The School-Based Telehealth Initiative called the Health-E Learners Program gives your child an opportunity to be seen by a licensed healthcare provider without having to leave the school building. The school nurse or **school counselor** will use Telehealth to communicate with a doctor, nurse practitioner or other licensed health professional via audio/video conferencing. An explanation of services offered by the Health-E Learners Program providers is listed below.

Description of Services

Healthcare Providers with the Health-E Learners Program provide the following services:

- Primary care services, in Westmoreland County Public Schools beginning the 2017-18 school year, including care for acute illness and minor injuries, such as strep throat, ear infections, rash, and influenza.
- Behavioral health services in Northumberland (2018-19 school year), Westmoreland (second semester of 2018-19 school year), and Essex County (2019-20 school year) Public School Systems via telehealth through the school counselor, nurse or administrative office including counselling, medication monitoring, and/or crisis intervention. Counseling services may be provided by the Middle Peninsula Northern Neck Community Services Board or possibly Virginia Commonwealth University Treatment Center for Children.
- If appropriate, prescriptions will be ordered for you to pick-up from your pharmacy.

And in the future to be provided:

- Nutrition counselling for chronic conditions (obesity, diabetes, allergies) and dental screenings.

The following services are **NOT** provided at Health-E Learners:

- prescribing and dispensing contraception,
- abortion counseling, and
- long-term psychotherapy.

Consent for Services

You do not have to be present for your child to be seen, however, an opportunity to join the videoconference may be available via computer depending on technology/broadband connectivity **.** A consent form ***must*** be signed by you in advance and be on file in the school for your child to receive health care services. Crisis interventions and emergency health care services ***do not*** require consent. Please note life-saving interventions MAY be initiated without prior consent. We will conduct a study on the effectiveness of healthcare services provided via telehealth to students. No individuals will be identified in this study, so we invite you to sign a consent form (page 7) to participate in the effectiveness study. This allows us to make future program improvements.

Payment for Services

As in any health clinic or doctor's office, exact charges depend on the service(s) provided. When available, insurance or Medicaid will be billed, and if applicable, you will be responsible for a copay or coinsurance. It is important to note Optima Health Plan is not accepted for primary care services, but it is available for behavioral health services. If you do not have any type of insurance, you may apply to BRTA for financial assistance in paying your bill for these services.

The healthcare provider may release information regarding treatment to third party payors for billing purposes.

Please contact us if you have any questions or concerns at the following number: (804) 443-6286.

Confidentiality of Services

Under the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA), confidentiality between the student, parents and the health clinic is assured.

Health-E Learners Program staff and Healthcare Providers will share confidential information only in the following situations:

- when it is educationally relevant for a student's academic progress
- when necessary to address a student's potential health care needs
- to ensure the safety of the student, other students and school personnel
- other situations specified by law.

For example, the Health-E Learners Program and Healthcare Providers may discuss the student's medication and other health care needs with the appropriate staff members who will administer the student's medication and provide care to the student while the student is at school.

By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. Current Virginia Law mandates (requires) confidential services to be available to minors in the following areas:

- pregnancy
- sexually transmitted infections (STI)
- human immunodeficiency virus (HIV) testing and counseling
- behavioral health counseling
- substance abuse counseling.

The staff will encourage every student to involve his/her parent/guardian in health care decisions.

STUDENT ENROLLMENT FORM

Name of School the Student is attending:

_____

STUDENT INFORMATION

Last Name: _____First Name: _____ Middle Name:_____

Preferred Name/Nickname: _____

Date of Birth: _____ Grade: _____

Street Address: _____

City/State/Zip code: _____

Gender: _____ Race: _____ Latino/Hispanic: Y/N _____

Email: _____Cell: _____

PARENT / GUARDIAN CONTACT INFORMATION

Father's Name: _____

Father's phone (Home) _____(Work)_____ (Cell)_____

Father's email: _____

Mother's Name: _____

Mother's phone (Home) _____(Work)_____ (Cell)_____

Mother's email: _____

Guardian's Name: _____

Guardian's phone (Home) _____(Work)_____ (Cell)_____

Guardian's email: _____

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

EMERGENCY CONTACT INFORMATION

In case of emergency, please tell us a local friend or relative (not living at the same address as the child's parent/guardian whom we could contact:

Name: _____

Relationship: _____

Phone (Home) _____(Work)_____ (Cell)_____

STUDENT HEALTH INFORMATION

1. List any allergies your child may have (such as bee stings or peanuts):

   _____

2. List any medications your child is allergic to or should not take:

   _____

3. List any medications your child currently takes and why:

Name of Medication	Dose (for example 10mg 3x daily)	Reason for medication

4. Child's Physician Name: _____Phone #: _____ (or None)

   Dentist: _____

5. Please indicate if you have received or are receiving services from the Middle Peninsula Northern Neck Counseling Center (Warsaw Counseling Center): ☐ Yes ☐ No

6. If we need to call in a prescription, which pharmacy would you like us to call? Phone #:

   _____

7. **Medical Conditions:** Please check all that apply for your child:

❑ ADD/ADHD
❑ Allergy Symptoms- please list
_____
❑ Anemia
❑ Anxiety
❑ Asthma - please list date of last asthma attack:
_____
❑ Bleeding Disorder
❑ Depression
❑ Diabetes: Type I or Type II
❑ Diseases in siblings – please List:
_____

❑ Hay Fever/Allergies
❑ Headaches
❑ Hearing Problems
❑ Heart Problems – please list:
_____
❑ High Blood Pressure
❑ Learning Disability
❑ Obesity
❑ Operations/hospitalizations – please list:
_____
❑ Orthopedic (bone/joint) Problems – please list:

