**SCHOOL-BASED HEALTH CENTER EXPANSION**

**TOOL KIT**

**JANUARY 2018**



**INTRODUCTION**

Approximately 16 million children nationwide come from economically disadvantaged households and are at risk for a variety of negative outcomes including:

* Increased rates of health problems and mortality, and
* Increase risk of academic underachievement and school-drop-out.

School-based health centers (SBHCs) are recognized as an effective means of delivering physical health, behavioral health, and dental services that can significantly reduce barriers to health care for those living in poor communities. The barriers of cost, transportation, and hours of operation along with the lack of knowledge around how to manage one’s health and when to access health care are readily addressed through SBHCs. SBHCs not only increase access to healthcare, but also improve school attendance and academic achievement for these students.

The scope of services for these centers include but are not limited to:

* Diagnosis and treatment of acute and chronic illnesses and minor injuries
* Routine health and sports physicals
* Health Check (EPSDT) screenings/immunizations
* Vision, hearing and dental screenings
* Laboratory testing
* Mental Health Services (individual, group, and family counseling)
* Social Service support
* Health Education/Health Promotion
* Referrals to medical sub specialists and community agencies

In order to replicate this health care model, four basic elements are required:

* Recognized Community Need and Support
* Evidence of health and cost impact
* Sustainability and
* Fidelity to an exemplar model

Following an exemplar model (Whitefoord Elementary School-Based Health Center in Atlanta, Georgia) and under the direction of PARTNERS for Equity in Child and Adolescent Health of the Department of Pediatrics at Emory University, the Georgia SBHC Project was created to expand SBHCs in Georgia with 3 phases – 1) planning, 2) implementation, and 3) sustainability.

The purpose of this tool kit is twofold:

* Provide information on the process from planning to sustainability
* Provide templates for various documents needed during the process

Visit our website at [www.gasbha.org](http://www.gasbha.org) or contact Ruth Ellis at [relli01@emory.edu](mailto:relli01@emory.edu) for questions or additional information.

**PLANNING**

It is important that the community is informed about the basic tenets of SBHCs and the value they provide to the students, parents, faculty and the community at large. In 2010, PARTNERS for Equity in Child and Adolescent Health began awarding one-year planning grants (funded through the Zeist Foundation) to Georgia counties for local stakeholders to provide evidence of community need and support for local SBHCs. See **Appendix A** for the latest Request for Proposals. The purpose of the planning grants is to increase knowledge and public will around the development of SBHCs. Grantees were required to create a community advisory group consisting of stakeholders in child and adolescent health and education. Members included representatives from the school system, health care providers, community agencies, parents, local politicians and child advocates. Some communities invited local law enforcement in addition to matriarchs and patriarchs of the community to the discussion. In addition to forming the community advisory group, Grantees conducted the following activities:

* Producing a needs assessment to define the health and academic need of students (training provided by staff from the national School-Based Health Alliance),
* Defining strategies to address needs,
* Identifying specific school(s) for clinic services, and
* Developing a business plan for establishing the SBHC (training provided by the national School-Based Health Alliance).

See **Appendix B** for sample needs assessment tool including student, parent, teacher and community surveys.

At the end of the planning grant year it is expected that:

* The community will have a clearer understanding of the healthcare needs of the children and adolescents;
* A determination will be made that a school-based health center is or is not needed in their community;
* If the community decides to move forward with the development of a SBHC, they will have a clearer understanding of the costs associated with start-up and would be closer to choosing a school (based on the needs assessment) and a medical sponsor/provider (based on interest expressed by medical providers in their area during the planning phase). Possible medical providers could be private pediatricians, academic centers, hospital systems or Federally Qualified Health Centers (FQHCs).

**IMPLEMENTATION**

Budget planning and the procurement of start up funds are the first steps in implementation. In considering costs for a SBHC start-up, a sample budget was developed. See **Appendix C**. It is expected that space and utilities would be an in-kind donation from the local school system. The medical sponsor is expected to fund clinic staff (nurse practitioner or physician assistant and medical assistant), provide physician oversight (.1FTE) and administrative overhead to include billings and collections. The staff of the SBHC would be the employees of the medical sponsor.

Other elements include:

* **District and School engagement along with School Board approval**
  + Required creating a Memorandum of Understanding (MOU) with the School District that may require School Board approval (see **Appendix D** for sample MOU)
  + Involved legal review by the School District and the sponsoring medical organization
  + Required a champion within the School District to advocate on behalf of the SBHC
* **Identification of Space for SBHC, Renovation of Space, and Purchasing of major equipment and supplies**
  + It is ideal for renovation of space to be negotiated as a cost to the School District, however some FQHCs have taken on this responsibility through grants or internal budgets
  + See **Appendix E** for sample floor plans
  + See **Appendix F** for recommended equipment/supplies/furniture to outfit a 2 exam room center.
* **Hiring of Staff**
  + Requires, on average, 2-3 months to identify and on-board new staff
  + It is recommended that core staff include:
    - A provider (nurse practitioner or physician assistant);
    - A medical assistant to provide front office/back office support;
    - A Licensed Clinical Social Worker to provide behavioral health services (hired directly by medical sponsor or in collaboration with local mental health organization).
  + Staff to be added as funding is available could include:
    - A dentist and dental assistant/hygienist
    - A health educator
    - A nutritionist
* **For FQHC sponsoring organizations, obtaining a “Change of Scope” approval from the Health Resources and Services Administration (HRSA)**
  + Requires at least 3 months for approval from HRSA
* **Certifying the SBHC site with Medicaid and private insurers**
  + Establish as a satellite of the FQHC; requires a minimum of 30-60 days after the “Change of Scope” is approved.
* **Credentialing staff with Medicaid and private insurers**
  + Can take from 3 to 10 months.
* **Student Recruitment and Enrollment**
  + Market SBHC services and benefits to school, parents, and community. Ideally this marketing would have started during the Planning phase.
  + SBHCs should distribute parent consents for student enrollment in the SBHC along with other school documents (i.e., beginning of year school registration), at Parent Teacher Organization meetings, and at health fairs. See **Appendix G** for sample parental consent form.
  + Recruitment and enrollment should occur throughout the school year
* **Clinic Utilization**
  + Requires coordination and collaboration with school nurse and staff
  + Establish benchmarks for clinic services. See **Appendix H** for sample benchmarks.
  + Utilize a data template to capture patient utilization and health outcome. See **Appendix I** for sample utilization template.
* **Advisory Council Input**
  + Establish an advisory council for the SBHC to assure the quality and the alignment of the SBHC with school and community needs, and to provide guidance and feed-back to the SBHCs.
  + Advisory council members should consist of school administrators and nurse staff, SBHC staff, parents, community members (i.e., school board members, local politicians, and Emory PARTNERS staff if requested).

During the implementation phase, it is important to closely monitor clinic enrollment and utilization and impact on quality health measures. **See Appendix I**

**SUSTAINABILITY**

From historical data, most SBHCs required at least three years of extramural funding to become sustainable. It takes that amount of time to recruit and enroll a sufficient patient base that will utilize the services and for whom the SBHC can bill for services rendered. Sustainability depends not only upon patient utilization but also on insurance status and patient satisfaction which is a reflection of the patient’s perception of the quality of care he/she receives. Finally, sustainability involves strong business practices and community collaboration.

The School Based Health Alliance has developed a sustainability model (<http://www.sbh4all.org/resources/sbhc-sustainability>).

Sustainability plans should include the following key components:

* Developing strong partnerships between the school district, the medical sponsor, school administration and nursing staff, parents, and the community at large,
* Robust program marketing outreach and promotion to recruit a sufficient number of patients to utilize the services of the SBHC,
* Establishing quality benchmarks to promote healthy outcomes and patient satisfaction, and
* A strong business model to maximize billings and collections from Medicaid and private payers while insuring that all patients are seen regardless of their ability to pay.

Federally qualified health centers (FQHCs), due to their enhanced Medicaid reimbursements and access to federal funds, are good sponsors for SBHCs in terms of sustainability criteria. Their capacity to bill and receive ‘cost based’ (cost of care) reimbursements from Medicaid and Medicare gives them an advantage over private providers in that their payments can be twice as high. FQHCs are also required by federal guidelines to establish benchmarks for health outcomes and reporting. Establishing benchmarks contributes to the quality of services provided which affects sustainability.

