

# The Weight Of Our Children

## 2011 New Mexico Childhood Obesity Report



**HEALTHY KIDS**  
**NEW MEXICO**  
Building a Fit Future



SUSANA MARTINEZ, GOVERNOR

CATHERINE D. TORRES, M.D., CABINET SECRETARY

I am very pleased and proud to announce the latest New Mexico Department of Health (DOH) childhood obesity report, “The Weight of Our Children.” Through this report, policy makers have clear and scientific data on the extent of childhood obesity in New Mexico, better preparing us to tailor prevention programs more effectively.

To compile the report’s data, DOH randomly selected 28 schools from across New Mexico. We measured more than 3,600 kindergarten and third-grade students using a standard protocol at each school. The data was used to calculate a Body Mass Index (BMI) percentile. The BMI percentile includes height, weight, age and gender to calculate weight status. The University of New Mexico Prevention Research Center and the CDC collaborated with the Department of Health on the data analysis.

Unfortunately, the report tells us that we are facing a public health epidemic regarding children who fall into the overweight and obese categories. The report shows that 15 percent of kindergarten and 21.9 percent of third grade students were obese. We also found that obesity is occurring at very young ages among children, signifying that they are developing unhealthy eating habits earlier, which makes it more difficult for them to adopt a healthy lifestyle later.

The report heightens DOH’s dedication to the issue of childhood obesity, a main priority of the Department for the past four years and the incentive for creating Healthy Kids New Mexico. Included in the report are strategies developed by DOH for measures legislators, families and communities can take to help shape children’s healthy eating and physical activity behaviors.

DOH will continue this survey on an annual basis to continue to develop this much-needed information. We hope you will share our concern for this important issue and take a minute to read the attached BMI Surveillance Report. Thank you.

Be healthy,

Catherine Torres, M.D.  
Cabinet Secretary of Health



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# Acknowledgements

Healthy Kids New Mexico (HKNM) would like to thank many people for their significant contributions to this year's childhood obesity report.

First and foremost, thanks to all of the school nurses and health assistants who made it possible for HKNM to collect height and weight data on 3,658 kindergarten and third grade students across New Mexico. These dedicated school staff participated in trainings and worked with HKNM staff to schedule school visits, record student information and measure kindergarten and third grade students. Without their support, HKNM could not have compiled the data for this report.

Special thanks to Rebecca Trujillo, RN, MSN, Public Health Region 4 School Health Advocate. She initiated the idea of providing CEUs to school nurses who completed the BMI training workshops. She also provided guidance, support and help in completing the arduous CEU application process.

HKNM is deeply indebted to Vicky Howell, a skilled and pragmatic epidemiologist. She spent numerous hours of her own time analyzing the data as it was not part of her job responsibilities. Without her support, HKNM would still be analyzing the data. Thanks also go to epidemiologist Dan Green, who helped Dr. Howell in the development of the sampling and weighting protocols to ensure each area of the state was represented fairly.

This project was coordinated under the capable direction of Rita Condon, a HKNM health educator. Her indomitable spirit, perseverance and attention to detail were invaluable. She worked with school districts to strengthen their support for school BMI measurement, conducted training workshops, recruited schools, scheduled school visits and spent much of the fall collecting height and weight data across the state. HKNM is deeply grateful for all she did and continues to do.

Thanks also go to Yvonne Medina, a HKNM health educator. She too spent much of the fall collecting height and weight data. She also entered all the data into an Excel spreadsheet for data analysis.

Last, but not least, thanks to the University of New Mexico's Prevention Research Center staff for developing the height and weight data collection protocol and continuing to support our efforts and provide guidance.

January 2012  
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# Executive Summary

## Introduction

To better understand and combat the problem of childhood obesity, the New Mexico Department of Health established a childhood obesity surveillance system in 2010. It determines the prevalence of childhood obesity; identifies at-risk populations in order to better allocate prevention resources; increases public awareness to the extent of the problem; monitors trends over time; and evaluates efforts to reduce childhood obesity.

The Department's childhood surveillance system uses the Body Mass Index (BMI) percentile to measure the prevalence of childhood obesity. A BMI percentile measure is a reliable indicator of body fat for most children and the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) recommend the use of BMI percentile to monitor and screen for obesity in children beginning at age 2. The Department's surveillance system measures childhood obesity on a population level only. It does not use it as a screening tool to identify individuals with excess fat who may be at risk for health problems.

In the fall of 2011 BMI data was collected on 3,658 kindergarten and 3<sup>rd</sup> grade students in public elementary schools across the state. Using a standard data collection protocol, developed by UNM's Prevention Research Center, surveyors collected height and weight data on children in participating schools between mid-August and mid-November 2011. Results were weighted to provide state-level findings on the extent of childhood obesity in New Mexico and identify at-risk groups.

