!!TEMPLATE!!
Edit all appropriate details for your Telehealth offering

STUDENT HEALTH SERVICES CONSENT FORM

NOTE: *All students receive basic first aid treatment while at school. However, for students to be administered select stock over-the-counter (OTC) medications and/or to initiate a telehealth visit, parents/guardians must:*

1. *Sign the waiver below once per school year.*
2. *Give verbal consent at the time of the visit.*

STUDENT INFORMATION

Child's Name: _____ Birth Date: _____ Grade: _____

Gender: ▫ Male ▫ Female ▫ Other

Address: _____ Apt #: _____ City: _____ State: _____ Zip Code: _____

Father's name:_____ Home/Cell Phone: _____ Work Phone: _____

Mother's name: _____ Home/Cell Phone: _____ Work Phone: _____

STUDENT HEALTH HISTORY

Allergies to medication: ▫ Yes ▫ No

If yes, list medication: _____

Allergies to food: ▫ Yes ▫ No

If yes, list foods: _____

List medications taken daily: _____

List current medical conditions (ex: diabetes, asthma): _____

ADMINISTRATION OF STOCK MEDICATIONS AT SCHOOL

Parents/Guardians may elect which OTC medications are administered while at school. Please select the medications you are consenting to be given while at school.

IMPORTANT: *Medications selected will not be administered without written consent below AND verbal consent at the time of visit.*

- ☐ I consent to all of the OTC medications below
- ☐ I consent to only the selected OTC medications below

☐ Acetaminophen (Tylenol)	☐ Cough drops (grades 6-12 only)
☐ Allergy eye drops	☐ Delsym (cough suppressant for lingering coughs only)
☐ Artificial tears	☐ Hydrocortisone cream
☐ Benadryl	☐ Ibuprofen (Advil)
☐ Bengay	☐ Oral gel
☐ Chloraseptic spray	☐ Tums

TELEHEALTH SERVICES

All students and staff are eligible to participate in school-based telehealth clinics, regardless of insurance coverage or financial status. To participate, a parent or guardian must complete this consent form and provide verbal authorization at the time of the visit. Telehealth provides students with virtual visits at school with an advanced practice provider (MD, DO, NP, or PA) through a secure platform.

District Nurses and Health Aides support students by assisting with the technology and equipment during the visit. Parents or guardians may also join the visit virtually. *Please specify during consent if you would like to be invited.*

For insured patients, any applicable billing is the responsibility of the patient and **not** the District.

Please choose ONE:

▫ I give consent for my child to be treated at school through a telehealth visit if deemed necessary by both the District Nurse AND parent/guardian at the time of the visit.

▫ I do NOT want my child to participate in the tele-health program.

Choose ALL that apply (optional):

▫ If possible, I prefer my child to be virtually connected with their own doctor, and subsequently billed.

Provider Name: _____ Office Phone: _____

▫ I am concerned about my ability to pay for a visit (uninsured, financial hardship, etc.) and would like to be considered for financial assistance.

TERMS & CONDITIONS

1. I certify that the information provided above is true and correct to the best of my knowledge and belief.
2. I understand that the clinic will attempt to contact me if my child seeks care beyond routine first aid, and that a visit will not be initiated without verbal consent from a parent or guardian at the time of service.
3. If selected above, I consent to my child receiving health services, which may include physical examinations; treatment of acute and chronic health conditions; health education; and limited diagnostic testing (e.g., throat cultures, urine dip tests).
4. I understand that school personnel do not have access to medical records and that all examination results and counseling are strictly confidential. I authorize patient records to be shared with the [State Health Center/healthcare consulting physicians] as necessary for care coordination.
5. If my child is diagnosed with a communicable disease, I consent to the [Clinic/Health Center/School District Clinic] sharing relevant medical information with the student's school, as required.
6. I understand that if my child must be sent home during school hours for medical reasons, a parent or guardian is required to pick them up within 45 minutes of notification from the school office.
7. I understand that services provided by the medical provider may be billed. I am responsible for any charges not covered by my insurance. Financial assistance is available for families without insurance or experiencing financial hardship.
8. I understand that I may withdraw my consent for my child to receive services at the [Clinic/Health Center/School District Clinic/Telehealth Clinic] at any time by submitting written notice to clinic staff.

CLINIC SERVICES WILL NOT BE DENIED BECAUSE OF INABILITY TO PAY

Printed Name of Parent/ Legal Guardian: _____

Signature of Parent/ Legal Guardian: _____

Date: _____