Care At the Schools
C.A.T.S.
School-Based Telehealth Clinic Program
Consent to Treat

Name of Child:_____Date: _____
(Please Print Full Name)

I, the undersigned, hereby, consent for my above-named child to receive health care services at the Ocoee Regional Health Corporation's School-Based Telehealth Clinic, which is staffed by State-licensed professionals of Ocoee Regional Health Corporation and licensed and credentialed members of ORHC's medical staff. School-based telehealth clinic services include, but are not limited to medical care and treatment, including diagnosis of acute illness and disease and prescribing medications in person or via video conferencing technology (telemedicine).

I understand that some parts of a telemedicine exam may involve physical tests conducted by the individuals at my/my child's location at the direction of the telemedicine consulting health care provider. I understand that video conferencing will not be the same as a direct patient care visit because I/my child will not be in the same room as the health care provider. I understand the potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue my/my child's telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation.

I understand that the school-based health clinic staff will notify me prior to my child's encounter with the medical provider including potential telemedicine visits and I hereby give my permission for my child to receive care at the Ocoee Regional Health Corporation's School-Based Telehealth Clinic whether I can accompany my child for the medical visit each time. I understand that during the telehealth consult, details of my child's medical history, examinations, and tests will be discussed using interactive video, audio, and telecommunication technology. I understand that a physical examination may take place. I understand that a non-medical technician may be present in the telemedicine studio to aid in the video transmission. I understand that video, audio and/or photo recordings may be taken of the patient during the telemedicine consultation. I understand that all existing laws regarding access to my child's medical records apply to these telehealth consultations.

I authorize the Ocoee Regional Health Corporation School-Based Telehealth Clinic staff to disclose all or any portion of my child's medical record to persons or entities pertinent to his/her health care, including but not limited to his/her primary care physician, other health providers on the care team, care coordinators, pediatric subspecialty medical providers, the school nurse and the ORHC staff. I further understand that all information in my child's medical record is confidential and will not be released to any unauthorized person or agency without written consent. I acknowledge that I have received a copy of the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices of the Ocoee Regional Health Corporation's School-Based Telehealth Clinic Program. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Tennessee state law apply to information disclosed during a telemedicine consultation. It is my right to withhold or withdraw consent to the telemedicine consultation at any time without effecting my child's right to future care or treatment or risking the loss or withdrawal of any program benefits to which my child would otherwise be entitled.

I authorize staff to summon emergency services (9-1-1) for my child if necessary. Expenses related to ambulance or other emergency referral will be my responsibility.

I will attempt to make myself available for communication regarding my child's health needs. I understand that there are certain hazards and risks connected with all forms of treatment and consent is given in light of this knowledge. I understand it is my duty to inform the Ocoee Regional Health Corporation's School-Based Telehealth Clinic staff of any change in the child's guardianship.

I also certify, by signing this form, that I am legally authorized to provide this consent. This consent will remain in force for a period of one year, or until I revoke said consent in writing.

Parent/Guardian Signature	**Parent/Guardian PRINTED Name**	**Date**

Care At the Schools
C.A.T.S.
Student Registration Form

Please ask your school nurse for details

Student/Patient Information: (blue or black ink only)

Student Last Name _____ First _____ Middle _____

Student Street Address _____ City _____ State _____ Zip _____

Student Social Security Number _____ Date of Birth _____ Primary Care Doctor _____ Phone _____

Pharmacy Name/Location: _____ Pharmacy Phone: _____

Sex: (Circle One) M F Race: (Circle One) White Black Hispanic Asian Bi-Racial Other

Language of Choice: _____ Student Grade in School: _____

School: _____ Teacher: _____

Parent/Guardian Information Name: _____

Relationship to Student/Patient: _____ Date of Birth: _____

Parent/Guardian Employer: _____

Preferred Daytime Phone: _____ Other Phone: _____

May we leave a message? _____Yes _____No

Insurance Information: Please complete all applicable information

My child has:
- _____ No insurance
- _____ TennCare (please provide all details below)
- _____ Private/Commercial Insurance (please provide all details below)

Homeless ☐ Yes ☐ No Migrant work ☐ Yes ☐ No
Shelter ☐ Yes ☐ No Public Housing ☐ Yes ☐ No

Annual Household Income _____ Family Size ____

Primary Insurance Company: _____

Insurance address on the back of the card _____

Name of Policy Holder: _____ Relationship to Student: _____

Member ID or Policy #: _____ Group #: _____

Policy Holder Social Security #: _____ Policy Holder Date of Birth: _____

Emergency Contact Information: ***In case parent /guardian cannot be reached, please list someone else***

Name: _____ Relationship: _____ Phone: _____ Message? Y N

Please list anyone else you authorize to have access to your child's health information:

As a Parent/Guardian of the above student: I authorize the release of any medical information necessary to process insurance claim for payment of medical benefits to the School-Based Telehealth Program.