## Key Findings

- Consistent with last year's findings, the extent of childhood obesity in New Mexico is disturbing. In 2011, 15.0% of kindergarten and 21.9% of third grade students were obese (See Appendix A for 2010 and 2011 results). Students in the obese category weighed substantially more than their counterparts in the healthy weight category. For example, the average weight of third grade students in the healthy weight category was 60.4 pounds compared to obese third grade students' average weight of 101.5 pounds, with some weighing more than 140 pounds.
- Significant differences in the prevalence of obesity between kindergarten and third grade students continued for the second year and support the 2010 finding that obesity increases sharply during the elementary school years (See Figure 1). The massive weight gain at this early age contradicts the widely held assumption that obesity occurs at older ages. In fact, this early onset of obesity makes it increasingly difficult for a child to later return to a healthy weight.
- Significantly more American Indian children in New Mexico experience childhood obesity. One-in-three American Indian third grade students were obese in 2011 compared to one-in-five Hispanic and one-in-eight White, non-Hispanic third graders. Obesity only exacerbates the numerous health disparities already faced by American Indians.

# Introduction

Childhood obesity is a growing problem nationally and in New Mexico. What is particularly troubling is that obesity in New Mexico is occurring at very young ages, signifying that children are developing unhealthy eating and sedentary habits earlier, making it more difficult to adopt a healthy lifestyle later. Obese children are more likely to become obese adults and suffer from chronic diseases, such as heart disease, certain cancers and diabetes.<sup>1</sup>

## Health Consequences

Type 2 diabetes is no longer called adult-onset because of its alarming rates in our youth – a phenomenon that rarely existed a generation ago. In the 1980s, type 2 diabetes was virtually unknown in teens.<sup>2</sup>

Childhood obesity increases the risk of high cholesterol, hypertension and other precursors to cardiovascular disease. For example, the Bogalusa Heart Study found that 70% of obese children had at least one additional cardiovascular risk factor such as hypertension, high cholesterol, and abnormal glucose levels, and 30% had two or more.<sup>3</sup> In several recent studies, childhood obesity is associated with increases in non-alcoholic fatty liver disease in children, which can lead to liver scarring and cirrhosis.<sup>4</sup> Obese children also may be more vulnerable to weight-based bullying and social isolation, thereby resulting in a greater risk of low self-esteem, depression and suicide.

## Economic Burden

The economic burden of chronic diseases related to obesity is devastating in New Mexico's and the national economies. In the past 10 years, the cost associated with obesity has increased substantially. One study estimated that approximately 9% of all medical costs in 2008 were obesity-related and amounted to \$147 billion, compared with \$78.5 billion 10 years earlier.<sup>5</sup>

The financial burden of Type 2 diabetes alone is considerable in New Mexico. At an average annual cost of more than \$13,000 per case to treat diabetes and an estimated 121,170 New Mexicans with diagnosed diabetes,<sup>6</sup> the annual cost to New Mexico for diabetes treatment is well over the 2006 estimate of \$1.2 billion, which includes excess medical costs attributed to diabetes and lost productivity.<sup>7</sup>

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<sup>1</sup> Dietz, W. (1998). Health Consequences of Obesity in Youth. *Pediatrics*, 101(3) Suppl: 518-525.

<sup>2</sup> CDC Grand Rounds: Childhood Obesity in the United States. *Morbidity and Mortality Weekly Report*, January 21, 2011.

<sup>3</sup> Freedman, DS et al. (2007). Cardiovascular Risk Factors and Excess Adiposity among Overweight Children and Adolescents: The Bogalusa Heart Study. *J. Pediatrics*, 150:12-17.

<sup>4</sup> Nature Reviews – Gastroenterology and Hepatology, 2010.

<sup>5</sup> Finkelstein, E.A., Trogdon, J.G., Cohen, J.W., Dietz, W. Annual Medical Spending Attributable to Obesity: Payer- and service-specific Estimates. *Health Aff (Millwood)* 2009; 28:w822-31.

<sup>6</sup> Behavioral Risk Factor Surveillance System, 2009.

<sup>7</sup> American Diabetes Cost Calculator.

# Methods

## Sample Selection and Response Rate

A representative sample of New Mexico public elementary schools was selected based on 2010-2011 school enrollment data. Of the 35 selected schools, 28 or 80% agreed to participate. In participating schools, 88.2% of students, or 3,658 students participated.

