


Name MRN DOB (Patient Identification)	 VCU Health TM VCU Medical Center School Telemedicine Program Consent to Participate
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I agree to allow my child _____ to participate in a telemedicine consultation with a provider at MCV Associated Physicians and/or Virginia Commonwealth University Health System (collectively, MCVPCUHS) during the 2024-2025 school year. A Telemedicine consultation means that through a video or Internet connection, my child, or the school nurse on behalf of my child, will be able to consult with a provider about their medical condition, The purpose of this consultation is to provide access to health care services through the use of a real-time interactive video link, or a store and forward consultation.

Since this telemedicine consultation may be different than the type of consultation with which I am familiar, I understand and agree to the following:

1. Details of my child's medical history, examinations and tests may be discussed with providers participating in the telemedicine visit at MCVPCUHS or with other personnel as indicated prior to the evaluation in preparation for my child's consultation.
2. The MCVPCUHS physician or other health care provider will determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter
3. The physician or other health care provider examining my child may transmit, store on Internet-accessible web servers and share electronically via computer and network topologies or interactive two-way video systems, details of my child's medical history, physical examinations, prescriptions and tests (including photographs or X-rays) to physicians or other health care providers at MCVPCUHS, my child's primary care provider, as well as to my child's school nurse. Patient-identifiable information will not be shared with other parties without my express consent.
4. Encryption and security measures will be used, and with the exception of video conferencing, my child's identification will remain anonymous to anyone except those providing the care during the telehealth visit. I understand that there may be a potential risk to privacy as information transferred electronically may be more vulnerable to disclosure or tampering than information transferred by hand.
5. I agree to hold VCUHS/MCVP staff harmless for information lost due to technical failures.
6. Other medical or non-medical personnel may be present at the MCVPCUHS site during the video consultation.
7. Data, including x-rays, images and photos transmitted to the MCVPCUHS site, and the video recording of my child's consultation may be kept, reviewed, and used by the MCVPCUHS consultant in my child's medical record.
8. The physician or health care provider for whom the on-site examination or treatment is performed will keep a record of any report generated by the MCVPCUHS healthcare provider in my child's medical record.

My child's participation in telemedicine consultations is voluntary, and I understand that I have the right to terminate my child's participation at any time. I further understand that I have the right to:

1. Request that the referring physician or other health care provider (e.g. school nurse) omit specific details of my medical history or prior examinations that are personally sensitive to me.
2. Request that the referring physicians or other health care provider(s) refrain from transmitting my child's information if I make the request before the information is transmitted.

I have read this form, or it has been read to me. I have had the opportunity to ask questions and have my questions answered. By my signature, I agree for my child to participate in a telemedicine consultation as described above.

Child's Full Name _____ Date of Birth _____

Parent Name _____

Parent Signature _____ Date _____ Time _____



Telehealth Pilot Patient Questionnaire

Child's Name: _____ Birthdate: _____

We appreciate your cooperation in providing essential information about your child's medical care. Please answer the following:

1. Does your child have a doctor or family nurse practitioner he or she sees regularly?

_____ No _____ Yes

If yes, Name of Doctor/Nurse Practitioner/Clinic: _____

2. Do you give Children's Hospital of Richmond At VCU consent to send a summary of the telehealth visit to your child's medical provider? _____ No _____ Yes

Parent/Guarding Name (PRINT)

Parent/Guardian Name Signature

Date

Insurance Information

1. Is your child enrolled in Medicaid or other health insurance (OHI)? _____ Yes _____ No

If Medicaid, what is your child's Medicaid #: _____

2. For other health insurance please provide the following information and attach a copy of your health insurance card.

Name of Insurance Company: _____

Plan Name: _____

Group Number: _____

ID Number: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

Attach a copy of insurance card (scan or photo)

School Health Services Section only

School Name: _____

Grade: _____