CONSENT TO TREAT

To Parent(s) and/or Guardian(s):

Your school is now offering a telehealth clinic to provide medical care for your child when they become ill during school hours. The school-based telehealth clinic gives your child the opportunity to be seen by a licensed healthcare provider without having to leave school. Information regarding the telehealth clinic is listed below. Also, an explanation of services offered, including services by telehealth, is listed below. You do not have to be present for your child to be seen; however, a consent form must be signed by you in order for any services to be rendered.

DESCRIPTION OF SERVICES

Care for your child will be provided by a licensed healthcare provider either in person or by telemedicine. Telemedicine is the use of telecommunication and information technology to provide clinical health care from a distance. In our setting, there will be two-way video conferencing between a healthcare provider, the school nurse or assigned school official, and your child. Any exam that is requested by the healthcare provider will be accomplished by technology that allows a high-resolution visualization of ears, throat, and skin as well as a high-fidelity sound of heart and lungs. This will allow almost any visit to the nurse's office to result in an accurate medical assessment without your child needing to leave school. When your child presents with symptoms that are beyond the scope of care for a school nurse, your child will be seen virtually using diagnostic equipment via telehealth. An attempt to contact parents will be made prior to initiation of the primary care visit.

Services that will be provided at the school-based clinic for your child, include:

- Diagnoses and treatment for acute illnesses and minor injuries such as strep throat, ear infections, rash, and influenza
- Limited laboratory testing
- Management and ongoing care of existing medical conditions such as diabetes, asthma, etc.

Your insurance will be billed for services provided in the My Virtual Clinic. If you do not have insurance or Medicaid coverage, services can be provided on a sliding fee scale that is based on your household income. Applications are available at the registration desk. If you or your family is underinsured or uninsured, please contact Kristie Hardesty with Claim Aid at (812) 699-6067, the PACE Community Action Agency at (812) 890-2322 or the Indiana Division of Family Resources at (800) 403-0864 to assist you with obtaining insurance coverage or other resources that may be available to you and your family.

By signing this form, it means that you understand that this is a Telehealth visit. You also understand that you are ultimately responsible for any charges that are not otherwise covered by insurance or any other payer source.

STUDENT INFORMATION

Student's Name (Last, First, Middle Initial)

____

HOURS OF OPERATION

The school-based telehealth clinic will be open Monday-Friday from 8:00 am -3:00 pm.

Gender: M_ F_ Birth of Date: ______________________________

Address: ____

City: _______________ Zip: __________ Primary Phone: ____________________

Parent Email: ____

Mother/Guardian: ____________________________ Phone: ______________________

Father/Guardian: ____________________________ Phone: ______________________

Guarantor: ___________________________________ DOB: ________________________

In case of an emergency, please tell us a local friend or relative (not living in the same address) whom we may contact.

Name: ________________________ Relationship: _______________ Phone: ______________

INSURANCE INFORMATION (check all that apply to your child)

***** Please attach a copy of your insurance card**

□ ***Commercial/Private***

Name of Primary Insurance Company: ______________________________________

Insurance ID #__________________________ Group Number ____________________

Policy Holder Name: ________________________ Date of Birth: __________________

Relationship to Patient: ____

Place of Employment: ____

Name of Secondary Insurance Company: ____________________________________

Insurance ID #__________________________ Group Number _____________________

Policy Holder Name: ________________________ Date of Birth: ___________________

Relationship to Patient: ____

Place of Employment: ____

□ ***Medicaid***

Medicaid ID#____

Please check one:

Anthem ___ MHS ____

CareSource ___ Other ____

MDwise ___ Unsure ____

□ ***No Health Insurance***

If your child does not have health insurance, would you like someone from Greene County General Hospital to contact you to enroll into health insurance?

Yes _____ No _____

HEALTH QUESTIONNAIRE

Does your child have any known allergies (foods, medications, etc)? Yes____ No____

List all known allergies: ____

____

Does your child have any physical disabilities? Yes _____ No _____

If yes, please explain: ____

Is your child currently being treated for any health or mental health problems?

Yes ____ No_____

If yes, explain and list who is providing the treatment: ____________________________

____

Does your child receive daily medications? Yes ____ No ___

Please list all medications, the dosage, and when given:

(Please use a seperate page if needed)

Name of Medication	Dosage	Time Given
1.		
2.		
3.		
4.		

Primary Care Doctor: ____

Office Address: ____

Telephone Number: ____

If we need to call in a prescription, which pharmacy would you like us to call?

____

FAMILY HISTORY

(Mother-M, Father-F, Brother-B, Sister-S, Grandmother-GM, Grandfather-GF)

Please specify who has or had any disease listed below by using the abbreviations above.

	Family Member		Family Member		Family Member
Asthma		Allergies		Birth Defects	
Blood Disorders		Cancer		Tumors	
Cystic Fibrosis		Diabetes		Ear/Eye Disorder	
Heart Trouble		High Blood Pressure		Kidney Problems	
Lung Disease		Tuberculosis		Seizures	
Mental Illness		Muscle Disease			

There is no family history of the above diseases ______

Does the student or anyone in the home:

	Yes	No	Name of Person	Relationship to student
Smoke				
Drink				
Use drugs				
Chew tobacco				

CHILD’S MEDICAL HISTORY

Please check if your child has or had any diseases listed below.

