W.A.S.H

Wilson Area School Health

W.A.S.H. Center
1210 Forest Hills Road NW
Wilson, NC 27893
252-360-0769

Dear Parent:

The Wilson County School Based Health Center advocates for the health of children and addresses a broad range of needs. Our purpose is to provide affordable, and accessible, physical, and preventive health services to adolescents.

The Wilson County School Based Health Center here at Forest Hills Middle School is located on the campus and is open Monday through Friday from 8am to 4pm. The staff includes a full time Registered Nurse, an Advance Practice Provider (APP), and an Office Coordinator.

Students with health insurance or Medicaid coverage will be asked to provide information to allow for billing of medical services. Students without insurance coverage will be billed on a sliding fee scale according to their household income and number of supported members in the household. Please contact our office to discuss income sources. The Wilson County School Based Health Center **can bill most commercial insurances and Medicaid.** No sick student that has a signed consent form will be turned away for failure to pay or lack of insurance.

The goal for the Wilson County School Based Health Center is to help students succeed in school by promoting healthy lifestyles, and providing comprehensive health care to meet the needs of all students.

If you have any questions or concerns, please contact Wilson County Health Department at 252-237-3141 or the W.A.S.H. Center at 252-360-0769. We appreciate your interest and support of the Wilson County School Based Health Center.

Thank you,

W.A.S.H. Center Staff

Student Name: _____

Student Date of Birth: _____ Grade: _____

WILSON COUNTY SCHOOL BASED HEALTH CENTER NOTICE OF PRIVACY PRACTICES

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU.

Each time you visit a hospital, physician or healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you receive
- Means by which you or a third-party payer can verify that services billed were actually provided a tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool we can assess and continually work to improve the care we render and outcomes we achieve

Understanding what is in your record and how your health information is used to help you to ensure its accuracy, better understand who, what, when, where, and why others may access your information so you can make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

Although your health record is the physical property of the healthcare provider or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain an accounting of disclosures of your health information
- Request communication of your health information by alternative means or locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization (Wilson County School Based Health Center) is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we were unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Examples of Disclosures for Treatment, Payment and Health Operations

- We will use your health information with treatment
- We will use your health information for payment
- We will use your health information for regular health operation

Business Associates: There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to them so that they can provide the service we've asked them to do and bill you at your third party payer for services rendered. All standards of confidentiality are rendered under Wilson County Health Department policy.

Notification: We may disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product/product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your health information or public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or in the public.

If you have any questions concerning these Privacy Practices you may contact the privacy Officer at (252) 237-3141.

I have read and understand the Notice of Privacy Practices of the Wilson County School Based Health Center.

Signature_____ **Date**_____

Student Name: _____

Student Date of Birth: _____ Grade: _____

REIMBURSEMENT INFORMATION

***** SERVICES CAN NOT BE PROVIDED WITHOUT THIS INFORMATION!**

Please provide your insurance or Medicaid information so that we can bill for the medical services provided. No one will be denied care due to inability to pay.

Please circle which pay source your child has:

Medicaid / NCHC **Private Insurance** **Uninsured**

Please provide the following information as applicable:

Medicaid and NCHC*:

Medicaid / NCHC Policy Number_____

Private Insurance*:

Insurance Company _____ **Plan Name** _____
Policy Holder's Name _____ **Date of Birth** _____
Policy #_____ **Group#** _____
Insurance Provider Contact Phone Number (on back of card) _____

Uninsured:

Please provide copy of your last paycheck stub or proof of income source to avoid being charged at 100%. With this information, we will be able to place your child on a sliding fee scale based on the household income to receive a possible discounted visit.

The WCSBHC will work with individuals to set up monthly payments if requested.

