2021-2022 HEALTH SERVICES CONSENT

SCHOOL: _____ TEACHER: _____

STUDENT'S FULL NAME:

_____

STUDENT'S SOCIAL SECURITY # _____ BIRTHDATE: _____

MALE _____ FEMALE _____ RACE _____

ADDRESS: _____ CITY: _____ ST: KY ZIPCODE: _____

ANY KNOWN DRUG ALLERGIES: NO_____ YES_____ IF YES, PLEASE LIST _____

MEDICAL INSURANCE: _____ POLICY # _____

PRIMARY CARE PROVIDER: _____ PHONE #: _____

PHARMACY: _____ PHONE #: _____

MOTHER'S NAME: _____ _____ PHONE # _____

FATHER'S NAME: _____ PHONE # _____

EMERGENCY CONTACT: _____ _____ PHONE # _____

PLEASE LIST ANY OPERATIONS, HOSPITALIZATIONS OR SERIOUS INJURIES OR ILLNESSES: _____

_____

PLEASE LIST ANY OF THE STUDENT'S FAMILY MEMBERS HEALTH PROBLEMS:

MOTHER: _____ FATHER: _____ GRANDPARENTS: _____

I authorize payment to be made to Family Health Care Associates (FHCA) on my behalf for services received. I also release this information to Medicaid/ K-Chip for billing purposes for visits to the school health clinic. I understand that no guarantees are being made as to the effects of any exam or treatment on my child. I acknowledge receipt of the Notice of Privacy Practices (NPP) and Bill of Rights. I request that payment of authorized medical insurance benefits be made to FHCA on my behalf for services rendered to my child. I have read this statement and understand that my signature indicates that I do consent and assign benefits as stated above. I also authorize FHCA staff providing services at the school clinic to provide health information from my child's medical record to and from the designee of the school and my child's physician only as needed under the guidelines of HIPAA and FERPA consistent with Federal Laws for the purpose of providing safe and appropriate school health services and programs. I consent to care which may include screening, assessments, lab tests, treatment, first-aid, over the counter and/or prescription medication, telemedicine and any other health service given to my child by staff or agents of FHCA. I authorize the school health clinic staff to release medical information about my child that impacts learning environment to his/her/primary care provider, school principal/guidance counselor or designee. Incase you are going to have clinical visits using videoconferencing technology; you will be able to see and hear the provider and they will be able to see and hear you, just as if I were in the same room. Since 1994, the technology has connected tens of thousands of patients and providers in Kentucky. The information may be used for diagnosis, therapy, and follow-up and/or education. Expected Benefits: Improved access to care by enabling a patient to remain within the facility and obtain services from providers at distant sites; Patient remain closer to home where local healthcare providers can maintain continuity of care; Reduced need to travel for the patient or other provider. The Process**:** I will be introduced to the provider and anyone else who is in the room with the provider. I may ask questions of the provider or any telemedicine staff in the room with me, if I am unsure of what is happening. If I am not comfortable with seeing a provider on videoconference technology, I may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are being implemented to insure videoconference is secure, and no part of the encounter will be recorded without your written consent. Possible Risks**:** There are potential risks associated with the use of telemedicine which include, but may not be limited to; A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision; Technology problems may delay medical evaluation and treatment for an encounter; In very rare instances, security protocols could fail, causing breach of privacy of personal medical information. By Signing this Form, I understand the following:1.) I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent, except as noted above. 2.) I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. 3.) I also understand that if the provider believes I would be better serviced by a traditional face-to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit. 4.) I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. 5.) I release the School District/Board of Education and Family Health Care Associates from any liability related to the administration of medication or treatment so long as Reasonable and Customary Care is provided. Patient Consent to the Use of Telemedicine: I have read and understand the information provided above regarding telemedicine, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care. I hereby authorize FHCA to provide any services listed above in the course of my diagnosis and treatment.

Parent/Legal Guardian Signature: _____ Date_____