School-Based Telehealth Clinic

Enrollment Packet

To Parent(s) and/or Guardian(s):

The School-Based Telehealth Clinic gives your child the opportunity to be seen by a licensed healthcare provider without having to leave school. An explanation of services offered by the telehealth clinic is listed below. You do not have to be present for your child to be seen; however, a consent form must be signed by you in order for any services to be rendered.

DESCRIPTION OF SERVICES

- Diagnoses and treatment for acute illnesses and minor injuries such as strep throat, ear infections, rash, and influenza
- Limited laboratory testing
- Behavioral health services and referrals

Your insurance will be billed for services provided in the clinic. If you do not have insurance, services will be provided on a sliding fee scale that is based on the student's income. If you or your child is uninsured, please contact CKF of Madison County at 765-608-3062 to assist you with obtaining insurance.

STAFF, CONTACT INFORMATION, AND HOURS

Staff:

Physical Health-St. Vincent Mercy Medical Group

Behavioral Health- Aspire Indiana, Inc.

Contact Information:

Shari Vehikite (Elementary): 765-552-7381

Heather Gordon (Intermediate School & High School): 765-552-7378

Hours:

The School-Based Telehealth Clinic will be open Monday-Friday from 8:00am-3:00pm.

STUDENT INFORMATION

Student's Name (Last, First, Middle Initial) _____

Gender: M F Birth Date: _____ Social Security #: _____

Address: _____ City: _____ Zip: _____

Primary Phone: _____ Parent Email: _____

Mother/Guardian: _____ Phone: _____

Father/Guardian: _____ Phone: _____

Who does the child live with most of the time? _____

In Case of Emergency, please tell us a local friend or relative (not living in the same address) whom we may contact.

Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION (check all that apply to your child)

☐ ***Commercial/Private***

Name of Primary Insurance Company: _____

Insurance ID # _____ Group Number _____

Policy Holder Name: _____ Date of Birth: _____

Place of Employment: _____

Name of Secondary Insurance Company: _____

Insurance ID # _____ Group Number _____

Policy Holder Name: _____ Date of Birth: _____

Place of Employment: _____

☐ ***Medicaid***

Medicaid ID# _____

Please check one:

Anthem _____ MHS _____

Care Source _____ Other _____

MDWise _____ Unsure _____

☐ ***No Health Insurance***

If your child does not have health insurance, would you like someone from Covering Kids and Families of Madison County to contact you to enroll into health insurance?

Yes _____ No _____

HEALTH QUESTIONNAIRE

Does your child have any known allergies (foods, medications, etc)? Yes_____ No_____

List all known allergies:

_____

_____

Does your child have any Physical Disabilities? Yes____ No____

If yes, please explain: _____

Is your child currently being treated for any health or mental health problems?

Yes____ No____

If yes, explain and list who is providing the treatment:

_____

_____

Does your child receive daily medications? Yes___ No____

Please list all medications, the dosage, and when given:

Name of Medication	Dosage	When Given

1.

2.

3.

4.

Primary Care Doctor: _____

Office Address:_____

Telephone Number:_____

If we need to call in a prescription, which pharmacy would you like us to call?

_____

FAMILY HISTORY

(Mother-**M**, Father-**F**, Brother-**B**, Sister-**S**, Maternal Grandmother-**MGM**, Paternal Grandmother-**PGM**, Maternal Grandfather-**MGF**, Paternal Grandfather-**PGF**, Maternal Aunt-**MA**, Paternal Aunt-**PA**, Maternal Uncle-**MU**, Paternal Uncle-**PU**)

Please specify who has or had any disease listed below by using abbreviations above. Also, please fill in the type of disease where applicable.

Disease	Who	Type	Disease	Who	Type	Disease	Who	Type
Asthma			Muscle Disease			Birth Defects		
Blood Disorder			Seizure			Cancer		
Cystic Fibrosis			Mental Illness			Tumors		
Allergies			Kidney Problems			Diabetes		
High Blood Pressure			Heart Trouble			Lung Diseases		
Tuberculosis			Eye/Ear Disorder			Other		

There is no family history of the above diseases _____

Does the student or anyone in the home:

	Yes	No	Name of Person	Relationship to student
Smoke				
Drink				
Use drugs				
Chew tobacco				

CHILD'S MEDICAL HISTORY

Please check if your child has or had any diseases listed below.