***You may send a copy of your insurance card, Medicaid card, or verification of income by your child to school or bring a copy by and meet our staff. We will immediately return the copy to your child.**

We would appreciate you completing this form and returning any other necessary information to the W.A.S.H. Center **within 30 days from the first day of school.**

Student Name: _____

Student Date of Birth: _____ Grade: _____

Wilson County School Based Health Center
AUTHORIZATION FOR CARE AND RELEASE OF INFORMATION

- As the parent or legal guardian of (**student name**) _____, I hereby give my permission for my child to receive health care services, including required immunizations and flu shots, provided by the staff and contracted staff at the WASH Center and to share appropriate health information with each other and with the specified provider.
- I also authorize Eastern Carolina Pediatrics, the Wilson County Health Department, Wilson Medical Center, PRIDE, and the Wilson County Department of Social Services and/or any physician or other medical facility who has provided medical services to my child to exchange health information, medical records, and/or immunization records concerning my child's health with the WASH Center.
- I have received the materials regarding the services of the WASH Center including the WASH Center Notice of Privacy Practice. I give my permission to the WASH Center to release information regarding treatment and/or services to my or my child's insurance provider(s) for the purpose of billing. I authorize payments to be made directly to the WASH Center for services provided. I understand that I am responsible for any amount not covered by insurance, and I agree to pay this amount to the Wilson Area School Health Center or contracted agencies/individuals.
- I understand that this consent form will be good for the current school year or until I provide the WASH Center with written directions otherwise. I understand that I should inform the WASH Center staff if there are any changes in the information provided above, including my child's mental and/or physical health.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ Date: _____

NUTRITION:

I give my permission for my child to receive nutritional counseling services at Wilson Area School Health Center with a Registered Dietician affiliated with the W.A.S.H. Center. Students may be referred for (1) nutritional guidance, (2) weight management, and (3) instruction on healthy eating habits.

** _____ _____

PARENT SIGNATURE **DATE**

Student Name: _____

Student Date of Birth: _____ Grade: _____

WILSON COUNTY SCHOOL BASED HEALTH CENTER

School Year 2017-2018 (July 1, 2017-June 30, 2018)

NOTE: This Permission Form is valid for the 2017-2018 school year. Please complete in black ink.
***If Legal Guardian, you must provide copy of the Guardianship record with this form.**

Student Name _____ **School** _____ **Grade** _____

Sex (Circle One): Male Female **Date of Birth** _____

Social Security # _____ **Ethnicity (Circle One):** Hispanic Non-Hispanic

Race (Circle One):
White
Black
American Indian
Native Alaskan
Asian
Native Hawaiian
Other Pacific Islander

Address _____ **City** _____ **State** ____ **ZIP** _____

Name of Parent/Legal Guardian* _____

Relationship to Student _____

Parent/Legal Guardian Social Security # _____

Home Phone # _____ **Cell Phone #** _____

Email address _____

Employer _____ **Work Phone #** _____

Student's Physician _____ **Office Phone #** _____

Preferred Pharmacy _____ **Phone #** _____

Dentist _____ **Phone #** _____

Emergency Treatment

An emergency exists if, in the judgement or the WCSBHC staff, treatment is immediately required to prevent deterioration or worsened patient condition. In emergency situations requiring acute care, WCSBHC personnel will contact the Emergency Medical System for transport of the student to the appropriate medical facility. In case of emergency, whom should we contact?

Name	Phone Number	Relationship to Student
1.		
2.		

NC Child Health Program Initial History Questionnaire *(created 7/1/2012)*

Patient Name: | Date of Birth: | Sex: (Circle) Male Female

Person Who Filled Out Form: | Date Filled Out: | Relationship to Patient:

PREGNANCY AND BIRTH HISTORY

Is the child adopted? No Yes
Birth Weight: _____ pounds _____ ounces
Was baby born on time? No Yes _____ weeks
Was the birth Vaginal C-Section If C-Section, Why?_____

Were there any problems during the pregnancy or at birth?
No Yes If yes, explain: _____

During pregnancy did mom:
Use tobacco? No Yes Drink alcohol? No Yes
Use drugs or other medications? No Yes What: _____
Use prenatal vitamins? No Yes When:_____
Did baby have problems or need to stay in a NICU?
No Yes If yes, explain: _____
The initial feeding for the baby was: Formula Breast milk
How long did the baby breastfeed? _____
Did the baby go home with mom? No Yes
If no, explain: _____

HOUSEHOLD

List names, relationships to child, and ages of all people living with the child:

Are there siblings not listed? If so, list names, ages and where they live:

What is your child's living situation?

Joint custody Single custody Foster care

If one or both parents are not living in the home, how often does the child see the parent not in the home?

