Dear Parent:

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. **How many times in the past 12 months has your child or children been ill enough to stay home?** ____________________________

4. **Where do you regularly take your child for routine health care or when he/she gets sick? Check all that apply.**
   - ____ a. Doctor or clinic
     - Check your primary care center-
       - i. Hughes Spalding Primary Care Center ____
       - ii. Asa Yancey Clinic ____
       - iii. West End Medical Center ____
       - iv. Good Samaritan Health Clinic ____
       - v. Private Doctor ____
   - ____ b. Emergency room
   - ____ c. Buy something at the drug store
   - ____ d. Other____________________________

5. **Do you have a regular source of dental care for your child?**
   - ____ a. Yes ____ No
6. Do you have someone you could go to for counseling services for behavioral problems? (e.g., unusual or extreme fears, depression, nervousness)
   a. ___Yes ___No

7. How do you currently pay for health services?
   a. ___Private insurance or belong to an HMO
   b. ___Medicaid
   c. ___Peach Care
   d. ___Armed Services medical plans
   e. ___No insurance and generally pay out-of-pocket
   f. ___Other____________________________________________

8. What is (are) the reason(s) that your child might not get the health care he/she needs?
   □ Transportation □ No money □ No insurance
   □ Cultural Differences □ Work Schedule

9. 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 use the Center
   c. ___ Would probably not use the Center
   d. ___ Would definitely not use the Center

10. What medical services would you like to see offered at a school-based health clinic? Choose all that apply
    □ Health Checks/Sports Physicals □ Immunizations
    □ Treatment for acute illnesses □ Treatment for injuries
    (colds, ear aches, sore throats) □ Vision and Hearing screenings
    □ Treatment for chronic illnesses □ Treatment for teeth
    (asthma, diabetes, anemia) □ Treatment for emotional problems
    or behavior problems
    Other_________________________________________________

10. 8. At what hours would you be most likely to use the clinic? Check all that apply.
    a. ___a. Before school
    b. ___b. Evenings
    c. ___c. During school
    d. ___d. Saturdays
    e. ___e. Immediately after school

11. THANK YOU!
Teacher Survey
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 ______
   l. Bedwetting ______

2. 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: __________

3. Do you feel there is a need for a school-based health clinic at the School? □ Yes □ No
   Please explain________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

4. 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________________________________________________________________

5. How likely are you to use the health clinic if services were offered for the staff?
   a. ___ Would definitely use the Center
   b. ___ Would probably use the Center
   c. ___ Would probably not use the Center
   d. ___ Would definitely not use the Center
6. What types of services would you like to have offered for the staff? Check all that apply.
   a. ___Medical
   b. ___Dental
   c. ___Weight Management
   d. ___Other

_____________________________________________________________________________
_____________________________________________________________________________

Thank You!