School-Based TeleHealth Enrollment Forms Overview

We are so excited to offer the School-Based Telehealth Program in your child's school! There are **three places for you to sign** to enroll your child in the program:

Form Name	Signature Required	Purpose
Demographic Information	No	Information to enroll your child in Telehealth Program
Pediatric History Questionnaire	No	**Complete these forms:** Please answer all question to the best of your knowledge, these forms provided valuable information to the medical provider.
Consent for Treatment	Yes	Signing this form allows your child **to receive medical care in the school.**
Consent for Release of Education Records and Information	Yes	**This form allows the school to work with the healthcare team.** Signing this form allows the school to share medical, psychological and other personal information about your child with the healthcare provider.
Authorization to Disclose Protected Health Information	Yes	**This form allows the health care team to work with the school.** Signing this form allows the healthcare providers to share medical, psychological, and other personal information about your child with the healthcare provider.

If you have any additional questions, please contact your school nurse or Little River Medical Center, School-Based Telehealth Coordinator at (843) 663 – 8032 or email to Telehealth@LRMCenter.com

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If you do not wish for your child to participate in the program, check the box below and return this page to your school nurse.

☐ I do not wish for _____ (student's name) to participate in the School-Based Health program at this time.

_____ _____

Parent/Legal Guardian's Signature Date

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School Based TeleHealth Clinic Patient Demographic Form

School's Name: _____ Grade: ____ Teacher Name: _____

Patient Name: _____ _____ _____

Last First MI

Patient Birth Date: _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female

Social Security Number _____ - _____ - _____ Primary Language: ☐ English ☐ Spanish ☐ Other _____

Is your child enrolled in the LRMC 's School Mobile Dental Program "Miles for Smiles" ☐ Yes ☐ No

Primary Care Provider: _____ Telephone Number: _____

Pharmacy Name & Location: _____ Telephone Number: _____

Parent or Guardian Name: _____ Relationship to Patient: _____

Parent or Guardian Birth Date: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone (_____) _____ Cell Phone (_____) _____

Work Phone (_____) _____ Ext: _____ (if applicable)

Best way to contact you ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Emergency Contact: Provide 2 emergency contacts in the event the parent/guardian cannot be reached.

Name: _____ Phone Number: _____Relationship:

_____

Name: _____ Phone Number: _____Relationship:

_____

PATIENT INSURANCE INFORMATION. Include a copy of the front & back of your Insurance card(s).

☐ 1. Medicaid Number: _____ Medicaid Plan:_____

☐ 2. Private Insurance Name: _____Policy Number: _____

Insured's Name: _____ Relationship to patient:_____

☐ 3. No Insurance, need information for special fee application.

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CONSENT FOR TREATMENT

Student Name: _____

I give my consent for my child, named above, to receive medical care from the School-Based TeleHealth Program. Care will be provided in a private manner and information will not be released without my consent. I allow physicians or designated health professional to provide necessary and/or advisable treatment for my child and to bill for this service. I understand that my child may receive medical care from providers, who are authorized by my child's school district but who are otherwise not affiliated with Little River Medical Center.

I authorize the holder of medical or other information about me to release to any other third party responsible for payment such as information needed for decisions of Medicare, Medicaid, or third-party claims.

I acknowledge that I will be responsible for any payments not covered by my health plan, to include deductibles. I understand this consent form is valid, until I revoke it.

I received a copy of the LRMC "Notice of Privacy Practices". To obtain an electronic copy of our "Notice of Privacy Practices" please visit our website at https://www.lrmcenter.com/wp-content/uploads/2017/06/Privacy-Notice-2017.pdf

_____ _____

Signature of Legal Guardian/Representative
(or student if 18 years or older or otherwise permitted by law)

Date

_____

Printed Name of Legal Guardian/Representative
(or student if 18 years or older or otherwise permitted by law)

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SCHOOL BASED AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

All healthcare information is private. By signing this form, you are giving the school clinic, the school nurse, and the student's main health care provider consent to speak with and share medical information about the student's health with LRMC as needed. This information will be treated in a confidential way.

The purpose of the disclosure is: participation in school-based telehealth services.

Examples of protected health information that may be shared include but are not limited to

- medical history (including any medical diagnosis and treatment),
- physical examinations,
- consults,
- lab reports,
- and a list of current medications.

I understand this information may include references to psychiatric/psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV/AIDS and /or alcohol abuse.

I understand that this information may be exchanged by mail, fax, email, phone, or a secure web-based software.

I understand that I have a right to cancel this permission at any time. I understand that if I cancel this permission I must do so in writing and present my written cancellation to the School-Based TeleHealth Program office. I understand that the cancellation will not apply to information that has already been released in response to this permission, as stated in the Notice of Privacy Practice. I understand this consent form is valid until I revoke it.

I understand that permitting the release of protected health information is voluntary. I can refuse to sign this form. I do not need to sign this form to receive treatment. I understand I may review and/or copy the information to be disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person/organization receiving the information. I understand I will be given a copy of this authorization. Parental consent for release of health information is not required for students who are 18 years or older.