Parent/Guardian Signature _____ **Parent/Guardian PRINTED Name** _____ **Date** _____

Student Health History Form

Student's Name:_____ **Date of Birth:**_____

Pediatrician:_____ Pediatrician's Phone#:_____ Last Physical:_____

Patient's Medical History

ADD/ADHD	Yes	No	Heart Disease	Yes	No
Asthma	Yes	No	Kidney/Renal Disease	Yes	No
Bladder/Urinary Problems	Yes	No	Nosebleeds:_____		
Depression/Anxiety	Yes	No	Pneumonia	Yes	No
Diabetes Mellitus	Yes	No	Premature Birth	Yes	No
Earaches/Ear Infections	Yes	No	Spine Disorders	Yes	No
Eczema	Yes	No	Seizures	Yes	No
Frequent Infections	Yes	No	Sickle Cell	Yes	No
Headaches	Yes	No	Stomach Aches	Yes	No
Blood Disorder	Yes	No	Wears Glasses/ Contacts	Yes	No
Bowel Problems/Constipation	Yes	No	Wears Hearing Aid	Yes	No
Cancer/Leukemia	Yes	No	Weight Issues	Yes	No

Other:_____

Current Medications:

Does your child take any medications, vitamins, supplements, or natural remedies? Yes No

If yes, please list:_____

Allergies:

Does your child have allergies? Yes (if yes, please list allergies below) No

Food Allergies: _____

Medication Allergies: _____

Animal or insect Allergies:_____ Do allergies Require Epi Pen? Yes No

Asthma Information:

Does your child have an inhaler? Yes No If yes type of preventive inhaler:_____

Will your child bring inhaler to school? Yes No If yes type of emergency inhaler:_____

Does your child use a nebulizer at home? Yes No

Surgeries/Hospitalizations:

Please list serious injuries, surgeries, and hospitalizations:_____

_____

Family History (maternal and paternal grandparents, parents, siblings)

Have any Blood Relatives of your child had the following problems (please circle all that apply)

Anemia	AIDS	High Blood Pressure	Sickle Cell
Diabetes	High Cholesterol	Asthma	Drug Abuse
Headaches/Migraine	Muscle/Joint Problems	Stroke	Tuberculosis
Sudden Infant Death	Arthritis	Alcoholism	Seizures
Early Deafness	Cystic Fibrosis	Heart Disease	Cancer

Social History

Exposed to cigarette smoke at home? Yes No Primary guardian(s): _____

Relationship: _____

Signature

_____ _____ _____

Parent/Guardian's Signature **Parent/Guardian's Printed Name** **Date**

Care At The Schools

Name of Child/Patient: _____ **Date:** _____

School Attending: _____

HIPAA NOTICE OF PRIVACY PRACTICES

I understand, that as, part of my health care, Ocoee Regional Health Corporation, receives, originates, maintains, discloses, and uses my protected health information, including, but not limited to, health records and other health information describing my health history, symptoms, examinations and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. Health information is maintained both in paper format and electronic media. I authorize Ocoee Regional Health Corporation to use this information for the purpose of treatment, payment, or healthcare operations. This authorization specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases included but not limited to blood-borne diseases. I understand that I may revoke this consent in writing and Ocoee Regional Health Corporation will comply if possible. However, Ocoee Regional Health Corporation will not be held responsible for any actions or disclosures already taken prior to revocation of this authorization

I have been provided a ***Notice of Privacy Practices*** that fully explains the uses and disclosures that Ocoee Regional Health Corporation may make with respect to the protected health information. I understand that I have the right to review the **Notice** before signing this consent. I also understand that Ocoee Regional Health Corporation reserves the right to change the ***Notice of Privacy Practices*** and should the privacy practices change, I will be notified of any changes upon my next visit to Ocoee Regional Health Corporation. Also, I may obtain a current copy of this notice at **www.ocoeeregional.com.**

I understand that I do not have to consent to use or disclosure of my protected health information for treatment, payment, and health care operations. If I do not consent, Ocoee Regional Health Corporation may refuse to provide me health care services unless applicable state or federal laws require Ocoee Regional Health Corporation to provide such services.

I understand that I have the right to request restriction on the use or disclosure of the protected health information to carry out treatment, payment, or health care operations. I further understand Ocoee Regional Health Corporation is not required to agree to the requested restriction but that, if it does agree, it is bound by such agreement. If a request for restriction on the use or disclosure of individually identifiable health information is made the Corporate Privacy and Security Officer (CPSO) is to be notified immediately. No one is authorized to accept a request for restriction other than the CPSO.

I understand that I may revoke this authorization in writing and Ocoee Regional Health Corporation will comply if possible. However, Ocoee Regional Health Corporation will not be held responsible for any actions or disclosures already taken prior to revocation of this authorization.

_____ _____

Parent/Guardian Signature (if student) **Date**
Signature of patient (if staff member)