in 1953 entitled, "School Health Records in Health Counseling of Children and Parents."[56] The interview technique was used in this study. Out of a total of 300 school personnel, 100 participated in the interviews, discussions and conferences. The objective of the study was to analyze the difficulties obstructing the use of school health records for health counseling purposes of a certain elementary school district.

In discussing the need for this study, the investigator made these statements:

> A nurse servicing the school is expected to promote and encourage the recording on the cumulative records of the results of health examinations, teachers' observations and other pertinent data, and to help in getting this information utilized to the best advantage.
>
> Furthermore, responsible expenditures of public funds demand continual critical examinations of all phases of the school curriculum. Details of school health recording and health counseling are no exceptions; health records, to be of value to anyone, must be used, not filed. There is evidence that traditional practices of filing rather than using records are still being followed in district X as well as

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[55]Dorothy Nyswander, Solving Health Problems (New York: The Commonwealth Fund, 1942), p. 109.

[56]Charlotte E. Ehling, "School Health Records for Health Counseling Children and Parents," (unpublished Ed. D. Dissertation, Stanford University, Stanford, 1953), p. 2.

throughout the nation. This procedure is a waste of money, time and effort.[57]

This study was of value for school personnel in that it drew attention to students' records as a source that could be used effectively in the counseling of children and parents on matters of health. It also provided further stimulus for the present study of the use of students' records for curriculum improvement in health education.

The second study was in 1942 by Cowan entitled, "Identifying Pupil Needs, Concerns, and Problems as Basis for Curriculum Revision in Stephen-Lee High School, Asheville, North Carolina."[58] The investigator based his study on the assumption that "direction for a program of curriculum revision may be derived from criteria drawn from many sources or areas of study." He pinpointed a number of areas for research from which he selected the needs, concerns and problems of youth for his study. The Mooney Problem Check Lists were the research tool used. Some of the conclusions drawn from this study were as follows:

1. The subject matter approach to curriculum making should be with the more dynamic individual or group needs approach.
2. Students' responses seemed to reflect a general demand for a dynamic curriculum improvement that is responsive to the changing needs, concerns and problems of the individual as

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[57] *Ibid.*

[58] Vernon D. Cowan, "Identifying Pupil Needs, Concerns, and Problems as Basis for Curriculum Revision in Stephen-Lee High School, Asheville, North Carolina," (unpublished Master's Thesis, Ohio University, Columbus, 1942).

well as the group.[59]

This study was of value because it provided a source of curriculum improvement for curriculum planners and afforded a plan for curriculum revision of Stephen-Lee High School.

The third study was a survey made by Ross L. Mooney. In this study Mooney surveyed the data furnished by Cowan, who made the original study using the check lists. The purpose of this study was to illustrate the type of results which could be obtained from the Mooney Problem Check Lists and some of the uses to which the data might be used in counseling and curriculum building. Some of the conclusions drawn from this survey pointed to certain steps which might be made by the school in considering a general program of development. Some of these steps were:

1. Increasing vocational and educational guidance functions in the school.

2. Analyzing the academic difficulties of the students and evaluating teaching practices and curriculum organization in relation to the most prevalent needs of the situation.

3. Providing more opportunities in individual guidance, homeroom procedure and curriculum content for students to express and deal completely with their every day psychological problems.

4. Accepting health as one of the first objectives of the school and securing the cooperation of the community agencies for a first-class program in this area.[60]

IX. SUMMARY

The review of the literature indicated that problems of health

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[59] Ibid., p. 80

[60] Ross L. Mooney, "Surveying High School Students Problems by Means of a Problem Check Lists," Education Research Bulletin, 21:57-69, 1942.

are very real in the adolescent, and that there is a need to recognise that this situation does exist. Moreover, ways and means ought to be investigated that may be profitably incorporated into the curriculum of health education. Although physical examinations and records are pertinent sources of information concerning the health of the adolescent, problems of concern are often more readily revealed by questionnaires or forms that the adolescent fills in himself.

CHAPTER III

METHOD OF STUDY AND COLLECTION OF DATA

I. THE METHOD OF STUDY

The purpose of this study was to ascertain the value of the data recorded on two of the students' records which could be used for curriculum improvement in health education. These records were the Medical Examination of Academy Students by Private Physician, and the Mooney Problem Check Lists.

Selection of the research method. The method of educational research which seemed to adapt itself best to this type of study was the descriptive survey. The descriptive research method is also known as "fact-finding with adequate interpretation."[61] According to Good and Scates, there are various techniques that an investigator may use in gathering facts to meet the needs of the varying purposes of research. For example, in gathering facts from people about themselves they may be interviewed, asked to fill out a questionnaire, given a test or examination, or asked to produce some piece of work in either verbal or written form.[62] Travers advocated inspection of the "already existing records." Thus, the descriptive survey method made possible

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[61] Carter V. Good and Douglas E. Scates, Methods of Research (New York: Appleton-Century-Crofts, Incorporated, 1954), p. 553.

[62] Ibid.

the study of records in gathering data as used in this study.[63]

Selection of facility. Along with these aspects of approach to the study, the possibility of procuring records to be studied was considered. Time, distance and finance were limiting factors to the study. In view of these limitations a Seventh-day Adventist church-sponsored school was selected. The school strives to implement its religious philosophy, which is "the harmonious development of the physical, mental and spiritual powers.[64] This is achieved by way of its curriculum, selection of teachers and teaching procedures, organizations and activities. This school conducts a 12-grade, non-boarding academy located in a suburban community. It is a member of the Association of Seventh-day Adventists Secondary Schools and Colleges and is also accredited by the Western Association of Schools and Colleges. The school requires each student enrolled for the first time to have a physical examination, preferably by a private physician. This must be done within thirty days after enrollment.

For the school year, 1960-1961, the total enrollment was 396. According to grades, the enrollment was: Grade 9, 118 students; Grade 10, 93 students; Grade 11, 106 students; and Grade 12, 79 students. The ages ranged from 12 to 18 years.

The request for use of this school for the study setting was made through interviews with the administrator of the school, the

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[63]Robert M. W. Travers, An Introduction to Educational Research (New York: The Macmillan Company, 1958), p. 246.

[64]Ellen G. White, Education (Mountain View: Pacific Press Publishing Association, The Ellen G. White Publications, 1942), p. 13.

school nurse and the school registrar. The problem and purpose of the study were explained. Permission was secured to use the students' records for analysis and the school proper as the study setting.

Selection of the tools of research. The philosophy underlying modern education is that the school is concerned with the "whole child." This belief has been instrumental in bringing about changes in the curriculum and in providing a variety of services for the students.

> At the center of this emphasis on the mental hygiene and pupil personnel points of view, is the idea that to understand students better the school should employ methods of systematically discovering what problems are bothering them. Knowing these problems--those of each individual--and those characteristic of the group itself--the school can mobilize its curricular offerings to meet these needs.[65]

In agreement with the above stated philosophy, the tools of research selected for the study were the records of Medical Examination of Academy Students by Private Physician* and the Mooney Problem Check Lists.* These two types of records were selected on the assumption that they revealed enlightening aspects of the physical, mental and emotional health of the students, which could be used by administration and staff for curriculum improvement in health education. The Medical Examination of Academy Students by Private Physician, form M. E114, was developed by the Department of Education of the General Conference of Seventh-day Adventists. It is intended for use in church-sponsored schools of the Seventh-day Adventist denomination. It contains thirteen items to be checked by the physician on his physical findings. In

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[65]Ross L. Mooney and L. V. Gordon, The Mooney Problem Check Lists Manual (New York: The Psychological Corporation, 1950), p. 3.

*See appendix for sample.

addition, the physician is to write a description of other physical findings on the space provided, including recommendation for the student's academic and activity program. (See appendix)

The Mooney Problem Check Lists originated with the senior author, Ross L. Mooney who had a desire to systematize his methods of discovering problems of young people.[66] In connection with his work as an administrator, educator and psychological counselor, he had a felt need for amore efficient group of methods to identify problems. This led to the exploration of the check list approach in surveys of students in schools and young people in communities.

The problem check lists are not tests. They are self administered. The directions for use are explained on the cover page. The students simply check the items. In the college and high school forms, there are 330 items. These items in turn are classified into 11 areas. They are: I. Health and Physical Development; II. Finances, Living Conditions and Employment; III. Social and Recreational Activities; IV. Courtship, Sex and Marriage; V. Social-Psychological Relations; VI. Personal-Psychological Relations; VII. Morals and Religion; VIII. Home and Family; IX. The Future: Vocational and Educational; X. Adjustment to College (School) Work; XI. Curriculum Procedure and Teaching.

