School District Telehealth Consent Form

Read, complete, and sign this form before returning to Garfield Elementary.

Please note:

- Your child/student ("Student") will be evaluated by a YVFWC provider and may be examined by the school nurse under the provider's direction.
- Computers and monitors are used so that everyone can see each other and communicate.
- You and Student each have the right to ask the healthcare provider to discontinue the telehealth visit, as well as participation in this program at any time.
- You and Student can use this program and still see other providers.
- Participating in this program **does not** change your primary care provider, **does not** change your insurance and **does not** affect the number of times you can see your regular health care professionals.

The health care services ("Services") that may be provided under this program may include, but are not limited to:

1| Mandated school health services, including: screening for vision (including eyeglasses), hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and required and recommended immunizations.
2| Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and immigration.
3| Medically prescribed laboratory tests such as for anemia, strep throat, glucose levels and urine studies.
4| Medical care and treatment, including diagnosis of acute and chronic illnesses, administration of medications at school, and prescription of medications.
5| Behavioral health services including evaluation, diagnosis, treatment, and referrals.
6| Health education and counseling for the prevention of risk-taking behaviors such as drug, alcohol, and smoking abuse, sexually transmitted infections, and HIV, as age appropriate and medically indicated.
7| Referrals for service not provided at the school.

You understand that:

1| There are limitations in the provision of health care and treatment via telehealth. Student may not be able to receive diagnosis and/or treatment through the Services for every condition possible. Equipment deficiencies of failures could lead to delays in evaluation or treatment. Security protocols failure may cause a breach of privacy.
2| The practice of medicine is not an exact science. No guarantees or promises regarding the result have been made.
3| This consent will remain in effect until withdrawn. You have the right to withdraw your consent to the use of the Services at any time, which you may exercise by providing written notice to the school office or YVFWC. You understand that the withdrawal of such consent will prevent Student from using the Services. Any withdrawal of your consent will be effective upon receipt of the written notice described above, except that such withdrawal will not have any effect on any action taken by a provider(s) in reliance on this consent before it received your written notice of withdrawal.
4| Nothing in this consent modifies, or enlarges, any rights you may, or may not, have to review or receive a copy of Student's medical records from the Student's providers, including any information included in such health records that has been transmitted through the Services.
5| A provider may determine in his or her sole discretion that Student's condition is not suitable for diagnosis and/or treatment using the Services, and that Student may need to seek care and treatment from a specialist or other healthcare provider, outside of the Services.
6| Some photographic or other images of Student may be obtained during the course of Services and they may be shared with others for the limited purpose of providing care to Student.
7| By law, parental consent is not required for the conduct of mandated screenings, the application of first aid treatment, prenatal care, services related to sexual behavior and pregnancy prevention, and the provision of health care or treatment where the health of the Student appears to be endangered. Also, you understand that parental consent is not required for Students who are 18 years or older or for Students who are parents, married or legally emancipated or deemed "Mature Minors" by the treating health care provider.
8| You may refuse to sign this consent, however, such refusal may prevent Student from receiving Services.
9| You have the right to review the YVFWC Notice of Privacy Practices ("Notice") before deciding to sign this form. The Notice is also posted at YVFWC offices, is available online at www.yvfwc.org and is subject to change.
10| Information related to the Student released in accordance with your consent granted below, may include references to sexual behavior, pregnancy, drug abuse, results of tests for all infectious diseases, including HIV/AIDS, and alcohol abuse. You understand that with all medical services offered through this program (including confidential services); Students will be encouraged to involve their parents or guardians in counseling and health care decisions. You understand that information released under this authorization may be re-disclosed by the recipient of the information and may no longer be protected by state and federal law.

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT FORM.

Yakima Valley Farm Workers Clinic
we are family

School District Telehealth Consent Form

Today's Date	School District	School Name	Grade
	Spokane	Garfield Elementary	

☐ **Mark this box to indicate you are declining consent for telehealth services for the above named student.**

Sign here only if DECLINING telehealth services _____ Name _____ Date _____

Do not complete the rest of this form if you are declining telehealth services.

STUDENT: Name (Last, First) _____ Student Date of Birth _____ **Sex:** ☐Male ☐Female

Student Address _____ City, State, Zip Code _____

Medical Provider/PCP _____ Pharmacy for Prescriptions _____

Ethnicity: ☐Hispanic ☐Black ☐White ☐American Indian ☐Asian/Pacific Islander ☐Other _____

PARENT/LEGAL GUARDIAN

Parent/Legal Guardian Name (Last, First) _____ Parent/Legal Guardian Date of Birth _____ Relationship to Student _____

Email Address _____ Home/Cell Number _____ Work Phone Number _____ Preferred Language _____

EMERGENCY CONTACT

Printed Name _____ Relationship to Student _____ Home/Cell Number _____ Work Number _____

INSURANCE INFORMATION

Medicaid/Apple Health Insurance: ☐No ☐Yes- ID# _____

Private Insurance: ☐No ☐Yes- Name of Insured _____ Health Insurance Name _____

Member ID/Policy Number _____ Insurance Phone Number _____

The undersigned have read and understand the services listed on the next page (the "Services") and related disclosures, and each understands the risks and benefits of the Services in the care and treatment for above identified "Student". The undersigned's signature provides consent for the Student to receive Services provided by Yakima Valley Farm Workers Clinic ("YVFWC") and the School District as described both in this Consent and at the time of evaluation or care. Each has received a copy of the Notice of Privacy Practices (the "Notice").

The undersigned further consents to the release and exchange of all (specifically and expressly including, but not limited to, information deemed "sensitive" or otherwise protected by law), medical, dental, psychological, and any other personally identifiable or otherwise confidential information of the Student, deemed so by the Family Educational Rights and Privacy Act ("FERPA"), the Health Insurance Portability and Accountability Act of 1996, as amended, ("HIPAA"), any other state or federal privacy policies, statutes or regulations, and the School District policies, as necessary, to any applicable party, as determined by the representatives of YVFWC and/or the School District, for the provision of Services. The undersigned's signature also gives consent and release to YVFWC and the School District to contact other health care providers who have examined the Student and for them to obtain copies of any health care or other information, protected or otherwise.

The undersigned further hereby each assign to YVFWC all rights, benefits, and interest under Medicare/Medicaid or any insurance policy, health plan, or other third party liable to me, in consideration for services rendered by YVFWC to Student. The undersigned hereby authorizes payment directly to YVFWC by Medicare/Medicaid or any insurance policy, health plan, or third party payor for treatment received from YVFWC providers. The undersigned understands that certain Services may not be covered under the Medicare/Medicaid program or insurance and that each may be responsible for the entire charge incurred for such Services. The undersigned also understand all deductibles are due unless they have been met within the applicable period.

Parent/Legal Guardian Signature _____ Printed Name _____ Date _____

Student (if over 13 years of age) Signature _____ Printed Name _____ Date _____

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT FORM.