❑ Seizures/epilepsy – date of last seizure:
_____
❑ Scoliosis
❑ Sickle Cell Anemia
❑ Stomach Problems
❑ Urinary Tract Infections
❑ Vision Problems
❑ Other problems – please list:
_____
_____

HEALTH INSURANCE INFORMATION

☐ **MEDICAID:** *Please check this box if your child is covered by Medicaid and provide the following information:* Only check one for Medicaid health insurance provider:

Anthem ❑ Optima ❑ Virginia Premier ❑

Aetna ❑ United Healthcare ❑ ❑ Other _____

Medicaid ID# _____ Medicaid Card Date of Birth _____

☐ **HEALTH INSURANCE**: *If you have any type of health insurance or Medicaid, please check this box. Complete the information below and provide a photocopy (front and back) of your Insurance Card and Driver's License***:**

Name of Insurance Company: _____

Address: _____

City/State/Zip Code: _____ Insurance Phone #: _____

Policy/ID #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

If policy holder address is different from student/grandparent/legal guardian, provide the address below:

_____

If applicable, provide place of employment for policy holder:

_____

☐ **NO HEALTH INSURANCE/SELF PAY**

Please check this box if you DO NOT HAVE health insurance.

Payment Source:

Cash/Check: _____

Credit Card: _____

NOTE: If you would like to speak with a medical provider about regularly scheduled healthcare services for your child's health needs, please contact your child's Primary Care Physician's office.

By signing this form, I am stating the information that I have provided is accurate and up-to-date. I will update the School Health Nurse or School Counselor with any changes as soon as possible.

Parent/Guardian Signature _____ Date: _____

Consent for Health-E Learners Program Services

Child's Name: _____ Child's Date of Birth: _____

I, the undersigned parent/guardian of the above-named student, give consent for my child to receive treatment through and by the Health-E Learners Program Healthcare Providers. I understand that this consent form is valid for as long as the above-named student is enrolled in the Health-E Learners Program or until I provide the clinic staff with written directions otherwise.

By signing below, I also:

- acknowledge that I understand the nature of this treatment, the way it is provided, and the details and limitations of this form and style of treatment.
- give permission for the health care provider to communicate and share medical information with my child's primary care doctor regarding my child's medical condition on an as-needed basis with the understanding that this information will continue to be treated in a confidential manner.
- agree to release all records related to this treatment to the Primary Care Provider.
- agree that I will be responsible for all costs associated with said treatment and that I will provide any insurance information as requested. All costs and fees not covered by insurance will be my responsibility.
- authorize the release of any information necessary to process insurance claims for payment of benefits to the health care provider and report to the funders of these services.
- authorize payment of benefits to the health care provider for services rendered.
- agree to provide details of all insurance policies that cover my child.
- acknowledge that I have been offered a copy of the Notice of Privacy Practices of the health care provider.

By signing I confirm that I am the legal guardian of the above-named child. I understand that if guardianship changes a new consent must be signed by the legal guardian.

I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above-named child will be shared between the medical provider and the alternative contact.

Parent/Guardian name PRINTED: _____

Parent/Guardian name SIGNATURE: _____

Date: _____

Informed Consent Form for Health-E Learners Program Study

Purpose and Procedures: I have been asked to participate in a research study to determine the impact of telehealth to the care and well-being of children in a rural school setting. If my child and I choose to participate, I understand that health-related data will be collected about my child as part of this telehealth study. Most of this health-related data is already collected by my child's school or healthcare provider, and is being shared with the research team for further analyses. Some of the data will be collected from the Riverside Medical Group and/or other healthcare providers that may provide healthcare for my child via telehealth. I will also be asked to complete a survey about my perceptions the care provided to my child through telehealth.

Risks/Discomforts: There are minimal risks associated with this study. There is a possibility that my child may disclose personal and sensitive information, which will be addressed one on one with an expert at the school or with the healthcare provider.

Benefits: I understand that my child will benefit by being able to access care with a healthcare professional based on the school nurse's or school counselor's assessment. I will benefit by reducing time away from work or other activities that would be spent traveling to/from a physician office for this care.

Confidentiality and Anonymity: I understand that a number will be used to identify my responses and that my name, address, and other identifying information will not be directly associated with any information obtained from me. Therefore, my responses will remain anonymous. When results of this study are published, all responses will be reported in aggregated only. Names or other identifying information will not be used.

Right to Withdraw: I may withdraw from the study at any time without fear of losing any services or benefits to which I am entitled. Refusal to participate in the study will not impact my child or the programs and services provided through the school.

Contact Information for Researchers: Researchers for this project are Viola Vaughn-Eden, Ph.D, Norfolk State University, School of Social Work and Christy Jensen, Ph.D., Riverside Center for Excellence in Aging and Lifelong Health. I understand that I may contact Dr. Viola Vaughan-Eden at 757-823-8668 or NSU Internal Review Board (IRB)/Human Subjects IRB Chairperson, Dr. Rowena Wilson at 757-823-2113, or Dr. Christy Jensen at 757-220-4751, or Riverside IRB Manager, Jennifer Brown at 757-594-3054 if I have any questions or concerns about this study.

Signatures: I understand my rights as a participant, and I voluntarily consent to participate in this study. I have read and received a copy of this informed consent. I also understand what this study is about, and how and why it is being conducted.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Investigator Date

Assent

I understand that this research is to help children get access to care via special equipment known as telehealth. When this study is done, a written report will be completed to tell others what the researchers learned. This report will not include my name. My parent(s) have explained to me the purpose of this study. I agree to be in the study by signing my name below.

_____ _____

Signature of Student Date