NorthShore
HEALTH CENTERS

To Parent(s) and/or Guardian(s):

Your school is now offering an in-person and telehealth clinic which will provide medical care for your child when they become ill during school hours. The School-Based Health and Telehealth Clinic gives your child the opportunity to be seen by a licensed healthcare provider without having to leave school. Information regarding the onsite clinic and an explanation of services offered, including services by telehealth, 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 services to be rendered.

DESCRIPTION OF SERVICES

Care for your child will be provided by a licensed healthcare provider either in-person or by telemedicine. Telemedicine is the use of telecommunication and information technology to provide clinical health care from a distance. In our setting, this means that there will be two-way video conferencing between the healthcare provider and your child with the school nurse. Any exam that is requested by the healthcare provider will be accomplished by state-of-the-art technology, allowing high-resolution visualization of ears, throat, and skin as well as sound of heart and lungs. This will allow almost any visit to the nurse's office to result in an accurate medical assessment without your child needing to leave school. When your child represents symptoms that are beyond the scope of care for a school nurse, your child can be seen in-person or virtually using diagnostic equipment via telehealth. Parents will be contacted prior to initiation of any visit. Parents will also be given the option to be present at all primary care visits.

Services that will be provided at the school-based clinic for your child, include:

- Diagnoses and treatment for acute illnesses such as strep throat, ear infections, rash, and influenza
- Limited laboratory testing

Your insurance will be billed for services provided in the clinic. If you do not have insurance or Medicaid coverage, services will be provided on a sliding fee scale that is based on the student's income. If you or your child is uninsured, please contact NorthShore Health Centers at (219) 763-8112 or the Indiana Division of Family Recourses at (800) 403-0864 to assist you with obtaining insurance.

HOURS of Operation

The School-Based Clinic will be open Monday-Friday from 8 am- 3 pm during the normal school year. This excludes summer school, all scheduled holidays, breaks, and e-learning days. The Clinic will be telehealth-based on Mondays, Tuesdays, Thursdays, and Fridays. The Nurse Practitioner will be in-person on Wednesdays.

STUDENT INFORMATION						Today's Date: ___ / ___ / ______
Last Name			First			M.I.
Date of Birth ___ / ___ / ______	Primary Phone		Email			
Street Address				Apartment/Unit#		
Mailing Address						
City	State	Zip Code		Township		

PARENT OR GUARDIAN #1			
Last Name	First	M.I.	Relationship to Patient
Address			Apartment/Unit#
City		State	Zip Code
PARENT OR GUARDIAN #2			
Last Name	First	M.I.	Relationship to Patient
Address			Apartment/Unit#
City		State	Zip Code

EMERGENCY CONTACT		
Name	Relationship	Telephone

INSURANCE INFORMATION			
Primary Insurance:	ID:	Group:	
Insurance Phone:	Subscriber Name:	Date of Birth:	___ / ___ / ______
Social Security Number - -	Employer		
Secondary Insurance:	ID:	Group:	
Insurance Phone:	Subscriber Name:	Date of Birth:	___ / ___ / ______
Social Security Number - -	Employer		

MEDICAL HISTORY
Does your child receive daily medications? Yes No **Please list all medications, the dosage, and when given:** ____ **Does your child have any known allergies (foods, medications, etc)? Yes No** **List all known allergies:** ____ ____ **Does your child have any Physical Disabilities? Yes No** **If yes, please explain:** ____

CURRENT HEALTHCARE PROVIDERS	
Does your child currently have a Primary Care Provider?	☐ Yes ☐ No
If yes – please list: **Name:** ____ **Office Address:** ____ **Telephone Number:** __________________________	
If you need to call in a prescription, which pharmacy would you like us to call? ____	

FAMILY HISTORY					
Please specify who has or had any disease listed below by using the following abbreviations. (Mother-**M**, Father-**F**, Brother-**B**, Sister-**S**, Grandmother-**GM**, Grandfather-**GF**, Aunt-**A**, Uncle-**U**)					
	Who		Who		Who
Asthma		Allergies		Birth Defects	
Blood Disorders		Cancer		Tumors	
Cystic Fibrosis		Diabetes		Ear/Eye Disorder	
Heart Trouble		High Blood Pressure		Kidney Problems	
Lung Diseases		Tuberculosis		Seizures	
Mental Illness		Muscle Disease		**There is no family history of the above diseases ___________**	

SOCIAL HISTORY (please check those that apply):

Tobacco Use

Is the student a current smoker: ☐ Yes ☐ No

Is anyone in the student's home a current smoker:
☐ Yes ☐ No

Other Tobacco

Does the student use other tobacco products?
☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Does anyone in the student's home use other tobacco products? ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use

