SBHC Parent Survey

This survey is being used to gather your opinions about the school-based health/wellness center (SBHC) in your child's school. The information you provide will be used to improve services offered at the SBHC. Your answers will be kept confidential. You are not required to answer these questions, and if you choose not to do so, it will not affect your ability or your child's ability to use health services at the SBHC. Thank you for sharing your thoughts with us!

Please have your child return the completed survey to the SBHC by: _____.

Date: _____ School: _____

1. Are you this child's: *(Please mark **only one**)*

   - □ a. Mother
   - □ b. Father
   - □ c. Step-parent
   - □ d. Foster parent
   - □ e. Grandparent
   - □ f. Other_____

2. What grade is your child currently in? *(Please mark **only one**)*

   □K □1st □2nd □3rd □4th □5th □6th □7th □8th □9th □10th □11th □12th □Other

3. What type of health insurance does your child have today? *(Mark **all** that apply)*

   - □ a. None
   - □ b. WV CHIP
   - □ c. Medicaid
   - □ d. Medicaid HMO
   - □ e. Private
   - □ f. Private HMO
   - □ g. Other_____

4. What types of staff has you child seen at the SBHC? *(Mark **all** that apply)*

   - □ a. Nurse
   - □ b. Mental Health Counselor
   - □ c. Doctor, Nurse Practitioner, Physician's Assistant
   - □ d. Dentist
   - □ e. Health Educator
   - □ f. Nutritionist

5. Is your child using the SBHC to care for any of the following illnesses? *(Mark **all** that apply)*

   - □ a. Asthma
   - □ b. Heart problems
   - □ c. Seizures or epilepsy
   - □ d. Diabetes
   - □ e. Physical disability
   - □ f. Developmental disability
   - □ g. Attention deficit disorder (ADD)
   - □ h. Other _____

6. During the past year, where has your child gone **the most** for medical care (example: shots, check-ups, physicals, sickness, colds)? *(Please mark **only one**)*

   - □ a. My school's SBHC
   - □ b. The emergency room
   - □ c. A medical clinic or private doctor's office
   - □ d. Some other place
   - □ e. There is no **one** particular place where my child usually goes.

Please turn page to continue ⟶

7. Where does your child go **most often** for mental health services? *(Please mark **only one**)*

- □ a. My school's SBHC
- □ b. A medical clinic or private doctor's office
- □ c. Some other place
- □ d. There is no **one** place where my child usually goes.
- □ e. I have never sought mental health services for my child.

8. What services has your child received at the SBHC? *(Mark **all** that apply)*

- □ a. Care when they were sick
- □ b. Care for ongoing health problems
- □ c. Head-to-toe physical exam
- □ d. Sports exam
- □ e. Counseling for emotional issues
- □ f. Care for injuries received at school
- □ g. Care for injuries not received at school
- □ h. Dental services
- □ i. Other_____

9. Thinking about the services your child has received at the SBHC, how would you rate the following?

a. The people there are good with children.	□ Not so Good	□ Good	□ Very Good
b. The appointments are convenient.	□ Not so Good	□ Good	□ Very Good
c. I did not have to leave work.	□ Not so Good	□ Good	□ Very Good
d. The staff talk to me about my child's illness.	□ Not so Good	□ Good	□ Very Good
e. My child did not miss school because of health problems.	□ Not so Good	□ Good	□ Very Good
f. The quality of health care was…	□ Not so Good	□ Good	□ Very Good

10. If health care services were **not available** at the SBHC, would you be able to get health care for your child? *(Mark **all** that apply)*

- □ a. Yes, it would be easy to get other care.
- □ b. Yes, my child would get care, but it would be harder to get.
- □ c. Yes, but I would have to take my child to an emergency room.
- □ d. No, I don't think I could get the care this child needs.
- □ e. No, I would have trouble getting time off work.
- □ f. No, I could not afford to get the care my child would need.
- □ g. No, I would have trouble with transportation.
- □ h. No, my child does not have a regular doctor.
- □ i. No, it is hard for me to get an appointment with our regular doctor.
- □ j. I don't know.

11. What services would you like to see your SBHC provide **more** of? *(Mark **all** that apply)*

- □ Counseling
- □ Support Groups
- □ Drug and Alcohol Counseling
- □ Dental Care
- □ Health Education
- □ Other, Specify:_____

Please make any additional comments that you like: _____

_____

_____

_____

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Please have your child return this form to the SBHC as soon as possible.

THANK YOU for completing our survey!