

 A Division of Centennial Medical Group

**2570 NW Edenbower Blvd., Suite 100, Roseburg, OR 97471 Phone (541)677-7200 http//www.efmpc.com**

**School Based Telehealth Consent Form**

**STUDENT INFORMATION \***

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student SS #:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip:

Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_ Birth date:

Gender: *Female or Male* Race: *White, Black, Hispanic or Other if so list:*

**PARENT / GUARDIAN INFORMATION**

Father: Phone (H) (W) (C)

Mother: Phone (H) (W) (C)

Guardian: Phone (H) (W) (C)

Alternate Contact: Phone (H) (W) (C)

**CONSENT FOR School Based Telehealth Services**

I, the parent/guardian of said student, give consent for my child to receive services from Evergreen Family Medicine. I understand that this consent form is valid for the 2020-2021 school year.

All healthcare information is confidential. By signing the consent form you are giving Evergreen Family Medicine, school nurse and your child’s regular doctor (if applicable) permission to communicate and share medical information regarding your child’s medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay. As in any health center, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing purposes.

Confidentiality between the student, parents and the health center is assured. By law, some information requires the student’s signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions. 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.

Signature of Parent / Legal Guardian Date

**Health Information** *(Additional health, family & developmental history may be collected by your site)*

1. Please list any allergies:
2. Does your child have a primary care provider? Yes / No

Primary Provider’s Name/ phone number:

**Child’s Insurance Information**

* **Primary Health Insurance:**

Name of Insured Parent / Guardian

Birth date of Card Holder SSN of Card Holder

Address (if different from child) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment

Name of Insurance Company

Insurance Address

Insurance Phone / Fax Number

Group & ID Number

* **Secondary Health Insurance**:

Name of Insured Parent / Guardian

Birth date of Card Holder SSN of Card Holder

Name of Insurance Company

Insurance Address

Insurance Phone / Fax Number

Group & ID Number

* **No health insurance / Request application for sliding fee or assistance with state Medicaid program.**