## Data Collection

A standard measurement protocol was used to collect heights and weights of all kindergarten and third grade students in selected schools. Data collection occurred from mid-August through November 2011. A standardized data collection protocol and form, developed by UNM's Prevention Research Center, were used to collect the height and weight information throughout the state. The protocol included measuring each child's height and weight twice as well as making other quality control checks on a periodic basis. In addition, all participating schools received scales and stadiometers to reduce measurement error. HKNM staff and school nurses collected student height and weight data and were trained on the data collection protocol prior to data collection.

## Data Analysis

BMI percentile rather than a BMI score was used to determine students' weight status. Unlike adults, children are still growing physically. The BMI percentile includes not only height and weight, but age and gender to calculate weight status. All height, weight, age and gender data was entered into a tool developed by CDC to determine BMI percentile. Based on BMI percentiles, students were classified as underweight (<5<sup>th</sup> percentile), healthy weight (5<sup>th</sup> to less than the 85<sup>th</sup> percentile), overweight (85<sup>th</sup> to less than the 95<sup>th</sup> percentile), and obese (95<sup>th</sup> percentile and above).

The data were then analyzed by grade, gender and race/ethnicity using the statistical software SAS and weighted to represent the kindergarten and third grade public school populations in New Mexico. The weighting process involved the probability of selecting the school and a student-level non-response adjustment for each school.

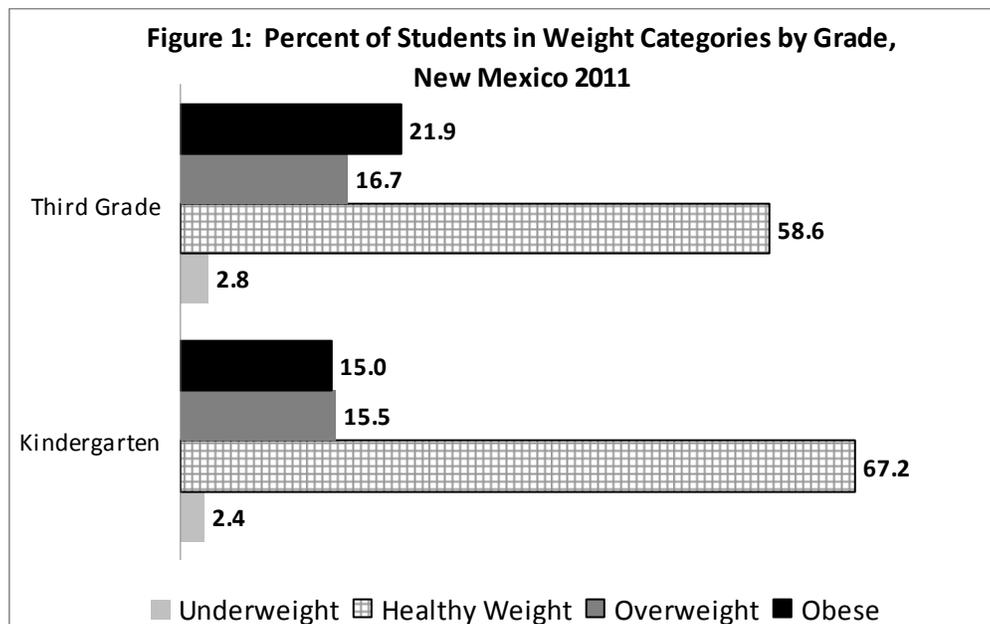
# Results

This report presents findings from the 2011 New Mexico Department of Health’s childhood obesity surveillance system. While the findings vary slightly from 2010, the differences are not statistically significant. It is too premature to know whether childhood obesity rates are leveling off. It will take several more years of data collection to look at trends over time. See Appendix A for complete 2011 and 2010 results.

