Get Quality Health Care *AT SCHOOL*

Services

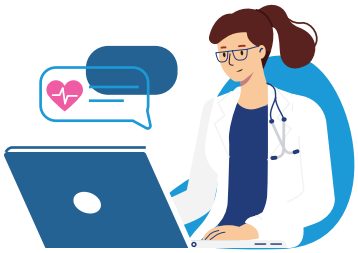
First Aid, Vision/Hearing/Blood Pressure Screenings, Information, Health Education and Referrals, Diagnosis/Treatment of Acute Illnesses (i.e. sore throats, earaches, etc.), Comprehensive/Well Child Physical Exams, Lab Tests, Prescriptions, Adolescent Immunizations, Tuberculin Skins Tests, Management of Chronic Illnesses (i.e. asthma, etc.)

See a provider during *school hours.*

Sarah Schindler, FNP-BC & Candace Vinson, FNP

The provider is available to see your child conveniently while school is in session.

Telehealth Services *available!*



Whether your child is in school or learning from home, we can provide their care. Using phone and/or video chat, you and your provider can easily discuss health concerns and treatment options.

No Insurance? *No Worries!*

It's great if you have insurance, but even if you don't, we will help make care for **your child affordable** through our sliding fee program.

Your child doesn't miss *school.*

Imagine how easy life will be when your child gets medical attention without leaving school.

And you don't miss *work!*

You've got enough to worry about at work. **Save the travel time and the days off it takes to** care for your sick child.

Valley Health SBHC *Harts Intermediate*

1246 McClellan Highway, Harts, WV 25524 | 304.310.1246

Hours: Tuesday and Thursday 8:00 a.m. - 12:00 p.m.

VALLEY HEALTH
Quality healthcare in your neighborhood.

VALLEY HEALTH

School-Based Health Enrollment Consent Form

Lives with: ☐ Father ☐ Mother ☐ Both ☐ Other: _____

Student Date of Birth _____ Social Security Number _____ Grade _____

Name: _____

Mailing Address _____

Gender: _____ Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Other ☐ Asian ☐ American Indian Alaska Native ☐ More than one race

City _____ State _____ Zip Code _____

PARENTS/LEGAL GUARDIANS

Parent or Legal Guardian Name _____ Phone Number (Home or Cell) _____ Phone Number (Work) _____ Email Address _____

Parent or Legal Guardian Name _____ Phone Number (Home or Cell) _____ Phone Number (Work) _____ Email Address _____

Mother Maiden Name _____ Other Information _____

Please list any individual(s) other than yourself who have permission to bring your child to a Valley Health Center for healthcare services:

Name: _____ Phone: _____ Name: _____ Phone: _____

INSURANCE INFORMATION

Please check all that apply and send in a copy of insurance card(s).

☐ **HEALTH INSURANCE** (Private Insurance, Medicaid, ID Number/Policy Number, Chip, etc.) ☐ **NO HEALTH INSURANCE**

Name of Insurance Company _____ ID Number/Policy Number _____ Group Number _____

Billing Address _____ Phone Number _____

Insurer Name _____ Insurer SSN _____ Insurer Date of Birth _____ Place of Employment _____

HEALTH INFORMATION

1) Doctor's Name: _____ Current Medications: _____

2) **Please Check** the following services you want provided to your child during the current school year in the school health center:

_____ Annual Well Child Exam _____ Immunizations _____ Sports Physical ($20)

3) Does your child have any allergies? Please list: _____

4) Have you ever had the Chicken Pox illness? *(Please Circle)* YES NO Have you ever had the Chicken Pox vaccine? *(Please Circle)* YES NO

5) Should your child need medication, what pharmacy would you like the prescription sent to?

Pharmacy _____ Location _____ Phone Number _____

CONSENT FOR OVER THE COUNTER MEDICATION ADMINISTRATION

No Over the Counter Medication (OTC) will be given to a child who does not have a registration/consent of the for the current school year. I grant permission for the School Health Center clinical staff to administer the following OTC medication to my child as he/she requests. I and my child understand that a total of only three OTC medication will be administered in the course of one school year. Frequent requests for OTC medications could suggest the need for an examination by a healthcare provider.