_____ _____

Signature of Legal Guardian/Representative Date
(or Student if 18 years or older or otherwise permitted by law)

_____

Printed Name of Legal Guardian/Representative
(or Student if 18 years or older or otherwise permitted by law)

_____

Relationship to Patient

To contact the School-Based TeleHealth Program office at LRMC, in writing, the address is 4303 Live Oak Drive, Little River, SC 29566; the phone number is (843) 663-8032.

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CONSENT FOR RELEASE OF EDUCATION RECORDS AND INFORMATION

The Horry County School District (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 personally identifiable confidential information, as necessary, to representatives of the School-Based Health 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 time. 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). I understand this consent form is valid until I revoke it.

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 or commercial insurances. 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 by the requirements of the Family Educational Rights Act (FERPA). This consent remains effective until written notification is received.

_____ _____

Student's Name Student's Date of Birth

_____ _____

Parent's/Legal Guardian Signature Date

To contact the School Based TeleHealth Program office at LRMC, in writing, the address is 4303 Live Oak Drive, Little River, SC, 29566; the phone number is (843) 663 – 8032.

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School Based Pediatric Health Questionnaire (K-4 to 5th)

Complete this form and return it to your child's school nurse. **(Please Print)**

Form completed by: _____ Date: _____

_____	_____/_____/_____	_____	____' ____"	_____
Child/Student Name	Age Date of Birth (MM/DD/YYYY)	Age	Height	Weight

Child's Past Medical History (PMH)

No Significant PMH: ☐ Correct			Congenital Heart Disease:	☐ Yes	☐ No	Preterm Infant:	☐ Yes	☐ No
Abuse/Neglect:	☐ Yes	☐ No	Diabetes:	☐ Yes	☐ No	Seizure Disorders:	☐ Yes	☐ No
Allergic Rhinitis:	☐ Yes	☐ No	Drug Related Disorders:	☐ Yes	☐ No	Sinusitis:	☐ Yes	☐ No
Anemia:	☐ Yes	☐ No	Eyesight problems:	☐ Yes	☐ No	Special Education:	☐ Yes	☐ No
Asthma, bronchitis:	☐ Yes	☐ No	Fracture/broken bones:	☐ Yes	☐ No	Speech Difficulties:	☐ Yes	☐ No
Attention Deficient:	☐ Yes	☐ No	GERD/Acid Reflux:	☐ Yes	☐ No	Tuberculosis:	☐ Yes	☐ No
ADHD:	☐ Yes	☐ No	Headache:	☐ Yes	☐ No	Urinary Tract Infections:	☐ Yes	☐ No
Blood Disorders:	☐ Yes	☐ No	Hearing loss:	☐ Yes	☐ No	**Others:**		
Cancer:	☐ Yes	☐ No	Jaundice:	☐ Yes	☐ No	Kidney Disease:	☐ Yes	☐ No
Cerebral Palsy:	☐ Yes	☐ No	Mental Illness:	☐ Yes	☐ No	HIV:	☐ Yes	☐ No
Chickenpox:	☐ Yes	☐ No	Mumps:	☐ Yes	☐ No	History of family violence:	☐ Yes	☐ No
Concussion:	☐ Yes	☐ No	Otitis Media/Eye infection:	☐ Yes	☐ No	Obesity:	☐ Yes	☐ No
Constipation:	☐ Yes	☐ No	Pneumonia:	☐ Yes	☐ No	Developmental Delay:	☐ Yes	☐ No

Explain items above that have been checked Yes: _____

_____

_____

Family History (Father, Mother, Siblings, Grandparents, Aunts, Uncles)

Alcoholism:	☐ Yes	☐ No	Who: _____	High Cholesterol:	☐ Yes	☐ No	Who: _____	
Asthma:	☐ Yes	☐ No	Who: _____	High Blood Pressure:	☐ Yes	☐ No	Who: _____	
Birth defects:	☐ Yes	☐ No	Who: _____	Kidney disease:	☐ Yes	☐ No	Who: _____	
Blood Disorders:	☐ Yes	☐ No	Who: _____	Mental Illness:	☐ Yes	☐ No	Who: _____	
Cancer:	☐ Yes	☐ No	Who: _____	Mental Retardation:	☐ Yes	☐ No	Who: _____	
Coronary artery disease:	☐ Yes	☐ No	Who: _____	Migraines:	☐ Yes	☐ No	Who: _____	
Crohn's disease:	☐ Yes	☐ No	Who: _____	Obesity:	☐ Yes	☐ No	Who: _____	
Diabetes:	☐ Yes	☐ No	Who: _____	Tuberculosis:	☐ Yes	☐ No	Who: _____	
Drug use:	☐ Yes	☐ No	Who: _____	Liver disease:	☐ Yes	☐ No	Who: _____	
Epilepsy/seizures:	☐ Yes	☐ No	Who: _____	Immune problems (HIV, etc)	☐ Yes	☐ No	Who: _____	

Additional Information: _____

Child's Social History:

Household: Please list all those living in the child's home

Name	Age	Relationship to Child	Health Problems	Name	Age	Relationship to Child	Health Problems