**APPENDIX A**

**REQUEST FOR PROPOSALS**

**Comprehensive School-Based Health Center Program**

**Offered by PARTNERS for Equity in Child and Adolescent Health**

**Emory University School of Medicine, Department of Pediatrics**

[www.pediatrics.emory.edu/centers/PARTNERS](http://www.pediatrics.emory.edu/centers/PARTNERS)

[www.gasbha.org](http://www.gasbha.org)

**Background:** According to the 2016 KIDS COUNT Data Book, a study on the well-being of America's children, Georgia ranks 42nd in the nation in child well-being and 39th in education nationally. Georgia ranks in the bottom 10% in four categories: high-school dropouts; teens not attending school and not working; low birth weight babies; and children in single-parent families. In addition, over 189,000 of Georgia’s children are uninsured and as a result do not have a medical home and have very limited access to routine health care.

**Goals of the Comprehensive School-Based Health Center (SBHC) Program:**

* To increase access to quality health care (physical, behavioral, oral), improve the delivery of health services and improve the overall health of the children of Georgia.
* To improve the academic achievement of Georgia’s children through increased school attendance.
* To facilitate the expansion of school-based health centers throughout the state.
* To establish a state alliance for school-based health centers – Georgia School-Based Health Alliance (GASBHA).

Through the expansion of school-based health center services, children in Georgia will benefit from improved access to primary health care, improved health outcomes, and improved school attendance. The state will benefit from reduced costs to the Medicaid system through the reduction in inappropriate emergency room visits; hospitalizations for chronic illnesses

(i.e., asthma, diabetes, etc.); and transportation costs.

**Grant Purpose:** The purpose of this request for proposals is to stimulate planning and facilitate collaboration and community discussion to expand the number of school-based health centers in Georgia.

**Note:** PARTNERS for Equity in Child and Adolescent Health(PARTNERS)will provide technical assistance throughout the planning process as needed and requested.

**Award Amount: Up to $10,000.**

**Project Period: 12 months**

**Timetable:**

|  |  |
| --- | --- |
| April 10, 2017 | Publish, release, distribute RFP |
| April 24-26, 2017 | Potential grantees submit questions to PARTNERS for Equity in Child and Adolescent Health. Email questions to [relli01@emory.edu](mailto:relli01@emory.edu) |
| April 27, 2017  2:00pm – 3:00pm | Statewide telephone conference to review RFP and respond to questions  **Call-in # is 1-605-475-3220; access code 952430#** |
| June 9, 2017 | Proposal deadline  Submit proposals to PARTNERS for Equity in Child and Adolescent Health, Department of Pediatrics  Emory University  Deadline via e-mail is 5:00 pm  Via US mail, proposal must be postmarked no later thanJune 9, 2017 |
| July 3, 2017 | Award selection |
| July 17, 2017 | Award announcements |
| October 2, 2017 | Funds released |

**Successful proposals will demonstrate:**

1. How planning grant recipients will bring potential partners together in meetings, focus groups, planning teams, etc., to develop plans to improve the health of school students and their siblings. Potential partners should include, but are not limited to:
   * Local planning organizations, i.e., Georgia Family Connection Partnership collaboratives;
   * School systems, i.e., local school administrators (principals, teachers, etc.), school superintendents, school health personnel (nurses, social workers, counselors, etc.) and school boards;
   * Medical service providers and 3rd party payers, i.e., Community Health Centers, local hospitals/emergency departments, universities, private physician offices, Medicaid Managed Care Organizations, private insurers;
   * Medical and Training programs, i.e., academic centers;
   * Public Health Departments;
   * Behavioral and Mental Health Providers and organizations;
   * Community leaders;
   * Parents and PTA members;
   * Local businesses.

Proposals should provide letters of support from key planning partners. Partners should include but not be limited to the school superintendent; school board; local health department; community leaders; community medical providers; parents or PTA representative.

1. Strategic plans to engage and facilitate discussions with potential partners to develop and expand community support for the concept of comprehensive school-based health care. It is expected that successful grantees will provide the names and affiliations of advisory board members within two months of receiving grant funds. It is strongly recommended that parents of the school children you propose to serve be included as members of the advisory board.
2. Capacity for clinic development within the school:
   * Space allocation for **on-site** integrated primary care services
   * Potential providers
   * Potential funding grants or partners
3. Effective planning for resource development:
   * Capacity for grant writing
   * Facilitators
   * Data collection and analysis
4. The development of specific outcomes measures for use of grant funds.

**Budget:**

Grants will be approved for a 12-month planning period up to the amount of $10,000. The budget should include items for meeting facilitation, communications (i.e., postage, printing of flyers), community engagement activities, travel, office supplies, etc. Include in the budget the following expenditures:

* Membership in the School-Based Health Alliance. Visit their website at [www.sbh4all.org](http://www.sbh4all.org)

for information on this organization and their current organizational membership fee schedule.

* Three trips to Atlanta, Georgia during the grant year to attend vital grantee meetings/workshops (mileage and hotel, if applicable). Continental breakfast and lunch will be provided at each meeting.

**This is a planning grant. No funds are available for space renovation, furniture, medical equipment and supplies, and clinic operations.**

**Reporting:**

* At 3 months the grantee must submit a financial report of funds expended.
* At 6 months the grantee must submit a financial and progress report, to include a completed needs assessment.
* At the end of the 12-month planning cycle, the grantee must submit a completed project report and a financial report. The project report must reflect a summary of outcomes measures as documented in the grant proposal, i.e., number of partners/collaborators and collaborative meetings, grants written, and overall progress toward plan development, etc. It should also provide a draft business plan and a summary of strategies for ongoing SBHC development past the 12 month planning period.
* The PARTNERS staff will also conduct monthly telephone conferences with each grantee to receive updates and assess technical assistance needs. Participation in these monthly phone conferences is mandatory.
* An evaluator will be in contact with each grantee to collect data on partner engagement, community awareness and support, capacity building and plans for marketing, recruitment and resource development. Methods of data collection will include quarterly evaluation phone calls, community readiness interviews (at the beginning and the end of the grant year), and a survey of community partners at the end of the grant year.

**Contact and sources of additional information:**

For general information please contact Ruth Ellis @ 404-778-1402; e-mail: [relli01@emory.edu](mailto:relli01@emory.edu)

For questions on the RFP, join us April 27, 2017 for a conference call. See timetable above for call-in instructions.

Visit the Georgia School-Based Health Alliance website at [www.gasbha.org](http://www.gasbha.org) for information on activities in Georgia and various resources.

Please view a video on school-based health centers: <https://youtu.be/DJ0tB2DR23A>

**Submit proposals via US mail or Federal Express to**:

Ruth Ellis

Program Director

PARTNERS for Equity in Child and Adolescent Health, Department of Pediatrics

Emory University School of Medicine

49 Jesse Hill Jr. Dr. SE

Atlanta, GA 30303

**Submit proposals via e-mail to**: [relli01@emory.edu](mailto:relli01@emory.edu).

**REQUEST FOR PROPOSALS**

**Grant Application Required Attachments**

**Please include a full description of your proposal based on guidelines outlined above.**

* An introductory letter describing the purpose and amount of the request.
* The one page “Grant Application Form” with pertinent contact information (Pages 6-7)
* A narrative **(no more than three pages)**:
  1. Describe the applicant organization and its history.
  2. List and describe factors within the community that would support the development of a school based health center, i.e., number of uninsured, limited number of providers and clinics in the community, limited number of school nurses in district, etc.
  3. Describe how you will facilitate planning, collaboration, coordination, and communication for the development of a comprehensive school-based health center within your community.
  4. List and describe current and potential partners. Describe how you are currently working together and how you will recruit additional partners in the development of a school-based health center.
  5. Outcome measures.
* Provide job descriptions for personnel who will be supported by these funds, if applicable.
* Provide a project budget, budget narrative and timeline for the project. (Sample budget is found on Page 8).
* 501(c)(3) status or name of fiscal agent.
* Most recent audit report of fiscal agent.
* Names of Board of Directors.
* Letters of Support (at least three). One should be from the local school system administration.

