Child Advocacy Center
OF AIKEN COUNTY
Post Office Box 1763 • Aiken, SC 29802 • (803) 644-5100

Child's name: _____

Date of Birth: _____

I understand that according to SC Code 63-11-310 Child Advocacy Centers are required to release all information that they gather pursuant to an investigation of child abuse or neglect to the county DSS office, law enforcement and to the circuit solicitor.

_____ _____
Initials of Legal Guardian on behalf of Child Date

I authorize the Child Advocacy Center of Aiken County to release information to/receive information from:

Mental Health / Therapist_____

Medical Provider_____

Other_____

_____ _____
Signature of Legal Guardian Date

Print Form

SOUTH CAROLINA Children's Advocacy Medical Response System

Child Maltreatment Protocol

CONSENT FOR MEDICAL DIAGNOSIS AND TREATMENT

I, _____, in my capacity as

Mother **Father** **Legal Representative**

(please circle)

Other: (please specify relationship to child) _____,

of the child named below, consent to a physical exam concerning allegations or suspicions of maltreatment, and if necessary to collect evidence and provide treatment. This procedure has been fully explained to me, and I understand that this examination may include clinical observation for evidence of physical or sexual abuse or both, and tests for sexually transmitted diseases (STDs). In addition, I consent to photographs and/or X-rays of any significant findings. I do consent to the use of these photographs or X-rays by this facility, or its staff, for medical, teaching, and/or legal purposes. I fully understand the nature of the examination and medical information obtained by this means may be used as evidence in a court of law or in connection with the enforcement of public health rules and laws. I do consent to HIV antibody testing if found necessary by the healthcare provider. I understand that if HIV testing is done, information regarding that test will be explained to me by the healthcare provider. I understand a positive or negative test may need to be confirmed or repeated at a later date.

Child's Name: _____ Date of Birth: _____ Age: _____

By signing below, I consent to the diagnosis and treatment of the named child as described above.

_____ _____ Date: _____

Signature of Parent/Legal Representative Printed Name

_____ _____ Date: _____

Signature of Parent/Legal Representative Printed Name

_____ _____ Date: _____

Signature of Witness Printed Name

SOUTH CAROLINA Children's Advocacy Medical Response System

Child Maltreatment Protocol

AUTHORIZATION AND RELEASE

I authorize The Child Advocacy Center of Aiken County to release medical information
Facility Name
related to this incident to:

- ☒ Department of Crime Victim Compensation (DCVC)
- ☒ Department of Social Services
- ☒ Law Enforcement
- ☐ Community Based Prevention Services
- ☐ Guardian ad Litem
- ☒ Solicitor

and hold harmless this facility and its staff, from any and all liability and claims of injury which may in any manner result from the release of such information.

I also authorize the release of medical information to/from:

- ☒ Private Physician
- ☐ Mental Healthcare Provider
- ☒ Children's Advocacy Center
- ☐ Other *Specify* _____

for the continuing diagnosis and treatment of this child.

I request and authorize the Department of Crime Victim Compensation (DCVC) to assign the payment for medical services provided on this child's behalf to:

Facility Name The Child Advocacy Center of Aiken County

Address PO Box 1763

City Aiken State SC Zip Code 29801

I permit a copy of this authorization to be used. I understand that I have the right to withdraw this authorization at any time by notifying this facility in writing. I understand that the withdrawal is not effective for any actions taken prior to this withdrawal. Without a written notice to withdraw this authorization, it will expire 1 year from the date the medical service is provided.

Child's Name: _____ Date of Birth: _____ SSN: _____ (Last 5 digits)

Address: _____

Contact Phone Number _____

By signing, I consent to the authorization and release of medical information of the named child as described above.

_____ _____ Date: _____
Signature of Parent/Legal Representative — Printed Name

_____ _____ Date: _____
Signature of Parent/Legal Representative — Printed Name

_____ _____ Date: _____
Signature of Witness — Printed Name

CAREGIVER QUESTIONNAIRE

CHILD'S NAME: _____

DATE OF BIRTH: _____ **AGE:** _____
RACE:

Who is filling out this form? Name (Please print): _____

Your signature and date: _____

Your phone number: _____

Relationship to child:

- ☐ Legal Parent
- ☐ Foster Parent
- ☐ Other legal guardian
- ☐ GAL / CASA
- ☐ Therapist
- ☐ Law Enforcement
- ☐ CPS Caseworker
- ☐ DSS Treatment Worker
- ☐ DSS Foster Care Worker

1. Who lives with the child today?

Name	Age	Gender (Male or Female)	Relationship
		M F	
		M F	
		M F	
		M F	
		M F	
		M F	
		M F	
		M F	

Has the child recently changed homes? ☐ Yes ☐ No If YES, Who lived with the child before today?

