What are School Based Telemedicine Services?

Dear Parent/ Guardian,

Washington County School District and PanCare of Florida, Inc. are very excited to implement an innovative Telemedicine School Health Program for your child's school. **Below you will learn more information about the program, but please know that these services will only be provided to students whose parents/guardians opt in by providing written permission and completing the attached consent form.** Services will **NOT** be provided to students without a parent/guardian's consent.

Telemedicine (also referred to as "telehealth" or "e-health") allows the school health nurse to consult with PanCare medical professionals through the use of telecommunication technology. This new telemedicine program will make healthcare for students more convenient and accessible, avoid delays in treatment, and enhance learning by decreasing absenteeism.

The telemedicine school health model has become a standard medical practice and is in use across multiple states. If you want your sick child to have access to the telemedicine services while your child is in school, you will need to complete the Telemedicine Services Consent form and return it to your child's school.

With your consent, the School-Based Telehealth Clinic will give your child the opportunity to be seen by a PanCare Florida licensed healthcare provider without having to leave school. An explanation of services offered by the Telehealth school clinic is listed below. **You do not have to be present for your child to be seen; however, a consent form must be signed by you in order for any telemedicine services to be rendered.**

DESCRIPTION OF TELEMEDICINE SERVICES:

- Diagnoses and treatment for acute illnesses and minor injuries such as strep throat, ear infections, rash, and influenza
- Behavioral health services including Psychiatry, Medication Management, and Therapy

INSURANCE/MEDICAID:

If you do not have insurance, the fees for the services provided will be waived. If you do have insurance/Medicaid, PanCare will bill for services provided in the Telehealth clinic with parental consent. No child will be refused treatment due to inability to pay. If you still have questions, please contact PanCare Billing Department at 850-747-5599.

SCHOOL TELEHEALTH HOURS:

The School-Based Telehealth Clinic will be open when students are in school.

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School-Based Telemedicine Frequently Asked Questions

What is School-Based Telemedicine? School-Based Telemedicine is an innovative and established model to complement and expand existing school health services to meet the needs of children through the use of technology, i.e. interactive audio, video, or other telecommunications or electronic technology that connects the child and the nurse in the school to a health care provider in another location.

What is the goal of the School-Based Telemedicine Program? The program's goal is to keep children healthy, in school, ready and available to learn.

Who is eligible to access services in the School-Based Telemedicine program? Students at participating Washington County School locations are eligible to enroll in the School-Based Telemedicine program.

What services will be provided by the School-Based Telemedicine program? The program will provide acute care services such as checking for ear infections and sore throats. If needed the health care provider examining the child will write a prescription that can be sent electronically to the family's pharmacy.

How do children enroll in the School-Based Telemedicine program? Parents/Guardians have the option to complete the *Telemedicine Services Consent form* that will be sent home with students. Consent forms will also be available on the school's website and in the school nurse's office.

Is there a cost for the School-Based Telemedicine Program services? If you do not have insurance, the fees for the services provided will be waived. If you do have insurance/Medicaid, PanCare will bill for services provided in the Telehealth clinic with parental consent. No child will be refused treatment due to inability to pay. If you still have questions, please contact PanCare Billing Department at 850-747-5599.

When will health services be available in the School-Based Telemedicine program? Medical Services will be provided during the school day, with the exception of school holidays, at participating school locations.

Does a parent/guardian have to be present for the Telemedicine appointment? With your consent, the School-Based Telehealth Clinic will give your child the opportunity to be seen by a PanCare Florida licensed healthcare provider without having to leave school. An explanation of services offered by the Telehealth school clinic is listed below. **You do not have to be present for your child to be seen; however, a consent form must be signed by you in order for any telemedicine services to be rendered.**

What if the telemedicine provider orders labs for my child? Strep, Flu, and Urine Analysis may be performed at the school clinic. If additional labs are ordered by the telemedicine provider, you may take your child to the lab at PanCare of Florida, Inc. or any lab you prefer.

Will my child still be seen by the school "nurse" if I do not participate in the School-Based Telemedicine program? Yes. Students will be seen in the school health room by the school health personnel. However, they will not be seen by a telemedicine provider unless the *Telemedicine Services Consent form* is completed for the School-Based Telemedicine program.

Who will be providing the School-Based Telemedicine Program? PanCare of Florida, Inc. medical professionals in conjunction with the school telehealth nurse will provide medical services for the School-Based Telemedicine program.

How will the School-Based Telemedicine program be monitored? Monitoring of the Telemedicine system will be done in accordance with Florida State guidelines/regulations and standards of practice for Telemedicine. Protocols will provide guidance on the implementation of the project and to assure compliance with State medical regulations regarding but not limited to HIPAA, FERPA, and medical practice. Confidentiality of medical records will be maintained according to electronic health records standards and regulations.

Who owns the School-Based Telemedicine program medical records? Medical records will be maintained by PanCare of Florida, Inc. As typical of any other health care provider, parents always have access to their child's records.

School TeleHealth Program Information

The personal information you provide on this form will be kept confidential (in a protected area) and only used and disclosed by telehealth and school staff on a need-to-know basis.

Student Name

Last	First	Middle
Date of Birth: Does your child take medication? ☐ Yes ☐ No	If your child requires medication at school, all medication sent to the school must be in original prescription container with a current date and the child's name. Before medication can be dispensed, a "Permission to Administer Medication" form must be completed and signed by the physician and the parent and must be on file at the school.	