Since the Mooney Problem Check Lists are not tests, their validity was determined by the variety of uses and purposes for which the check lists had been constructed. The authors suggested several uses of the check lists and for each of these uses, the data must be

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[66] Mooney, Ibid.

studied in terms of particular people in specific situations. Hence, "a single over-all index of the validity of the check lists would be therefore quite meaningless."[67]

The reliability of the Problem Check Lists was obtained from two sources. The first was the test retest method by Gordon who used the revision of the Problem Check Lists on 116 college students. The frequency with which the items were marked on the first administration was correlated with the frequency with which each of the same items were marked on the second administration of the Problem Check Lists. A correlation of .93 was found.[68] The second source of reliability was derived from a study of four educational groups for which the Mooney Problem Check Lists were repeated from one to ten weeks following the first administration. This rank order correlation coefficient varied from .90 to .98.[69] It was therefore concluded that:

> While the Problem Check Lists must be and are so designed as to reflect changing situations and experiences in the individual case, they nevertheless, exhibit sufficient stability to warrant general program planning on the basis of survey results.[70]

The Mooney Problem Check Lists have presented no table of norms. Although check lists render a count for each person and for each of the areas, and for the total items, the count is not a real score. "It is simply a count which the student has identified as matters of concern to him."[71]

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[67]Mooney, Ibid., p. 9.

[68]Ibid.

[69]Ibid.

[70]Ibid.

[71]Ibid.

It is also believed by the authors that for the purpose of comparison wherever such is desirable, local norms would be more valuable. However, they considered these not to be as important as "the discovery of relatively numerous problems in each area in relation to what the school and community may be able or willing to do about a problem."[72]

It is further believed by the authors of the Mooney Problem Check Lists that their influence lies in their economy for appraising the major concerns of a group and for revealing the problem of each student within a group.[73] The Mooney Problem Check Lists are used for a number of reasons which fall under five categories or classes. They are: (1) to facilitate counseling interviews; (2) to make group surveys leading to plans for individualized action; (3) a basis for homeroom, group guidance and orientation program; (4) to increase teacher understanding in regular classroom teaching; (5) to conduct research on the problems of youth.[74]

The 1950 revised form of the Mooney Problem Check Lists was the one used in this study. There were eight suggested steps for analyzing the problems checked. The seventh step was used in the analysis of the check lists in this study. This step is described as:

> A most laborious but fruitful type of analysis involves the tabulation of the frequency with which each of the items has been checked. Then a summary is made ranking the items in order of frequency of mention. Those problems marked by more than 30, 20, 10 per cent of the students (whatever per cent the school decides on) may be considered for immediate solution, or at least evaluation and careful description in terms of causes

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[72] *Ibid.*, p. 10.

[73] *Ibid.*, p. 3.

[74] *Ibid.*

and effect.[75]

II. COLLECTION OF DATA

The two types of records, Medical Examination Record and the Mooney Problem Check Lists, of the selected church-sponsored secondary school were surveyed.

The Medical Examination Records surveyed covered the school year, 1960-1961. These records were kept on file in the school nurse's office. All of the records were arranged in alphabetical order without classification as to age, sex or grade. The medical examination form itself, did not provide space for indicating sex. Upon initial enrollment of each student, the medical examination form was completed by a private physician. Upon this form was recorded the student's grade. During the student's entire stay in the school, which may be from one to four years, the grade indicated on the record by the physician at the time of examination was not changed. In view of this record filing system, and the form of the medical record, the intended classification of the student by sex, age and grade was ruled out. The only possibility of classifying the students by grade was through access to a form called, "Student Enrollment Conduct-Rating," where the names of students were listed and the grade indicated opposite the name. This form, then became the means of classifying the students by grade and for determing the total enrollment for this study. The students listed on the "Students Enrollment Conduct-Rating" form were counted. The

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[75] Ibid., p. 10.

total was 396. It was assumed that this number represented the total student enrollment.

Out of the 396 students enrolled the available medical examination records were 358. According to grades, the medical examination record counts were: Grade 9, 106; Grade 10, 87; Grade 11, 104; and Grade 12, 79. All of these records were individually surveyed. This number of records was used in order that each item in the population should have an equal chance of inclusion in the sample.

After the total enrollment of students was determined, tabulation sheets were made. The findings on the medical examination by the private physician were tabulated according to the thirteen categories listed on the record form. A frequency table was structured to find the distributions of findings falling under each category. No attempt was made to include the medical and social history in the gathering of data. However, other findings recorded by the physician, but which did not fall within any of the listed categories in the record, were listed under separate headings.

The next step, in the procedure for the analysis of the recorded data collected in the frequency table, was for the data to be placed in rank order. In the literature reviewed no criteria was found which could be used for ranking the items in a frequency table. In order to be able to make a rank order, the percentage of the total number of items checked by the private physician under each category was computed. When this was done, the items were arranged in terms of frequency from the highest to the lowest rank.

Inquiry was made as to whether there were other records on which data appeared besides the medical record. Referral to the school

counselor was made. He was then interviewed. Upon explanation of the problem and purpose of the study, he recommended the use of the Mooney Problem Check Lists which he administered to the students on October 24, 1961. Since the students themselves had to check the problems that were of concern to them the items checked seemed to reflect the students' emotional and mental health. It was assumed that the student's name on the check list did not influence the response sufficiently to invalidate its use.

As stated in the limitation of this study, only three categories were selected from the eleven categories on the Mooney Problem Check Lists. Since the primary objective of this study was to find recorded data on students' records that would be of value for the use in curriculum improvement of health education, the three problem areas chosen which seemed to be most closely related to the study were: (1) Health and Physical Development; (2) Social-Psychological Relations; and (3) Personal-Psychological Relations.

In order to score the items that the students had checked, tabulations were formulated into frequency tables. As indicated by the scoring guide those problems marked by more than 30, 20, 10 per cent of the students may be considered for immediate solution or at least evaluation. Upon the advice of experts and the major professor it was decided to use 10 per cent as the figure determining the rank order for analyzing and interpreting the collected data.

III. SUMMARY

The descriptive survey method was selected for this study because of its adaptability. The tools of research used were the

records of Medical Examination of Academy Students by Private Physician and the Mooney Problem Check Lists. The collection of data was done in a church-sponsored secondary school among 358 students. Although there were eleven categories on the Mooney Problem Check Lists, only three categories were selected as they met the purposes of the study most adequately for analysis and interpretation as being of value for the use in curriculum improvement of health education. Tabulations were formulated into frequency tables. As a scoring guide those problems marked by ten per cent of the students was used as the guiding figure determining the rank order, and for analyzing and interpreting collected data.

CHAPTER IV

ANALYSIS AND INTERPRETATION

The primary purpose of this study was to find data of value on students' records in a selected secondary church-sponsored school, which could be of use to administration and staff for curriculum improvement in health education. Two types of students' records on file were studied to achieve the aim of the study. These records were the Medical Examination Record and the Mooney Problem Check Lists.

I. MEDICAL EXAMINATION RECORD

A critical analysis of the recorded data on 358 Medical Examination Records revealed that 107 physical defects of some kind or another were discovered by the private physicians. The physical findings as shown in Table I, page 45, clearly indicated that skin conditions with a frequency of 22, exceeded all other defects. Kuhlen stated that skin conditions reach their peak at about ten years of age, and showed a high incidence in the early teens, then decreased rapidly at the age of twenty years.[76] Skin conditions, may affect individuals of different ages in different ways. Some persons may not exhibit conclusive enough symptoms for the skin condition to be called a disease. Nevertheless, slight disorders of the skin may be magnified by adolescents to such a degree as to be out of all proportion to the disorder because

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[76]Raymond G. Kuhlen, The Psychology of Adolescent Development (New York: Harper and Brothers, 1962), p. 62.

TABLE I

RECORDED FINDINGS ON ENTRANCE MEDICAL EXAMINATION RECORD BY PRIVATE PHYSICIANS FOR 358 SECONDARY STUDENTS OF A SELECTED CHURCH-SPONSORED SCHOOL

Physical defects	Frequency of body parts	Total frequency of body parts No.	%
Skin:		22	6.1
Acne	16		
Hives	2		
Blotches	4		
Eyes:		21	5.9
Myopia	9		
Nystagmus	1		
Referrals for glasses	6		
Conjunctivitis	3		
Eye ball laceration	1		
Partial amblyopia	1		
Ears:		17	4.8
Cerumen	2		
High frequency loss	1		
Referrals; Audiometry	14		
Nose and Throat:		14	3.9
Tonsils only	6		
Allergic rhinitis	6		
Hypertrophied tonsils and adenoids	2		
Nutritional Status:		9	2.5
Obesity	8		
Anemia	1		
Heart:		5	1.4
Grade 1 systolic murmur	4		
Septal defect	1		
Genito-Urinary:		4	1.1
Hydrocele	1		
Varicocele	1		
Menstrual disorder	2		
Extremities:		1	negligible
Weak ankles	1		

TABLE I (Continued)

Physical defects	Frequency of body parts	Total frequency of body parts No.	%
Other Findings:		14	3.9
Asthma	8		
Diabetes, controlled	1		
Hemorrhoids	1		
Posture	4		
Total	107	107	

of personal and social sensitivity.