## Extent of Childhood Obesity

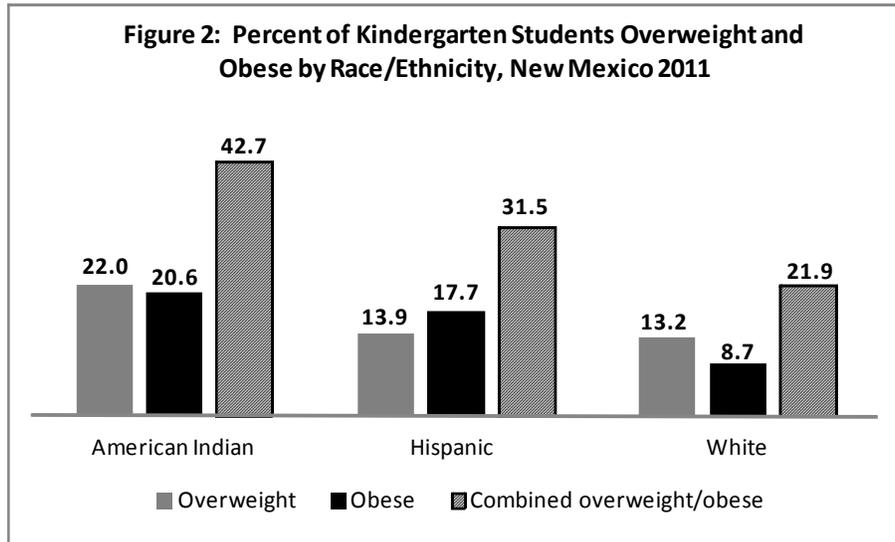
In the fall of 2011, 15.0% of kindergarten students were obese and, as in 2010, the prevalence of obesity increases sharply by third grade. In 2011, 21.9% of third grade students were obese. When adding overweight New Mexico students, the combined percentage of overweight and obese children is 38.6% for third graders and 30.5% for kindergarteners. By the third grade a greater proportion of children were obese than overweight. Less than 3% in either grade were classified as underweight. See Figure 1.

Students in the obese category weighed substantially more than their counterparts in the healthy weight category. The average weight for kindergarten students in the obese category was 62.6 pounds, with some students weighing more than 100 pounds. By contrast, the average weight for kindergarten students in the healthy weight category was 42.7pounds. Furthermore, the average weight for kindergarten students in the obese category was similar to that of third grade students (60.7 pounds) in the healthy weight category. Average weight for third grade students in the obese category was 101.5 pounds, with some children weighing over 140 pounds.

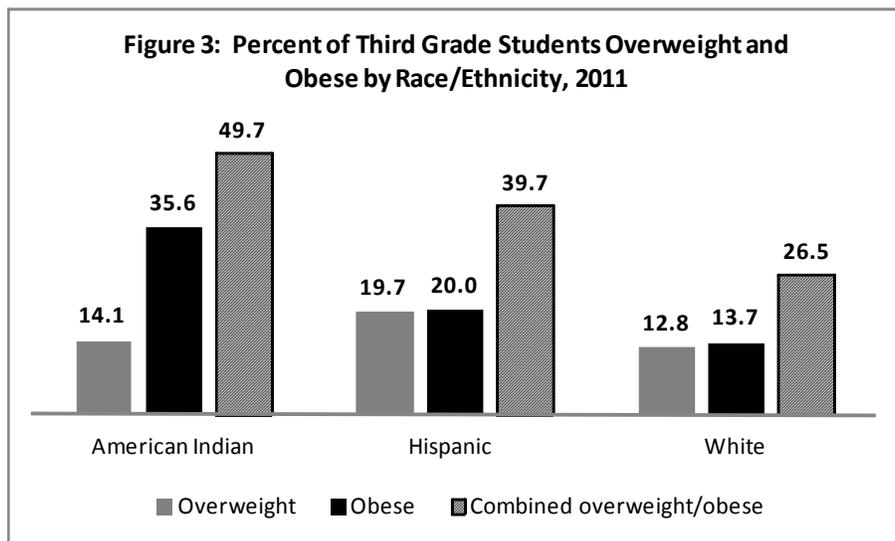


## Differences by Race and Ethnicity

American Indian children experience obesity more than other racial/ethnic groups. White non-Hispanic children experience obesity the least. In looking at disparities by grade, American Indian kindergarten students (20.6%) and Hispanic students (17.7%) were more than twice as likely as White non-Hispanic students (8.7%) to be obese. See Figure 2.

