Project VIDA HEALTH CENTER

Life In Community • Vida En Comunidad

A Project of the Cumberland Presbyterian Church • The Presbyterian Church (USA) • **www.pvida.net**

School Name: _____

Student ID: _____

Grade: _____

☐ Current Student

☐ Sibling of current student

Consent to PVHC School-Based Telehealth Services

STUDENT INFORMATION

Student Name:			Date of Birth:		
Street:			Apt Number:	Zip code:	
City:		Use of student's phone and email information will be based on parent/guardian's consent.			
Gender:	☐ Male ☐ Female	Student Phone:	Student Email:		
Race:	☐ White ☐ Other	☐ Black/African American ☐ I do not wish to report	☐ Asian ☐ American Indian/Alaskan Native	☐ Pacific Islander	
Ethnicity:	☐ Hispanic ☐ Non-Hispanic	Is student a returning patient of Project Vida Health Center?	☐ Yes ☐ No	Is student homeless?	☐ Yes ☐ No

PARENT INFORMATION

1.Parent/Guardian Name:	Phone:	Phone – Alternate:	Relationship to student:
2.Parent/Guardian Name:	Phone:	Phone – Alternate:	Relationship to student:
Emergency Contact Name:	Phone:	Phone – Alternate:	Relationship to student:
Parent/ Guardian email:	Do you consent for Project Vida to reach student for telehealth services through their personal email and/or phone through voice or text message?		☐ Yes ☐ No

INSURANCE

Does the student have insurance?	☐ Yes ☐ No	Type of insurance:	☐ Medicaid ☐ Private ☐ CHIP
If student is uninsured, Navigator can provide assistance for insurance enrollment or determine sliding scale eligibility.			
Name primary of insurance plan:		Insurance ID #:	
Name secondary of insurance plan:		Insurance ID #:	
Dental Insurance		Insurance ID #:	

Student Name: _____ DOB: _____

CONSENTS FOR PROJECT VIDA HEALTH CENTER TELEHEALTH SERVICES

- I am the custodial parent or legal guardian of the minor child named. I understand that I may not be required to attend my child's pediatric appointment, but I may if I choose. I authorize a Project Vida Health Center provider to treat my child in my absence and if necessary, an authorized adult may accompany my child to receive services. The authorized adult may be a Project Vida Health Center employee, Clint ISD employee and/or an adult named by either the parent/guardian.
- I understand that I must be present for the initial appointment for Therapy services and each appointment for Psychiatry services
- I authorize and consent to this child receiving the following services from Project Vida Health Center, and its affiliated providers under the terms provided below. Services may include, but are not limited to:
  - Services including but are not limited to: immunizations, well-child exams, sports physicals, acute care for minor illness and injury, management of chronic illness, mental health services and, basic health education.
  - Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
  - Medically prescribed laboratory tests as per providers' discretion and best practice.
  - Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
  - Behavioral health services including psychiatry, counseling, therapy, peer recovery coaching, evaluation, diagnosis, treatment and referrals.
  - Reproductive health care services, including contraception, testing for pregnancy, STI screening and treatment, HIV testing, and referrals for abnormal results, as age appropriate per the Texas Family Code.
  - Health education, peer support and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse. As well as education on prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate.

*See attached information regarding reproductive health services and parental consent.

Consent for: ☐ Pediatric Services ☐ Behavioral Health Services

Parent/Guardian Signature: _____ Date: _____

·I have read and understand the services listed above and consent for my child to receive medical care, treatments, and on-site diagnostic tests that Project Vida Health Center believe are necessary for my child

DISCLOSURES, RELEASES & AUTHORIZATIONS

- I authorize the school nurse/school representatives, the local public health department(s), dentist, and/or medical provider to obtain my child's medical records as needed based on the provider's discretion, which may include vaccine records, laboratory testing, radiograph results, HIV status, and behavioral health and substance abuse issues.
- A clinical summary is provided following most visits. This clinical summary will contain my child's personal health information which includes, but is not limited to: the patient's name, date of birth, medical diagnoses, medications and health education. This summary may be in the format a phone call, or if web-enabled through the HEALOW app.
- I have had the opportunity to ask any questions and have had them answered in a language that I understand. I further agree to abide by the terms of this consent. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.
- I acknowledge receiving notice of privacy practices today before signing.
- I understand that some of these services can be received in a virtual, or physical modality based on provider's assessment of client's needs.
- By signing below, I understand that in the case of an emergency, emergency medical services may be contacted per the discretion of the medical provider.
- I understand I may receive a bill for my co-payment or co-insurance. I also have been made aware of Project Vida Health Center's Financial Agreement.
- I agree to the terms and information above. I am giving this consent of my own free will.

Parent/Guardian Signature: _____ Date: _____