Tobacco use in family? No Yes Who?: _____

CHILD'S HEALTH HISTORY

Has the **child** ever had:

Hospitalizations	No	Yes
Serious Injuries/Broken Bones	No	Yes
Surgeries	No	Yes
Allergies To Medications/Other: _____	No	Yes
Chicken Pox (Year) _____	No	Yes
Frequent Ear Infections	No	Yes
Vision/Hearing Problems	No	Yes
Nasal Allergies	No	Yes
Asthma /Lung Problems	No	Yes
Tuberculosis(TB)/Risks for TB	No	Yes
Any Heart Problems/Murmur	No	Yes
Anemia/Sickle Cell	No	Yes
Bleeding Problems/Transfusion	No	Yes
Immune Problems/HIV	No	Yes
Cancer	No	Yes
Stomach Aches/Constipation	No	Yes
Bladder Infections/Kidney Disease	No	Yes
Birth Defects	No	Yes
Metabolic/Genetic Conditions	No	Yes
Sleep/Snoring/Bed Wetting Issues	No	Yes
Chronic Skin Problems/Eczema	No	Yes
Frequent Headaches	No	Yes
Seizures/Neurological Problems	No	Yes
Obesity	No	Yes
Diabetes	No	Yes
Thyroid/Endocrine Problems	No	Yes
High Blood Pressure	No	Yes
Alcohol/Drug Use/Tobacco	No	Yes
ADHD/Anxiety/Mood/Depression	No	Yes
Developmental Delay/Disability	No	Yes
Dental Decay/Cavities	No	Yes
History of Family Violence/Abuse	No	Yes
Sexual Infections/Pregnancy	No	Yes
Elevated Lead Level	No	Yes
Other: _____	No	Yes

BIOLOGICAL FAMILY HEALTH HISTORY

Has anyone in **the family of the child** (parents, grandparents, sisters/brothers) had:

			Who?
Childhood Hearing Loss	No	Yes	_____
Nasal Allergies	No	Yes	_____
Asthma	No	Yes	_____
Tuberculosis (TB)/Risks for Tuberculosis	No	Yes	_____
Lung Problems	No	Yes	_____
Heart Disease	No	Yes	_____
High Blood Pressure/Stroke	No	Yes	_____
High Cholesterol/Takes Cholesterol Medication	No	Yes	_____
Anemia/Sickle Cell	No	Yes	_____
Bleeding Problems	No	Yes	_____
Dental Decay (cavities)	No	Yes	_____
Cancer	No	Yes	_____
Liver Disease/Hepatitis	No	Yes	_____
Kidney Disease	No	Yes	_____
Diabetes (high blood sugar)	No	Yes	_____
Obesity	No	Yes	_____
Seizures/Epilepsy	No	Yes	_____
Alcohol Abuse	No	Yes	_____
Drug Abuse	No	Yes	_____
Mental Illness/Depression	No	Yes	_____
Development Delay/Disability	No	Yes	_____
Immune Problems/HIV/AIDS	No	Yes	_____
Other Family History: _____	No	Yes	_____

Additional Comments:

NC Child Health Program - Cuestionario de Historial Medico

Nombre del Paciente:	Fecha de Nacimiento:	Sexo: M (Masculino) (circule) F (Femenino)
Persona que llenó el formulario:	Fecha Completado:	Relación con el Paciente:

HISTORIAL DURANTE EMBARAZO Y AL NACER

¿Es el niño/a adoptado? No Sí
Peso al nacer: _____ libras _____ onzas
¿El bebé nació a tiempo? No Sí _____ semanas
¿El parto fue Vaginal? Cesárea?
¿Si tuvo cesárea, porque razón? _____
¿Hubo alguna complicación durante el embarazo o al bebé nacer?
No Sí Si respondió sí, explique: _____

Durante el embarazo, la mama:
¿Usó tabaco? No Sí Tomó alcohol? No Sí
¿Usó drogas o medicamentos? No Sí ¿Cuáles? _____
¿Usó vitaminas prenatales? No Sí ¿Cuando?: _____
¿Tuvo algunos problemas o necesidad de que el bebé se quedara en la unidad de cuidados intensivo?: No Sí
Si respondió sí, explique: _____
La alimentación inicial fue: Formula Leche materna
¿Cuánto duró tomando el pecho?: _____
¿Su bebé se fue del hospital a la casa junto con la madre?
No Sí Si no, explique:

HISTORIAL DEL HOGAR

Mencione a todos los que vivan en el hogar del niño/a, y las relaciones/ el parentesco con el niño/a y sus edades.