PARTNERS for Equity in Child and Adolescent Health

Emory University School of Medicine

Department of Pediatrics

**Comprehensive School-Based Health Center Program**

Grant Application Form

|  |
| --- |
| Date of Application: |
| Organization Official Name: |
| Otherwise Known as (DBA): |
| Organization EIN#: |
| Name & Title of Person to Contact Regarding this Proposal: |
| Email Address: |
| Telephone Number: |
| Fax Number: |
| Address: |
| City: State: ZIP: |
| Amount Requested: |
| Total Project Budget: |
| Overall Organization Budget: |

Organization Mission Statement:

Please summarize your request (one to three sentences):

PARTNERS for Equity in Child and Adolescent Health

Emory University School of Medicine

Department of Pediatrics

**Comprehensive School-Based Health Center Program**

Sample Budget

**INCOME**

***Source***

Government Grants

Foundations

Emory University PARTNERS for Equity in Child and Adolescent Health

Corporations

Individual Contributions

Fundraising Events

In-Kind Support

**TOTAL INCOME**

**EXPENSES**

***Item (Describe each line item in the budget narrative)***

Consultants & Professional Fees (i.e., conveners; data gatherers/analysts)

Membership Fees

Travel

Supplies

Printing & Copying

Telephone & Fax Charges

Postage & Delivery

Community Engagement Expenses

Other (be specific)

**TOTAL EXPENSES**

**APPENDIX B: SAMPLE SURVEYS AND NEEDS ASSESSMENT**

SBHC - Student Survey

Dear Student,

The (Insert Name) School District is discussing the possibility of opening a School-Based Health Center to provide physical, dental, and mental health services for all students and their families.

We are in the process of conducting a needs assessment to determine the specific needs of students and their families.  In order to help us plan for the School-Based Health Center, we would like to ask you a few questions.  Your answers are completely confidential.

Thank you for your help.

Please Answer the Following Questions.

Page 1 - Question 1 - Choice - Multiple Answers (Bullets)

What physical health problems or needs have you had in the past year?  Select all that apply.

* Headaches
* Toothaches or dental problems
* Sore throat or strep throat
* Stomachaches
* Colds/fevers
* Skin problems or rashes
* Often being really tired
* Diarrhea or vomiting
* Earaches or ear infections
* Problems with eating or weight
* Injuries or accidents
* Other, please specify

Page 1 - Question 2 - Choice - Multiple Answers (Bullets)

Have you been told by a doctor that you have any of the following health problems?  Check all that apply.

* Asthma
* Diabetes
* Allergies
* Attention deficit or hyperactivity
* Seizures
* Life threatening allergies
* Other, please specify

Page 1 - Question 3 - Choice - Multiple Answers (Bullets)

Where do you regularly go for health care?  Check all that apply.

* Family doctor
* Do not have family doctor
* Clinic (Urgent Care, Priority Care)
* Emergency room
* Other, please specify

Page 1 - Question 4 - Choice - One Answer (Bullets)

When was the last time you had a thorough physical other than a sports physical?

* Within the last year
* More than a year ago

Page 1 - Question 5 - Yes or No

Do you see a dentist regularly (every six months)?

* Yes
* No

Page 1 - Question 6 - Choice - Multiple Answers (Bullets)

Do you have any of these health concerns?  Check all that apply.

* Grief
* Anxiety
* Stress
* Eating disorders
* Behavior issues
* Depression
* Weight problems
* Other, please specify

Page 1 - Question 7 - Choice - Multiple Answers (Bullets)

Select all reasons that have prevented you from getting medical, dental, or mental health services for yourself.

* Transportation
* Cost
* No insurance
* Do not have a regular doctor
* No one to take me
* Hours not good for me
* Hard to schedule an appointment
* Other, please specify

Thank You Page

**SAMPLE PARENT/GUARDIAN SURVEYS**

**PARENTS:**

Dear Parent/Guardian:

The **INSERT SCHOOL DISTRICT** and **INSERT LICENSED MEDICAL PROVIDER** are thinking about opening a School‐Based Health Center. Children attending **INSERT NAME OF SCHOOL(S) TO BE SERVED** would be eligible to receive services at the School‐Based Health Center. Services might include immunizations, physical exams, care of minor illnesses (earaches, sore throats, cuts and bruises) and related family support services. The cost of services would be based on a sliding‐fee scale, and no one would be refused service because of inability to pay.

To help us plan for the School‐Based Health Center, we would like to ask a few questions about the health needs of your child. This information will help us decide what types of services and programs to offer at the Center.

**Your answers are completely confidential.** You do not need to put your name anywhere on this form.

Thank you for your help.

**1. What physical health problems or needs has your child had in the past month? Check all that apply.**

\_\_\_ a. Headaches

\_\_\_ b. Toothaches or dental problems

\_\_\_ c. Sore throat or strep throat

\_\_\_ d. Stomachaches

\_\_\_ e. Colds/fever

\_\_\_ f. Skin problems or rashes

\_\_\_ g. Often feeling really tired

\_\_\_ h. Diarrhea or vomiting

\_\_\_ i. Earaches or ear infections

\_\_\_ j. Problems with eating or weight

\_\_\_ k. Injuries or accidents

\_\_\_ l. Bedwetting

**2. Have you been told by a doctor that your child has any of the following chronic health problems?**

\_\_\_ a. Asthma

\_\_\_ b. Attention deficit or hyperactivity

\_\_\_ c. Diabetes

\_\_\_ d. Seizures

\_\_\_ e. Allergies

\_\_\_ f. Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Where do you regularly take your child for health care? Check all that apply.**

\_\_\_ a. Family doctor or clinic

\_\_\_ b. Emergency room

\_\_\_ c. Regular source of health care

\_\_\_ d. Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Do you have a regular source of dental care for your child?**

\_\_\_Yes \_\_\_No

**5. Do you have someone you could go to for counseling services for behavioral problems? (e.g., unusual or**

**extreme fears, depression, nervousness)**

\_\_\_Yes \_\_\_No

**6. How do you currently pay for health services?**

\_\_\_ a. Private insurance or belong to an HMO

\_\_\_ b. Medicaid, Child Health Plan *Plus*, or social security

\_\_\_ c. Armed Services medical plans

\_\_\_ d. No insurance and generally pay out‐of‐pocket

\_\_\_ e. Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. If we opened a School‐Based Health Center, how likely would you be to take your child there for service?**

**Check one.**

\_\_\_ a. Would definitely use the Center

\_\_\_ b. Would probably not use the Center

\_\_\_ c. Would probably use the Center

\_\_\_ d. Would definitely not use the Center

**8. At what hours would you be most likely to use the clinic? Check all that apply.**

\_\_\_ a. Before school

\_\_\_ b. Evenings

\_\_\_ c. During school

\_\_\_ d. Saturdays

\_\_\_ e. Immediately after school

THANK YOU!

**PARENTS:**

Month, Year

Dear Parent,

XXX County Board of Education and XXX Clinic are discussing the possibility of opening a School-Based Health Center to provide physical, dental and mental health services for students at XXX School(s).

We are in the process of conducting a needs assessment to determine the specific health needs of students and their families. In order to help us plan for the School-Based Health Center, we would like to ask you a few questions. Your answers are completely confidential. You do not need to put your name anywhere on this form. Thank you for your help.

**Why School-Based Health Centers?**

**Access to Health Care For All Children**  
School-based health centers provide health care to all children who have parental permission, regardless of insurance coverage or ability to pay (**often at** **no cost or low cost**).

**Regular Preventive Care**  
When health care is far away, expensive, or difficult to access, children are less likely to receive regular preventive care. School-based health centers offer care where the children are -- in schools.

**Keeping Children in School**   
School-based health centers help keep children in school and ready to learn, treating acute and chronic health problems immediately and returning students to class as soon as possible.

**Strong Parent and School Support**   
When parents give permission for their child to be seen at a school-based health center, they know they will not have to miss work to care for minor problems, and that their child will receive prompt attention from health providers trained at working with youth. School administrators and teachers are extremely supportive of school-based health centers because health centers allow them to focus on their role of educating students who are healthy and ready to learn.

