Parent Survey

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. ___ a. Headaches
    b. ___ b. Toothaches or dental problems
    c. ___ c. Sore throat or strep throat
    d. ___ d. Stomachaches
    e. ___ e. Colds/fever
    f. ___ f. Skin problems or rashes
    g. ___ g. Often feeling really tired
    h. ___ h. Diarrhea or vomiting
    i. ___ i. Earaches or ear infections
    j. ___ j. Problems with eating or weight
    k. ___ k. Injuries or accidents
    l. ___ l. Bedwetting

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

    a. ___ a. Asthma
    b. ___ b. Attention deficit or hyperactivity
    c. ___ c. Diabetes
    d. ___ d. Seizures
    e. ___ e. Allergies
    f. ___ 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. ___ b. Emergency room
    c. ___ c. Buy something at the drug store
    d. ___ 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, sorethroats) □ *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!