One of the commonest skin conditions that aggravates and embarrasses the adolescent is acne, of which there were 16 cases recorded or 4 per cent of the 358 students' records studied. The physician confirmed the presence of the skin disorder in his physical examination of the student. The result in this study of this particular physical problem was similar to those of other surveys. Loop and Tipton at Hunter College of the city of New York reported in 1952 that almost 40 per cent of their group had oily skin.[77] Bell, in 1943 at the University of Michigan, reported that 69 per cent of her group had no acne.[78] In Perberton's study of the health of 407 new students only 7 per cent were found to be suffering with acne.[79]

Eye defects were found to be second in frequency with a numerical count of 21. These conditions included myopia and other uncorrected acuity defects, including nystagmus and results of various injuries. In Britten's study of illness and accidents among persons living under different housing conditions, estimates of the frequency of visual defects were given to be from 20 to 30 per cent of the population.[80]

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[77] Anne S. Loop and Anne B. Tipton, "Health Survey of Hunter College Freshmen," Research Quarterly, 23:54-72, March, 1952.

[78] Margaret Bell, "Health Trends in University of Michigan Women Students," Journal of Lancet, 63:172-176, June, 1943.

[79] John Pemberton, "The Health of 407 New Students," British Medical Journal, 1:490-492, January-June, 1948.

[80] R. H. Britten, "Illness and Accidents Among Persons Living Under Different Housing Conditions," U.S. Public Health Reports, 56: 609-640, 1941.

On the basis of these estimates, Gover and Yaukey claimed that in a class of 30 pupils there may be an expectation of 5 to 10 with defective vision.[81] Loop and Tipton also reported that almost one-half of their college Freshmen students surveyed had defective vision, and of the 485 students whose vision were normal 86 per cent were wearing glasses.[82] The visual defects included nearsightedness, astigmatism and farsightedness.

The findings of eye defects in the present study was comparatively low in relation to the estimates as indicated by the Loop and Tipton studies. The apparent difference may be due to the (1) smallness of the sample; (2) the fact that the data gathered was only from the recommendation as recorded by the examining physician such as "must wear glasses" or "needs glasses;" (3) the possibility that this high school student group may not be using their eyes in close work as much as the college students on their study program; and (4) the observance of proper hygiene in eye care supposedly practiced by the students, who seemed to represent a more homogenous and health oriented religious group.

Ear defects were the third in frequency with a count of 17 or 5 per cent. Gover and Yaukey gave estimates of hearing loss to be 5 to

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[81]Gover, Mary and Jesse B. Yaukey, "Physical Impairments of Members of Low-Income Farm Families--11,490 Persons in 2,477 Farm Security Administration Borrower Families, 1940. I. Defective Vision as Determined by the Snellen Test and Other Chronic Eye Conditions," U.S. Public Health Reports, 59:1164-1184, September 8, 1944.

[82]Loop and Tipton, *op. cit.*, p. 57.

10 per cent of the population.[83] Accordingly in a class of 30 pupils there should be 3 or 4 pupils with a hearing defect. The apparent low incidence of hearing defects as found in the present study may be accounted for, in part, to the unavailability of the actual results of the screening tests done by the nurse or audiometrist.

Under the heading, "Nose and Throat," there were 14 deviant findings or 4 per cent. Gover and others reported that 45 per cent of children 15 to 19 years of age have slightly diseased tonsils, with 17 per cent being markedly diseased.[84] The result of the survey on students' records in the present study was relatively low as compared with the study conducted by Gover and Yaukey.[85] Dissimilarity in the result of Gover's study and the present one might lie in the difference between the socio-economic status of the two groups studied.

The physical defects were listed under nutritional status, cardiac involvement, genito-urinary, and extremities. Although the defects were few in frequency, nevertheless they were worthy of notice considering that a school health program is interested in obtaining a picture of the health of the individual child. Nutritional problems accounted for eight per cent of the total defects; and these were

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[83]Gover, Mary and Jesse B. Yaukey, "Physical Impairment of Members of Low-Income Farm Families--11,490 Persons in 2,477 Farm Security Administration Borrower Families, 1940. III. Impaired Hearing for Speech," U.S. Public Health Reports, 60:429-441, April 20, 1945.

[84]Gover, Mary and Jesse B. Yaukey, "Physical Impairment of Members of Low-Income Farm Families--11,490 Persons in 2,477 Farm Security Administration Borrower Families, 1940. IV. Defective Tonsils and Adenoids," U.S. Public Health Reports, 60:693-710, June 22, 1945.

[85]*Loc. cit.*

preventable conditions. The cardiac and genito-urinary problems (except menstrual disorders) were not preventable and are not unusual to find in small per cents among high school students.

Under the heading, "Other findings," there were fourteen defects including asthma, diabetes, hemorrhoids, and postural defects. A breakdown of the data showed that asthma and postural defects were the most common. The last two physical conditions mentioned are sometimes due to emotional tensions discussed further in the section that deals with the mental and emotional subjective reactions of the students as checked by them on the Mooney Problem Check Lists on page 53.

It was noted that there were no recorded physician's data of any glandular defects or deviations from the normal of the abdomen and lungs. (See appendix) This, together with the low incidence of physical findings recorded by the physicians of the other body parts, would lead one to assume that there is an over-all high level of health among these students. However, the medical examination record may not be the complete picture of mental and physical well being of these students. As Nemir pointed out, "health information supplied by private physicians may be too sketchy to be helpful."[86] In this selected secondary school a second record was studied to give a broader picture of student well being, the Mooney Problem Check Lists.

II. THE MOONEY PROBLEM CHECK LIST

In the use of the Mooney Problem Check Lists, it was assumed

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[86]Alma Nemir, The School Health Program (Philadelphia: W. B. Saunders Company, 1959), p. 298.

that the problems checked by the students were of concern to them. Recognition was given to the interrelatedness of the mental and emotional health with that of the physical health of the students. Hence, some aspect of the mental and emotional health must be included in any study of records if we would have a total picture of health as a baseline for health education in the curriculum.

On the basis of past studies, conclusions have been drawn that most problems of adolescents involve physical and psychological factors. Difficulties which they encounter in their relationships with teachers, parents, and with their own peer group influence these problems. A number of psychologists have categorized the health needs of adolescents into specific areas. The Mooney Problem Check Lists, for example, have grouped them into eleven categories. Three of which were selected for this research.

The Mooney Problem Check Lists were administered on admission to 359 students of adolescent age in a church-sponsored secondary school and became a part of the health records. The findings appeared to follow the pattern of adolescent problems as revealed by other studies in harmony with Jersild's statement that, "Many young people are obviously troubled and problems to themselves and to others."[87]

A critical examination of these three problem categories, which were arbitrarily selected, revealed human weaknesses recognizable in any age group but appear to be more prominent in the adolescent. These are problems that stem from physical growth and state of health, social

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[87]Arthur T. Jersild, The Psychology of Adolescence (New York: The Macmillan Company, 1957), p. 360.

relations, and emotional tensions.

Health and physical development. As evidenced by the results in Table II, on page 53, the "Poor complexion or skin trouble," was the biggest problem of concern, with eighty-eight responses checked. This result was four times higher than the figures revealed in the Medical Examination Records of these students discussed in the previous section of this chapter. The difference in the two may be due to: (1) manifestation of this defect was inapparent at the time of the physical examination; (2) the condition was not serious enough to arrest the attention of the physician; (3) or it may be that this condition was only magnified in the minds of the affected students. The concern over complexion seen in this study was unusual as compared with another study made at Stephen-Lee High School. In this school, the concern over "Poor complexion or skin trouble" did not have a place in the top ten per cent of the problems checked by the students in the Mooney Problem Check Lists. It might be speculated that since the girls in the church-sponsored secondary school were not permitted to use obvious make-up, they were most conscious of any skin blemishes and eruptions that would mar their complexions. In addition, many of these students might partake of a vegetarian diet comparatively high in nuts and nut foods which are known to have a high fat content and are contraindicated in acne skin conditions.

Some of the problems checked by the students as being of most concern to them were indicative of a desire to possess a good physical appearance. These problems which are also found in Table II, on page 53, along with "Poor complexion or skin trouble," 88 responses were:

TABLE II

RELATIVE RANK OF HEALTH AND PHYSICAL DEVELOPMENT PROBLEMS CHECKED BY 358 STUDENTS ON THE MOONEY PROBLEM CHECK LISTS ON OCTOBER 24, 1961

Mooney item number	Description of the items	No. of responses per item No.	%	Rank order
166	Poor complexion or skin trouble	88	24.6	1
113	Not getting enough sleep	82	22.9	2
2	Being overweight	76	21.2	3
170	Not very attractive physically	59	16.5	4
1	Being underweight	55	15.3	5
56	Frequent headaches	49	13.7	6
57	Weak eyes	48	13.4	7
5	Tire easily	47	13.1	8
59	Not eating the right food	46	12.9	9
3	Not getting enough exercise	43	12.3	10.5
111	Not as strong and healthy as I should be	43	12.3	10.5
167	Poor posture	42	11.6	12
112	Not getting enough outdoor air and sunshine	40	11.2	13.5
223	Allergies (hay fever, asthma, hives, etc.)	40	11.2	13.5
114	Frequent colds	35	.1	15

"not being attractive physically," 82 responses; "being overweight," 76 responses; "being underweight," 55 responses; and "Poor posture," 42 responses.