**Please Answer the Following Questions:**

1. What physical health problems or needs has your child had in the past year? Check all that apply.

|  |  |  |  |
| --- | --- | --- | --- |
|  | a. Headaches |  | b. Tooth aches or dental problems |
|  | c. Sore throat or strep throat |  | d. Stomach aches |
|  | e. Colds/fever |  | f. Skin problems or rashes |
|  | g. Often being really tired |  | h. Diarrhea or vomiting |
|  | i. Ear aches or ear infections |  | j. Problems with eating or weight |
|  | k. Injuries or accidents |  | l. Bedwetting |

1. Have you been told by a doctor that your child has any of the following chronic health problems?

|  |  |  |  |
| --- | --- | --- | --- |
|  | a. Asthma |  | b. Attention deficit or hyperactivity |
|  | c. Diabetes |  | d. Seizures |
|  | e. Allergies |  | f. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. Where do you regularly take your child for health care? Check all that apply.

|  |  |  |  |
| --- | --- | --- | --- |
|  | a. Family doctor or clinic |  | b. Emergency room |
|  | c. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

1. When was the last time your child had a thorough physical exam?

|  |  |  |  |
| --- | --- | --- | --- |
|  | a. Within the last year |  | b. More than a year ago |

1. Do you have a regular source of dental care for your child?

|  |  |  |  |
| --- | --- | --- | --- |
|  | a. Yes |  | b. No |

1. Do you have someone you could go to for counseling services for behavioral problems? (e.g., unusual or extreme fears, depression, nervousness)

|  |  |  |  |
| --- | --- | --- | --- |
|  | a. Yes |  | b. No |

1. How do you currently pay for health services?

|  |  |  |  |
| --- | --- | --- | --- |
|  | a. Private insurance or belong to an HMO |  | b. Medicaid or social security |
|  | c. No insurance generally pay out-of-pocket |  | d. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. If we opened a School-Based Health Center to provide health care to all children, how likely would you be to give permission for your child to use the services?

|  |  |  |  |
| --- | --- | --- | --- |
|  | a. Would definitely use the Center |  | b. Would probably not use the Center |
|  | c. Would probably use the Center |  | d. Would definitely not use the Center |

1. Have you had any problems getting Health Care, Mental Health Care or Dental Care for your child?

|  |  |  |  |
| --- | --- | --- | --- |
|  | a. Yes |  | b. No |

1. What are the reasons you have not been able to get these services for your child?

|  |  |  |  |
| --- | --- | --- | --- |
|  | a. Transportation |  | b. Health Insurance |
|  | c. Costs too much |  | d. Hours not good for me |
|  | e. Don’t have a regular doctor |  | f. Hard to get an appointment |
|  | g. Can’t take time off work |  | h. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. Does your child get depressed or stressed out?

|  |  |  |  |
| --- | --- | --- | --- |
|  | a. Yes |  | b. No |

1. Please check any child or adolescent health problems that concern you.

|  |  |  |  |
| --- | --- | --- | --- |
|  | a. Asthma |  | b. Weight |
|  | c. Dental Health |  | d. Mental Health |
|  | e. Smoking |  | f. Teen pregnancy |
|  | g. Behavior |  | h. Alcohol / drugs |
|  | i. Violence |  | j. Allergies |
|  | k. Vision |  | l. Lice |
|  | m. Sexually transmitted infections |  | n. Learning |
|  | o. Other |  |  |

1. If you would like to assist us in our efforts to acquire funding for a School-Based Health Center please write us a letter of support (hand written is fine) explaining why a school-based health center would be beneficial to you and your family and send it to school.

**Please return this form to school as soon as possible. THANK YOU!**

**SAMPLE TEACHER SURVEYS**

Dear Teacher and/or Staff Member:

*[Same basic introduction as on previous survey.]*

1. **On a scale of 1‐5 (1 being major, 5 being minor) rate each of the physical health**

**problems listed below for children in your classroom.**

a. Headaches \_\_\_\_

b. Sore throat or strep throat \_\_\_\_

c. Colds/fever \_\_\_\_\_\_

d. Often being really tired \_\_\_\_\_

e. Earaches or infections \_\_\_\_\_\_

f. Injuries or accidents \_\_\_\_\_\_\_

g. Toothaches or dental problems \_\_\_\_\_\_\_

h. Stomachaches \_\_\_\_\_\_\_\_

i. Skin problems or rashes \_\_\_\_\_\_\_

j. Diarrhea or vomiting \_\_\_\_\_\_\_

k. Problems with eating or weight \_\_\_\_\_\_

1. **We would like your perception on chronic health conditions. Please rate each of the problems listed below on a scale of 1‐5 (1 being major, 5 being minor) for children in your classroom.**

a. Asthma \_\_\_\_\_\_

b. Diabetes \_\_\_\_\_\_

c. Allergies \_\_\_\_\_\_

d. Behavior problems \_\_\_\_\_\_\_\_

e. Emotional problems \_\_\_\_\_\_\_\_

f. Seizures \_\_\_\_\_\_\_

g. Other:\_\_\_\_\_\_\_\_

1. **Please comment on anything you think we need to keep in mind as we plan for the School‐Based Health Center:**

Services\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prevention\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Month, Year

Dear Teacher / Staff,

XXX County Board of Education and XXX Clinic are discussing the possibility of opening a School-Based Health Center to provide physical, dental and mental health services for students at the XXX School(s).

We are in the process of conducting a needs assessment to determine the specific health needs of students and their families. In order to help us plan for the School-Based Health Center, we would like to ask you a few questions about what you see as the health needs of the children in your classroom. This information will help us decide where the greatest need is and what types of services and programs to offer at the center. Your answers are completely confidential. You do not need to put your name anywhere on this form. Thank you for your help.

**Why School-Based Health Centers?**

**Access to Health Care For All Children**  
School-based health centers provide health care to all children who have parental permission, regardless of insurance coverage or ability to pay (**often at** **no cost or low cost**).

**Regular Preventive Care**  
When health care is far away, expensive, or difficult to access, children are less likely to receive regular preventive care. School-based health centers offer care where the children are -- in schools.

**Keeping Children in School**   
School-based health centers help keep children in school and ready to learn, treating acute and chronic health problems immediately and returning students to class as soon as possible.

**Strong Parent and School Support**   
When parents give permission for their child to be seen at a school-based health center, they know they will not have to miss work to care for minor problems, and that their child will receive prompt attention from health providers trained at working with youth. School administrators and teachers are extremely supportive of school-based health centers because health centers allow them to focus on their role of educating students who are healthy and ready to learn.

1. Please rate each of the physical health problems listed below as major, moderate, or minor problem for children in your class room.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Major | Moderate | Minor |
| a. | Headaches |  |  |  |
| b. | Sore throat or strep throat |  |  |  |
| c. | Colds/fever |  |  |  |
| d. | Often being really tired |  |  |  |
| e. | Ear aches or infections |  |  |  |
| f. | Injuries or accidents |  |  |  |
| g. | Tooth aches or dental problems |  |  |  |
| h. | Stomach aches |  |  |  |
| i. | Skin problems or rashes |  |  |  |
| j. | Diarrhea or vomiting |  |  |  |
| k. | Problems with eating or weight |  |  |  |

1. We would like your perception on chronic health conditions. Please rate each of the problems listed below as a major, moderate, or minor problem for children in your classroom.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Major | Moderate | Minor |
| a. | Asthma |  |  |  |
| b. | Diabetes |  |  |  |
| c. | Allergies |  |  |  |
| d. | Behavioral Problems |  |  |  |
| e. | Emotional Problems |  |  |  |
| f. | Obesity |  |  |  |
| g. | Seizures |  |  |  |
| h. | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| i. | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

1. Please comment on anything you think we need to keep in mind as we plan for the School-Based Health Center:

|  |  |
| --- | --- |
| Services |  |
| Hours |  |
| Prevention |  |
| Other |  |
| Other |  |

Please return this to your principal as soon as possible. THANK YOU!

**Community Leader Opinion Survey**

Description of Respondent

Respondent's name

Record the following information for each respondent without input from the respondent if possible. To ensure confidentiality, separate this page from the rest of the survey before returning both to the survey coordinator.