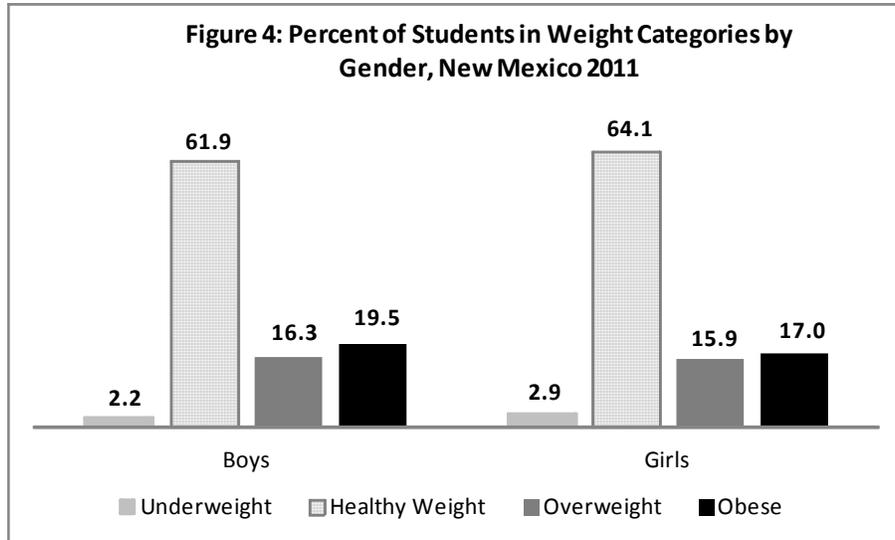


This disparity actually increased for third grade students. American Indian children were 2.5 times as likely as White non-Hispanic students to be obese and nearly twice as likely as Hispanic children. The differences between the groups were statistically significant for both the obesity and the combined overweight/obesity categories. By the third grade, more than 1-in-3 American Indian children were obese and nearly 1-in-2 was overweight or obese. See Figure 3.



## Differences by Gender

The percentages of boys and girls who were obese in 2011 were very similar to the findings in 2010, with 19.5% of boys and 17.0% of girls falling into this category, compared to the 2010 rates of 19.0 % and 16.8% respectively. Although girls were slightly more likely to be at a healthy weight and slightly less likely to be overweight or obese, the differences were not statistically significant.



## Conclusions

Consistent with last year's findings, the extent of childhood obesity in New Mexico is alarming. In 2011, one-in-five third grade students were obese. Even more disturbing are the racial and ethnic disparities. In 2011, one-in-three American Indian third grade students were obese and one-in-two were obese or overweight.

These findings are a call to action for families, schools, communities and the state to help children at younger ages develop healthy eating and active living behaviors and to create the environmental and policy changes to promote these behaviors. Healthy eating and active living are the two major lifestyle choices that can prevent obesity. Yet, like many Americans, New Mexican children and adolescents eat poorly and lead sedentary lives.

# Strategies for Change

Children do not live in isolation nor are they autonomous in decision-making. Children live in families, in neighborhoods and communities, going to and from school, and enjoying time with friends and family.

While children and their families make the final decisions, many of the social and environmental factors in which children and families live, learn, play and worship also influence choice. It is estimated that 40% of annual premature deaths could be prevented by altering environmental conditions, social inequities and behavioral choices.<sup>8</sup> Yet, over the last 30 years, these influences have changed dramatically making it far more difficult for children and families today to navigate a healthy diet and active lifestyle.

Children and families are now bombarded with advertising and the marketing of unhealthy food and beverages. In 2006, 44 companies spent \$1.6 billion on marketing food and beverages to children and adolescents, including \$492 million on carbonated sugar sweetened beverages alone.<sup>9</sup> Soft drinks are the largest contributor of caloric intake in the United States<sup>10</sup> and consumption has tripled from 1950 – 2008. Children now routinely purchase a 64 ounce container of soda to drink on their way home from school. Further, for every 2,000 New Mexicans there is a fast food restaurant and New Mexicans spend between \$500 and \$700 per year at these establishments.

In terms of physical activity, community planning often makes it difficult for people to walk or bike to and from commercial, residential and school areas due to large distances and unsafe pathways. The percentage of children walking or biking to school dropped from 66% in 1974 to 13% in 2000 nationwide.<sup>11</sup> Major reasons for this decline are parental safety concerns, poor lighting and infrastructure, and large distances between neighborhoods and schools. Increasingly, children and their families often find themselves locked out of schoolyards and have limited access to safe and active outdoor space. And, when children aren't in school they all too often sit indoors spending hours playing video games or watching television.

Genuine solutions to the challenging and complex problems of childhood obesity require the concerted efforts of families, schools, communities and state government. What follows are childhood obesity prevention strategies to create environmental and policies changes to support healthy eating and active living recommended by the Centers for Disease Prevention and Control, the Institute of Medicine and other health organizations.

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<sup>8</sup> McGinnis, J.M., P. Williams-Russi, and J.R. Knickerman. The Case for More Active Policy Attention to Health Promotion. *Health Affairs* 21.2 (2002): 78-93.

<sup>9</sup> Federal Trade Commission. Marketing food to children and adolescents. A review of industry expenditures, activities, and self-regulation. Federal Trade Commission, July 2008.

<sup>10</sup> NHANES (see CA state plan p.3 for reference).

<sup>11</sup> See CA p.4.

