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

School Year: _____ School Name: _____

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 will be good until my child leaves/graduates school or until I provide the Center staff with written directions otherwise.

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.**