_____

¿Hay hermanos/as que no fueron mencionados? Si es así, escriba sus nombres, edades, y dónde viven :

_____

¿Con quien vive el niño/a?
Esta en custodia con ambos padres
Esta en custodia individual con solo padre o madre
Vive con una familia asignada por ley (Foster Care)

Si uno o ambos padres no viven en casa, ¿con que frecuencia ve el niño/a al padre/madre que no esta en la casa?

_____

¿Usan tabaco en su familia? No Sí
¿Quién(es)?: _____

HISTORIAL DE SALUD DEL NIÑO/A

Alguna vez, **su niño/a** ha tenido/ha sido:		
Hospitalizado	No	Sí
Algunas heridas graves/ Fracturas	No	Sí
Alguna Cirugía	No	Sí
Alergias a Medicamentos/ u Otras Cosas Médicas: _____	No	Sí
Varicela (año): _____	No	Sí
Infecciones de Oídos Frecuentes	No	Sí
Problemas de Audición o de Visión	No	Sí
Alergias Nasales	No	Sí
Asma/Enfermedad del Pulmones	No	Sí
Tuberculosis/Riesgos de Tuberculosis	No	Sí
Algún Problema de Corazón/ Soplo en el Corazón	No	Sí
Anemia/Anemia Drepanocítica (Sickle Cell)	No	Sí
Trastornos Sanguíneos o Hemorrágicos	No	Sí
Problemas Inmunológicos/VIH o SIDA	No	Sí
Cáncer	No	Sí
Dolor Abdominal Frecuente/Estreñimiento	No	Sí
Recurrente Infección en las Vías Urinarias /Enfermedad Renal–de los Riñones	No	Sí
Defectos de Nacimiento	No	Sí
Trastornos Metabólicos/Genéticos	No	Sí
Problemas para Dormir/Ronquido /Orinarse en la Cama	No	Sí
Problemas Crónicas de la Piel /Eczema	No	Sí
Dolores de Cabeza Frecuentes	No	Sí
Convulsiones/Otros Problemas Neurológicos	No	Sí
Obesidad	No	Sí
Diabetes (azúcar en la sangre)	No	Sí
Tiroides/Otros Problemas Endocrino	No	Sí
Alta Presión Sanguínea	No	Sí
Uso de Alcohol o Drogas/Uso de Tabaco	No	Sí
Déficit de Atención/Ansiedad/Depresión	No	Sí
Retraso en el Desarrollo/Discapacitado	No	Sí
Caries Dentales	No	Sí
Historial de Violencia Familiar/Abuso	No	Sí
Infecciones de Transmisión Sexual/Embarazo	No	Sí
Nivel alto de plomo	No	Sí
Otras: _____	No	Sí
	No	Sí
	No	Sí

HISTORIAL DE SALUD DE LA **FAMILIA BIOLÓGICA**

Hay alguien **en la familia** del niño (padres, abuelos, hermanos/as) que hayan tenido:			¿Quién?
Perdida de la Audición en la Infancia	No	Sí	_____
Alergias nasales	No	Sí	_____
Asma	No	Sí	_____
Tuberculosis/Riesgos de Tuberculosis	No	Sí	_____
Enfermedad del Pulmones	No	Sí	_____
Enfermedad del Corazón	No	Sí	_____
Alta Presión Sanguínea/Ataque cerebral	No	Sí	_____
Colesterol Alto/Toma Medicina para el Colesterol	No	Sí	_____
Anemia/Anemia Drepanocítica (Sickle Cell)	No	Sí	_____
Trastornos Sanguíneos o Hemorrágicos	No	Sí	_____
Caries Dentales	No	Sí	_____
Cáncer	No	Sí	_____
Enfermedad del Hígado/Hepatitis	No	Sí	_____
Enfermedad de los Riñones	No	Sí	_____
Diabetes (azúcar en la sangre)	No	Sí	_____
Obesidad	No	Sí	_____
Epilepsia/Convulsiones	No	Sí	_____
Abuso de Alcohol/Drogas	No	Sí	_____
Enfermedad Mental/Depresión	No	Sí	_____
Retraso en el Desarrollo/Discapacitado	No	Sí	_____
Problemas Inmunológicos /VIH o SIDA	No	Sí	_____
Otro historial familiar: _____	No	Sí	_____