What is the child's living situation: ☐ Lives with biological parents; ☐ Lives with adoptive parents; ☐ Joint custody; ☐ Single custody; ☐ Group Home

☐ Legal Guardian;☐ Lives with foster family;; ☐ Homeless Shelter; ☐ Poverty Conditions; ☐ Relatives (not parents)

Any smokers in the home? ☐ No ☐ Yes; Any Pets? ☐ No ☐ Yes; Recent travel outside the USA? ☐ No ☐ Yes; _____

Birth History: ☐ Don't know child's birth history

Birth weight_____ Was the baby born at Full-Term (37-40 Weeks)? ☐ Yes ☐ No; if No how weeks? _____

Were there any prenatal or neonatal complications? ☐ No ☐ Yes, Explain: _____

Was a NICU stay required? ☐ No ☐ Yes, Explain: _____

During pregnancy, did mother use: Tobacco: ☐ No ☐ Yes: Drink alcohol: ☐ No ☐ Yes; Illicit Drugs: ☐ No ☐ Yes; Medications: ☐ No ☐ Yes:

If yes, describe: _____ _____

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School Based Pediatric Health Questionnaire (K-4 to 5th) page 2of 2

General Health: DK= Don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain: _____

Does your child have any serious illness, chronic conditions, or other medical conditions? ☐ Yes ☐ No ☐ DK Explain: _____

_____

Has your child had any surgeries? ☐ Yes ☐ No ☐ DK Explain: _____

_____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain: _____

_____

Is your child **allergic** to any of the following?

Latex Products? ☐ Yes ☐ No ☐ DK Explain: _____

Medications? ☐ Yes ☐ No ☐ DK Explain: _____

Pet? ☐ Yes ☐ No ☐ DK Explain: _____

Food? ☐ Yes ☐ No ☐ DK Explain: _____

Allergens? ☐ Yes ☐ No ☐ DK Explain: _____

Does your child have any developmental delay? (Developmental Delay is when your child does not reach their development milestones at the expected times). ☐ Yes ☐ No ☐ DK Explain: _____

Medical:

Childs Physician/Medical Provider: _____ Phone Number_____

Name of Office: _____ Address: _____

Pharmacy Name: _____ Location: _____ Phone _____

Student/Child Medication Log ☐ **No Medication**

Medication	Dose	How often taken	Reason for taking	Date started	Prescriber

Medical/Behavioral Diagnosis/Problems ☐ **None Identified**

Diagnosis/Problem	Onset Date (year)	Comments

Immunization/Vaccination Record

Has your child received his/her recommended vaccinations?	☐ Yes	☐ No
Is the child up-to-date on his/her vaccinations?	☐ Yes	☐ No
Has a copy of the child's vaccination records been provided to the child's school?	☐ Yes	☐ No

Thank you for choosing Little River Medical Center (LRMC) School-Based Health Program. If the event your child becomes sick at school, he/she will be evaluated by the school nurse, if deemed necessary to see a medical provider you will be contacted to approve of health services delivered by an LRMC medical provider and staff. The LRMC staff located at your child's school will assist the medical provider with the evaluation of your child. You may attend the health encounter by phone, in-person, or via a telehealth video link (smartphone/computer). A summary will be provided to you and the child's primary care provider you have listed. This summary will include any test performed, results of evaluation and recommendations. If the medical provider ordered any medications, an electronic prescription(s) will be sent to the pharmacy you have listed.

Please return all above forms to your child's school nurse.

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School-Based Telehealth Program Frequently Asked Questions (FAQs)

What is the School-Based Telehealth program?
The School Based Telehealth program allows LRMC to bring healthcare services, that would traditionally take place in an office, to your student at their school.

How does the medical provider interact with my child?
A medical provider from Little River Medical Center examines your child with the assistance of the school nurse and/or LRMC's telehealth nurse. Computers and monitors are used so that patients and providers can see each other, talk clearly, and share information. At times special equipment, like electronic stethoscopes, dermascope (to visualize the skin), and a high-definition camera/scope to look inside a child's ears, nose and mouth are used.

Why HealthCare in the Schools?

- Stay healthy and ready to learn; decrease absenteeism and presenteeism *(pretending to be ill to avoid school or work)*
- Safe, convenient place with trusted personnel and interest in the child's well being
- In general, kids accommodate well to technology
- Decreases parent's time from missing work
- Provides many families a point of entry into health care system

Who will be participating in the telehealth visit?
Individuals, such as the school nurse and LRMC's telehealth nurse will be present to operate the video/audio equipment. They will take reasonable steps to maintain confidentiality of the information obtained.

How will information collected from the telehealth visit be used?
Medical information from your child's medical chart will be used for reports and to evaluate the school-based telehealth program, but your child will not be identified with this information. The video session is not recorded.

Is there any other information I should know?
You and your child have the right to ask the healthcare provider to discontinue the conference at any time. In addition, some parts of the exam may be conducted by the school nurse,
or LRMC's telehealth nurse, under the guidance of the healthcare provider who is evaluating the child.