Name	Age	Gender (Male or Female)	Relationship
		M F	
		M F	
		M F	
		M F	
		M F	
		M F	
		M F	

2. Who is suspected of harming the child? (Give name, age)

3. How does the child know this person or persons?

4. How often did the child see this person or persons, and when was the last contact?

5. Tell us how you came to know there might be a problem. If the child said something to you, tell us what the child said, as close to the exact words as you can remember.

_____

_____

_____

_____

_____

_____

_____

6. What does the child know about coming here today? What was the child told?

7. Have previous interviews with the child been conducted?
If YES, describe:

☐ YES
☐ NO
☐ I DON'T KNOW

8. Do you have concerns about how the child is doing?
If YES, describe:

☐ YES
☐ NO
☐ I DON'T KNOW

9. Is the child receiving counseling or mental health services right now?
If YES, describe with whom and for what.

☐ YES
☐ NO
☐ I DON'T KNOW

10. Has there ever been a child abuse investigation involving this child before?
If YES, describe:

☐ YES
☐ NO
☐ I DON'T KNOW

11. What else would you like us to know about the child or the situation?

_____

_____

_____

_____

_____

Thank you for answering these questions. The professionals who interview and / or examine the child will use this information to further guide the process.

Do you have questions or concerns that you would like to talk to the Victim Advocate about? Please write them below:

_____

_____

Are there any immediate or pressing needs with which the Victim Advocate can help you?

_____

_____

Medical Questionnaire

Child's Name _____

Who is Filling Out This Form _____

Past Medical History

1. Has your child had any of these medical conditions?

- ☐ Attention Deficit Disorder with Hyperactivity (ADHD)
- ☐ Developmental delay (please specify):_____
- ☐ Learning disability (please specify):_____
- ☐ Depression
- ☐ Anxiety
- ☐ Opposition Defiant Disorder (ODD)
- ☐ Autism Spectrum Disorder
- ☐ Seizures
- ☐ Other: _____

2. Has your child had any of these injuries?

- ☐ Burns
- ☐ Head injury
- ☐ Ingestion/Poisoning
- ☐ Broken Bones
- ☐ Stitches

How old was your child? _____

Please provide details of injury _____

3. Has your child ever been admitted to a hospital? ☐ Yes ☐ No

(a) How old was your child? _____

(b) What was the admission for? _____

(c) Name of hospital _____

4. Has your child ever had surgery or a medical procedure? ☐ Yes ☐ No

   (a) How old was your child? _____

   (b) What was the surgery or procedure for? _____

   (c) Name of hospital _____

5. Is your child allergic to any foods or medicines? ☐ Yes ☐ No

   Please list them: _____

6. Is your child taking any medicines now? ☐ Yes ☐ No

   What is he or she taking? _____

   _____

   What is the medicine for? _____

   _____

7. Who is your child's doctor? _____

8. How is your child doing in school? Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor ☐

What is the name of your child's school? _____

What grade is your child in? _____

If your child is having difficulties at school, what is the problem? _____

_____

_____

Family History

1. Do any of your child's caretakers have any of these problems?

   Yes No

   ☐ ☐ Psychiatric or mental illness: _____

   ☐ ☐ Drug or alcohol addiction: _____

   Substances used: _____

   ☐ ☐ Past experience of physical or sexual abuse: _____

   ☐ ☐ Past involvement with law enforcement: _____

2. Has your family had any previous involvement with DSS? ☐ Yes ☐ No

   Please explain: _____

   _____

3. Has your child ever been around domestic violence? ☐ Yes ☐ No

Review of Symptoms

1. Does your child have any problems with today:

___Have difficulty sleeping
___Clinging Whining
___Hyperactive/impulsive
___Fearful of being left alone
___Sad or crying easily
___Quiet or withdrawn
___Angry outbursts
___Hitting/biting sibling/friends
___Difficulty making/keeping friends
___Ran away from home
___Have or had thoughts of hurting himself/herself
___Tried to hurt himself/herself
___Drinking alcohol
___Sexualized behavior
___Gang involvement
___Using drugs
___Started having sex
___In trouble with the law
___**NONE OF THE ABOVE**

