Consent for Telehealth Services at School Health Center
Tangipahoa Parish School Board
2021-2022 School Year

School: _____

I, _____(parent/ legal guardian name), give lawful consent for my child,

_____ _____ _____
Student's Last Name Student's First Name Student's Date of Birth

to receive health-related services. I understand that these services will be performed when my child is at school, and that visits will be performed through a live, "real time," audio-video connection, through telehealth, where a physician, nurse practitioner or physician assistant with the assistance of the school nurse, will examine child using specialized audio and video (camera and lenses) equipment, through a private, HIPAA Compliant internet connection. It will be my responsibility, as parent/guardian, to notify the clinic staff of any changes in parental guardianship, in legal custody arrangements, and of contact telephone numbers, e-mail address or other contact information.

I understand that health care provided at school may include preventive services, as well as other services related to health and wellness, and treatment for some illnesses. An attempt will be made to notify me so that I can attend all scheduled health care appointments for my child, either in-person, or using a speakerphone installed at my child's school campus. I understand that I will receive a follow-up notice from the clinic if additional health care services are recommended for my child. I understand that a visit summary may be provided to my child (to be brought home) or sent to his/her regular primary care provider to provide for continuity of care. I understand that although my child will be treated at school, my child's treatment will be provided under the supervision and care of the clinic and not by the school or school board. I further understand that although school nurses or other school personnel may assist the clinic in my child's treatment (e.g., by taking vital signs, administering medication, etc.), any such treatment is provided under the direction and care of the clinic. As a condition of my child's participation in the school health center, I hereby release the school board for any claims or damages resulting from my child's treatment by the clinic. As well, I grant the Tangipahoa Parish School Board consent to provide clinic with any personally identifying information needed to provide treatment for my child.

The following are the available clinics that will be providing telehealth visits through the school. Please select which clinic you would like to provide telehealth visits for your child. If no preference is desired, please mark the no preference box.

[ ] Total Family Medical **[ ] Family Healthcare of Loranger**

[ ] Family Healthcare of Bedico **[ ] Strawberry Patch Pediatrics**

[ ] No Preference

_____ _____
Parent/Guardian Signature (student under age 18) **Date**

_____ _____
Student Signature (if 18 or older or emancipated) **Date**

SERVICES WILL NOT BE PROVIDED WITHOUT CONSENT AS REQUIRED BY LAW.

_____ **I do not wish for my child to participate in telehealth visits.**

_____ _____
Parent/Guardian Signature (student under age 18) **Date**

_____ _____
Student Signature (if 18 or older or emancipated) **Date**