As physical development progresses and changes take place in size and contour of the body, there is an acute awareness of these changes by the adolescent. In their minds others are noticing them also. These may cause the adolescent to become self-conscious, bashful, and awkward. "The awkwardness," said Jersild, "may persist well even beyond the time when the physical aspect of growth is completed."[88] This may account for the feelings about being physically unattractive, and of the wrong weight.

Another reason for the desire to be physically attractive is the existence of social norms. In this connection Kuhlen stated that the existence of social norms as to physical beauty, and what is desirable in terms of physical make-up generally results in special problems for those who do not measure up to the norms.[89] Similar findings are discussed in a study covering a period of eight years, where it was found from physicians' records that 29 out of 93 boys and 23 out of 83 girls were definitely disturbed about their physical characteristics. Stolz and Stolz who made the study, further reported that five of the young people in the group faced a major problem of social adjustment because of difficulty in accepting their physical characteristics. They also stated that the figures represented were minimal estimates since

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[88]Jersild, _Ibid._, pp. 58-59.

[89]Raymond G. Kuhlen, _op. cit._, p. 71.

others might have had similar concerns which did not come to the physicians' attention. The sources of their anxiety in rank order were:

> Boys: Lack of size, Poor physique, Lack of muscular strength, Acne, Skin blemishes, Scars, Bowed legs, Obvious scoliosis, Lack of shoulder breadth, Unusually small genitalia, Unusually large genitalia.
>
> Girls: Tallness, Fatness, Facial features, General physical appearance, Tallness and heaviness, Smallness and heaviness, Eyeglasses and strabismus, Thinness and small breasts, Late development, Tallness and thinness, Acne, Hair, Big legs, One short arm, Scar on face, Brace on back.[90]

The other problems tabulated under the Health and Physical development category in Table II, page 53, seemed to indicate a conscious need on the part of the church-sponsored secondary school students for physical fitness. Their problems as checked were: "Frequent headaches," 49 responses; "Weak eyes," 47 responses; "Tire easily," 47 responses; "Not as strong and healthy as I should be," 43 responses; "Poor posture," 42 responses; "Allergies (hay fever, asthma, hives, etc.)," 40 responses; and "Frequent colds," 35 responses.

These problems of lack of physical fitness among the adolescents do exist in spite of a common pre-conceived idea that the adolescent period is the most healthy. Kuhlen has also contended that although the period of adolescence is relatively healthy, it certainly is not prudent to say there is no disease for actually there is considerable illness among adolescents.[91] He further stated that most of the conditions are found in the skin, eyes, ears and teeth. According to

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[90]H. R. Stolz and L. M. Stolz, "Adolescent Problems Related to Somatic Variations," Adolescence, Chapter V, pp. 80-90, in National Society for the Study of Education, 43rd Yearbook, Pt. I, 1944.

[91]Kuhlen, *op. cit.*, p. 61.

Briggs the most common ailments of adolescents are anemia, nosebleed, nervousness, "growing pains," palpitation of the heart, and especially for girls, sick headaches, "green sickness"--a form of anemia in adolescent girls due to faulty diet during puberty--which has been found in more than one-third of a population, chorea, and thyroid enlarging to goiter.[92] This author further stressed that the school should be alert to such ailments in order to make necessary adjustments for work. He further emphasized the importance of teaching hygiene courses as well as the promotion of interest in sports and outdoor activities in the secondary schools which will lessen the physiological crisis of puberty.[93]

The conditions enmerated above revealed a similar trend in the youth of the selected church-sponsored secondary school, as may be noted in Table II, page 53. However, in some respects results were lower as compared with findings of other studies. In one such study by Loop and Tipton of Hunter College Freshmen, findings ranked high in eye defects. Only one-half of the group had normal vision and almost one-fifth had frequent headaches. The incidence of colds was also high with a recurrence from four to six times a year for the majoity of the students.[94]

In the study by Cowan in Stephen-Lee High School, the complaint, "Weak eyes," was high, ranking first on the top ten per cent of the

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[92]Thomas H. Briggs, et. al., Secondary Education (New York: The Macmillan Company, 1950), p. 126.

[93]Ibid.

[94]Loop and Tipton, op. cit., p.57

problems checked by students on the Mooney Problem Check Lists.[95] The incidence of colds was second in the rank order. The apparent discrepancy between the cited two studies and the study of the students of the selected secondary church-sponsored school might be due to the students' socio-economic status and background of health knowledge. Loop and Tipton reported that only 13.1 per cent of their heterogenous group had previously received instruction in hygiene.[96] The students at Stephen-Lee High School came largely from a low income Negro community; whereas, the majority of students in this study came from homes where their parents were assumed to be health conscious and had moderate incomes. Moreover, many of the parents were of professional status, including the profession of medicine. Furthermore, a large number of students in this school had attended a church-sponsored elementary school in which healthful living and disease prevention were stressed.

It is interesting to note that 13.5 responses by the students indicated that they had an allergy. According to Thorndike, in his study of 594 college students, he found that more neurasthenic traits were found among students with allergies such as hay fever, asthma, migraine, eczema, etc., than the non-allergic individuals. The deeply differentiated neurasthenic traits were:

> Slowness of making up mind, difficulty in making decisions.
> Difficulty in thinking, forced to grope ideas.
> Feelings of inferiority.
> Excessive self-consciousness.
> Dreading the round of day-to-day tasks.

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[95] Cowan, _op. cit._, p. 64.

[96] Loop and Tipton, _op. cit._, p. 56.

Feeling of vagueness.[97]

In addition to problems of physical appearance and ill-health checked by the students, there seemed to be problems suggestive of faulty habits involving nutrition and unbalanced work and study. These problems were: "Not getting enough sleep," with 82 student responses; "Not eating the right food," 46 responses; "Not getting enough exercise," 43 responses. These problems coincided remarkedly with Briggs' observation that the adolescent must combat bad habits of eating, rest, sleep, and overwork in school and play which are crucial to health.[98]

This observation seemed to have a close similarity with the findings of a research study made in selected secondary schools and colleges in the Los Angeles area for the years 1954 to 1959. This study revealed that inadequate sleep, rest and relaxation were some of the great weaknesses common to students of the tenth and eleventh grades.

In the analysis of the problems on Health and Physical Development it was shown that these problems could be subdivided into three problem areas. They are: (1) the self-image of the adolescent; (2) physical changes as perceived by the adolescent, and problems that pertain to self-recognized biological deficiencies as he progresses from childhood to adolescence; and (3) faulty health habits that may have been acquired from childhood.

Social-Personal relations. In this category which is tabulated

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[97]R. L. Thorndike, "A Note on the Relationship of Allergy to Neurasthenic Traits," Journal of Genetic Psychology, 17:153-155, 1937.

[98]Briggs, op. cit., p. 131.

in Table III, page 60, the concern over "Wanting a more pleasing personality" was prominent being checked by 104 students. This figure indicated that a little more than one-half of the total number of students studied were concerned with this problem. The figure exceeded that of Cowan's study in which a little over one-fifth of the group were concerned with the same problems. The problem of "Wanting a more pleasing personality" ranked the highest (in the top ten per cent) of the problems checked by the church-sponsored school students.

The next highest problems of concern were "Wanting to be more popular," with 123 responses; and "Worrying how I can impress people," with 107 responses. These two problems seemed closely related to the first problem of greatest concern that of "Wanting a more pleasing personality." The aggregate of these three problems seemed to indicate a conscious need on the part of adolescents for social status and acceptance which are fundamental in every individual. However, Kuhlen has stated that this is more exaggerated in adolescents because it is at this age, that status and acceptance among members of the group, the opposite sex and among adults are more keenly felt.[99]

School activities force adolescents into close contact with individuals from different socio-economic backgrounds. Kuhlen observed that in school, individuals with certain deficits rub shoulders with those who possess greater poise, better clothes, better family standing and social status which may cause a consciousness of differences.[100] It is also in school that the formation of cliques and social groups

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[99]Kuhlen, op. cit., pp. 290-291.

[100]Kuhlen, Ibid.

TABLE III

RELATIVE RANK OF SOCIAL-PSYCHOLOGICAL RELATIONS PROBLEMS CHECKED BY 358 STUDENTS ON THE MOONEY PROBLEM CHECK LISTS ON OCTOBER 24, 1961

Mooney item number	Description of the items	No. of responses per item No.	%	Rank order
76	Wanting a more pleasing personality	164	45.8	1
241	Wanting to be more popular	123	34.4	2
78	Worrying how I can impress people	107	29.9	3
132	Being timid or shy	63	17.6	4
297	Speaking or acting without thinking	60	16.8	5
80	Lacking leadership ability	57	15.9	6.5
133	Feelings too easily hurt	57	15.9	6.5
245	Sometimes acting childish or immature	55	15.4	8
21	Getting into argument	52	14.5	9.5
299	Finding it hard to talk about my troubles	52	14.5	9.5
189	Being left out of things	49	13.7	11
23	Being talked about	48	13.1	12.5
135	Feeling inferior	48	13.1	12.5
242	Disliking someone	42	11.7	14
131	Slow in making friends	38	10.6	15
134	Getting embarrassed too easily	36	10.1	16
79	Too easily led by people	35	.1	17

emphasize the need to "belong." The adolescent who fails to be accepted, and is left out of things often undergoes a traumatizing experience.