Comentarios adicionales:

Student Name: _____

Student Date of Birth: _____ Grade: _____

ALLERGIES AND MEDICATIONS:

Has your child had a physical in the last 12 months? Yes _____ No _____
If yes, where? _____ Please provide the date of last exam: _____

Is your child allergic to any medicines? Yes _____ No _____
If yes, please list: _____

Is your child allergic to any foods? Yes _____ No _____
If yes, please list: _____

Is your child currently taking any medicine? Yes _____ No _____
If yes, please provide the following information on the medicines taken:

Name of Medicine	Dosage	How is it taken?	Reason taken?	How long taken?
Ex: Zyrtec	**10 mg**	**1 per day**	**Seasonal Allergies**	**3 years**

Has your child ever been hospitalized overnight? Yes _____ No _____
If yes, give age at the time of hospitalization and describe the problem:

Age	Problem

HOUSEHOLD INFORMATION

Please provide the following information regarding your household:

Name of Person in Household	Date of Birth	Age	Relationship to Student	Health Status
Ex: John Doe	**1/10/1972**	**45**	**Father**	**Diabetes Type 1**

DOB: _____

PEDIATRIC SYMPTOM CHECKLIST (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these question. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

	Never	Sometimes	Often
1. Complains of aches and pains			
2. Spends more time alone			
3. Tires easily, has little energy			
4. Fidgety, unable to sit still			
5. Has trouble with teacher			
6. Less interested in school			
7. Acts as if driven by a motor			
8. Daydreams too much			
9. Distracted easily			
10. Is afraid of new situations			
11. Feels sad, unhappy			
12. Is irritable, angry			
13. Feels hopeless			
14. Has trouble concentrating			
15. Less interested in friends			
16. Fights with other children			
17. Absent from school			
18. School grades dropping			
19. Is down on him or herself			
20. Visits the doctor with doctor finding nothing wrong			
21. Has trouble sleeping			
22. Worries a lot			
23. Wants to be with you more than before			
24. Feels he or she is bad			
25. Takes unnecessary risks			
26. Gets hurt frequently			
27. Seems to be having less fun			
28. Acts younger than children his or her age			
29. Does not listen to rules			
30. Does not show feelings			
31. Does not understand other people's feelings			
32. Teases others			
33. Blames others for his or her troubles			
34. Takes things that do not belong to him or her			
35. Refuses to share			

Total Scores_____

Does your child have any emotional or behavioral problems for which she/he needs help? Yes____ No____
Are there any services that you would like your child to receive for these problems? Yes____ No____
If yes, what type of services?

English PSC Gouverner Revision 01-06-03

Bright Futures Previsit Questionnaire
Early Adolescent Visits

Bright Futures

For us to provide you with the best possible health care, we would like to get to know you better and know how things are going for you. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. Thank you for your time.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

What changes or challenges have there been at home since last year?

Do you live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Growing and Changing Body	☐ Teeth ☐ Appearance or body image ☐ How you feel about yourself ☐ Healthy eating ☐ Good ways to be active ☐ How your body is changing ☐ Your weight
School and Friends	☐ Your relationship with your family ☐ Your friends ☐ How you are doing in school ☐ Girlfriend or boyfriend ☐ Organizing your time to get things done
How You Are Feeling	☐ Dealing with stress ☐ Keeping under control ☐ Sexuality ☐ Feeling sad ☐ Feeling anxious ☐ Feeling irritable
Healthy Behavior Choices	☐ Smoking cigarettes ☐ Drinking alcohol ☐ Using drugs ☐ Pregnancy ☐ Sexually transmitted infections (STIs) ☐ Decisions about sex and drugs
Violence and Injuries	☐ Car safety ☐ Using a helmet or protective gear ☐ Keeping yourself safe in a risky situation ☐ Gun safety ☐ Bullying or trouble with other kids ☐ Not riding in a car with a drinking driver