# What Families Can Do

**Families play an important role in shaping children's healthy eating and physical activity behaviors. Here are some ways families can instill healthy behaviors in their children.**

- \* Prepare and eat more meals together: Create routines and traditions that work best for your family, make mealtime a special time to eat and talk together.
- \* Boost your family's intake of fruits, veggies and whole grains: Keep washed, ready-to-eat produce within easy reach, try at least 3 bites of a new fruit, veggie or whole grain each time – it can take 7-10 tries before your family likes it.
- \* Downsize portions: Share a meal or take half home when eating out, use smaller plates and glasses for family meals.
- \* Be active for at least 60 minutes a day: Create family routines and traditions for active living, turn off the TV and play games together.
- \* Re-think your drink: Replace sugar sweetened beverages like sodas with water, 100% fruit juices, tea, and low fat milk.
- \* Limit eating out: Stock your fridge and pantry with staples to whip up a meal in 30 minutes or less, cook enough for a second meal.
- \* Get the facts: When you eat at a restaurant, ask for the nutritional information of menu items before you order, if unavailable go to [www.fastfoodnutrition.org](http://www.fastfoodnutrition.org).
- \* Tame the TV: make more family time without it, turn it off during meals and remove it from your child's room.
- \* Make sure family members get 8 to 9 hours of sleep.
- \* Take the 5.2.1.0 Challenge. Eat 5 fruits and vegetables every day. Limit TV watching and video game playing to 2 hours a day. Be active for at least 1 hour a day and eliminate sugary beverages from your diet.

# What Schools Can Do

**Here are some childhood obesity prevention strategies schools can incorporate.**

- \* Implement a strong school-wide wellness policy, including the establishment of a School Health Advisory Council.
- \* Support local and regional food purchases for school lunches.
- \* Encourage your school meals staff to work toward meeting USDA's Healthier US School Challenge which is open to all schools participating in the National School Lunch Program.
- \* Offer a different fruit and vegetable in school meals every day a week and offer a serving of whole grains at least 3 times a week.
- \* Offer only skim or low fat milk in school meals.
- \* Prohibit the use of food as a reward.
- \* Prohibit the use of restricting physical activity as a means of punishment.
- \* Partner with community members to establish and maintain school edible gardens.
- \* Make water readily available and allow students to bring water bottles to school.
- \* Implement safe walking and biking to school programs.
- \* Train teachers to incorporate movement in the classroom with academic benchmarks, such as the Take 10 curriculum.
- \* Offer at least 30 minutes of quality physical activity daily.
- \* Create safe, active and welcoming outdoor school space for community and staff use during non-school hours.
- \* Schedule recess before lunch.
- \* Establish a 5.2.1.0 Challenge, which supports the American Academy of Pediatrics recommendation to eat 5 or more fruits and vegetables a day; restrict TV and video games time to 2 hours a day; get at least 1 hour of physical activity a day; and eliminate sugary beverages.

# What Communities Can Do

**Local communities play an important role in creating and sustaining healthy environments and policies to support healthy eating and physical activity. Check out ways your community can address the problem of childhood obesity.**

- \* Create a community-wide childhood obesity prevention initiative to connect and build on a cross-section of community efforts to motivate children and youth to eat healthier and be more physically active.
- \* Establish a municipal Complete Street Policy to ensure that transportation planners and engineers consistently design and operate the entire roadway with all users in mind - including bicyclists, public transportation vehicles and riders, and pedestrians of all ages and abilities.
- \* Create an interconnected network of greenways, trails and parks to support active transportation and active recreation.
- \* Establish a joint-use agreement between the municipality and the school district to permit public access to school facilities, especially outdoor green or open space during non-school hours.
- \* Establish a Food Policy Council to examine the operation of the local food system and provide ideas and recommendations for improvement through public policy change.
- \* Support local farmers' markets to provide opportunities for farmers to sell their produce directly to consumers while providing consumers opportunities to buy locally grown produce directly from farmers.
- \* Support community edible gardens by providing free access to land to grow fresh fruits and vegetables as a way to encourage families and individuals to eat well and nurture a spirit of community.
- \* Establish a community-wide 5.2.1.0 Challenge which supports the American Academy of Pediatrics recommendation to eat 5 or more fruits and vegetables a day; restrict TV and video game time to 2 hours a day; get at least 1 hour of physical activity a day; and eliminate sugar sweetened beverages from your diet.

# What the State Is Doing

The New Mexico Interagency Council for the Prevention of Obesity was established in 2007 to build sustainable and collaborative healthy eating active living initiatives across more than 35 state programs in seven state departments to address the growing problem of obesity, especially childhood obesity. Chaired by the New Mexico Department of Health state government membership includes:

**Department of Health:** Women, Infants, and Children (WIC) program; WIC Farmers' Market Program; Diabetes Prevention and Control; Office of School and Adolescent Health; Office of Health Promotion and Community Health Improvement; Office of Nutrition and Physical Activity; Healthy Kids NM; Commodity Supplemental Food Program; and Fruits & Veggies: More Matters.