Medication

Medication	Dosage	Hour(s) Given

Health Insurance Information

Please check appropriate box: ☐ Family Health Insurance ☐ Florida Healthy Kids ☐ Florida Kid Care ☐ None ☐ Medicaid # _____ ☐ No Health Insurance ☐ Other _____

IF NONE, do we have your permission to forward the parent's name and phone number to Florida Kidcare Insurance for health insurance screening to see if you may be eligible for health insurance coverage? If Yes, please sign: _____

Vision and Hearing

Does your child wear contacts/glasses? ☐ Yes ☐ No		Does your child wear hearing aid(s)? ☐ Yes	☐ No
Pharmacy:		Phone:	

Health Care Providers

Physician	Name	Phone
Dentist	Name	Phone

Medical Conditions

Check all that apply:

- ☐ Asthma — If checked, uses inhaler? ☐ Yes ☐ No ☐ On daily medication?
- ☐ Seizures — If checked, on medication? ☐ Yes ☐ No
- ☐ Diabetes — If checked, insulin dependent? ☐ Yes ☐ No
- ☐ Movement Limitations _____
- ☐ Recent illness/hospitalization/surgery (describe) _____
- ☐ Other _____
- ☐ Severe allergies? If checked, please specify: _____
  - ☐ Food/environmental
  - ☐ Insect stings/bees
  - ☐ Medicines/Drugs
  - ☐ Other

Allergies require:

- ☐ EpiPen
- ☐ Benadryl
- ☐ Other

Release of Medical Information

I understand and agree that certain educational records of my child will be shared with the district's health care partners as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by the health care personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such treatment records. I further authorize the district's health care partners to contact my child's pediatrician(s) or physician(s) to obtain personal medical information as it pertains to student health services.

I hereby authorize for my child's medical information, parental contact information, and other health information (collected from health services provided at school, including information stored electronically) to be shared with emergency personnel and health department officials to address conditions of public health importance, including information to meet and to prepare for potential or confirmed health conditions.

Emergency Treatment

The school has my permission to seek emergency medical treatment in case of a serious accident or illness. In case of an accident or illness where immediate treatment of my child is not indicated but where he/she is unable to remain in school, I request that the person(s) listed on FOCUS Parent Portal be contacted and requested to care for my child in the event I cannot be reached. I also authorize the exchange of medical information as necessary to support the continuity of care for my child.

Parent Signature _____ Date _____

Medical and other information will be disclosed without consent from the parent/eligible student in case of health emergencies, as permissible by FERPA. The school will call for emergency medical care as deemed necessary. Emergency transportation to a health care facility, as determined by paramedics, will be authorized.

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PANCARE OF FLORIDA, INC.

Telemedicine Services Consent Form

Student Name: _____ **Date of Birth:** _____
School Name: _____ **Grade:** _____

Telemedicine (also referred to as "telehealth" or "e-health") allows the school telehealth health nurse to consult with PanCare medical professionals through the use of telecommunication technology.

By signing this form, I understand the following:

1. I give my consent for my child to be enrolled in the school's Telemedicine Program and that PanCare and its providers can access my child's personal health information if needed.
2. I understand that I have the right to withhold/withdraw my consent to the use of Telemedicine/Telehealth at any time without affecting my child's right to future care or treatment. Furthermore, I understand that alternative methods of medical/health care may be available, including face-to-face interaction, and that I may choose another alternative at any time.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a Telemedicine/Telehealth interaction and may receive copies of this information in accordance with Florida law.
4. I understand that the information disclosed by my child during the course of my child's treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and vulnerable adult abuse.

Electronic communication allows, at a minimum, the use of audio and video equipment for two-way, real time interactive communication between the patient (at the school/originating site) and the healthcare provider (at the remote/distant site). Providers may include primary care practitioners, nurse practitioners, specialists, and/or subspecialists and therapists.

I understand that as with any medical procedure, there are expected benefits and potential risks associated with the use of Telemedicine/Telehealth that I need to be aware of.

Expected Benefits include the following:

- Improved access to care by enabling a patient to remain at a remote site while receiving professional care from a healthcare provider.
- More efficient medical and health evaluation and management.
- Earlier diagnosis/treatment.

Possible Risks include, but are not limited to:

- As with any healthcare providers, despite reasonable safeguarding efforts, the transmission of my child's medical information could be disrupted or distorted by technical failures resulting in delays in evaluation or access by unauthorized persons.
- As with any healthcare providers, Telemedicine/Telehealth based services may not be as complete as the parent would prefer. I understand that if my child's Telemedicine/Telehealth provider believes that my child will be better served by another form of services (e.g. face-to-face services) my child will be referred to another provider and it is my responsibility to ensure that referral instructions are followed timely.
- As with any healthcare providers, in rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the Telemedicine/Telehealth healthcare provider.
- As with any healthcare providers, in rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- As with any healthcare providers, in rare cases, a lack of access to complete and/or accurate medical records or information may result in adverse drug reactions, allergic reaction, or other judgment error.

I have read and understand the information provided above regarding Telemedicine/Telehealth and all of my questions have been answered to my satisfaction. I understand any cause of action arising out of this service must do so exclusively in Florida and I knowingly waive my right to access any other legal forum.

I hereby give my informed consent for the use of Telemedicine/Telehealth in my child's medical/ health care.

Signature of Patient (or person authorized to sign for Patient): _____ *Date:* _____

If authorized signer, relationship to Patient: _____

☐ I give consent for my child to receive Mental Health counseling services if referred by WCSD. Parent Initials_____
☐ I give consent for PanCare of Florida, Inc. to bill my insurance for services provided. Parent Initials_____