Conditions

- ☐ Allergies
- ☐ Allergic to drugs
- ☐ Anemia
- ☐ Kidney/Urinary Tract Problems
- ☐ Problems walking
- ☐ Other respiratory problems
- ☐ Asthma
- ☐ Shortness of breath during exercise
- ☐ Stomach ulcers
- ☐ Skin rashes
- ☐ Abdominal pain
- ☐ Constipation/diarrhea
- ☐ Serious digestive problems
- ☐ Chicken pox AGE _____
- ☐ Ear problem
- ☐ Ear infections
- ☐ Hearing aid
- ☐ Eye problem
- ☐ Wears glasses
- ☐ Musculo-skeletal problems
- ☐ Rheumatic fever
- ☐ Physical/sexual abuse
- ☐ Hemophilia
- ☐ Fainting spells/knocked out
- ☐ Frequent sore throats
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Injuries (major)
- ☐ Broken bones

Behavior History

- ☐ Nightmares
- ☐ Bedwetting
- ☐ Eating problems
- ☐ Thumb sucking
- ☐ Discipline problems
- ☐ Overactive/hyperactive
- ☐ Shy
- ☐ Sleeping problems
- ☐ Slow development
- ☐ Learning disability
- ☐ Smoker
- ☐ Former smoker
- ☐ Alcohol
- ☐ Inhalant abuse
- ☐ Other drugs
- ☐ Depression
- ☐ Other behavioral problems

Other Medical History

- ☐ Frequent colds
- ☐ Lung problems
- ☐ Meningitis
- ☐ Menstruation Started AGE ____
- ☐ Menstrual problems
- ☐ Premature birth WEIGHT ____
- ☐ Obese/Overweight
- ☐ Underweight
- ☐ Serious acne
- ☐ Speech problem
- ☐ Pregnant
- ☐ Other blood disorders
- ☐ Cancer

Explain any CONDITIONS, BEHAVIOR or MEDICAL HISTORY checked: (use backside if needed)

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.

St. Vincent Medical Group Physicians may, depending on the diagnosis, prescribe medication to students seen at the Telehealth Clinic. In the event that the Telehealth Clinic physician prescribes medication, they will make every effort to contact the student's primary care provider (identified on page 4 of this Packet). Such a contact requires the consent of the student's parent or guardian. Please check the appropriate box below regarding contacting your child's primary care provider.

- ☐ I consent to the Telehealth Clinic notifying my child's primary care provider (identified on page 4 of this Packet) that the Telehealth Clinic provider has issued a prescription for my child.

- ☐ I DO NOT consent to the Telehealth Clinic notifying my child's primary care provider (identified on page 4 of this Packet) that the Telehealth Clinic provider has issued a prescription for my child.

I, the undersigned,

- Give permission and consent for my child to have 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 Elwood Community School Corporation and that I may revoke this consent at any time by providing notice to Stacey Bock and/or Shari Vehikite at 1137 N 19th Street, Elwood, IN 46036.
- Understand that this consent constitutes the establishment of a Physician-Patient relationship between my child and any Physician, employed by St. Vincent Medical Group, who examines my child through the Telehealth Clinic for any and all encounters as long as the student is enrolled in Elwood Community School Corporation and that I may revoke this consent at any time by providing notice to Stacey Bock and/or Shari Vehikite at 1137 N 19th Street, Elwood, IN 46036.
- Give permission for the Physician, the school nurse, and your child's primary health care provider 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 St. Vincent Medical Group to receive information from the school about my child's health history.
- Acknowledge that the school nurse is an employee of Elwood Community School Corporation and will be participating and assisting in the treatment of the student.
- Understand that St. Vincent Medical Group will document each encounter with my child in a medical record maintained by St. Vincent Medical Group and not the Elwood Community School Corporation.
- Acknowledge that I have been offered a copy of the Notice of Privacy Practices, which addresses the ways in which St. Vincent Medical Group maintains, uses and discloses my child's protected health information (available on the school website or at the school nurse 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 or over the phone, 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 St. Vincent Medical Group.
    - Authorize payment of benefits to St. Vincent Medical Group 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 PRINTED: _____

Parent/Guardian SIGNATURE: _____

Date: _____