Does the student drink alcohol? ☐ Yes ☐ No

Does anyone in the student's home drink alcohol?
☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Drug Use

Has the student used any recreational drugs?
☐ Yes ☐ No

Has anyone in the student's home used any recreational drugs? ☐ Yes ☐ No

MEDICAL HISTORY (please check those that apply):

☐ Allergies
☐ Anemia
☐ Kidney/Urinary Tract Problems
☐ Problems walking
☐ Other respiratory problems
☐ Asthma
☐ Shortness of breath during exercise
☐ Stomach ulcers
☐ Skin rashes
☐ Abdominal pain
☐ Constipation/diarrhea
☐ Serious digestive problems
☐ Chicken pox – Age _______
☐ Ear problems
☐ Broken bones

☐ Ear infections
☐ Hearing aid
☐ Eye problem
☐ Wears glasses
☐ Muscular-skeletal problems
☐ Rheumatic fever
☐ Physical/sexual abuse
☐ Hemophilia
☐ Fainting spells/knocked out
☐ Frequent sore throats
☐ Headaches
☐ Heart murmur
☐ Diabetes
☐ Hepatitis
☐ Injures

☐ Heart problems
☐ High blood pressure
☐ Thyroid problems
☐ Nightmares
☐ Bedwetting
☐ Eating problems
☐ Thumb sucking
☐ Discipline problems
☐ Overactive/ hyperactive
☐ Shy
☐ Sleeping problems
☐ Slow development
☐ Learning disability
☐ Smoker
☐ Depression
☐ Other behavioral problems

☐ Frequent colds
☐ Lung problems
☐ Meningitis
☐ Menstruation Started – Age ___
☐ Menstrual problems
☐ Premature birth
☐ Obese/overweight
☐ Underweight
☐ Serious acne
☐ Speech problem
☐ Pregnant
☐ Other blood disorders
☐ Cancer

CONSENT TO TREAT

Child's Name____ D.O.B.____________________

This consent is for the treatment of your child by NorthShore Health Centers, a licensed healthcare provider that provides standard clinical health care treatment and telemedicine. Telemedicine is the use of telecommunication and information technology to provide clinical health care from a distance and in this case, provided through a telehealth clinic. This means that there will be two-way video conferencing between the healthcare provider located at NorthShore Health Centers and your child with the school nurse. Any exam that is requested by the healthcare provider will be accomplished, depending on the school location, either onsite at the clinic or by state of the art technology allowing high-resolution visualization of ears, throat, and skin as well as high fidelity sound of heart and lungs. This will allow almost any visit to the nurse's office to result in an accurate medical assessment without your child needing to leave school.

Before any student is seen at the NorthShore Health Centers clinics, a signed consent form must be on file. In addition to the consent on file, the parent/guardian will be contacted before each visit to receive verbal consent.

NorthShore Health Centers may, depending on the diagnosis, prescribe medication to students seen at the Clinic. In the event that the Clinic physician prescribes medication, they will make every effort to contact the student's primary care provider (identified on page 3 of this Packet). Such a contact requires the consent of the student's parent or guardian. Please check the appropriate box below regarding contacting your child's primary care provider.

- ☐ I consent to the Clinic notifying my child's primary care provider (identified on page 3 of this Packet) that the Clinic provider has issued a prescription for my child.
- ☐ I DO NOT consent to the Clinic notifying my child's primary care provider (identified on page 3 of this Packet) that the Clinic provider has issued a prescription for my child.

I, the undersigned,

- Give permission and consent for my child to have treatment through and by NorthShore Health Centers, including via telemedicine technology.
- Have received information describing telemedicine and NorthShore Health Centers. I understand the information provided including the details and limitations of the form and style in which medical services will be provided.
- Understand that this consent form is valid for the school year in which this form is signed and dated, and must be updated every school year.
- Give permission for NorthShore Health Centers, the school nurse, and my child's primary health care provider to speak with and share medical information about my child's health issue on an as needed basis, with the understanding that this information will be treated in a confidential way.

- Give permission for NorthShore Health Centers to receive information from the school and my child's primary health care provider about my child's health history.
- Acknowledge that I have been offered a copy of the Notice of Privacy Practices (available on NorthShore Health Center's website).

Child's Name____D.O.B. ______________________

- As Parent/Guardian of the above student, I:
    - Authorize the release of any information necessary to process insurance claims for payment of benefits to NorthShore Health Centers.
    - Authorize payment of benefits to NorthShore Health Centers for services rendered.
    - Have provided details of all insurance policies that cover my child.

The information above and on the proceeding pages are true and complete to the best of my knowledge.

Parent/Guardian name PRINTED: ____

Parent/Guardian SIGNATURE: ____

Date: ____