



## **SB388: Standardized Behavioral Health Questionnaire for Students - Development and Implementation Bill**

Dear Education, Energy, and the Environment Committee Member,

My name is Catherine Carter, Vision/Health Advocate who worked on the [Atticus Act](#) 2018. For the 2023 session, I am asking for a favorable report for SB388 Standardized Behavioral Health Questionnaire for Students - Development and Implementation. This Bill complements the work of the Blueprint for Maryland's Future and the Blueprint's Maryland Consortium on Coordinated Community Supports by enabling this group of experts to create guidelines for the schools to follow for their parent student health questionnaires at registration. It allows parents to ask for help to report and update their student's needs and facilitate connecting to resources.

This bill was inspired by my positive experience and collaborative work with HCPSS staff. The bill will help find kids like Atticus who struggle to see clearly and went years misdiagnosed and lacked the right vision care and school accommodations. This bill will help kids like my daughter. After struggling to find local health resources who were open and accepting patients, her middle school that gave me a list of local behavioral health providers, so I was able to build a healthcare team to support her IEP goals. This team helped support her through the pandemic and re-enter high school.

In addition, when I updated my registration for my children for school, I was excited to see the behavioral health screening questions added (I attached screenshots below). There were questions on physical, dental, and eye exam. If your child has vision problems more specifically wears glasses, contacts, cross eyes. Questions on mental health. This health screening would have been such a valuable tool for me with Atticus, my daughter, and the parents of the 168 students we saw at the [2020 HCPSS Eye Exam Clinic](#). This tool is a chance for a struggling parent to ask for help. I contacted HCPSS to thank them. They said they were glad that students aren't coming in as blank slates so they can be better prepared to meet student needs. Now all my kids' teachers know they wear glasses. Guyeus first grade teacher helps make sure he wears his. Because my kids had an eye exam in the last year, they also don't need a vision screening.

With the HCPSS screening, struggling students are identified and resources can be put into place to support. Staff training, grants, student support teams, and special education teams can be better informed. Parents can be connected to local resources like I was. Because this screening is part of the annual registration, a student's behavioral health needs can be updated and to see if the resources are working. I didn't list my daughter's needs because she has the essential resources in place thanks to the school's help.

Please consider supporting this bill. I appreciate the years of support and hope this Committee sees this bill is a continuation of building upon the work of addressing the health needs of our students.

**The Bill:**

1. Tasks the Maryland Consortium on Coordinated Community Supports to:
  - i. Create guidelines for school district behavioral health coordinators to follow when developing their student behavioral health needs questionnaire
  - ii. Consult with experts, **including data protection specialists to ensure secure student data**
  - iii. Update these guidelines every 5 years
2. Questionnaire is given to parents/guardians at new registration and every year after

**Positive Impact:**

1. Allows parents to ask for help to support their struggling students
2. Facilitates connecting families to local resources
3. Keeps student behavioral health needs up to date
4. Provides expert guidelines to help schools more effectively identify students in need of behavioral health resources
5. Helps ensure equity in the distribution of the Consortium's resources (Coordinated Community Supports Partnership Fund)

**The Blueprint's Maryland Consortium on Coordinated Community Supports:** Coordinate the delivery of evidence-based, culturally competent mental and behavioral health services to Maryland students, in a manner that partners with providers in the surrounding community and leverages to the fullest extent possible federal and public funding.

**HB265 Consultant members:**

1. ONE MEMBER OF THE MARYLAND OPTOMETRIC ASSOCIATION
2. ONE MEMBER OF THE STATE TRAUMATIC BRAIN INJURY ADVISORY BOARD
3. ONE MEMBER OF THE MARYLAND ASSOCIATION OF SCHOOL HEALTH NURSES
4. ONE MEMBER OF THE DIVISION OF EARLY INTERVENTION AND SPECIAL EDUCATION SERVICES IN THE DEPARTMENT
5. ONE MEMBER OF THE MARYLAND ACADEMY OF AUDIOLOGY
6. ONE MEMBER OF THE MARYLAND ASSOCIATION OF NONPUBLIC SPECIAL EDUCATION FACILITIES
7. ONE EXPERT IN EARLY CHILDHOOD TRAUMA AND DEVELOPMENT; AND
8. ONE EXPERT ON DATA PROTECTION;
9. ANY OTHER INDIVIDUAL SELECTED BY THE CHAIR