These are the OTC medications we may administer: Tums (Antacid) Cough Drop Ibuprofen Hydrocortisone Cream 1% Tylenol Triple Antibiotic Cream

X _____ _____

Signature of Parent/Guardian **Date**

NOTICE OF PRIVACY PRACTICES/PARENTAL CONSENT

The Valley Health Systems Notice of Privacy Practices are posted in the Health Center. Also, I may obtain a Notice of Privacy Practices by contacting the School Health Center or Valley Health Systems (304-525-3334) office. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur for my treatment, payment of my bills or in the performance of Valley Health Systems healthcare operations and for other purposes that are permitted or required by law. It also describes my rights to access and control my protected health information. The Notice of Privacy Practices is also posted on the Valley Health Systems website at www.valleyhealth.org. I understand that Valley Health Systems reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the Valley Health Systems office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment, or accessing the Valley Health Systems website at www.valleyhealth.org.

I, the parent/guardian of said student, give consent for him/her to receive health services. I understand those services may include nursing care, medical treatment – in-person or via telehealth, and referral for counseling; and that all healthcare information is confidential. Routine information that is part of the school health record may be shared by the school health center with the county school nurse or designee and the county school nurse or designee may release my child's health record information to the school health center. Other information will only be shared with persons outside of the health center staff with my or my child's permission, unless legally obligated otherwise. I may withdraw consent at any time by contacting any member of the staff in writing. The health center may release information regarding treatment to third party payors for billing purposes. I understand that an attempt will be made to notify me of any service rendered to my child either by phone contact or letter. I also understand that I am responsible for any co pays or deductible set forth by my insurance.

By signing this consent form, (1) you are agreeing to accept the risks of medical procedures, medication, testing (including HIV), and other treatment, (2) you are agreeing to abide by the VH procedures and patient responsibilities set out in this form, and (3) are granting Valley Health permission to bill my insurance for services provided. I acknowledge that I have read this form and the informed consent form for telehealth services, or had this form and telehealth consent read and explain to me, that I understand it and agree to its content. I agree to be truthful in providing information.

X _____ _____

Signature of Parent/Guardian **Date**

VALLEY HEALTH

Informed Consent for Telehealth Services

This document is serves as Valley Health Systems (VHS) informed consent for telehealth services.

Telehealth is offered to improve access to services at Valley Health. Telehealth is the delivery of healthcare services when the healthcare provider and patient are not in the same physical location through the use of technology. Electronically transmitted information may be used for screening, diagnosis, therapy, follow-up, and/or patient education and may include both patient medical records, as well as medical images. The results of telehealth cannot be guaranteed or assured.

All aspects of Valley Health's informed consent for treatment apply to these services.

Please note:

- You are not required to use telehealth and have the right to request other service options or referrals or withdraw this consent at any time without affecting your right to future care or treatment at Valley Health.
- Telehealth may not be appropriate, or the best choice of services for a variety of reasons
- You have the right to request documentation regarding all transmitted medical information

All systems will incorporate network and software security protocol to protect the confidentiality of patient identification, including measures to safeguard the data and ensure its integrity against intentional or unintentional corruption. Telehealth services are conducted and documented in a confidential manner according to applicable laws in similar ways as in-person services. There are, however, additional risks including:

- Sessions could be disrupted, delayed, or communications distorted due to technical failures.
- Telehealth involves alternative forms of communication that may reduce visual and auditory cues and increase the likelihood of misunderstanding one another.
- Your provider may determine that telehealth is not an appropriate treatment option
- In rare cases security protocols could fail and your confidential information could be accessed by unauthorized persons.

Valley Health Systems works to reduce these risks by only using secure videoconferencing software. Should there be technical problems with video conferencing, the most reliable backup plan is contact by phone.

If your health care costs may be paid or partly paid by Medicare, Medicaid, or a health insurance plan, Valley Health will disclose to the payer such treatment information as it is necessary for payment. If you are under the age of 18, your parents or guardians may receive health care information about you from Medicaid or the insurance company or the plan under which you are covered. The circumstances under which we are required or authorized to share your health information with persons outside the VH workforce are outlined in the NOPP. I understand that it is my responsibility to provide Valley Health Systems with my insurance/medical card information and that this information will be used in order to bill for Telehealth services rendered. The Telehealth visit is the patient responsibility, and payment in full is expected upon receiving billing statements.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I authorize payment directly to Valley Health.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I authorize Valley Health to release any information acquired in the course of Telehealth services in order to facilitate care or payment.

The person giving consent (patient or parent/guardian) has capacity to consent for medical treatment.

I have read and understand the above information and all my questions have been answered. I hereby give informed consent to use telehealth in my care. This form is valid for one year from date of signature and must be updated annually or if any information changes.