The social pressures stemming from the adolescent's own peer group, are often more influential than parental authority or advice. Peer group pressure causes adolescents to become more aware of their personal appearance and personality. The desire for social acceptability stimulates their search for remedies to rectify deficiences or limitations. One of these cosmetic problems is acne. Byrd stated that acne may result in permanent scarring which detracts from the physical appearance of the young person and may lead to other undesirable psychological effects.[101]

The need for status and acceptance, the desire for fitness and attractiveness to the opposite sex stimulate a desire for self improvement which is healthy. Desires of these students are similar to those found by Strang and others.

> Personality, vivacity, enthusiasm, conversational ability, ability to get along with all kinds of people, consideration, the quality of a good listener, intelligence, lack of conceit, skill in sports, and a sense of humor.[102]

They also indicated that these needs emerge from the students' study of themselves and the community.

Other problems in Table III, page 60, are presented as: "Being timid or shy," 63 responses; "Lacking leadership ability," 57 responses; "Feelings too easily hurt," 57 responses; "Finding it hard to talk about my troubles," 52 responses; "Being left out of things," 49 responses;

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[101]Oliver E. Byrd, Health (Philadelphia: W. B. Saunders Company, 1961), pp. 121-122.

[102]Strang, op. cit., p. 93.

"Feeling inferior," 48 responses; "Slow in making friends," 38 responses; "Getting embarrassed too easily," 36 responses; "Too easily led by other people," 35 responses. These indicated a low estimate of themselves.

This apparent low self evaluation was probably due to the adolescent's feeling insecurity as he sought to gain acceptance from his peers or opposite sex but felt inadequate in biological make-up and skills to be acceptable. Jersild stated that those who were insecure tended to place a low estimate upon themselves and that a person's attitude concerning his own worth as a person would influence and would be influenced by the attitudes he has concerning his appearance.[103] In a study by Secord and Jourard, it was reported that there was a considerable degree of correspondence between the evaluation individuals gave when asked to record their feelings with regard to their bodies (hair, complexion, body build, etc.) and their feelings concerning themselves (morals, first names, popularity, moods, etc.)[104]

Kuhlen and Collister noted from their study of ninth graders that those who were failing in school and who were generally not well adjusted socially tended to be unattractive, poorly groomed, and lacked "know how."[105] They also tended to be withdrawn, shy and unhappy.

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[103] Jersild, op. cit., p. 32

[104] P. Secord and S. M. Jourard, "The Appraisal of Body-Cathexis: Body-cathexis and the Self," Journal of Consulting Psychology, 17:343-347, 1953.

[105] R. G. Kuhlen and E. C. Collister, "Sociometric Status of Sixth and Ninth Graders Who Fail to Finish High School," Educational and Psychological Measurements, 12:632-657, 1952.

The remaining problems of concern in social relations were: "Speaking and acting without thinking," 60 responses; "Sometimes acting childish or immature," 55 responses; "Getting into arguments," 52 responses; "Disliking someone," 42 responses. These seemed to be suggestive of awkward behavior. Manifestations of such actions are sometimes demonstrated to compensate for frustrations one has when he does not have the necessary skills and habits to handle relationship situations.

Kuhlen has made the observation that although acquired social skills and habits might enhance the social success of the adolescent, the school and the home have apparently made little effort to provide experiences for the acquiring of such skills.[106]

In the analysis of the problems of social relationships, it was revealed that a considerable number of the adolescent students of the selected secondary school have had high social interest common to adolescence.

Personal-Psychological relations. In this area, the item "Forgetting things" received 104 responses, the highest response in Table IV, page 64. The similarity between this figure and Cowan's study is significant. In this study, "Forgetting things" was a major problem of concern to the students being found in the top ten per cent of the problems checked by them. This item was checked by approximately one-third of the students who participated in Cowan's study.[107]

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[106]Kuhlen and Collister, *Ibid.*

[107]Cowan, *Loc. cit.*

TABLE IV

RELATIVE RANK OF PERSONAL-PSYCHOLOGICAL RELATIONS PROBLEMS CHECKED BY 358 STUDENTS ON THE MOONEY PROBLEM CHECK LISTS ON OCTOBER 24, 1961

Mooney item number	Description of the items	No. of responses per item No.	%	Rank order
83	Forgetting things	104	29.1	1
30	Worrying	102	28.9	2
26	Losing my temper	92	20.6	3
138	Afraid of making mistakes	83	23.2	4
27	Taking some things too seriously	78	21.8	5
85	Not taking some things seriously enough	78	21.8	6.5
250	Lacking self-confidence	76	21.1	7
81	Daydreaming	63	17.6	8
137	Trouble making up my mind about things	59	16.5	9
28	Being nervous	57	15.9	10
84	Being lazy	56	15.6	11
140	Sometimes wishing I'd never been born	48	13.4	12
246	Being stubborn or obstinate	47	13.1	13
136	Moodiness "having the blues"	46	12.9	14
82	Being careless	44	12.3	15
192	Failing in so many things I try to do	39	10.9	16
247	Tending to exaggerate too much	37	10.3	17
139	Too easily discouraged	34	.1	18

The similarities between the two studies are important to note in that the adolescents studied showed a high degree of preoccupation which is typical of adolescence. Akin to preoccupation, which tends toward "Forgetting things," is the problem of "Worrying." This was checked by 102 students which almost equaled that of "Forgetting things." Mohr and Despres advanced the assumption that the adolescent's major preoccupation is in the search of certainties about himself. Consequently, his worries center around the kind of person he is, whether he can measure up to his own standards and to the standards of his parents, teachers, and friends.[108] Other sources of worry in late adolescence pointed out by Hurlock, were those relating to physio-socio, sex and marriage, vocational and physical and financial problems.[109] Preoccupation and worry would add to the problem of "Forgetting things." The preoccupied person tends to brood and worry. Along with "Forgetting things" is the tendency toward carelessness and absent-mindedness, or "Taking some things too seriously" and "Not taking some things seriously enough." These last two problems of concern checked by the students showed an equal number of responses. Each had seventy-eight. The high incidence of "Forgetting things" and "Worrying" was suggestive of both physical and psychological conditions involving frustrations that accompany the emotional life of the adolescent.

There appeared to be evidence of defense reactions on the part of the students who checked the problem check lists. Aggressive

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[108]George H. Mohr and Marian Despres, The Stormy Decade: Adolescence (New York: Random House, 1958), p. 56.

[109]Elizabeth Hurlock, Adolescent Development (New York: McGraw-Hill Book Company, 1949), pp. 130-131.

behavior in the form of increased activity was seemingly suggested by such problems checked as "Losing my temper," 92 responses; "Not taking some things seriously enough," 63 responses; "Being stubborn or obstinate," 47 responses; "Being careless," 44 responses; "Tendency to exaggerate," 37 responses.

Aggressive behavior with increased activity may lead to acts that are unacceptable to the standards of society or to the peer group. These may be such things as destruction of others, destruction of property, and antisocial behavior.

The problems representing aggressive behavior by withdrawal were indicated by such problems checked as: "Forgetting things," 104 responses; "Worrying," 102 responses; "Afraid of making mistakes," 83 responses; "Taking some things too seriously," 78 responses; "Lacking self-confidence," 76 responses; "Daydreaming," 63 responses; "Trouble making up my mind," 59 responses; "Being nervous," 59 responses; "Being lazy," 56 responses; "Sometimes wishing I'd never been born," 48 responses; "Moodiness, 'having the blues,'" 46 responses; "Failing in so many things I try to do," 39 responses; "Too easily discouraged," 39 responses.

Aggressive behavior by withdrawal may lead to self-destructiveness in the form of suicide or suicidal attempts. Such expressions as, "Sometimes wishing I'd never been born," may suggest an inner desire of the girl or boy to isolate himself from society and shut himself in from the hurts of his environment. This tendency may deprive the individual of spontaneity for self expression and freedom.

Kuhlen indicated that although aggressive behaviors probably caused much friction and unhappiness in interpersonal relationships,

the person, who habitually adjusts by withdrawing represents (in the opinion of clinicians) the more serious mental hygiene problem.[110]

The personal-psychological problems listed in Table IV, page 64, would suggest the means by which adolescents react to their frustrations, which are but symptoms of emotional stress.

III. SUMMARY

This chapter has been concerned with the information gathered from the two types of students' records used in this study that might be of use to administrators and staff of a selected church-sponsored secondary school for curriculum improvement in health education. An attempt was made to identify the health education needs through appraisal of physical, social, and personal problems from the Medical Examination Records and the Mooney Problem Check Lists. These were problems of concern as seen by the physician and by the students themselves which were those checked by them in the Mooney Problem Check Lists, are of considerable importance and are the kind of things overlooked sometimes by sophisticated adults.

Poor complexion or skin condition was found to be high in the findings of the family physicians. This is a typical problem of adolescents as found in studies of different groups of students by other investigators. Favorable socio-economic status and a background of health knowledge are factors conducive to a low incidence of ill-health as seemed to be revealed by the analysis of the Medical Records. However, findings in only one type of record are not sufficient to

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[110] Kuhlen, op. cit., p. 261.

present a complete picture of the student group.

The Mooney Problem Check Lists showed that the students indicated many more problems than were revealed by the Medical Examination Record. Regardless of the socio-economic status of adolescents, their emotional problems have similarities to other adolescents that have been studied. Although display of emotion is typical of adolescence, the high school has a responsibility to help them control these emotions and diminish the negative ones. The relationship of emotional and physical health is vital to the total health of the student.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

I. SUMMARY

This study has been concerned with finding recorded data on students' records in a selected secondary Seventh-day Adventist church-sponsored school which could be of value for use in curriculum improvement in health education. Recognition was given to the broader meaning of curriculum defined as "all of the experiences of the learners under the guidance of the school."[111] Consideration was also given to the connotation of curriculum improvement which is betterment in the quality of experiences planned by the school for boys and girls to bring about desirable changes in their behavior and practices--the end products of education.

The need for the study developed out of a concern over how students' records of a particular high school might be used effectively by teachers. The review of literature revealed that record-keeping merely for the sake of "safe-keeping" was not an isolated instance but a tradition on a nation-wide practice.

Ehling's study of "School Health Records for Counseling Pupils and Parents" provided further stimulus for the study. The World Health Organization Expert Committee on Nursing Services suggested that research be done on school records in terms of their uses such as: (1) guidance

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[111] Mackenzie, *Loc. cit.*

of children and parents, (2) improving supervisory and administrative practices, and (3) providing basic research information for planned studies in child health. The present study was not directly concerned with the entire student's record but the data of health interest in the record.

Two kinds of available students' records were used in this study. They were the Medical Examination Record and the Mooney Problem Check Lists. Upon the advice of experts, three out of eleven categories were selected from the Mooney Problem Check Lists. These problem categories were (1) Health and Physical Development, (2) Social-Psychological Relations and (3) Personal-Psychological Relations.

It was assumed that the recorded data on the Medical Examination Records and the Mooney Problem Check Lists, which the students filled in or checked, indicated their true feelings as to what concerned them. It was felt that such data would be of value to the school administrator and staff in curriculum improvement to vitalize health education geared to the adolescent.

In former years, health education in the secondary school failed to receive the same degree of emphasis that it did in the elementary school. This was largely due to the belief that (1) adolescence is the healthiest age of childhood; (2) the period of adolescence is characterized by "storm" and "stress" that will disappear as adulthood is reached; (3) the emotions exhibited by adolescents are due to physical changes in the normal process of growing up. Contrary to these generally accepted beliefs, the literature indicated that there is disease and ill-health in adolescence. Physical defects and mental illnesses were the major causes of the large number of rejectees during

the two World Wars. These results aroused great interest in the health of youth. Physical stamina and emotional stability of the young people became the concern of the nation's leaders. It led educators to recognize more fully the school's responsibility for the education of the "whole adolescent," and health education was recognized as an integral part of the total curriculum. Ways were sought by which needs and problems of the school's youth might be discovered.

The literature has verified the value of health records in that in attempting to understand the adolescent, such records give information about needs, interests and problems. In the hands of the teacher they are instruments that may assist him in counseling particular students. In health education records become invaluable tools because they suggest places of emphasis, and indicate points at which teaching might bring the greatest return. They may act as guideposts which indicate a need for change of direction in the program of health promotion.

The method of study used was the descriptive survey. This research approach is known as "fact-finding with adequate interpretation." It is helpful in focusing attention on practical things which might remain unobserved for sometime. Record study was the manner of obtaining the data.

The facility for the study was a four-grade secondary church-sponsored Seventh-day Adventist school, located in a suburban community of Los Angeles. This educational institution strives to implement its religious philosophy of education which is the harmonious development of the physical, mental and spiritual powers. In the year 1960-1961, the total enrollment was 396 from grades nine through twelve. At the

time of study there were available records of health examination on 358 students. The Mooney Problem Check Lists of these students were studied and the top ten per cent of the problems checked by the students were determined. The data were tabulated and frequency tables constructed.

Analysis of the data recorded in the two kinds of records studied revealed to a degree the students' physical, social, mental and emotional health. Skin conditions were the highest physical defects reported by private physicians. Studies done by other investigators revealed similar results. Other findings of relative importance were found in the eyes, ears, nose and throat, and the nutritional status. The body area where the fewest defects were found was the extremities. Defects found, according to the comments of curriculum makers, health educators and psychologists, were those common among other adolescents.

The three problem categories of the Mooney Problem Check Lists (which the students themselves had checked) showed a greater number of health problems, than were recorded by private physicians on the Medical Examination Records. Analysis of the Health and Physical Development problem category revealed students' greatest concern was "Poor complexion or skin trouble." This was also the highest finding on the Medical Examination Records. Other problems that were high in the rank were: "Not getting enough sleep," "Being overweight," "Not very attractive physically," "Not eating the right food," and "Weak eyes." Of least concern was the incidence of colds.

The survey of the Social-Psychological problems showed that "Wanting a more pleasing personality" was highest, far exceeding every other problem of that entire problem category. One-third of the students were concerned with this particular problem. Two other

prominent problems were: "Wanting to be more popular" and "Worrying how I can impress people." Other problems of relative importance were: "Being timid or shy," "Lacking leadership ability," and "Feeling inferior."

The analysis of the Personal-Psychological Relations problems indicated that concern over "Forgetting things" and "Worrying" were most prominent. Less common concerns, but also suggestive of adolescent behavior, were: "Losing my temper," "Afraid of making mistakes," and "Daydreaming."

II. CONCLUSIONS

The Medical Examination Records

From the Medical Examination Records alone the inference could be made that the 358 students in the selected Seventh-day Adventist church-sponsored secondary school were a relatively healthy group with the exception of a small minority. This health picture of the students might be due to several factors: (1) the majority of the students in this study came from homes where the parents were assumed to be health conscious and where moderate income would provide necessities for health maintenance; (2) many parents are professional people (including the field of medicine) who could be expected to have a knowledge of health maintenance; (3) a large number of students had attended a church-sponsored elementary school in which healthful living was probably stressed; (4) these students were receiving continuous instruction by precept and example as they were currently enrolled in a health conscious educational institution.

The inference could also be made that since there was only one simple medical record with no subsequent entries of the student's

health, it could hardly be taken as valid evidence of the student's subsequent health status. Since a number of the students had been in this school from one to four years, it would seem that over this period of time there might have been a change in the health status of the students. Also the check marks and comments on the Medical Examination Records were rather brief, substantiating the comments of Nemir that the "private physician's medical examination report may be too sketchy to be helpful."[112] Although the result of the analysis of the data in the Medical Examination Records revealed a generally satisfactory picture of health, there were four major areas for needed follow-up: the skin eruptions, eye problems, hearing defects, and nose and throat troubles. Such problems are to a large extent preventable or correctable.

The Mooney Problem Check Lists

A careful consideration of the findings of the students subjective reactions on the three selected problem areas clearly indicated that they should receive more attention in health education.

Health and physical development. This problem category indicated that adolescents were concerned over their self image and any physical changes as perceived by them. The conclusion here has to do with the underlying factors that may cause the adolescent to live this way. These students appear to follow the existing pattern of other adolescents. For example, the girls' over concern with a slim figure causes them to eat fewer calories without thought for good nutrition.

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[112]Nemir, Loc. cit.

One of the causes of insufficient sleep is an unbalanced work and study program. The students may have too many home chores, or too many social activities which may be encouraged by over ambitious parents. Thus, pressure to do things may cause the adolescent to allot shorter time for eating, sleeping, and exercising, especially when parents and the school may not place the proper emphasis on a balanced work-study-social life program. Physical fitness has received too little emphasis even in the Seventh-day Adventist schools.

Social-Personal relations. The data showed two major sources of adolescent concern--those of social acceptance and social status. This was indicated by the selection of statements as "Wanting a more pleasing personality," "Wanting to be popular," and "How I can impress people." Many times physique has to do with personality development. In other instances a lack of "know how" may account for the occurrence of this concern. These suggest a need for cultivation of social skills and greater self-confidence. The selection of statements such as "Being timid," and "Feeling inferior" are indicative of a low evaluation of self. Mental health needs seem to be inherent in many of these students' responses. One cannot look at the health of the adolescent comprehensively without some evaluation of mental health.

Personal-Psychological relations. Although the group studied would be considered to have a well-integrated personality, nevertheless, the results showed emotional concerns and limitations which could require counseling and direction. Among these were "Forgetting things," "Worrying," "Loses temper," "Afraid of making mistakes," and "Moodiness." Problems of the emotions, though they may appear trivial to adults, may

hamper the emotional stability of the adolescent. It is for this reason that students with the manifestations of emotional stress need help. Self-control, self-confidence and self-direction seem to be the particular areas of mental health needs among these adolescents. The mental and physical health needs found in the study group of students are common to other adolescents in secondary schools, and offer a rich field for instruction.

III. RECOMMENDATIONS

If there is to be a dynamic program of curriculum improvement in health education in the secondary school, the curriculum maker needs to be imbued with the spirit of exploration, experimentation and adventure in the area of health knowledge, attitudes and practices. This study seemed to indicate the following recommendations:

1. That the Medical Examination Records, and selected areas of the Mooney Problem Check Lists could well be used by the administrators and staff of secondary schools as a beginning assessment to discover mental, physical, social and emotional needs as a baseline for curriculum study in health.

2. That a part of an in-service education program for teachers might be a study of findings on students' health records.

3. That a study be made on the Seventh-day Adventist medical examination record form to seek a format that will discourage "sketchy reportings" by private physicians.

4. That efforts should be made to acquaint parents with findings on records that indicate a need for improved mental health.

5. That improvement should be made gradually in teaching; and

that items with the highest frequency should receive immediate attention.

For further study the following recommendations are offered:

1. Study might be made in the area of mental health; using students' health records to discover the degree of the mental health problems and the extent to which they receive attention in the secondary schools of the Seventh-day Adventist denomination.

2. Study may be given to the other categories of the Mooney Problem Check Lists, other than the three categories surveyed, with consideration to age, sex, grade level, and home and community backgrounds of Seventh-day Adventist students.

3. Study other available records such as the absentee records, dental examination records, teachers' observation, and other records that might be of assistance in discovering the needs of adolescents pertinent to improved health teaching.

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APPENDIX

Name of Student: ______________________________
(Last) (First)

LYNWOOD ACADEMY
11081 Harris Avenue
Lynwood, California

(Stamp name of academy.)

TO THE PRIVATE PHYSICIAN: In order that the student's program can be adjusted to his physical condition, and in order that sound health-counseling can be given him, it is necessary for the school to have a report of his health examination. This report will be held in confidence and used only for the protection and aid of the student in his education. Kindly record on this form the positive findings of your examination, and, especially, your recommendations to the school. Thank you.

MEDICAL EXAMINATION
OF ACADEMY STUDENT BY PRIVATE PHYSICIAN

Name ______________________ Age ______
Address ______________________

____
School ______________________ Grade ______
Date of examination ______________________

IMMUNIZATIONS AND TESTS

	(*Date*)		(*Date*)
Smallpox		Chest X-ray	
Diphtheria		Tuberculin Test	
Tetanus		Other (Specify)	
Polio			

1. Significant illnesses, accidents, operations, congenital defects, family history, etc.: ______________________

____

2. Significant factors in home situation: ______________________

____

3. Please indicate below, by a check (✓) in the column on the left, any positive findings on medical examination, or any handicapping disability, and describe fully in section on right.

	SKIN
	EYES
	EARS
	NOSE AND THROAT
	MOUTH
	GLANDS
	HEART
	LUNGS
	ABDOMEN
	HERNIA
	EXTREMITIES
	GENITO-URINARY
	NUTRITIONAL STATUS

Description:

Treatment advised:

Vision (if done) R ________ L ________
Hearing (if done) R ________ L ________

4. Specify medical recommendations to school for academic and activity program:
(Use other side of sheet for additional comments, if necessary.)

Examining Physician ______________________ Address ______________________

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1950
REVISION

MOONEY PROBLEM CHECK LIST

Ross L. Mooney
Bureau of Educational Research
Ohio State University

H **HIGH SCHOOL FORM**

Age...........Date of birth...Boy...........Girl...........

Your class, or the number
of your grade in school..

Name of school..

Name of the person to whom
you are to turn in this paper..

Your name or other identification,
if desired..

Date...

DIRECTIONS

This is not a test. It is a list of problems which are often troubling students of your age—problems of health, money, social life, home relations, religion, vocation, school work, and the like. Some of these problems are likely to be troubling you and some are not. As you read the list, pick out the problems which are troubling you. There are three steps in what you do.

First Step: Read through the list slowly, and when you come to a problem which suggests something which is troubling you, *underline* it. For example, if you are troubled by the fact that you are underweight, underline the first item like this, "1. Being underweight." Go through the whole list in this way, marking the problems which are troubling you.

Second Step: When you have completed the first step, look back over the problems you have underlined and pick out the ones which you feel are *troubling you most.* Show these problems *by making a circle* around the numbers in front of them. For example, if, as you look back over all the problems you have underlined you decide that "Being underweight" is one of those which troubles you most, then make a circle around the number in front of the item, like this, " (1.) Being underweight."

Third Step: When you have completed the second step, answer the summarizing questions on pages 5 and 6.

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The Psychological Corporation
304 East 45th Street, New York 17, N. Y.

50-125T
Printed in U.S.A.

First Step: Read the list slowly, and as you come to a problem which troubles you, underline it.

1. Being underweight
2. Being overweight
3. Not getting enough exercise
4. Getting sick too often
5. Tiring very easily

6. Needing to learn how to save money
7. Not knowing how to spend my money wisely
8. Having less money than my friends have
9. Having to ask parents for money
10. Having no regular allowance (or income)

11. Slow in getting acquainted with people
12. Awkward in meeting people
13. Being ill at ease at social affairs
14. Trouble in keeping a conversation going
15. Unsure of my social etiquette

16. Having dates
17. Awkward in making a date
18. Not mixing well with the opposite sex
19. Not being attractive to the opposite sex
20. Not being allowed to have dates

21. Getting into arguments
22. Hurting people's feelings
23. Being talked about
24. Being made fun of
25. Being "different"

26. Losing my temper
27. Taking some things too seriously
28. Being nervous
29. Getting excited too easily
30. Worrying

31. Not going to church often enough
32. Not living up to my ideal
33. Puzzled about the meaning of God
34. Doubting some of the religious things I'm told
35. Confused on some of my religious beliefs

36. Worried about a member of the family
37. Sickness in the family
38. Parents sacrificing too much for me
39. Parents not understanding me
40. Being treated like a child at home

41. Unable to enter desired vocation
42. Doubting the wisdom of my vocational choice
43. Needing to know my vocational abilities
44. Doubting I can get a job in my chosen vocation
45. Wanting advice on what to do after high school

46. Missing too many days of school
47. Being a grade behind in school
48. Adjusting to a new school
49. Taking the wrong subjects
50. Not spending enough time in study

51. Having no suitable place to study at home
52. Family not understanding what I have to do in school
53. Wanting subjects not offered by the school
54. Made to take subjects I don't like
55. Subjects not related to everyday life

56. Frequent headaches
57. Weak eyes
58. Often not hungry for my meals
59. Not eating the right food
60. Gradually losing weight

61. Too few nice clothes
62. Too little money for recreation
63. Family worried about money
64. Having to watch every penny I spend
65. Having to quit school to work

66. Not enough time for recreation
67. Not enjoying many things others enjoy
68. Too little chance to read what I like
69. Too little chance to get out and enjoy nature
70. Wanting more time to myself

71. No suitable places to go on dates
72. Not knowing how to entertain on a date
73. Too few dates
74. Afraid of close contact with the opposite sex
75. Embarrassed by talk about sex

76. Wanting a more pleasing personality
77. Not getting along well with other people
78. Worrying how I impress people
79. Too easily led by other people
80. Lacking leadership ability

81. Daydreaming
82. Being careless
83. Forgetting things
84. Being lazy
85. Not taking some things seriously enough

86. Parents making me go to church
87. Disliking church services
88. Doubting the value of worship and prayer
89. Wanting to feel close to God
90. Affected by racial or religious prejudice

91. Not living with my parents
92. Parents separated or divorced
93. Father or mother not living
94. Not having any fun with mother or dad
95. Feeling I don't really have a home

96. Needing to decide on an occupation
97. Needing to know more about occupations
98. Restless to get out of school and into a job
99. Can't see that school work is doing me any good
100. Want to be on my own

101. Not really interested in books
102. Unable to express myself well in words
103. Vocabulary too limited
104. Trouble with oral reports
105. Afraid to speak up in class discussions

106. Textbooks too hard to understand
107. Teachers too hard to understand
108. So often feel restless in classes
109. Too little freedom in classes
110. Not enough discussion in classes

111. Not as strong and healthy as I should be
112. Not getting enough outdoor air and sunshine
113. Not getting enough sleep
114. Frequent colds
115. Frequent sore throat

116. Wanting to earn some of my own money
117. Wanting to buy more of my own things
118. Needing money for education after high school
119. Needing to find a part-time job now
120. Needing a job during vacations

121. Nothing interesting to do in my spare time
122. Too little chance to go to shows
123. Too little chance to enjoy radio or television
124. Too little chance to pursue a hobby
125. Nothing interesting to do in vacation

126. Disappointed in a love affair
127. Girl friend
128. Boy friend
129. Deciding whether to go steady
130. Wondering if I'll find a suitable mate

131. Slow in making friends
132. Being timid or shy
133. Feelings too easily hurt
134. Getting embarrassed too easily
135. Feeling inferior

136. Moodiness, "having the blues"
137. Trouble making up my mind about things
138. Afraid of making mistakes
139. Too easily discouraged
140. Sometimes wishing I'd never been born

141. Wondering how to tell right from wrong
142. Confused on some moral questions
143. Parents old-fashioned in their ideas
144. Wanting to understand more about the Bible
145. Wondering what becomes of people when they die

