SCHOOL-LINKED TELEHEALTH SERVICES & FINANCIAL RESPONSIBILITY CONSENT FORM

Anne Arundel County Public Schools and Department of Health partners with Total Health Care, Inc. to offer school-linked telehealth services. Completion of this consent for treatment form is required for your child to receive school linked telehealth services. **School nursing and emergency services will be provided whether you choose to take part in these added services or not.**

Student/Patient Information	
Student Last Name: Student First Name:	
Date of Birth:	Student ID No.
Birth Sex Female ☐ Male ☐	Gender Identity Female ☐ Male ☐ Transgender ☐ Non-Binary ☐ Declined ☐
Home Address:	City:
State: Zip Code:	Phone Number:
School Name:	
Preferred Language:	Do you identify as Hispanic/Latino? □ Yes or □ No
Race (please X box): □ Native American/Alaskan Native □ Asian □ African American / Black □ Native Hawaiian/ Other Pacific Islander □ Caucasian / White □ Declined □ Other:	
Name of Primary Care Provider/Physician (PCP):	

Legal Guardian Information	
Guardian's Last Name: Guardian's First Name:	
Date of Birth:	Social Security #:
Email Address:	Cell Phone:
Employer:	Employer Phone:

Student/Patient Insurance Information	
Child/Teen has insurance (please X box): ☐Yes or ☐No	
Name of Insurance Company:	Subscriber's Name:
Group Number:	Subscriber ID:

Additional Contact Information	
Name:	Relationship:
Phone Number:	May we leave a message? (please X box): ☐Yes or ☐No

Student Health History (to be completed by parent/legal guardian)

Patient/Student Medical History (please X all that apply)

☐ Asthma	☐ Cancer/Leukemia	☐ Eczema	☐ Migraines
☐ Premature Birth	☐ Sickle Cell	☐ Spine Disorders	☐ Bladder/Urinary Problems
☐ Seizures	☐ Kidney/Renal Disease	☐ Hearing Aids	☐ Mental Health Issues
☐ Blood Disorder Heart Problem	☐ Diabetes	☐ Pneumonia	☐ Tuberculosis/TB
☐ Other (Please explain)	☐ Development Problems	☐ Bowel Issues/Constipation	☐

Patient/Student Current Medications (vitamins, inhalers, prescriptions, other)

Name of Medication	Dose	Amount Taken	Times per Day

Preferred Retail Pharmacy Name:

Note: If no pharmacy is listed prescriptions will be sent to the Total Health Care pharmacy and delivered to student's residence

Address:	Phone Number:

Patient/Student Allergies

☐ **YES** - Please list below:	☐ **NO KNOWN ALLERGIES**
Food:	
Medications:	
Insects:	
Seasonal:	
Animals:	
Other:	

Immunization History

Has your child ever had a reaction to any immunizations/shots? (please X box)	☐ Yes ☐ No
If YES, please explain the reaction::	
What immunization/shot caused reaction:	

Patient Hospital/Surgery History

Past Hospital Stays: ☐ Yes ☐ No	Explain:
Past Surgeries ☐ Yes ☐ No	Explain:
ER visits in past year: ☐ Yes ☐ No	How many:

Family History (please X all that apply) and list who has the problem next to it (Mother, Father, grandparent, brother, sister)

☐ Anemia		☐ High Blood Pressure	
☐ SIDS/Sudden Infant Death		☐ Asthma	
☐ Headaches		☐ Stroke	
☐ Diabetes		☐ Alcohol/Drug Use	
☐ AIDS/HIV		☐ Cáncer	
☐ Artritis		☐ High Cholesterol	
☐ Heart Disease		☐ Seizures	
☐ Sickle Cell		☐ Tuberculosis/TB	
☐ Mental Health Issues		☐ Other	

School-Linked Telehealth Services Consent Form

The purpose of this Consent Form is to allow parents/guardians/emancipated minors/students over the age of 18 to:

