McLeod Health
The Choice for Medical Excellence

School-Based Telehealth Program

We are excited to announce that we are working with McLeod Health for our School-Based Telehealth Program (SBTP).

The SBTP will allow students to receive health care services conveniently during school hours in the school health room. This service is not designed to replace your primary care provider; rather it will provide diagnosis and treatment of non-emergent conditions that may occur during the school day. These visits include the ability for rapid testing (i.e flu, strep, urine).

A McLeod Health Board Certified Nurse Practitioner or Physician will provide the clinical assessment and treatment plan. The service will be just like a normal doctor's visit but the student will connect with the provider using video conferencing equipment. The school nurse will make every effort to contact the parent or legal guardian before the visit occurs and will send a link to the parent to join the visit. Following the visit, a summary will be sent to the student's doctor and any necessary medications will be sent to the pharmacy listed on the Demographic and Health Questionnaire.

This service is designed to:

- Get students better, quicker
- Reduce the number of days the student will be absent from school
- Reduce the amount of time the parent/legal guardian will be away from work
- Eliminate barriers (i.e. transportation issues, parent/legal guardian unable to leave work) that may interfere with the student's access to healthcare

If you would like for your child to have the opportunity to participate in this program (SBTP), check here:

- o Yes
- o No

For additional information, please contact your designated School Nurse or McLeod Health Representative below.

Ebony Legette
Telehealth Manager
843-777-5897
Ebony.Legette@McLeodHealth.org

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Florence 1 Schools
Students first

School-Based Telehealth Program (SBTP)
CONSENT FOR RELEASE OF EDUCATION RECORDS & INFORMATION

Florence Schools (the District) shall obtain written consent before disclosing any personally identifiable information from an education record. I understand that the District will operate under the guidelines of the Family Educational Rights and Privacy Act (FERPA), state statutes and regulations, and state and District policies and procedures to ensure confidentiality regarding the release of student information. No information will be released or secured without prior approval from the parent, except as provided by law.

The District has my permission to release and exchange medical, psychological, and other educational or personally identifiable confidential information (i.e., absences, academics or nurse visits), as necessary, to representatives of the School-Based Telehealth Program. I understand that the purpose of this consent is to refer my child for health-related services and treatment.

Consent to Release Confidential Information

By providing my signature below, I understand that granting consent for the release of personally identifiable information from my child's education records is voluntary and may be revoked at any item. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

By providing my signature below, I understand the recipient of these records must obtain my written consent before it can further share my child's information from the District with any other party, such as for the purpose of billing Medicaid. If I provide written consent for the service provider to share my child's information with another party, the re-disclosure of my child's information by the recipient may no longer be protected.

_____	_____	_____
Parent/Legal Guardian (*Printed)*	Student's Name *(Printed)*	Student's Date of Birth

_____	_____	_____
Parent/Legal Guardian Signature	Relationship to Student	*Date/Time

**** Required if date and/or time does not populate in the electronic signature box or when hand-signing this document.***

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McLeod School-Based Telehealth Program: Consent for Treatment

I_____am the parent/guardian of_____whose date of birth is_____. I hereby give my consent to the McLeod School-Based Telehealth Program, in coordination with the school nurse or school clinic, to perform the telehealth examinations, treatments and related services as may be necessary in accordance with the judgment of the telehealth providers **WITHOUT MY BEING PRESENT.** I understand the school nurse or school clinic will make every effort to contact me prior to or during treatment to let me know my child is being taken care of. I consent to the care or treatment, which may encompass necessary laboratory, diagnostic or medical treatment and procedures; and prescribed medication information, if available; or recordings and/or filming for internal purposes, which the telehealth providers may deem necessary or advisable during this episode of care. I understand this care and treatment will be provided by the authorized workforce members of McLeod Health, including its physicians, nurse practitioners, physician assistants and nurses.

I understand I have the right to ask the telehealth provider to discontinue the telehealth conference at any time.

I acknowledge that cameras and video cameras may be used for observation, medical documentation purposes, telemedicine and that the images are the property of McLeod Health unless I withdraw my consent in writing. I acknowledge that other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.

I give my permission to share my child's electronic medical record among his/her health providers and obtain medication history through a provider Health Information Exchange (HIE) which will follow state and federal laws regarding access by medical providers of any protected health information. I may opt out of the HIE exchange, in writing, and will continue to receive care.

I consent to the use of the electronic prescription system, which allow prescription history and related information to be electronically shared between the child's providers and my pharmacies.

I understand that certain medical information is required to be disclosed to organizations such as some state health departments. An example of a disclosure is to a statewide immunization registry, which complies with federal health information privacy laws.

I agree to provide current medical history on my child and provide contact information related to any current medical providers for my child. I give permission to send or fax childhood immunization records to schools or upon my request.

Medicare-Medicaid Patient's Certification: Payment Request: I assign payment for the unpaid charges for certain physician services furnished by specialists, and physicians for whom McLeod Health is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance. I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security act is correct. I request that payment of authorized benefits be made on my behalf.

Payment Guarantee: I hereby jointly and severally agree to pay all charges, not covered by my health plan, for services received by the patient named above during this episode of care.

I consent to all communications by McLeod Telehealth School-based program to my telephone or cell phone, via text messages or emails. I acknowledge and understand that methods of contact may include using a pre-recorded/artificial voice message and/or use of an automatic telephone-dialing device.