1. Sex: \_\_\_Male \_\_\_Female

2. Race: \_\_\_White \_\_\_Hispanic \_\_\_Black

\_\_\_Asian or Pacific Islander \_\_\_American Indian or Alaska Native

\_\_\_Other

3. Age: \_\_\_<18 \_\_\_18‑24 \_\_\_25‑44 \_\_\_45‑64 \_\_\_65+

4. Affiliation that resulted in respondent being selected:

\_\_\_A. Business person

\_\_\_B. Citizen activist

\_\_\_C. City/ county official

\_\_\_D. Civic association member

\_\_\_E. Community outreach worker

\_\_\_F. Health professional

\_\_\_G. Law enforcement person

\_\_\_H. Leader of faith organization

\_\_\_I. Local celebrity

\_\_\_J. Media/news person

\_\_\_K. Neighborhood formal/ informal leader

\_\_\_L. School board member/ administrator/ teacher

\_\_\_M. Social services provider

\_\_\_N. Voluntary health agency

\_\_\_0. Youth peer leader

\_\_\_P. Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Member of community: \_\_\_<3 \_\_\_3‑9 \_\_\_10 + years

6. Geographic area: \_\_\_urban \_\_\_rural

Neighborhood:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Community Leader Opinion Survey**

1. What do you think the main health problems are in our community?

2. What do you think are the causes of these health problems?

3. How can these problems be reduced or eliminated in our community?

4. Which of these problems do you consider to be the most important one in our community?

5. Can you suggest three other people with whom I might talk about the health problems in our community?

Thank you very much for your help. I do not have any more questions right now, but I may contact you in the future if other issues come up.

**Community Leader Opinion Survey Data**

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Data collection method Number of interviewers | | | |
|  | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date collected  Total number interviewed From: \_\_\_\_ to: \_\_\_\_\_ | | | |
|  |  | # identifying as | % identifying as |
| Rank | Health Problem | problem | problem |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |
| 6 |  |  |  |
| 7 |  |  |  |
| 8 |  |  |  |
| 9 |  |  |  |
| 10 |  |  |  |
| Source: | | | |

**Sample Data Based Needs Assessment**

There are several types of needs assessment strategies. One of the most basic is collecting existing statistics. Once this data is collected, move on to other types of needs assessment strategies that involve community members, such as surveys or focus groups.

\_\_\_\_\_\_\_\_ High School serves the suburban and/or rural areas of \_\_\_\_\_ County. The demographics of the students are:

Hispanic \_\_\_\_, Anglo \_\_\_\_, African American \_\_\_, Native American \_\_\_\_, and Asian \_\_\_\_. (Source: \_\_\_\_\_\_\_\_\_\_\_High School)

**Income and Employment**

The volume of enrolled students for the school year 200XX‐20XX is \_\_\_\_; \_\_\_\_percent of the students are eligible for free

and reduced lunch. (Source: \_\_\_\_\_\_\_\_\_\_High School)

In 20XX, \_\_\_percent of children under 19 lived in poverty in \_\_\_\_\_ County. (Colorado Children’s Campaign)

In 20XX, \_\_percent of the labor force in \_\_\_\_ County was unemployed. (Source: State Dept of Labor & Employment)

**Depression and Suicide**

In 20XX, \_\_ percent of \_\_\_\_\_ School students felt sad and hopeless every day for two weeks in the past year, and

\_\_percent made a suicide plan. (Source: State Youth Risk Behavior Survey ‐ YRBS)

In 20XX, \_\_\_percent of \_\_\_\_\_\_ School students surveyed attempted suicide in the past year, and \_\_\_percent suffered

injuries as a result. (Source: State YRBS)

**Physical Activity and Nutrition**

In 20XX, \_\_\_\_\_\_\_percent of \_\_\_\_\_\_ students surveyed did not do the minimum recommended moderate or vigorous physical activity. (Source: State YRBS)

In 20XX, \_\_\_\_ percent of \_\_\_\_\_ students surveyed were overweight, and \_\_\_\_\_percent were at risk of being overweight.

(Source: State YRBS)

**Risk Behavior**

In 20XX, \_\_percent of births were to teens 19 years and younger. (Source: State Dept of Public Health & Environment)

In 20XX, \_\_percent of the \_\_\_\_\_\_\_\_ students surveyed had their first sexual experience at age 12 or younger. (Source: State YRBS)

The dropout rate (and/or retention, suspension, expulsion rates) for the \_\_\_\_\_\_\_\_ School District in 20XX‐20XX was \_\_percent compared to the state rate of \_\_percent. (Source: State Department of Education)

**Substance Abuse**

In 20XX, \_\_ percent of students surveyed had smoked a cigarette, and \_\_percent were current smokers.

In 20XX, \_\_percent of \_\_\_\_\_students surveyed had consumed alcohol, and \_\_\_percent were current drinkers.

In 20XX, \_\_\_\_\_ percent of \_\_\_\_\_\_\_students surveyed were current users of marijuana.

(Source for all: State YRBS)

**Violence and Crime**

In 20XX, \_\_\_percent of students surveyed had been in a physical fight in the past 12 months, and \_\_\_\_\_percent of the males had carried a weapon at school in the previous 30 days. (Source: State YRBS)

**Sample School and Community Needs Assessment**

Describing the Student Population of the School.

1 . Grades the school(s) include:

2. Total school(s) population:

3. Number of students in each age group that is served:

Pre‑kindergarten (≤ 4 yrs)\_\_ Ages 8‑10\_\_\_

Ages 5‑7\_\_\_ Ages ≥11\_\_\_

4. Description of the school community (urban, suburban, rural, mixed):

5. Racial composition of the student body (percentage):

White \_\_\_\_

Hispanic\_\_\_\_

African American\_\_\_\_\_

Asian/Pacific Islander\_\_\_\_\_

American Indian/Alaskan Native\_\_\_\_\_

Other\_\_\_\_\_

Unknown\_\_\_\_\_

6. Languages spoken by students:

- percentage that do not speak English:\_\_\_\_\_

- percentage speaking English as a second language:\_\_\_\_\_

7. Socioeconomic status of students at your school(s):

‑average family income (or range of incomes): \_\_\_\_\_\_\_\_

‑percentage of student body eligible for the free‑lunch program: \_\_\_\_\_\_

‑percentage of parents/guardians currently unemployed\_\_\_\_\_\_\_\_

**Source: The Comprehensive School Health Manual, Massachusetts Department of Public Health**

**(Education Development Center, Newton, MA. 1993. Adapted with permission.)**

**Sample School Needs Assessment**

Which of the following are major health‑related problems or issues among students?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| RANK TOP  FIVE | PROBLEMS/ ISSUES | NO | YES | ESTIMATED  PREVALENCE | SERVICES/ SUPPORT FOR STUDENTS AVAILABLE IN YOUR SCHOOL (S) |
|  | absenteeism |  |  |  |  |
|  | nutrition/ eating disorders |  |  |  |  |
|  | sexually transmitted diseases |  |  |  |  |
|  | HIV/AIDS |  |  |  |  |
|  | pregnancy |  |  |  |  |
|  | chronic illness |  |  |  |  |
|  | children assisted by medical technology |  |  |  |  |
|  | unintentional injuries |  |  |  |  |
|  | depression |  |  |  |  |
|  | stress |  |  |  |  |
|  | suicide |  |  |  |  |
|  | relationships with family and friends |  |  |  |  |
|  | sexual identity issues |  |  |  |  |
| RANK TOP  FIVE | PROBLEMS/ ISSUES | NO | YES | ESTIMATED  PREVALENCE | SERVICES/ SUPPORT FOR STUDENTS AVAILABLE IN YOUR SCHOOL (S) |
|  | alcohol and other drug abuse |  |  |  |  |
|  | sexual assault/ rape |  |  |  |  |
|  | acquaintance violence |  |  |  |  |
|  | family violence and abuse |  |  |  |  |
|  | school dropout |  |  |  |  |
|  | parental substance abuse |  |  |  |  |
|  | runaway |  |  |  |  |
|  | lack of regular physical activity |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