146. Being criticized by my parents
147. Parents favoring a brother or sister
148. Mother
149. Father
150. Death in the family

151. Choosing best subjects to take next term
152. Choosing best subjects to prepare for college
153. Choosing best subjects to prepare for a job
154. Getting needed training for a given occupation
155. Wanting to learn a trade

156. Not getting studies done on time
157. Not liking school
158. Not interested in some subjects
159. Can't keep my mind on my studies
160. Don't know how to study effectively

161. Not enough good books in the library
162. Too much work required in some subjects
163. Not allowed to take some subjects I want
164. Not getting along with a teacher
165. School is too strict

166. Poor complexion or skin trouble
167. Poor posture
168. Too short
169. Too tall
170. Not very attractive physically

171. Living too far from school
172. Relatives living with us
173. Not having a room of my own
174. Having no place to entertain friends
175. Having no car in the family

176. Not being allowed to use the family car
177. Not allowed to go around with the people I like
178. So often not allowed to go out at night
179. In too few student activities
180. Too little social life

181. Being in love
182. Loving someone who doesn't love me
183. Deciding whether I'm in love
184. Deciding whether to become engaged
185. Needing advice about marriage

186. Being criticized by others
187. Being called "high-hat" or "stuck-up"
188. Being watched by other people
189. Being left out of things
190. Having feelings of extreme loneliness

191. Afraid to be left alone
192. Too easily moved to tears
193. Failing in so many things I try to do
194. Can't see the value of most things I do
195. Unhappy too much of the time

196. Can't forget some mistakes I've made
197. Bothered by ideas of heaven and hell
198. Afraid God is going to punish me
199. Troubled by the bad things other kids do
200. Being tempted to cheat in classes

201. Being an only child
202. Not getting along with a brother or sister
203. Parents making too many decisions for me
204. Parents not trusting me
205. Wanting more freedom at home

206. Deciding whether or not to go to college
207. Needing to know more about colleges
208. Needing to decide on a particular college
209. Afraid I won't be admitted to a college
210. Afraid I'll never be able to go to college

211. Trouble with mathematics
212. Weak in writing
213. Weak in spelling or grammar
214. Trouble in outlining or note taking
215. Trouble in organizing papers and reports

216. Classes too dull
217. Teachers lacking personality
218. Teachers lacking interest in students
219. Teachers not friendly to students
220. Not getting personal help from the teachers

221. Trouble with my hearing
222. Speech handicap (stuttering, etc.)
223. Allergies (hay fever, asthma, hives, etc.)
224. Glandular disorders (thyroid, lymph, etc.)
225. Menstrual or female disorders

226. Parents working too hard
227. Not having certain conveniences at home
228. Not liking the people in my neighborhood
229. Wanting to live in a different neighborhood
230. Ashamed of the home we live in

231. Wanting to learn how to dance
232. Wanting to learn how to entertain
233. Wanting to improve myself culturally
234. Wanting to improve my appearance
235. Too careless with my clothes and belongings

236. Going with someone my family won't accept
237. Afraid of losing the one I love
238. Breaking up a love affair
239. Wondering how far to go with the opposite sex
240. Wondering if I'll ever get married

241. Wanting to be more popular
242. Disliking someone
243. Being disliked by someone
244. Avoiding someone I don't like
245. Sometimes acting childish or immature

246. Being stubborn or obstinate
247. Tending to exaggerate too much
248. Having bad luck
249. Not having any fun
250. Lacking self-confidence

251. Sometimes lying without meaning to
252. Swearing, dirty stories
253. Having a certain bad habit
254. Being unable to break a bad habit
255. Lacking self-control

256. Clash of opinions between me and my parents
257. Talking back to my parents
258. Parents expecting too much of me
259. Wanting love and affection
260. Wishing I had a different family background

261. Lacking training for a job
262. Lacking work experience
263. Afraid of unemployment after graduation
264. Doubting ability to handle a good job
265. Don't know how to look for a job

266. Don't like to study
267. Poor memory
268. Slow in reading
269. Worrying about grades
270. Worrying about examinations

271. Teachers not considerate of students' feelings
272. Teachers not practicing what they preach
273. Too many poor teachers
274. Grades unfair as measures of ability
275. Unfair tests

276. Poor teeth
277. Nose or sinus trouble
278. Smoking
279. Trouble with my feet
280. Bothered by a physical handicap

281. Borrowing money
282. Working too much outside of school hours
283. Working for most of my own expenses
284. Getting low pay for my work
285. Disliking my present job

286. Too little chance to do what I want to do
287. Too little chance to get into sports
288. No good place for sports around home
289. Lacking skill in sports and games
290. Not using my leisure time well

291. Thinking too much about sex matters
292. Concerned over proper sex behavior
293. Finding it hard to control sex urges
294. Worried about sex diseases
295. Needing information about sex matters

296. Being too envious or jealous
297. Speaking or acting without thinking
298. Feeling that nobody understands me
299. Finding it hard to talk about my troubles
300. No one to tell my troubles to

301. Too many personal problems
302. Having memories of an unhappy childhood
303. Bothered by bad dreams
304. Sometimes bothered by thoughts of insanity
305. Thoughts of suicide

306. Sometimes not being as honest as I should be
307. Getting into trouble
308. Giving in to temptations
309. Having a troubled or guilty conscience
310. Being punished for something I didn't do

311. Friends not welcomed at home
312. Family quarrels
313. Unable to discuss certain problems at home
314. Wanting to leave home
315. Not telling parents everything

316. Not knowing what I really want
317. Needing to plan ahead for the future
318. Family opposing some of my plans
319. Afraid of the future
320. Concerned about military service

321. Getting low grades
322. Just can't get some subjects
323. Not smart enough
324. Afraid of failing in school work
325. Wanting to quit school

326. School activities poorly organized
327. Students not given enough responsibility
328. Not enough school spirit
329. Lunch hour too short
330. Poor assemblies

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TOTAL. . . .		

Second Step: Look back over the items you have underlined and circle the numbers in front of the problems which are troubling you most.

Third Step: Pages 5 and 6

Third Step: Answer the following four questions.

QUESTIONS

1. Do you feel that the items you have marked on the list give a well-rounded picture of your problems? ....Yes. ....No. Add anything further you may care to say to make the picture more complete.

2. How would you summarize your chief problems in your own words? Write a brief summary.

(Questions are continued on next page→)

3. Would you like to have more chances in school to write out, think about, and discuss matters of personal concern to you? ....Yes. ....No. Please explain how you feel on this question.

4. If you had the chance, would you like to talk to someone about some of the problems you have marked on the list? ....Yes. ....No. If so, do you have any particular person(s) in mind with whom you would like to talk? ....Yes. ....No.

LOMA LINDA UNIVERSITY

School of Graduate Studies

STUDENT RECORD DATA USEFUL IN SECONDARY

SCHOOL CURRICULUM IMPROVEMENT

FOR HEALTH EDUCATION

By

Feliza I. Mopera

An Abstract of a Thesis

in Partial Fulfillment of the Requirements

for the Degree Master of Science

in the Field of Nursing

June 1963

ABSTRACT

The purpose of this study was to find recorded data on students' records in a selected Seventh-day Adventist church-sponsored secondary school which could be of acceptable value in curriculum improvement in health education.

A survey method of research was chosen with the study of two available records which were: (1) the Medical Examination Records and (2) the Mooney Problem Check Lists. The Medical Examination Records were filled out by the students' private physicians on their first admission to the school; the Mooney Problem Check Lists were administered by the school on October 24, 1961. These students were from grades nine through twelve and included both sexes whose ages ranged from thirteen to eighteen. The data gathered from the records were tabulated, analyzed and interpreted.

The Medical Examination Records showed an apparently healthy adolescent student group with the exception of a small minority with possible remedial defects of the skin, vision, hearing, nose and throat. The three problem categories selected for study from the Mooney Problem Check Lists indicated varying degree of deviations in mental and emotional behavior patterns. The outstanding problem that was most disturbing in this student group was found in the area of Social-Psychological Relations, which was, "Wanting a more pleasing personality." The next highest problem of concern was indicated in the Personal-Psychological Problem category as evidenced by a high response in "Forgetting things." The problem of Health and Physical

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Development although not as disturbing as the other two problem categories was relatively high which was indicated by a prominent concern over "Poor complexion or skin trouble."

The analysis of this data has brought into focus some of the physical, mental and emotional health needs of adolescents. Based upon these findings, recommendations were suggested for improving the curriculum in health by: (1) the school administrator and staff using the data as a beginning assessment to discover physical and emotional needs which might serve as a baseline for a study in health; (2) studying the findings as a part of an in-service education program for teachers might lead to a fuller understanding of students' needs, problems and interests; (3) giving study to the medical record format to discourage sketchy reportings by private physicians; (4) acquainting parents with the findings on records that indicate needs for improving mental health; and (5) implementing a gradual improvement in health teaching in which the item of highest frequency might receive first attention.

Realizing that the school is in a strategic position to meet the health needs of the students, it is hoped that the findings of this survey will pave the way for further studies.

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