Questions

Dyslipidemia	Do you smoke cigarettes?	☐ Yes	☐ No	☐ Unsure
Alcohol or Drug Use	Have you ever had an alcoholic drink?	☐ Yes	☐ No	☐ Unsure
	Have you ever used marijuana or any other drug to get high?	☐ Yes	☐ No	☐ Unsure
STIs	Have you ever had sex (including intercourse or oral sex)?	☐ Yes	☐ No	☐ Unsure
Anemia	Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ No	☐ Yes	☐ Unsure
	Have you ever been diagnosed with iron deficiency anemia?	☐ Yes	☐ No	☐ Unsure

For Females Only

Anemia	Do you have excessive menstrual bleeding or other blood loss?	☐ Yes	☐ No	☐ Unsure
	Does your period last more than 5 days?	☐ Yes	☐ No	☐ Unsure

Growing and Developing

Check off all of the items that you feel are true for you.

- ☐ I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- ☐ I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- ☐ I feel like I have at least one friend or a group of friends with whom I am comfortable.
- ☐ I help others on my own or by working with a group in school, a faith-based organization, or the community.
- ☐ I am able to bounce back from life's disappointments.
- ☐ I have a sense of hopefulness and self-confidence.
- ☐ I have become more independent and made more of my own decisions as I have become older.
- ☐ I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:

Bright Futures

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Cuestionario de Bright Futures previo a la visita médica—Visitas en la adolescencia temprana

Para poder brindarte la mejor atención posible, nos gustaría conocerte mejor y saber cómo estás. Lo que hablemos será en privado. Esperamos que nos hables abiertamente sobre tu vida y tu salud. Esta información no la compartiremos con nadie sin tu permiso, a menos que creamos que alguien está en peligro. Gracias por tu tiempo.

¿De qué te gustaría hablar hoy?

¿Tienes alguna preocupación, pregunta o problema que te gustaría tratar hoy?

¿Qué cambios o retos ha habido en tu casa desde el año pasado?

¿Vives con alguien que usa tabaco o pasas tiempo en algún lugar donde la gente fuma? ❑ No ❑ Sí

Nos interesa contestar tus preguntas. Por favor marca las cajitas correspondientes a los temas que te gustaría tratar hoy.

Tu cuerpo crece y cambia	❑ Dientes ❑ Aspecto físico o imagen corporal ❑ Cómo te sientes acerca de ti mismo(a) ❑ Alimentarte bien ❑ Buenos modos de estar activo(a) ❑ Cómo cambia tu cuerpo ❑ Tu peso
La escuela y los amigos	❑ Relación con tu familia ❑ Tus amigos ❑ Cómo te va en la escuela ❑ Novio o novia ❑ Organizar tu tiempo para hacer lo que tienes que hacer
Cómo te sientes	❑ Asumir el estrés ❑ Tener las cosas bajo control ❑ Sexualidad ❑ Sentirte triste ❑ Sentir ansiedad ❑ Sentirte irritable
Conductas saludables	❑ Fumar cigarrillos ❑ Beber alcohol ❑ Usar drogas ❑ Embarazo ❑ Infecciones de transmisión sexual ❑ Decisiones sobre el sexo y las drogas
Violencia y lesiones	❑ Seguridad en el auto ❑ Usar casco y equipo protector ❑ Protegerte de situaciones riesgosas ❑ Seguridad con las armas ❑ Agresión o problemas con otros chicos ❑ No ir en un auto con un conductor que ha bebido alcohol

Preguntas

Dislipidemia	¿Fumas cigarrillos?	❑ Sí	❑ No	❑ No sé
Uso de alcohol o drogas	¿Has tomado alguna vez una bebida alcohólica?	❑ Sí	❑ No	❑ No sé
	¿Has consumido alguna vez marihuana o alguna otra droga alucinógena?	❑ Sí	❑ No	❑ No sé
Infecciones de transmisión sexual	¿Has tenido relaciones sexuales (incluyendo penetración o sexo oral)?	❑ Sí	❑ No	❑ No sé
Anemia	¿Incluyes en tu alimentación alimentos ricos en hierro como carnes, huevos, cereales enriquecidos con hierro o frijoles?	❑ No	❑ Sí	❑ No sé
	¿Te han diagnosticado alguna vez con anemia por deficiencia de hierro?	❑ Sí	❑ No	❑ No sé