**THE CONSORTIUM CONSISTS OF THE FOLLOWING MEMBERS:**

- (1) THE SECRETARY OF HEALTH, OR THE SECRETARY'S DESIGNEE;
- (2) THE SECRETARY OF HUMAN SERVICES, OR THE SECRETARY'S DESIGNEE;
- (3) THE SECRETARY OF JUVENILE SERVICES, OR THE SECRETARY'S DESIGNEE;
- (4) THE STATE SUPERINTENDENT OF SCHOOLS, OR THE STATE SUPERINTENDENT'S DESIGNEE;
- (5) THE CHAIR OF THE COMMISSION, OR THE CHAIR'S DESIGNEE;
- (6) THE DIRECTOR OF COMMUNITY SCHOOLS IN THE STATE DEPARTMENT OF EDUCATION, OR THE DIRECTOR'S DESIGNEE;
- (7) ONE MEMBER OF THE MARYLAND COUNCIL ON ADVANCEMENT OF SCHOOL-BASED HEALTH CENTERS, APPOINTED BY THE CHAIR OF THE COUNCIL;
- (8) ONE COUNTY SUPERINTENDENT OF SCHOOLS, DESIGNATED BY THE PUBLIC SCHOOL SUPERINTENDENTS ASSOCIATION OF MARYLAND;
- (9) ONE MEMBER OF A COUNTY BOARD OF EDUCATION, DESIGNATED BY THE MARYLAND ASSOCIATION OF BOARDS OF EDUCATION;

- (10) ONE TEACHER WHO IS TEACHING IN THE STATE, DESIGNATED BY THE MARYLAND STATE EDUCATION ASSOCIATION;
- (11) ONE SOCIAL WORKER PRACTICING AT A SCHOOL IN THE STATE, DESIGNATED BY THE MARYLAND CHAPTER OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS;
- (12) ONE PSYCHOLOGIST PRACTICING IN A SCHOOL IN THE STATE, DESIGNATED BY THE MARYLAND SCHOOL PSYCHOLOGISTS ASSOCIATION;
- (13) ONE REPRESENTATIVE OF NONPROFIT HOSPITALS, DESIGNATED BY THE MARYLAND HOSPITAL ASSOCIATION;
- (14) THE FOLLOWING MEMBERS APPOINTED BY THE GOVERNOR:
  - (I) ONE REPRESENTATIVE OF THE COMMUNITY BEHAVIORAL HEALTH COMMUNITY WITH EXPERTISE IN TELEHEALTH;
  - (II) ONE REPRESENTATIVE OF LOCAL DEPARTMENTS OF SOCIAL SERVICES;
  - (III) ONE REPRESENTATIVE OF LOCAL DEPARTMENTS OF HEALTH; AND
- (15) THE FOLLOWING MEMBERS APPOINTED JOINTLY BY THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE:
  - (I) ONE INDIVIDUAL WITH EXPERTISE IN CREATING A POSITIVE CLASSROOM ENVIRONMENT
  - (II) ONE INDIVIDUAL WITH EXPERTISE IN EQUITY IN EDUCATION; AND
  - (III) TWO MEMBERS OF THE PUBLIC, APPOINTED BY THE PRESIDENT OF THE SENATE

(I) THE NATIONAL CENTER FOR SCHOOL MENTAL HEALTH SHALL PROVIDE TECHNICAL ASSISTANCE.

**Coordinated Community Supports Partnership Fund:** (I) \$25,000,000 IN FISCAL YEAR 2022; (II) \$50,000,000 IN FISCAL YEAR 2023; (III) \$75,000,000 IN FISCAL YEAR 2024; (IV) \$100,000,000 IN FISCAL YEAR 2025; AND (V) \$125,000,000 IN FISCAL YEAR 2026 AND EACH FISCAL YEAR THEREAFTER

<b>Registration by District</b>	
Registration sample not accessible*	
<ul style="list-style-type: none"> <li>• Allegany County Public Schools*</li> <li>• <a href="#">Anne Arundel County Public Schools</a></li> <li>• <a href="#">Baltimore City Public Schools</a></li> <li>• <a href="#">Baltimore County Public Schools</a></li> <li>• Calvert County Public Schools*</li> <li>• Caroline County Public Schools*</li> <li>• <a href="#">Carroll County Public Schools</a></li> <li>• Cecil County Public Schools*</li> <li>• <a href="#">Charles County Public Schools</a></li> <li>• Dorchester County Public Schools*</li> <li>• <a href="#">Frederick County Public Schools</a></li> <li>• Garrett County Public Schools*</li> </ul>	<ul style="list-style-type: none"> <li>• Harford County Public Schools*</li> <li>• Howard County Public Schools</li> <li>• <a href="#">Kent County Public Schools</a></li> <li>• <a href="#">Montgomery County Public Schools</a></li> <li>• Prince George's County Public Schools*</li> <li>• Queen Anne's County Public Schools*</li> <li>• <a href="#">Saint Mary's County Public Schools</a></li> <li>• Somerset County Public Schools*</li> <li>• <a href="#">Talbot County Public Schools</a></li> <li>• <a href="#">Washington County Public Schools</a></li> <li>• <a href="#">Wicomico County Public Schools</a></li> <li>• <a href="#">Worcester County Public Schools</a></li> </ul>

# Visual Comparison of Maryland Parent Student Health Questionnaire at Registration

## HCPSS Student Health Questionnaire

Please fill out if applicable. If not applicable leave blank and press save and continue

Need help finding a doctor?

Need help finding a dentist?

Date of Physical Exam

Date of Dental Exam

Date of Vision Exam

Has Insurance

Will the student require medication to be given at school?

If YES, a Medication Order Form must be completed for each prescription and over the counter medication to be given during school.

Medications taken at school:

Medications taken at home:

Physician Name

Physician Name

Phone Number

Extension

Preferred Hospital

Dentist Name

Phone Number

Extension

Office

[< Previous](#) [Save And Continue >](#)

### Health Concerns:

Does your student have any of the following Health concerns. Please give more details if yes is selected for any item.

Allergies?

Is a Nut Free Table Required for this Student?

Medical Conditions?

Hospitalizations or Operations?

Physical Handicapping Conditions?

Activity Restrictions?

Assistive Devices?

Mental Health Issues?

Speech Difficulties/Developmental Delays?

Activity Restrictions?

Assistive Devices?

Mental Health Issues?

Speech Difficulties/Developmental Delays?

Vision Difficulties? For example: Wears Glasses or Contacts, Crossed Eyes...

Hearing Difficulties?

Any Other Health Concerns? For Example: eating/sleeping habits, posture, skin/teeth...etc.

Best form of contact to discuss the listed health items?

Best contact phone number

### Student Medical Conditions:

Please list known medical conditions

[< Previous](#) [Save And Continue >](#)

**New Student Health History**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Gender: Male  Female

Last school your child attended? \_\_\_\_\_ DOB: \_\_\_\_\_

Has your child traveled or resided outside of the U.S. in the past year? Yes  No

If yes, list countries: \_\_\_\_\_

Where do you usually take your child for routine medical care?

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Does your child take any medication? Yes  No  If yes, list medications: \_\_\_\_\_

Does your child require any special health treatments or procedures (e.g. tube feeding or catheterization)? Yes  No

If yes, describe: \_\_\_\_\_

Where do you usually take your child for routine dental care? \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**To the best of your knowledge, has your child had any of the following?**

	Yes	No	If yes, describe:
Prematurity			
Birth defect			
Immunity problems			
Bleeding problems			
Lead poisoning			
Sickle Cell Disease			
Diabetes			
Anaphylaxis			
Seasonal allergies			
Food allergies			
Medication/Drug allergies			
Mental health/emotional problems like depression			
ADHD/ADD			
Concussion or traumatic brain injury			
Migraines			
Learning problems/disabilities			
Seizures			
Speech problems			
Ear or hearing problems			
Eye or vision problems			
Dental problems			
Asthma or breathing problems			
Heart problems			
Stomach problems			
Bowel problems			
Bladder problems			
Musculoskeletal problem (including cerebral palsy)			
Limited physical activity			
Other:			
Is your child toilet trained?			

Hospitalization Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Hospitalization Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Surgery Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Surgery Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Telephone: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Address: \_\_\_\_\_

# Baltimore City

## STUDENT WHOLENESS INVENTORY (OPTIONAL)

Please check all items below that apply to the student

(NOTE: This section is optional but assists City Schools in providing needed supports/services).

- |   |  |
|---|--|
| <input type="checkbox"/> Student enjoys participating in extracurricular and enrichment activities (i.e., student government, academic clubs, debate team, culture clubs, etc.) | <input type="checkbox"/> Student has a history of drug/alcohol use                               |
| <input type="checkbox"/> Student feels unsafe/alienated/disenfranchised   | <input type="checkbox"/> Student has asthma and/or other medical concerns                        |
| <input type="checkbox"/> Student has a history of abuse/victimization   | <input type="checkbox"/> Student has hearing problems  |
| <input type="checkbox"/> Student has a strong interest/skill in sports/athletics/physical activities  | <input type="checkbox"/> Student has long-term use of medication                                 |
| <input type="checkbox"/> Student has antisocial/delinquent behaviors  | <input type="checkbox"/> Student has vision problems   |
| <input type="checkbox"/> Student has experienced the death of a parent/guardian and/or sibling  | <input type="checkbox"/> Student has/had delayed speech/language                                 |
| <input type="checkbox"/> Student has mental health difficulties   | <input type="checkbox"/> Student has/is receiving occupational therapy                           |
| <input type="checkbox"/> Student has/had a serious trauma exposure and/or injury  | <input type="checkbox"/> Student has/is receiving speech/language therapy                        |
| <input type="checkbox"/> Student is/was in a gang   | <input type="checkbox"/> Student is not fully toilet trained                                     |
| <input type="checkbox"/> Student could benefit from additional testing regarding cognitive development  | <input type="checkbox"/> Student has a parent or sibling receiving special education services    |
| <input type="checkbox"/> Student has a strong interest/skill in arts-based programming (i.e., dance, film, music, theatre, visual arts, etc.)                                   | <input type="checkbox"/> Student has a parent/guardian that has a chronic illness or is disabled |
| <input type="checkbox"/> Student has experienced academic failure/frustration   | <input type="checkbox"/> Student has a sibling with learning difficulties                        |
| <input type="checkbox"/> Student had a birth weight of six pounds or less   | <input type="checkbox"/> Student has family members in a gang                                    |
| <input type="checkbox"/> Student had exposure to lead   | <input type="checkbox"/> Student is a parenting teen   |
|   | <input type="checkbox"/> Student is/was in foster care   |
|   | <input type="checkbox"/> Other considerations _____  |

# Anne Arundel

## Medical/Emergency Information



In case of emergency, if neither parent/guardian can be reached, an Emergency Contact will be called.

### Emergency Contact #1

Include Contact?  Yes  No

### Emergency Contact #2

Include Contact?  Yes  No

### Medical Concerns

Optional. Allergies, Asthma, Diabetes, etc.

### Medication(s)

Optional.

# Kent

**Part 5 - Health & Immunization Information:**

Is immunization record complete?  Yes  No

DHMD 896 Form Completed/Approved by School Nurse (Name/Date: \_\_\_\_\_)

Temporary Approval of record by other School Official (Name/Date: \_\_\_\_\_)

As required by law for all students entering MD public schools for the first time, has the child received a physical exam in the past 9 months?  Yes  No If "NO", please list reason:  finances,  lack of access,  other (please indicate: \_\_\_\_\_)

Please list any health concerns (medications, allergies, medical conditions, etc)


# St. Mary's

**MEDICAL INFORMATION:**

Health Insurance?  Yes  No

Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_ Immunizations Complete?  Yes  No

Medications at school:  Yes  No **PS 109 MUST be completed for medications.**

Any Medical Concerns if appropriate:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Talbot

Doctor Name/Phone:	Dentist Name/Phone:
<b>Health Information</b>	
List medications taken regularly at home at school	
List any life-threatening allergies	

# Frederick

## CONFIDENTIAL HEALTH INFORMATION

*In case of an emergency, the school staff will contact 911.*

*Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.*

STUDENT INFORMATION					
Last:	First:	Middle:	Date of Birth:	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Grade
School Name:					
Does the student have health insurance? <input type="checkbox"/> Private <input type="checkbox"/> Medical Assistance <input type="checkbox"/> No Insurance			Does the student have dental insurance? <input type="checkbox"/> Y <input type="checkbox"/> N		

CURRENT HEALTH CONCERNS	
<i>Please check the following health concerns that may impact the student's educational day. This information may be shared with FCPS staff as appropriate.</i>	
<input type="checkbox"/> <b>The student does not have any medical concerns</b>	
<input type="checkbox"/> ADD/ADHD <input type="checkbox"/> allergies <b>(choose all that apply)</b> <input type="checkbox"/> foods _____ <input type="checkbox"/> bee sting/insect bite _____ <input type="checkbox"/> medicines _____ <input type="checkbox"/> pesticides/chemicals* _____ <input type="checkbox"/> other _____ <input type="checkbox"/> asthma: Has the student experienced an asthma episode in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> blood disorder _____	<input type="checkbox"/> cancer <input type="checkbox"/> diabetes <input type="checkbox"/> hearing problems <input type="checkbox"/> hearing aid(s) <input type="checkbox"/> heart problems _____ <input type="checkbox"/> mental health diagnosis _____ <input type="checkbox"/> physical disability _____ <input type="checkbox"/> seizures <input type="checkbox"/> vision problems _____ <input type="checkbox"/> glasses <input type="checkbox"/> contacts <input type="checkbox"/> other _____
<input type="checkbox"/> <b>This information is a change in health condition from the last school year</b>	
<small>*FCPS uses the Integrated Pest management programs to identify and control pest problems in schools. <b>Elementary</b> schools must notify staff and parents/guardians of all students 24 hours before pesticides are to be applied inside the school building or on the grounds. <b>Middle and high schools</b> must notify only those parents, guardians or staff who have filed a written request for notification; forms are available at each school and must be updated every school year. See the FCPS Calendar Handbook for details, or contact your child's school.</small>	

MEDICATIONS
<b>List all medications and dosages your child receives on a routine basis</b>
<input type="checkbox"/> <b>Medications are not required at school</b>
<small>If the student requires over-the-counter or prescription medications or treatments at school, the health care provider and parent <b>must</b> complete and submit the appropriate authorization form(s). Obtain forms from the health staff at your child's school or at <a href="http://www.fcps.org/">http://www.fcps.org/</a> (click on Forms).</small>
Medications: _____ _____

<small>I hereby give authorization and consent to the school, in the event that I cannot be contacted, to obtain emergency medical care and necessary emergency transportation to a healthcare facility. I understand and authorize that my child's medical records or other medical information, furnished to the school, will be shared with FCPS/Frederick County Health Department staff and emergency personnel who have a legitimate medical/educational purpose for accessing such medical records and information.</small>
Parent/Guardian name (please print): _____ Primary Contact Ph# _____
<b>Signature of Parent / Guardian:</b> _____ <b>Date</b> _____



# Washington

## Documentation Required for Enrollment

Do you have verification of residency? (Must be current within 3 months)  Yes  No

Gas, Electric, Water, Oil, Sewer Bill

Lease/Mortgage

Property Tax Bill/Statement

Do you have verification of age?  Yes  No (Birth Certificate Preferred)

Do you have the following Health Related Documents?  Yes  No

Immunization Certificate

Physical Examination Record

Blood Lead Testing Certificate  
Pre-K, K and 1<sup>st</sup> Grade

**If any box is marked "no", please request assistance from school staff. Maryland Law requires that you provide all of the above information before a child may attend/enroll in school.**

# Carroll

**Proof of Immunization Compliance: (Initial next to document received)**

DHMH Certificate 896 \_\_\_\_\_ Clinic Record or Physician's Office Record \_\_\_\_\_ Other State Official Immunization Record \_\_\_\_\_  
Official School Record \_\_\_\_\_



## ENROLLMENT INFORMATION FOR PARENTS/GUARDIANS

If you are enrolling your student in Wicomico County Public Schools for the first time, please complete the following forms:

- ❖ Student Personal Data and Enrollment Information Form
- ❖ Maryland Schools Record of Physical Examination
- ❖ Personal Race and Ethnicity Form
- ❖ PreK3 or PreK 4 Application (if applicable)
- ❖ PreKindergarten Experience Form (PreK3 – Kindergarten)
- ❖ Survey of Children (PreK3 – Kindergarten only)
- ❖ Judy Center Partnership Center Form (Beaver Run and Pemberton PreK3 – Kindergarten only)