Conditions

- ◻ Allergies
- ◻ Allergic to drugs
- ◻ Anemia
- ◻ Kidney/Urinary Tract Problems
- ◻ Problems walking
- ◻ Other respiratory problems
- ◻ Asthma
- ◻ Shortness of breath during exercise
- ◻ Stomach ulcers
- ◻ Skin rashes
- ◻ Abdominal pain
- ◻ Constipation/diarrhea
- ◻ Serious digestive problems
- ◻ Chicken pox AGE ____
- ◻ Ear problem
- ◻ Ear infections
- ◻ Hearing aid
- ◻ Eye problem
- ◻ Wears glasses
- ◻ Muscular-skeletal problems
- ◻ Rheumatic fever
- ◻ Physical/sexual abuse
- ◻ Hemophilia
- ◻ Fainting spells/knocked out
- ◻ Frequent sore throat
- ◻ Headaches
- ◻ Heart murmur
- ◻ Heart problems
- ◻ High blood pressure
- ◻ Thyroid problems
- ◻ Diabetes
- ◻ Hepatitis
- ◻ Injuries (major)
- ◻ Broken bones

Behavior History

- ◻ Nightmares
- ◻ Bedwetting
- ◻ Eating problems
- ◻ Thumb sucking
- ◻ Discipline problems
- ◻ Overactive/hyperactive
- ◻ Shy
- ◻ Sleeping problems
- ◻ Slow development
- ◻ Learning disability
- ◻ Smoker
- ◻ Former smoker
- ◻ Alcohol
- ◻ Inhalant abuse
- ◻ Other drugs
- ◻ Depression
- ◻ Other behavioral problems

Other Medical History

- ◻ Frequent colds
- ◻ Lung problems
- ◻ Meningitis
- ◻ Menstruation Started AGE ____
- ◻ Menstrual problems
- ◻ Premature birth WEIGHT _____
- ◻ Obese/Overweight
- ◻ Underweight
- ◻ Serious acne
- ◻ Speech problem
- ◻ Pregnant
- ◻ Other blood disorders
- ◻ Cancer

Explain any CONDITIONS, BEHAVIOR or MEDICAL HISTORY checked: (use backside if needed)

MY CLINICS
From the family of Greene County General Hospital

CONSENT

Child's Name________________________ D.O.B.________________________

This consent is for the treatment of your child by the school-based telehealth clinic through My Clinics, a department of Greene County General Hospital, hereafter referred to as My Clinics, a licensed healthcare provider that provides standard clinical health care treatment and telemedicine.

Telemedicine is the use of telecommunication and information technology to provide clinical health care from a distance and in this case, provided through a telehealth clinic. This means that there will be two-way video conferencing between the healthcare providers, located at My Clinics, and your child with the school nurse or assigned school official. Any exam that is requested by the healthcare provider will be accomplished either onsite at the clinic or by technology that allows a high-resolution visualization of ears, throat, and skin as well as a high-fidelity sound of heart and lungs. This will allow almost any visit to the nurse's office to result in an accurate medical assessment without your child needing to leave school.

Before a student is seen by a My Clinics healthcare provider, a signed consent form authorizing the services must be on file. In addition to the consent on file, an attempt will be made to contact the parent/guardian before each visit in an effort to receive verbal consent for the child to be seen. Please check the appropriate box below regarding verbal consent.

- ☐ I give permission for my child to be seen by a My Clinics healthcare provider if verbal consent from parent/guardian is not received, e.g., unable to contact parent/guardian by telephone, etc.
- ☐ I DO NOT give permission for my child to be seen by a My Clinics healthcare provider if verbal consent from parent/guardian is not received. I want to speak with the school nurse before my child is seen.

A My Clinics healthcare provider may, depending on the diagnosis, prescribe medication to students seen at the school-based telehealth clinic. In the event that the My Clinics provider prescribes medication, they will make every effort to contact the student's primary care provider (identified on page 4 of this packet). Such a contact requires the consent of the student's parent or guardian. Please check the appropriate box below regarding contacting your child's primary care provider.

- ☐ I consent to the school-based telehealth clinic notifying my child's primary care provider (identified on page 4 of this packet) that a My Clinics provider has issued a prescription for my child. I understand that the school-based telehealth clinic may provide instructions to follow at home and that it is my responsibility to arrange follow-up care and to follow through on any instructions provided. I understand that I should contact the school-based telehealth clinic for any necessary follow-up care or instructions.

- ☐ I DO NOT consent to the school-based telehealth clinic notifying my child's primary care provider (identified on page 4 of this packet) that a My Clinics provider has issued a prescription for my child.

I, the undersigned,

- Give permission and consent for my child to have treatment through and by My Clinics, including via telemedicine technology.
- Have received a brochure describing telemedicine and My Clinics. I understand the information provided including the details and limitations of the form and style in which medical services will be provided.
- Understand that this consent form is valid for as long as the student is enrolled in the school or until I provide the school nurse with written directions otherwise.
- Give permission for My Clinics, the school nurse, and my child's primary health care provider to speak with and share medical information about my child's health issue on an as needed basis, with the understanding that this information will be treated in a confidential way. I understand that I have the right, upon request, to inspect and receive a copy of all such records being disclosed.
- Give permission for My Clinics to receive information from the school and my child's primary health care provider about my child's health history.
- Acknowledge that I have been offered a copy of the Notice of Privacy Practices (available on the school website or at the school nurse office).

Child's Name_________________________ D.O.B. ______________________

- As Parent/Guardian of the above student, I:
    - Authorize the release of any information necessary to process insurance claims for payment of benefits to My Clinics.
    - Authorize payment of benefits to My Clinics for services rendered.
    - Have provided details of all insurance policies that cover my child.

I have read and understand this entire form and attest that the information above and on the proceeding pages are true and complete to the best of my knowledge. By typing your name below, you understand that you are electronically signing this document and are agreeing to all of the policies, terms, and conditions set forth above. You further understand that Greene County General Hospital, will rely upon your electronic signature to the same extent as if you had signed this document in ink.

Parent/Guardian name PRINTED: ______________________________________

Parent/Guardian SIGNATURE: ______________________________________

Date: ______________________________________