2. Does your child have any problems with today:

___Pain when peeing
___Blood in urine
___Peeing frequently
___Peeing in underwear (circle one):
Day Night Day & Night
___Pooping in underwear
___Constipation
___Urinary tract infections
___Change in appetite
___Frequent headaches
___Frequent stomachaches
___Genital itching
___Genital rash
___Genital pain or bleeding
___Anal itching
___Anal rash
___Anal pain or bleeding
___Vaginal or penile discharge
___Sexually transmitted infections
(please specify):
_____
___**NONE OF THE ABOVE**

3. Does your child have any problems with today:

General:
___Abnormal weight gain
___Abnormal weight loss
___Fatigue/weakness
___Trouble sleeping
Skin:
___Rash
___Lumps
___Bruises
Head/Neck:
___Neck pain
___Neck stiffness
___Swollen glands
Eyes/Ears/Nose:
___Blurry or double vision
___Vision loss
___Wear glasses/contacts
___Decreased hearing
___Ear drainage
___Frequent nosebleeds
___Decreased sense of smell
Throat/Mouth:
___Bleeding gums
___Thrush
___Non-healing sores
Respiratory:
___Shortness of breath
___Wheezing
Cardiovascular:
___Chest pain or discomfort
___Rapid heart rate
Musculoskeletal:
___Painful joints
Neurologic:
___Dizziness
___Seizures
___Weakness
___**NONE OF THE ABOVE**

Reviewed with _____ on_____by_____

Date *Signature*

Child Advocacy Center
OF AIKEN COUNTY

I acknowledge receipt of the Notice of Privacy Practices – Health Insurance Portability & Accountability Act (HIPAA) from the Child Advocacy Center of Aiken County. I am also aware that if I have any questions about the Privacy Practices/HIPAA, I can speak with one of the CAC of Aiken staff members.

_____

Child's Name (printed)

_____

Signature of Parent/Guardian/Personal Representative

_____

Print Name (Parent/Guardian/Personal Representative)

_____

Date

Privacy and Your Health Information

Your Privacy Is Important to All of Us

Most of us feel that our health and medical information is private and should be protected, and we want to know who has this information. Now, Federal law

- Gives you rights over your health information
- Sets rules and limits on who can look at and receive your health information

Your Health Information Is Protected By Federal Law

Who must follow this law?

- Most doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other health care providers
- Health insurance companies, HMOs, most employer group health plans
- Certain government programs that pay for health care, such as Medicare and Medicaid

What information is protected?

- Information your doctors, nurses, and other health care providers put in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your clinic
- Most other health information about you held by those who must follow this law

The Law Gives You Rights Over Your Health Information

Providers and health insurers who are required to follow this law must comply with your right to

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes
- If you believe your rights are being denied or your health information isn't being protected, you can
  - File a complaint with your provider or health insurer
  - File a complaint with the U.S. Government

You should get to know these important rights, which help you protect your health information. You can ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint, from the website at www.hhs.gov/ocr/hipaa/

PRIVACY

The Law Sets Rules and Limits on Who Can Look At and Receive Your Information

To make sure that your information is protected in a way that does not interfere with your health care, your information can be used and shared

- For your treatment and care coordination
- To pay doctors and hospitals for your health care and help run their businesses
- With your family, relatives, friends or others you identify who are involved with your health care or your health care bills, unless you object
- To make sure doctors give good care and nursing homes are clean and safe
- To protect the public's health, such as by reporting when the flu is in your area
- To make required reports to the police, such as reporting gunshot wounds

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot

- Give your information to your employer
- Use or share your information for marketing or advertising purposes
- Share private notes about your mental health counseling sessions

For More Information

This is a brief summary of your rights and protections under the federal health information privacy law. You can learn more about health information privacy and your rights in a fact sheet called *"Your Health Information Privacy Rights."* You can get this from the website at www.hhs.gov/ocr/hipaa/.

Other privacy rights
Another law provides additional privacy protections to patients of alcohol and drug treatment programs. For more information, go to the website at www.samhsa.gov.

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The Law Protects the Privacy of Your Health Information

Providers and health insurers who are required to follow this law must keep your information private by

- Teaching the people who work for them how your information may and may not be used and shared
- Taking appropriate and reasonable steps to keep your health information secure