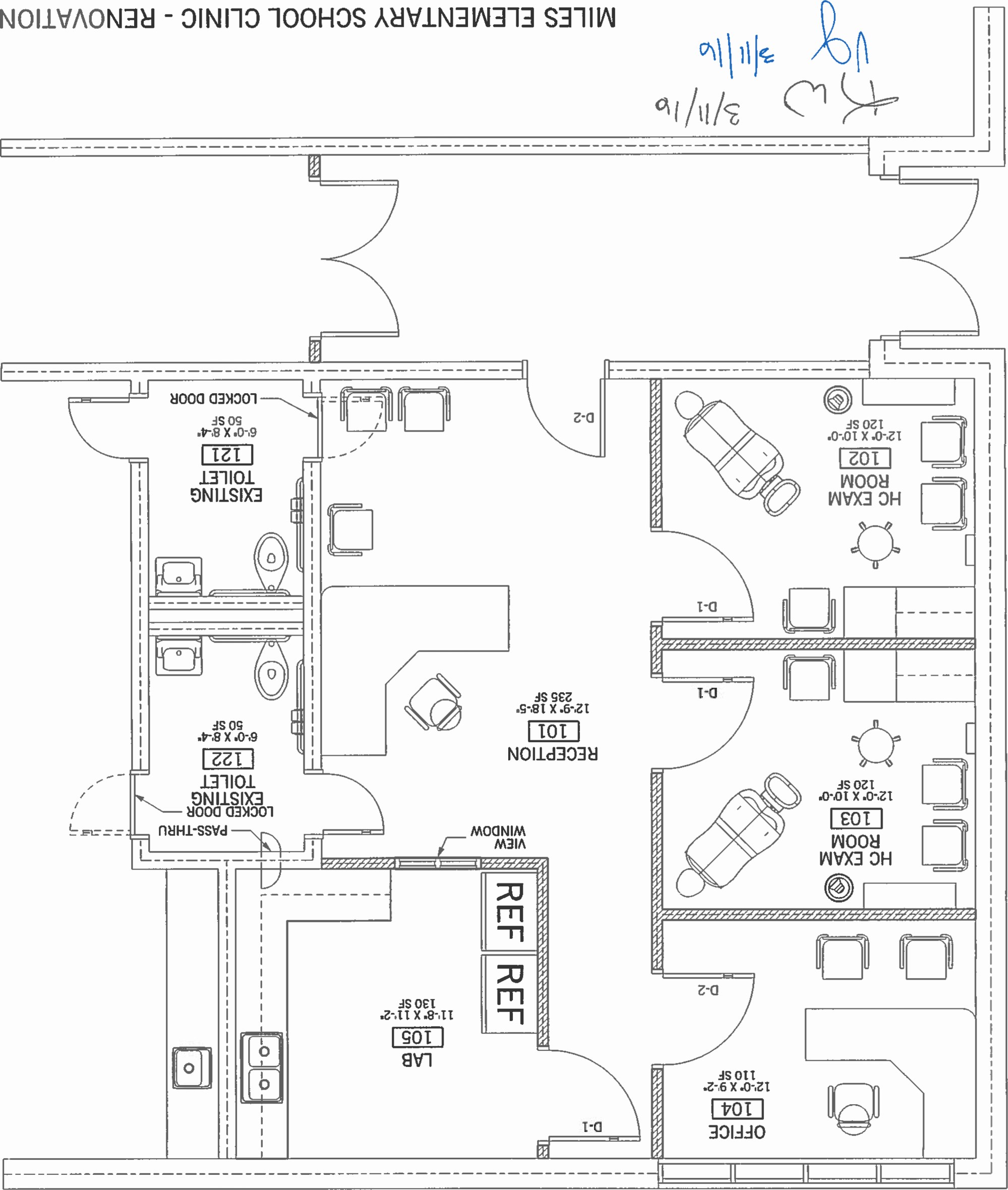
**Source: The Comprehensive School Health Manual, Massachusetts Department of Public Health (Education Development Center, Newton, MA. 1993. Adapted with permission.)**

**APPENDIX C: SAMPLE START-UP BUDGET** 

**APPENDIX D: SAMPLE MEMORANDUM OF UNDERSTANDING**



**APPENDIX E: SAMPLE FLOOR PLAN**



**APPENDIX F: EQUIPMENT LIST**





**APPENDIX G: SAMPLE PARENTAL CONSENT FORM**

**CONSENT FORM**

**In order for your child to receive services with [Insert Medical Sponsor] at [Insert School Name], this consent form must be completed and proper documentation of insurance obtained. Please complete all sides of this consent form. Please initial the area for acknowledgment of receiving the clinics’ Notice of Privacy Policies.**

**I hereby voluntarily give my consent for \_\_\_\_\_\_ to receive the health,**

**Name of Child**

**services with [Insert Medical Sponsor] at [Insert School Name]. I further authorize any physician or physician-designated health professional working for the clinic to provide such medical tests, procedures, and treatments as are reasonably necessary or advisable for the medical evaluation and management of my child’s health care.**

I understand that my signing this consent allows the physician and professional clinic staff of [Insert Medical Sponsor] at [Insert School Name] to provide comprehensive health services which includes physical, behavioral and dental health services. I authorize periodic dental examinations for my child, which may include photographs, radiographs, and any other acceptable methods for the dental evaluation and management of my child’s dental health.

I authorize release of information from my son or daughter’s medical record to the family doctor or primary care provider designated by me whenever necessary for his or her care including referrals and/or emergency services. I also authorize the Clinic to release information regarding treatment to third party payers such as Medicaid or other insurers for the purposes of billing or for any other reason in accordance with acceptable medical practice pursuant to the law. Medicaid and other insurers will be billed for services rendered. Charges for services rendered to students not insured will be based on a sliding fee scale**. No patients will be denied services because of inability to pay.**

Finally, I give consent to share my child’s health information between the school nurse and the school based health center in order to obtain information needed to provide the best healthcare possible.

I have read and understand the above information and give permission for my child’s care as described. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the clinic at **[Insert Phone Number]**. I also understand that I have the right to withdraw this consent at any time upon written notice to the clinic director.

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ **Name of Patient Date of Birth Date**

**(PLEASE PRINT)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent or Legal Guardian** **Parent or Legal Guardian** **Date**

**(PLEASE PRINT) (PLEASE SIGN)**

Please complete all information on this permission form. You must **COMPLETE USING INK** then sign and date it in order for your child to receive services from the Health Clinic. It is your responsibility to notify us immediately of any changes in address, phone numbers or insurance.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_\_\_\_\_\_ Race\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Remedial/Special Education Yes No

Marital Status: Married Single Widowed Divorced Separated Unknown

Consent to receive texts? Yes or no Consent to access the Patient Portal? Yes or No Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apt.#\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long at present address? \_\_\_\_Years \_\_\_\_Months How long at previous address? \_\_\_\_\_\_Years \_\_\_\_\_\_Months

Is present housing: \_\_\_\_Permanent\_\_\_ Temporary \_\_\_\_\_\_\_ Shelter \_\_\_\_\_\_ Institution \_\_\_\_\_\_None \_\_\_\_Unstable \_\_\_\_Foster Care \_\_\_\_Other

Who lives with student: Please list everyone who lives in home including yourself:

**NAME RELATIONSHIP AGE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

Does anyone in the home smoke cigarettes or use tobacco products? Yes or No

Emergency Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

==========================================================================================================

**WHAT TYPE OF MEDICAL INSURANCE DO YOU CURRENTLY HAVE?**

Please provide proof of insurance or you may be held financially responsible for services rendered. Please list all insurance coverage the child is eligible for.

Name of Policy Holder/Guarantor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_No Insurance

**You may be eligible for free insurance. Would you be interested in someone contacting you regarding this “free” insurance? Yes or No**

**General History**

Does the patient have any allergies to medications, food and /or anything else?

List here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reactions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List Daily Medication Names and Dosages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Health Problems Under Treatment? \_\_\_ Yes \_\_\_No, if yes explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specify where treatment was received? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child seen a doctor in the last year?** \_\_\_\_\_Yes \_\_\_\_No

**If yes, how many time?** Circle: 1 time 2 times 3 times 4 or more times

Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child used a Hospital Emergency Room in the last year**? \_\_\_\_Yes \_\_\_\_No

**If yes, how many times**? Circle: 1 time 2 times 3 times 4 or more times

Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Was your child in the hospital overnight in the last year**? \_\_\_\_Yes \_\_\_\_No

Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How Long\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Where do you take your child for Primary care/Routine care and Acute care/Emergency/Sick visits? In the columns below check the ones that apply and fill in names, addresses and phone numbers.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **PRIVATE DOCTOR OR CLINIC** | **HOSPITAL OUTPATIENT CLINIC** | **NAME / ADDRESS/**  **PHONE NUMBER** |
| **PRIMARY CARE/ROUTINE CARE** |  |  |  |
| **ACUTE CARE EMERGENCY SICK VISITS** |  |  |  |

**Family History**

Please specify who has or had any disease listed below by using abbreviations below.