_____	_____	_____
Patient's (Guarantor's Signature)	Relationship to Patient	*Date/Time
_____	_____	
Patient's Name	Date of Birth	

Acknowledgment of the Notice of Privacy Practices

I acknowledge I have been given the opportunity to review the McLeod Health Notice of Privacy Practices which explains how my protected health information may be used or disclosed and outlines my HIPAA rights. I acknowledge that I have been allowed to ask questions. If I am not the patient, I represent that I am authorized, by law, to act for and on the patient's behalf.

_____	_____	_____
Signature of Patient or Authorized Agent	Relationship to Patient	*Date/Time

McLeod Health complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, disability, age, sex, religion, gender identity or sexual orientation.

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Authorization for the Use or Disclosure of Protected Health Information for the McLeod School-Based Telehealth Program

Patient Name:_____ Date of Birth: _____

I authorize McLeod Health (Provider) to disclose the "protected health information" (PHI) of the above named child to the _____ (Name of School) school nurse or clinic.

Purpose(s): The purpose of the disclosure of PHI to the above named school is the participation in the school-based health services.

I understand that PHI may include records disclosed by health care providers and facilities that previously provided treatment to the child.

A) I understand that PHI may include information and records protected under Federal Law (such as alcohol and drug abuse treatment and 42 CFR Part 2) and/or State Law (such as mental health, AIDS, or HIV).
B) I understand I may revoke this Authorization at any time however, the revocation will not apply to PHI that has already been used or disclosed pursuant to this authorization. Contact the McLeod Health HIPAA Officer to initiate the revocation process.
C) I understand that McLeod Health will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
D) I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy standards.
E) I understand that this Authorization will expire at the conclusion of the school's participation in the McLeod Health School-Based Telehealth Program.

I understand that medical information will be used for reports and to evaluate the school-based telehealth program however my child will not be identified in the information.

I have read and understand this Authorization. I certify that I am the Patient listed above or a person authorized to permit release of records on the Patient's behalf. I hereby release the Provider (as named above) from any liability or damages arising in connection or related to with the use and/or disclosure of my protected health information pursuant to this Authorization.

_____	_____	_____
Print Patient Name	Patient Signature	*Date/Time
_____	_____	_____
Authorized Representative	Relationship to Patient	Telephone Number

PROVIDER USE ONLY:

Received on: _____ Disclosure on _____ Copy to Patient on _____

Disclosure by: _____ Authority: _____

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School-Based Telehealth Program: Demographic Information

PROVIDE PATIENT INFORMATION:

Grade: _____ Birth Date: _____ Age: _____

Name (Last): _____ (First): _____ Middle Name:_____

Street Address: _____ City: _____ State: _____ Zip: _____

Gender: ☐ Male ☐ Female

Primary Language: ☐ English ☐ Spanish ☐ Other

Race: ☐ Black ☐ White ☐ Hispanic ☐ Asian ☐ Other

Parent or Guardian Name: _____

Relationship to Patient: _____

Parent or Guardian Birth Date: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ (Cell): _____ (Work): _____

Parent or Guardian Email Address: _____

Doctor's Name: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

PROVIDE PATIENT INFORMATION.
Please submit a copy of the front and back of your Medicaid/Insurance card to the patient's school.

☐ 1. Medicaid Number: _____

Medicaid Plan: _____

☐ 2. Private Medical Health Insurance: _____

Name: _____

Policy: _____ Group ID#: _____

Who (Name) Insures Child?_____

Insurer's Phone Number: _____

Relationship to insured child: _____

Employer's Name: _____

☐ 3. No Insurance

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School-Based Telehealth Program (SBTP)
HEALTH QUESTIONNAIRE

Patient Information

Patient's Full Name: _____
Last Name *First Name* *Middle Name*

Date of Birth: _____

Known Allergies: _____

_____

_____

_____

Medications Currently Taking: _____

_____

_____

_____

Medical History of Patient (check all that apply):

- ☐ Ear infections (Frequent)
- ☐ Dizziness/Fainting
- ☐ Nose Bleeds
- ☐ Sore Throats (Frequent)
- ☐ Hayfever/Allergies
- ☐ Asthma/Wheezing
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Loss of Appetite
- ☐ Indigestion or Heartburn
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Urine Infections (Frequent)
- ☐ Blood in Urine
- ☐ Weight Loss –Recent
- ☐ Anemia
- ☐ Diabetes
- ☐ Convulsions/Seizures
- ☐ Headaches (Frequent)
- ☐ Bone Fracture/Joint Injury
- ☐ Rashes
- ☐ Hives
- ☐ Eczema
- ☐ Nervousness
- ☐ Depression
- ☐ Moodiness-Excessive
- ☐ Phobias
- ☐ Mental Illness
- ☐ Lactose Intolerance
- ☐ Frequent Infections

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HEALTH QUESTIONNAIRE

Hospitalizations or Surgeries

Date:_____ Reason:_____

Date:_____ Reason:_____

Date:_____ Reason:_____

Date:_____ Reason:_____

Family History of Immediate Family Members (check all that apply)

Condition

- ☐ Alcoholism
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Epilepsy/Convulsions
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Migraine
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other:_____
- ☐ None