Sólo para mujeres

Anemia	¿Tienes sangrado menstrual excesivo o algún otro tipo de pérdida de sangre?	❑ Sí	❑ No	❑ No sé
	¿Te dura el período o la regla más de 5 días?	❑ Sí	❑ No	❑ No sé

Crecimiento y desarrollo

Marca cada una de las cosas que se ajustan a ti:

❑ Tengo conductas que reflejan un estilo de vida saludable, como alimentarme bien, hacer ejercicio y protegerme de los peligros.
❑ Siento que tengo en mi vida por lo menos un adulto responsable que se preocupa por mí al que puedo acudir si necesito ayuda.
❑ Siento que tengo por lo menos un amigo o un grupo de amigos con los que me siento bien.
❑ Ayudo a otras personas por mi cuenta o a través de un grupo de voluntarios de la escuela, una organización religiosa o la comunidad.
❑ Soy capaz de sobreponerme a las desilusiones de la vida.
❑ Tengo un sentido de esperanza en la vida y confianza en mí mismo(a).
❑ Me he vuelto más independiente y tomo mis propias decisiones a medida que crezco.
❑ Soy particularmente hábil en una determinada cosa, como matemáticas, fútbol, teatro, cocina o cacería. Descríbelo:

Bright Futures
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Bright Futures.

Bright Futures Previsit Questionnaire
Older Child/Early Adolescent Visits—For Parents

For us to provide your child with the best possible health care, we would like to know how things are going.
Thank you.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

What changes or challenges have there been at home since last year?

Does your child have any special health care needs? ☐ No ☐ Yes, describe:

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes, describe:

How many hours per day does your child watch TV, play video games, and use the computer (not for schoolwork)? _____

Questions About Your Child

Vision	Does your child complain that the blackboard has become difficult to see?	☐ Yes	☐ No	☐ Unsure
	Has your child ever failed a school vision screening test?	☐ Yes	☐ No	☐ Unsure
	Does your child hold books close to read?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble recognizing faces at a distance?	☐ Yes	☐ No	☐ Unsure
	Does your child tend to squint?	☐ Yes	☐ No	☐ Unsure
Hearing	Does your child have a problem hearing over the telephone?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble following the conversation when 2 or more people are talking at the same time?	☐ Yes	☐ No	☐ Unsure
	Does your child have trouble hearing with a noisy background?	☐ Yes	☐ No	☐ Unsure
	Does your child ask people to repeat themselves?	☐ Yes	☐ No	☐ Unsure
	Does your child misunderstand what others are saying and respond inappropriately?	☐ Yes	☐ No	☐ Unsure
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Is your child infected with HIV?	☐ Yes	☐ No	☐ Unsure
Dyslipidemia	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	☐ Yes	☐ No	☐ Unsure
	Does your child have a parent with an elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	☐ Yes	☐ No	☐ Unsure
Anemia	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ No	☐ Yes	☐ Unsure
	Has your child ever been diagnosed with iron deficiency anemia?	☐ Yes	☐ No	☐ Unsure

For Females Only

Anemia	Does your child have excessive menstrual bleeding or other blood loss?	☐ Yes	☐ No	☐ Unsure
	Does your child's period last more than 5 days?	☐ Yes	☐ No	☐ Unsure

Your Growing and Developing Child

Check off all of the items that you feel are true for your child.

- ☐ My child engages in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping herself safe.
- ☐ My child has at least one responsible adult in his life who cares about him and to whom he can go to if he needs help.
- ☐ My child has at least one friend or a group of friends with whom she is comfortable.
- ☐ My child helps others individually or by working with a group in school, a faith-based organization, or the community.
- ☐ My child is able to bounce back from life's disappointments.
- ☐ My child has a sense of hopefulness and self-confidence.
- ☐ My child has become more independent and made more of his own decisions as he has become older.
- ☐ My child is particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe: