Greater Clark County Schools
Wellness for Life Medical, LLC

Telemedicine Consent and Release

School: _____ School Year: 2018-2019

PLEASE PRINT

Student's Legal Name: _____ DOB: _____ Sex: F/ M Grade: _____
Home Phone: _____ Student Cell Phone#: _____ Student ID#:_____
Street Address: _____ City: _____ Zip:_____

Mother/Guardian:_____ Father/Guardian: _____
Mother/Guardian Daytime Contact Phone:_____ Father/Guardian Daytime Contact Phone: _____
Mother/Guardian Email: _____ Father/Guardian Email: _____

Student Resides With (Names/Relationships): _____
Emergency Contact Name/Relationship: _____ Phone: _____
Emergency Contact Name/Relationship: _____Phone: _____

Student's Primary Care Doctor (Name/Address): _____
Phone: _____ Approximate Date Last Seen: _____
Student's Dentist (Name/Address): _____
Phone: _____ Approximate Date Last Seen: _____
Pharmacy (Name/Address): _____
Phone: _____ Name of prescription plan, if applicable:_____

Please read and initial the appropriate statements:

____ (Initial) My child has a primary care doctor (listed above). I authorize the Nurse Practitioner to communicate with the doctor/office to obtain information necessary to treat and/or to release information necessary to provide continuity of care for my student.

____ (Initial) My child **does not have** a primary care doctor. I would like the Nurse Practitioner to provide health care as necessary.

Please read and sign the consent below:

I give consent for the above-named child to receive health care services provided by the Nurse Practitioner (NP) (or other WFL licensed health care provider) via telemedicine* without an accompanying parent/guardian present if parent/guardian is unavailable. The student may be transported by Greater Clark County Schools (GCCS) for said purpose. The NP is providing services to students under a joint agreement between GCCS and Wellness for Life Medical, LLC (WFL). Services may include those normally performed by a NP, including prescribing medications to be dispensed by Health Services staff. I give consent to health information being shared with the Health Services staff, WFL, and the primary care physician. I give consent for the NP or staff to send a summary of treatment to the email provided on this form. This consent shall be effective during the 2018-2019 school year. My signature also indicates I have received a copy of the Notice of Privacy Practices. I agree to hold GCCS and WFL harmless from any liability associated with treatment or transportation.

I UNDERSTAND THAT I MUST NOTIFY GCCS IN WRITING IF I WISH TO REVOKE THE CONSENT.

_____ _____ _____
(Signature of Parent/Guardian) (Printed Name of Parent/Guardian) (Date)

_____ _____ _____
(Signature of Parent/Guardian) (Printed Name of Parent/Guardian) (Date)

*Telemedicine services include- (1) details of your child's medical history, examinations, x-rays, and tests may be discussed through the use of interactive video, audio, and telecommunication technology. (2) Video, audio, and/or photo recordings may be taken of your child during the procedure(s) or service(s).