(1) give informed consent for your child to participate in and receive treatment from a Total Health Care physician or healthcare provider through its School-Linked Telehealth Program with or without the presence of a parent/guardian;
(2) acknowledge that care will be provided by telehealth. The main difference between telehealth and in-person care is the provider's inability to have direct, physical contact with the patient. Also, the quality of telehealth transmission might affect the quality of healthcare services. The patient may stop using telehealth at any time without jeopardizing access to future care, services or benefits.
(3) acknowledge responsibility for the payment of charges and fees not covered by insurance;
(4) give permission to release your child's protected health information ("PHI") from Total Health Care to the Anne Arundel County Public Schools staff involved in the operation and administration of its health program, including but not limited to nurses, physical therapists, occupational therapists, speech therapists, psychologist, social worker, health coordinator, and administrative staff (collectively, "Anne Arundel County Public Schools Health Personnel") for purposes of treatment and care coordination; and
(5) give permission for Anne Arundel County Public Schools staff to release your child's medical information and other relevant personal information to Total Health Care to facilitate the assessment of your child's health needs, coordinate your child's care, provide treatment or referral, and/or evaluate the School-Linked Telehealth Program and the services provided.
(6) allow Total Health Care to release medical information to Anne Arundel County Public Schools staff and school health record for any medical treatment provided by the Anne Arundel County Public Schools Health Personnel per recommendation of a Total Health Care provider.

Consent for Health Services/Treatment

By signing below, the Parent/Guardian consents for your child to receive the necessary and/or advisable School-linked Telehealth Services listed below in this section of the Consent Form (the "Service") from a Total Health Care physician or healthcare provider through Total Health Care's School-Linked Telehealth Program. The Parent/Guardian understands that he/she has the opportunity to ask and have any questions answered about the risks, benefits, and alternatives of the Services by contacting Total Health Care at (410) 383-8300 and that Total Health Care recommends the Parent/Guardian do so prior to signing this Consent Form if he/she has any questions about the Services. The Parent/Guardian further understands that examination and treatment will be by telehealth. The Parent/Guardian acknowledges and understands that by signing this Consent Form, he or she is consenting to the Services directly below.

If there are particular services you do not want your child to have, please circle those services.

Over the Counter (OTC) Stock Medications:	Purpose	Consent to Administer (Yes/No)
Acetaminophen 160 mg chewable tablets	Children's Pain Relief/Fever Reducer	☐ YES ☐ NO
Acetaminophen 325 mg tablets	Pain Relief/Fever Reducer	☐ YES ☐ NO
Ibuprofen 100 mg chewable tablets (dye-free)	Pain Relief/Fever Reducer	☐ YES ☐ NO
Ibuprofen 200 mg tablets	Pain Relief/Fever Reducer	☐ YES ☐ NO
Diphenhydramine 12.5 mg chewable tablets	Allergy symptoms/Allergic reaction	☐ YES ☐ NO
Calcium Carbonate 400 mg chewable tab (Pepto™ Kids Chewable Tablets)	Upset stomach	☐ YES ☐ NO
Bismuth subsalicylate (Liquid Pepto)	Nausea, Indigestion, Upset stomach	☐ YES ☐ NO
Hydrocortisone 1% cream (Anti-Itch Cream)	Inflammation/itch	☐ YES ☐ NO
Bacitracin Zinc - Neomycin Sulfate - Polymyxin B Sulfate	Antibiotic Ointment for cuts/abrasions/ minor skin infections	☐ YES ☐ NO

Prescription Medication	Purpose	Consent to Administer (Yes/No)
Albuterol Sulfate inhalation solution (0.083% 2.5mg/3mL)	Asthma Nebulizer treatment for wheezing, chest tightness, or shortness of breath	☐ YES ☐ NO
Albuterol Inhaler	Rescue Inhaler for wheezing, chest tightness, or shortness of breath	☐ YES ☐ NO
Polymyxin B Sulfate/ Trimethoprim Sulfate	Bacterial Conjunctivitis prescription eye drops (generic)	☐ YES ☐ NO

Point of Care Test	Purpose	Consent to Administer (Yes/No)
Rapid Streptococcal Antigen testing	Rapid Strep Testing for sore throat	☐ YES ☐ NO
Rapid Influenza Assay for Flu A/B	Rapid Flu Testing for flu-like symptoms (cough, fever, body ache, headache, etc)	☐ YES ☐ NO

Additional Consent	Consent to Administer (Yes/No)
Care and treatment for injury/illness	☐ YES ☐ NO
Care for common pediatric/adolescent health concerns (such as weight, acne, menstrual problems	☐ YES ☐ NO
Care for certain chronic conditions (such as asthma, seizure disorders, diabetes, etc.	☐ YES ☐ NO

Agreement of Financial Responsibility

Some School-linked Telehealth Services are provided at no cost to families whether or not a student has insurance or the ability to pay. You may get a bill for some services if not covered by insurance. If applicable, Total Health Care will bill your child's insurance carrier(s) for charges and fees covered by your child's insurance plan. Parent/Guardian agrees to provide complete, accurate and timely information relating to any available health insurance in order for Total Health Care to seek payment in a timely manner. Parent/Guardian understands that a failure to provide complete, accurate and timely information, including any changes in insurance coverage, may prevent the provider from complying with the administrative rules of your child's insurance plan. Parent/Guardian may obtain a list of usual and customary charges from Total Health Care upon request.

