SCHOOL-BASED TELEHEALTH CLINIC CONSENT

Child's Name _____ D.O.B. _____

Before any student is seen at the School-Based Telehealth Clinic ("Telehealth Clinic"), a signed consent from must be on file. In addition to the consent on file, the parent/guardian will be contacted before each visit to receive verbal consent for the child to be seen. Please check the appropriate box below regarding verbal consent.

❑ I give permission for my child to be seen at the Telehealth Clinic if verbal consent from parent/guardian is **not** received. (Unable to answer phone, phone number disconnected, etc.)

❑ I DO NOT give permission for my child to be seen at the Telehealth Clinic if verbal consent from parent/guardian is not received. I want to speak with the school nurse before my child is seen. I understand that if I cannot be reached, my child will not be seen at the Telehealth Clinic.

I, the undersigned,

- Give permission and consent for my child to be seen by a licensed health care provider through and by the Telehealth Clinic. I have received information on and understand the nature of the treatment provided at the Telehealth Clinic, the way it is provided, and the details and limitations of this form and style of treatment.

- Understand that this consent form is valid for as long as the student is enrolled in New Castle Community School Corporation and that I may revoke this consent at any time by providing notice to the New Castle Community School Corporation Nurse, Community Education Center, 322 Elliott Avenue, New Castle, IN 47362.

- Understand that this consent constitutes the establishment of a Provider-Patient relationship between my child and any Provider, employed by Henry Community Health, who examines my child through the Telehealth Clinic for any and all encounters as long as the student is enrolled in New Castle Community School Corporation and that I may revoke this consent at any time by providing notice to New Castle Community School Corporation Nurse, Community Education Center, 322 Elliott Avenue, New Castle, IN 47362.

- Give permission for the Provider and the school nurse to speak with and share medical information about your child's health issue on an as needed basis, with the understanding that this information will be treated in a confidential way.

- Give permission for Henry Community Health to receive information from the school about my child's health history.

- Acknowledge that the school nurse is an employee of New Castle Community School Corporation and will be participating and assisting in the treatment of the student.

- Understand that Henry Community Health will document each encounter with my child in a medical record maintained by Henry Community Health and not the New Castle Community School Corporation.

- Acknowledge that I have been offered a copy of the Notice of Privacy Practices, which addresses the ways in which Henry Community Health maintains, uses and discloses my child's protected health information (available on the Henry Community Health website or at the school office).

- Understand that I will be contacted after my child is seen to discuss my child's diagnosis, treatment options and any need to seek in person care.

- Understand that I will receive a visit summary for my child's encounter, either in writing, over the phone, or via the Henry Community Health electronic portal which will include any instructions for follow-up care and any prescriptions issued for my child.

- As Parent/Guardian of the above student, I:
    - Authorize the release of any information necessary to process insurance claims for payment of benefits to Henry Community Health.

    - Authorize payment of benefits to Henry Community Health for services rendered.

    - Have provided details of all insurance policies that cover my child.

I have had the opportunity to read this form and the information provided. All my questions have been answered to my satisfaction. The information on the proceeding pages is true and complete to the best of my knowledge.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____