(Mother-M, Father-F, Brother-B, Sister-S, Grandmother-GM, Grandfather-GF, Aunt-A, Uncle-U)

**WHO WHO**

Asthma \_\_\_\_\_ Heart Trouble \_\_\_\_\_\_

Allergies \_\_\_\_\_ High Blood Pressure \_\_\_\_\_\_

Birth Defects \_\_\_\_\_ Kidney/Bladder Problems \_\_\_\_\_\_

Blood Disorders/Anemia \_\_\_\_\_ Lung Diseases \_\_\_\_\_\_

Cancer \_\_\_\_\_ Tuberculosis \_\_\_\_\_\_

Tumors \_\_\_\_\_ Seizures \_\_\_\_\_\_

Cystic Fibrosis \_\_\_\_\_ Mental Retardation/Illness \_\_\_\_\_\_

Diabetes (before 40) \_\_\_\_\_ Muscle Disease/Weakness \_\_\_\_\_\_

Early Childhood Death \_\_\_\_\_ Death Under Age 50 \_\_\_\_\_\_

Ear/Eye Disorders \_\_\_\_\_ There is no family history of the above

Diseases? \_\_\_\_\_\_\_

**CHILD’S MEDICAL HISTORY**

**ILLNESS HISTORY BEHAVIOR HEALTH (Cont’d)**

Allergies \_\_Yes \_\_No Nightmares \_\_Yes \_\_No

Allergic to drugs \_\_Yes \_\_No Bedwetting \_\_Yes \_\_No

Anemia \_\_Yes \_\_No Discipline Problems \_\_Yes \_\_No

Asthma \_\_Yes \_\_No Overactive/Hyperactive \_\_Yes \_\_No

Other Respiratory Problems \_\_Yes \_\_No Shy \_\_Yes \_\_No

Stomach Ulcers \_\_Yes \_\_No Sleeping Problems \_\_Yes \_\_No

Abdominal Pain \_\_Yes \_\_No Slow Development \_\_Yes \_\_No

Constipation/Diarrhea \_\_Yes \_\_No Learning Disability \_\_Yes \_\_No

Serious Digestive Problems \_\_Yes \_\_No Smoker \_\_Yes \_\_No

Chicken Pox Age\_\_\_\_ \_\_Yes \_\_No Alcohol \_\_Yes \_\_No

Ear Problem \_\_Yes \_\_No Inhalants \_\_Yes \_\_No

Ear Infections \_\_Yes \_\_No Other Drugs \_\_\_\_\_\_\_ \_\_Yes \_\_No

Hearing Aid \_\_Yes \_\_No Depression \_\_Yes \_\_No

Eye Problem \_\_Yes \_\_No Other Behavior Problems \_\_Yes \_\_No

Wears Glasses \_\_Yes \_\_No Other Mental Problems \_\_Yes \_\_No

Physical/Sexual Abuse \_\_Yes \_\_No Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Yea \_\_No

Fainting Spells/Knocked Out \_\_Yes \_\_No Explain any behavior or mental problems

Frequent Sore Throat \_\_Yes \_\_No noted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Headaches \_\_Yes \_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Murmur \_\_Yes \_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Problems \_\_Yes \_\_No **Please list any present concerns:**

High Blood Pressure \_\_Yes \_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid Problems \_\_Yes \_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_Yes \_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis \_\_Yes \_\_No \*\*\*Explain any illnesses marked yes:

Injuries (major) \_\_Yes \_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Musculoskeletal Problems \_\_Yes \_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Broken Bones \_\_Yes \_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problems Walking \_\_Yes \_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney/Urinary Tract Problems \_\_Yes \_\_No **DENTAL**

Frequent Colds \_\_Yes \_\_No Dental Problems \_\_Yes \_\_No

Lung Problems \_\_Yes \_\_No Pregnant \_\_Yes \_\_No

Meningitis \_\_Yes \_\_No AIDS/HIV \_\_Yes \_\_No

Menstruation Started Age\_\_\_\_\_\_ \_\_Yes \_\_No Rheumatic Fever \_\_Yes \_\_No

Menstrual Problems \_\_Yes \_\_No Hemophilia \_\_Yes \_\_No

Premature Birth Weight\_\_\_\_\_\_ \_\_Yes \_\_No Underweight \_\_Yes \_\_No

Obese \_\_Yes \_\_No When was your child’s last dental visit?

Skin Rashes \_\_Yes \_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serious Acne \_\_Yes \_\_No

Sickle Cell Disease \_\_Yes \_\_No How often are your child’s teeth brushed?

Sickle Cell Trait \_\_Yes \_\_No \_\_Occasionally \_\_Once a Day \_\_Twice \_\_Other

Other Blood Disorders \_\_Yes \_\_No

Seizures/Epilepsy \_\_Yes \_\_No Has your child had a toothache recently? \_Yes \_No

Speech Problem \_\_Yes \_\_No

Tuberculosis \_\_Yes \_\_No Has your child had any injury to the teeth or jaws? \_\_Yes \_\_No

Cancer \_\_Yes \_\_No

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Yes \_\_No Does your child have a finger or thumb sucking habit?

**BEHAVIOR HEALTH** Generallyspeaking, what has been your child’s experience

Eating Problems \_\_Yes \_\_No with a dentist? \_\_Good \_\_Bad \_\_Very Bad

Thumb Sucking \_\_Yes \_\_No \_\_No experience (the child’s first visit)

**Medical Information Release Form (HIPAA Release Form)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

**Release of Information**

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Child(ren)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Other relatives\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Information is not to be released to anyone.

**This Release of Information will remain in effect until terminated by me in writing.**

**Messages**

Please call

[ ] my home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] my work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] my cell number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] other number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The best day to reach me is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_between\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am/pm & \_\_\_\_\_\_\_\_\_\_\_\_\_am/pm

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

I understand the **[Insert Medical Sponsor] at [Insert School Name]** is permitted to disclose protected health information about my child for the purposes of payment, continued care or treatment, and healthcare operations. If my child’s protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS), drug or alcohol abuse and/or mental illness. I hereby give consent to the disclosure of this information by these clinics only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I also understand that I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

**I have received the [Insert Medical Sponsor] at [Insert School Name] School Health Clinics Notice of Privacy Practices.**

**(Please initial) (Date)**

**APPENDIX H: SBHC BENCHMARKS**

**Obesity**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **OBESITY GUIDELINES**  **Hard guidelines in bold, red font.** |  |  |  |  |
| STANDARD | OVERALL GOAL | BENCHMARK | FREQUENCY | COMMENTS |
| **Weight** | N/A |  | Each visit | Goal by each pt |
| **BMI** | Obtain BMI on all patients aged 2 yrs and above and ascertain risk factors for pts with BMIs > 85%ile. | 90% of patients | Each visit | Risk Factors : Parental obesity, Fam Hx, Abnormal labs, Lifestyle, BMI trajectory |
| **Blood Pressure** | < 90%ile for Ht | 75% of patients | Each visit | Use BP chart by age and sex |
| **AST, ALT**  Check if wt is:  >85% + 2 other risk factors  >95% all children | < 60 | 75 % of patients | Every 2 yrs in children 9+ yrs | If abnormal, repeat in 1 month. If result twice abnormal, consult Ped Hepatologist |
| **Lipid profile**  **All children if weight >85%** | TG < 130  HDL> 40  LDL<110  T CHOL < 170 | 75% of patients | Every 2 yrs in children 9+ yrs | If high levels (Total Cholesterol>200,LDL>130) Refer to Dietitian  If no improvement with diet/exercise refer to Ped Cardio or lipid expert |
| **Blood Sugar, (or Hgb A1C) if Weight**  **>85% + 2 other risk factors**  **>95 % all children** | <100 Blood Sugar  < 6 Hgb A1C | 75% of patients | Every 2 yrs in children 9+ yrs | If blood sugar >126 OR HbA1c >6, refer to Ped Endocrine |
| Set patient directed behavior goals for weight loss | All overweight and obese patients | 75% of patients | Every 3- 6 months | If no improvement refer to nutrition or more structured wt mgmt program. |
| Diet Education advice | All overweight and obese patients | 85% of patients | Each visit |  |
| Physical activity Education and advice | All overweight and obese patients | 85% of patients | Each visit |  |
| Screening for Obstructive Sleep Apnea, Cardiovascular, Psychiatric, Orthopedic, Endo | All overweight and obese patients | 85% of patients | Annually |  |

