Goodside Health

2021–22 Goodside Health SchoolMed Consent Form

Goodside Health ("GSH") has partnered with your district to bring on-demand telehealth services to your school! Through our partnership, your child can be tested and treated for Strep, Flu, and COVID-19 as well as sore throat, headache, skin rash, pink eye, upset stomach, and the common cold. Goodside Health even allows children to receive sports physicals and age-appropriate mental health screenings. The medical providers can treat all students regardless of residency or insurance status with most visits delivered at little to no cost to families and translation services are available. To participate in this program, please complete and return this form.

Program Registration

1) _____ **In order to receive services from Goodside Health, please initial to consent for your child to participate in the GSH in-person and telemedicine program**

2) _____ **I agree to the Terms and Conditions and acknowledge receipt of the Notice of Privacy Practices** (https://goodsidehealth.com/terms-conditions/) *(by opting out, we cannot treat your child)*

3) In partnership with your school district, GSH offers additional services such as mental health screenings. **Would you like your child to have access to these services and programs?** *Please note, in order to participate in optional services, you must initial above in question 1 and 2.*

   Yes / No Screening for mental/behavioral health by a GSH healthcare provider

   Yes / No Consent to share parent/guardian and student information with Vida Clinic, LLC (or similar partners) for students who on the screening are at increased risk for mental/behavioral health conditions

Student Information

First Name: _____ **Last Name:** _____

Date of Birth (MM/DD/YYYY): _____ **Grade Level:** _____

District: _____ **School/Campus:** _____

Primary Care Physician & Pharmacy

Does your child have a primary care physician? Yes / No

If "**Yes**", please provide the below information to maintain continuity of care:

Name of Primary Care Physician/Practice: _____

Preferred Pharmacy: _____ **Pharmacy Zip Code:** _____

Consent to share your health record with your primary care physician? Yes / No

HIPAA Contact

HIPAA Approved Contact Name: _____

Relationship to Patient: _____ **Phone Number:** _____

HIPAA approved contact has permission to:

Consent to Treat: Yes / No

Medical Information: Yes / No

Billing Information: Yes / No

Medical History

Current Daily Medications (Please write **NONE** if the patient is not taking any medications):

_____

_____

Known Allergies (Please write **NONE** if the patient does not have any known allergies):

_____

Patient Insurance

Does your child have health insurance? Yes / No

If "**Yes**", then what type of insurance?

Medicaid* / CHIP / STAR / Private Insurance / My child does not have health insurance**

Medicaid Information*

Member ID: _____

Private Insurance Information**

Insurance Name: _____

Policy Number: _____

Parent/Guardian Consent

By completing this form, I am confirming that I would like my child to participate in the district telemedicine program, operated by Pediatric Urgent Care, PA dba Goodside Health ("GSH"), and agree for them to have access to these enhanced medical services at school. This consent/authorization may be withdrawn in writing at any time.

Parent/Guardian Printed Name: _____

Email: _____

Phone Number: _____

Date of Birth (MM/DD/YYYY): _____

Relationship to Student: _____

Consent to Treat Signature: _____ **Date:** _____