**Public Education Department:** National School Lunch & Breakfast programs; Special Milk; Summer Seamless School Feeding; Fresh Fruit & Vegetable Snack Program; Physical Education; School District Wellness Policies and Nutrition Competitive Foods Rule.

**Human Services Department:** Supplemental Nutrition Assistance Program (SNAP); SNAP Nutrition Education; Commodity Purchase for School Meals programs; Food Distribution Program on Indian Reservations; and Medicaid.

**Children, Youth and Families Department:** Child and Adult Care Food Program & Summer Food Service Program.

**Department of Agriculture:** Farmers' Markets; Farm to Table programs; and Taste the Tradition Program.

**Department of Transportation:** Safe Routes to School and walking school bus programs.

**Aging and Long Term Services:** Senior Congregate Meals; Healthy Aging Collaborative; Senior Olympics, and Farmers' Market Pilot Program.

Several other state coalitions and organizations are non-voting members of the Interagency Council. They are: Envision New Mexico; the New Mexico Food and Agriculture Policy Council; New Mexico Cooperative Extension; New Mexico Healthier Weight Council; New Mexico Health Alliance; and UNM Prevention Research Center.

## Demonstrated Success

The Interagency Council in collaboration with its state and local partners played a key role in the enactment of several important state policy changes over the last several years. In 2007, the state enacted Nutrition: Competitive Food Sales Rule, which eliminated vending machines in public elementary schools and limited their use in middle and high schools. Also in 2007, the state enacted the New Mexico School District Wellness Policy Rule requiring all school districts to

develop wellness policies to support healthy eating and physical activity in the school environment. In 2008 and 2009, \$8 million additional dollars were appropriated for physical education in elementary schools. In 2010 the Department of Health implemented its statewide childhood obesity surveillance system and the NM legislature passed a measure requiring a health education class credit in order to graduate from high school. Also in 2010, the NM Children, Youth and Family Department issued final regulations governing child care centers and homes that require a minimum of 60 minutes of physical activity a day, limiting juices to offering only 100% fruit and vegetable juice, and making water freely available. Current regulations also include limiting children to one hour a day of TV and other screen time activities. To help address health disparities, the NMDOH partnered with Indian Affairs Department to convene a two day meeting in June 2010 to bring together more than 80 tribal leaders and senior policy advisors to develop effective and culturally appropriate strategies to reduce obesity and Type 2 diabetes in New Mexico's 22 tribal communities. Recommendations included strengthening traditional agriculture; establishing tribal wellness policies; and creating built environments to support physical activity and healthy eating.

In September 2011, the New Mexico Department of Health was awarded a \$1.5 million Community Transformation grant from the Centers for Disease Control and Prevention (CDC) to primarily address childhood obesity. The funding is the first of what is expected to be a five year award totaling \$7.5 million. The funding will expand the department's Healthy Kids Las Cruces community model to 10 counties and 4 tribal communities in New Mexico. The targeted communities were selected based on population size, poverty status, racial and ethnic, diversity, geographic diversity, chronic disease burden, and readiness to implement prevention programs. The targeted counties are: McKinley, Cibola, Rio Arriba, Guadalupe, Curry, Chaves, Lea, Socorro, Luna, and Dona Ana. The targeted tribal communities are: San Ildefonso, Santa Clara, Zuni, and Mescalero Apache.

In 2009 Healthy Kids Las Cruces (HKLC) was named one of the top 10 models in the nation for helping to reduce childhood obesity from the HSC Foundation, which works to improve access to services for individuals who face social and health care barriers due to disability and chronic illness. In 2010 HKLC received the NM Public Health Association Achievement Award. In 2011 the Mayor of Las Cruces received the US Conference of Mayors Award for his obesity prevention Fitness and Nutrition 5.2.1.0 Student Challenge.

# Appendix A

Table 1: Percent of Students in Weight Categories by Grade, 2011

Weight Category	Kindergarten			Third Grade			Significant Difference
	Percent	**CI/Lower	CI/Upper	Percent	**CI/Lower	CI/Upper	
Underweight	2.4	1.7	3.1	2.8	1.8	3.7	No
Healthy Weight	67.2	64.8	69.5	58.6	56.1	61.1	Yes
Overweight	15.5	13.7	17.2	16.7	14.8	18.6	No
Obese	15.0	13.1	16.7	21.9	19.8	24.0	Yes
Combined Overweight/Obese	30.5	28.2	32.7	38.6	36.4	41.1	Yes
Number in Sample	1,885			1,768			

\*\*CI-Confidence Interval

Table 2: Percent of Kindergarten Students in Weight Categories by Race/Ethnicity\*, 2011