**Asthma**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ASTHMA GUIDELINES**  **Hard guidelines in bold, red font.** |  |  |  |  |
| STANDARD | GOAL | BENCHMARK | FREQUENCY | COMMENTS |
| Diagnosis | Use medical history and physical examination to determine that symptoms of recurrent episodes of airflow obstruction are present. | 90% compliance | As required by symptomology |  |
| **Asthma Severity** | >90% classification for all asthmatics at every visit | 90% compliance | Every 3- 6 months | Use severity chart and questionnaire |
| **Asthma Assessment** | Asthma assessed using NAEP guidelines | 90% compliance | Each visit | **In the past week, how often did you:**  Wheeze, cough at night, tire faster than others with exercise, use albuterol |
| Asthma Monitoring | -follow up care – 2 to 6 week intervals initially, then every 1 to 6 months depending on status | 90% compliance | At least twice a year |  |
| Asthma Control: ER visits/ hospitalizations/exacerbations | - no ER visits  -no hospitalizations | 75% compliance | Assessed annually |  |
| Peak Flow Monitoring | Stabilized peak flow b/w visits | 75% compliance | Q visit |  |
| **Asthma Action Plan** | 100% inclusion on charts of all patients diagnosed with asthma | 80 % compliance | Once by the third visit and when therapy changes |  |
| Patient Education | 100% documentation that patient education performed  -appropriate language and literacy level  -asthma triggers documented | 90% compliance | At least once and then as indicated on pt understanding |  |
| Patient directed Goals | 100% inclusion on charts of all patients diagnosed with asthma | 80% compliance | Q visit | Physician and patient design goals |
| **Asthma Pharmacologic Therapy** | 100% patients on controller meds with mod – severe asthma. | 90% compliance | Each visit |  |
| Specialist Referral (asthma clinic or pulmonologist) | Refer all severe persistent asthma or poorly controlled mod persistent | 90% compliance | As required | Poorly controlled patients can be tracked through care management (FYI) status |
| **annual influenza vaccine** | Offered to 100% patients | 90% compliance | annually |  |

**Health Maintenance**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **STANDARD** | **BENCHMARK** | **OVERALL GOAL** | **FREQUENCY** | **COMMENTS** |
| **Immunizations (2year olds)**  **4 DTP/DTaP**  **3 IPV**  **1 MMR**  **3 Hib**  **3 HepB**  **1VZV (Varicella)**  **4 Pneumococcal conjugate**  **2 HepA**  **2 or 3 RV (Rotavirus)**  **2 Flu**    **4-6yo**  All vaccines above and additional booster dose of :  DTAP  IPV  MMR  Varicella  **Flu: annually** | Increase vaccination by 10% each year for next 5 years | **95% of all 2 year olds are fully immunized** | **Per Immunization Guidelines published annually by Committee on Infectious Diseases** | Vaccines should be reviewed at each visit and  catch up doses administered as early as possible |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Immunizations (Adolescents)  Menactra: 1-2 doses ≥ 11 y  HPV: 3 doses ≥ 11 y  Tdap: Booster ≥ 11 y  **Flu: annually** | Increase vaccination by 10% each year for next 5 years | **80 % adolescents compliant with immunizations** | **Per Immunization Guidelines published annually by Committee on Infectious Diseases** | Vaccines should be reviewed at each visit and  catch up doses administered as early as possible |
| Measurements  Length/ Height & Weight  HC: birth to 24mos  Wt for length: birth to 18ms  BMI: ≥ 2y  BP: ≥ 3y | 90 % compliance | 100% compliance | Each Well Child Visit  (3-5d, by 1mo, 2m, 4m, 6m, 9m, 12m, 15m, 18m, 24m, 30m, 3y and annually thereafter) |  |
| Sensory Screening   1. Vision 2. Hearing | 80% compliance | 100% compliance | 1. 3-6y, 8y, 10, 12y, 15y, 18y 2. NB, 4-6y, 8y, 10y | Rescreen uncooperative children within  6 months. |
| Physical Exam | 95% compliance | 100% compliance | Each Well Child Visit  (3-5d, by 1mo, 2m, 4m, 6m, 9m, 12m, 15m, 18m, 24m, 30m, 3y and annually thereafter) | Patients should be undressed |
| Procedures   1. NBS 2. **Lead** 3. Hb 4. PPD 5. Dyslipidemia Screen 6. STI Screen 7. Cervical  Dysplasia  Screen | Perform tests at suggested intervals with 80% compliance | 100% compliance | 1. 24-48 HOL 2. **12ms, 24ms** 3. 12ms, 24ms 4. ≥ 12ms 5. 24m, 4y, 6y, 8y, 10y and then annually 6. ≥ 11y 7. ≥ 11y | Risk assessment to be performed with  appropriate f/u action if +          **6. Screen all sexually active patients for STIs**  **7. Refer to Gyn/ Teen Clinic for pelvic exam/ screen**  **within 3 years of sexual activity** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Anticipatory Guidance | 90% compliance | 100% compliance | Each Well Child Visit  (3-5d, by 1mo, 2m, 4m, 6m, 9m, 12m, 15m, 18m, 24m, 30m, 3y and annually thereafter) | Specific guidance by age based on  Bright Futures Guidelines |
| **Developmental/ Behavioral Screen**   1. **Peds questionnaire** 2. **MCHAT** 3. Psychosocial/ Behavioral assessment 4. Alcohol and Drug Use assesment | 80% compliance | 100% compliance | 1. **9m, 18m,** 24m, **30m** 2. **18m**, 24m 3. Each Well Child Visit 4. ≥ 11y | Appropriate F/U action if screen + |
| Oral Health  Screening annually and referral to dentist annually beginning age 3yrs | 90% compliance | 100% compliance | 6m, 9m, 12m, 18m, 24m, 30m, 3y, 6y | Refer to dentist if screen + |

**Mental Health**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Column 1** | **Column 2** | **Column 3** | **Column 4** | **Column 5** | **Column 6** |
| **Expected Outcomes**  **What do you want to accomplish? List the results you will achieve at the end of the program. Outcomes must support the project goal stated above. Numbers served must tie to expected number served included in application.** | Strategies/Activities  How will you accomplish the outcome – what will participants do? List the activities participants will undertake to achieve each objective listed in Column 1. | Outcome Measures  How will you show the project worked/ had impact/ that change occurred? Propose numerical results you expect to see that will indicate success. Describe data sources for the measures. | Mid-Year Outcomes  List the actual results achieved, to date, against the Column 1 proposed outcomes. | Grant-End Outcomes  List the actual project results achieved against the Column 1 proposed outcomes. | **Lessons Learned/**  **Project Barriers/ Surprise Successes/ Comments** |
| **Outcome Objective #1**    **Access to primary care and behavioral health services will be increased by 50% for students** | **Activity 1 –Application for clinic enrollment to be included in school’s registration packet.**    **Activity 2 – Advisory group consisting of teachers, parents, and clinic staff developed to promote and direct clinic enrollment and services.**    **Activity 3 – Health check and behavioral health screening status monitored on all students enrolled in clinic.** | * **50% of students enrolled in clinic would have received annual health exam (health check) with behavioral health screening and services** |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Outcome Objective #2**  **Reduce absenteeism by 10% for students with Behavior Health Problems enrolled in tSBHC.** | **Activity 1 –Behavioral health screenings on all students receiving health checks, sports physical, and for those referred to clinic for behavioral health issues documented in patient chart/EHR**    **Activity 2 –Referral source (s) for mental health services developed and referrals documented into patient charts/EHR.**    **Activity 3 – Students enrolled and treated at SBHC included in monthly clinic enrollment and utilization report.**    **Activity 4- Student attendance obtained from school records and reported out on a quarterly basis within SBHC reports.** | * **Identify students with Behavior Health Problems by conducting MH screenings on 50% of students accessing SBHC.** * **Refer 100% of students with positive behavior health screens for behavior health services .** * **Enroll and treat 25% of students with behavioral health problems into SBHC mental health program.** * **Monitor attendance rates of students treated at SBHC quarterly** |
| **Outcome Objective #3**  **Reduce disciplinary referrals by 10% for students with Behavioral Health Problems Enrolled in SBHC.** | **Activity 1 – Diagnosis and treatment of students with targeted behavioral health problems documented in charts**    **Activity 2 – Disciplinary reports on students treated in SBHC reviewed on quarterly basis and entered into patient chart/EHR.** | * **Identify students with targeted behavioral health conditions to include: anger management, conflict resolution, depression and oppositional defiant behaviors** * **Provide behavioral health services targeting** * **Obtain Baseline disciplinary actions from school records** |

**APPENDIX I: SBHC UTILIZATION TEMPLATE**