I, PARENT/GUARDIAN, CERTIFY THAT I AM OF SOUND BODY AND MIND, THAT I HAVE READ THIS CONSENT FORM, THAT I HAVE RECEIVED INFORMATION ON THE PATIENT BILL OF RIGHTS AND RESPONSIBILITIES, INCLUDING THE PROCESS FOR FILING A COMPLAINT OR GRIEVANCE, THAT I UNDERSTAND AND AGREE WITH THE INFORMATION CONTAINED IN THIS CONSENT FORM, INCLUDING BUT NOT LIMITED TO THE CONSENT FOR HEALTH SERVICES/TREATMENT AND FINANCIAL RESPONSIBILITY SECTIONS, AND THAT I FREELY GIVE MY INFORMED CONSENT FOR MY CHILD TO RECEIVE THE RECOMMENDED SUPPLEMENTAL HEALTH SERVICES.

Signature of Parent/Legal Guardian: _____

Print Name of Parent/Legal Guardian: _____

Relationship to the Child/Student: _____ **Date:** _____

*Throughout this form the term "Parent/Guardian" means all of the following groups: parents/custodians/emancipated minors signing on their own behalf/students over the age of 18 signing on their own behalf.

Authorization to Release Health Information

I authorize Total Health Care to provide my child's medical information, including diagnosis, treatment records, vaccinations, and/or lab results to Anne Arundel County Public Schools Health Personnel for treatment, referral, and/or care coordination. To help coordinate care, I also authorize Anne Arundel County Public Schools staff to provide a copy of medical information or other relevant personal information within my child's school records to Total Health Care to facilitate the assessment of my child's health needs, coordinate my child's care, provide treatment or referral, and/or evaluate the School-Linked Telehealth Program and its services. This permission will expire when your child is no longer an enrolled student in Anne Arundel County Public Schools or when it is terminated in writing.

I understand that my express consent (or in some cases, my child's express consent) may be required for the disclosure of certain diagnosis and treatment information relating to sexually transmitted diseases, AIDS, HIV, mental illness, psychiatric treatment, and/or drug or alcohol abuse treatment. If you have consented for your child to be tested, treated, or diagnosed with any such injury, disease, or illness, Total Health Care is specifically authorized to disclose information relating to such diagnosis, testing, or treatment, as directed in this Authorization.

For records related to alcohol and drug treatment, federal law prohibits recipient from making further disclosure of this information unless the additional disclosure is expressly consented to in writing by the person to whom it relates or as otherwise permitted by federal law.

I understand that I am not required to sign this authorization, that I do so of my own free will, and that if I refuse to sign this authorization to disclose my child's health information, it will not in any way prevent my child from receiving care or treatment from Total Health Care or appropriate Anne Arundel County Public Schools Health Personnel I understand that I may terminate this authorization in writing at any time, prior to the release of my child's health information.

I am aware there is potential for information disclosed under this consent to be redisclosed by the recipient and no longer be protected.

Notice of Privacy Practices Acknowledgement

I have been notified that as a patient, I can ask for a copy of the Notice of Privacy Practices forms for Total Health Care, Inc. I know that I can also view them online:

Total Health Care, Inc.
https://www.totalhealthcare.org

I, PARENT/GUARDIAN, CERTIFY THAT I HAVE READ THIS AUTHORIZATION TO RELEASE HEALTH INFORMATION AND CONSENT TO THE RELEASE OF MY CHILD'S INFORMATION AS DESCRIBED IN THE ABOVE AUTHORIZATION.

I, PARENT/GUARDIAN, ACKNOWLEDGE THAT I HAVE RECEIVED INFORMATION ABOUT HOW TO RECEIVE NOTICE OF PRIVACY PRACTICES AS EXPLAINED IN THIS CONSENT.

THIS CONSENT FORM WILL REMAIN VALID WHILE PARTICIPANT IS ENROLLED IN ANNE ARUNDEL COUNTY PUBLIC SCHOOLS OR UNTIL TERMINATED IN WRITING.

Signature of Parent/Legal Guardian: _____

Print Name of Parent/Legal Guardian: _____

Relationship to the Child/Student: _____

Date: _____

Student Name:	**Student DOB:**	**Student School:**

*Throughout this form the term "Parent/Guardian" means all of the following groups: parents/custodians/emancipated minors signing on their own behalf/students over the age of 18 signing on their own behalf.