Weight Category	American Indian			Hispanic			White			Significant Difference
	Percent	**CI/Lower	CI/Upper	Percent	**CI/Lower	CI/Upper	Percent	**CI/Lower	CI/Upper	
Underweight	0.4	0.0	1.2	2.5	1.4	3.6	2.9	1.5	4.4	Yes
Healthy Weight	56.9	51.6	62.2	66.0	62.4	69.5	75.1	71.2	79.0	Yes
Overweight	22.0	17.6	26.5	13.9	11.4	16.4	13.2	10.3	16.2	Yes
Obese	20.6	16.3	33.1	17.6	14.7	20.6	8.7	6.1	11.3	Yes
Combined Overweight/Obese	42.7	37.4	47.9	31.5	28.0	35.0	21.9	18.2	25.7	Yes
Number in Sample	369			842			532			

\*Only those groups with sufficient sample size are included

\*\*CI-Confidence Interval

**Table 3: Percent of Third Grade Students in Weight Categories by Race/Ethnicity\*, 2011**

<b>Weight Category</b>	<b>American Indian</b>			<b>Hispanic</b>			<b>White</b>			<b>Significant Difference</b>
	Percent	**CI/ Lower	CI/ Upper	Percent	**CI/ Lower	CI/ Upper	Percent	**CI/ Lower	CI/ Upper	
Underweight	0.6	0.0	1.4	3.4	1.6	5.1	3.5	1.6	5.5	Yes
Healthy Weight	49.7	44.1	55.3	56.9	53.0	60.8	69.9	65.3	74.5	Yes
Overweight	14.1	10.3	17.9	19.7	16.6	22.8	12.8	9.5	16.1	No
Obese	35.6	30.2	40.9	20.0	17.0	23.1	13.7	10.2	17.2	Yes
Combined Overweight/ Obese	49.7	44.3	55.3	39.7	35.8	43.6	26.5	22.1	31.0	Yes
Number in Sample	342			802			460			

\*Only those groups with sufficient sample size are included

\*\*CI-Confidence Interval

**Table 4: Percent of Students in Weight Categories by Gender, 2011**

<b>Weight Category</b>	<b>Boys</b>			<b>Girls</b>			<b>Significant Difference</b>
	Percent	**CI/ Lower	CI/ Upper	Percent	**CI/ Lower	CI/ Upper	
Underweight	2.2	1.4	3.0	2.9	2.1	3.8	No
Healthy weight	61.9	59.5	64.4	64.1	61.7	66.6	No
Overweight	16.3	14.4	18.1	15.9	14.1	17.7	No
Obese	19.5	17.5	21.5	17.0	15.1	19.0	No
Combined Overweight/ Obese	35.8	33.4	38.2	32.9	30.5	35.3	No
Number in Sample	1,877			1,776			

\*\*CI-Confidence Interval

## Comparison with 2010

**Table 5: Percent of Students in Weight Categories by Grade and Year**

Weight Category	Kindergarten		Third Grade	
	2010	2011	2010	2011
Underweight	1.8	2.4	2.6	2.8
Healthy Weight	67.9	67.2	58.8	58.6
Overweight	17.1	15.5	16.1	16.7
Obese	13.2	15.0	22.6	21.9
Combined Overweight/Obese	30.3	30.5	38.7	38.6
Number in Sample	1,800	1,885	1,642	1,768

**Table 6: Percent of Kindergarten Students in Weight Categories by Race and Year**

Weight Category	American Indian		Hispanic		White	
	2010	2011	2010	2011	2010	2011
Underweight	0.0	0.4	2.3	2.5	1.9	2.9
Healthy Weight	59.0	56.9	65.9	66.0	73.3	75.1
Overweight	15.5	22.0	18.7	13.9	16.0	13.2
Obese	25.5	20.6	12.9	17.7	8.8	8.7
Combined Overweight/Obese	41.0	42.7	31.8	31.54	24.8	21.9
Number in Sample	232	369	927	842	466	532

**Table 7: Percent of Third Grade Students in Weight Categories by Race and Year**

Weight Category	American Indian		Hispanic		White	
	2010	2011	2010	2011	2010	2011
Underweight	0.9	0.6	2.3	3.4	4.3	3.5
Healthy Weight	43.8	49.7	58.3	56.9	64.0	69.9
Overweight	18.8	14.1	16.8	19.7	13.9	12.8
Obese	36.6	35.6	22.6	20.0	17.8	13.7
Combined Overweight/Obese	55.4	49.7	39.4	39.7	31.7	26.5
Number in Sample	194	342	983	802	369	460