School Health Center Consent Form

A health center at no cost to you is now available at your child's school. It is available during school hours to address your child's healthcare needs. The school can connect to a licensed medical practitioner through the Hazel Health system. By completing the following forms, your child can have access via the school health center.

CHILD / GUARDIAN INFORMATION

Child's Last Name	Child's First Name	Birthday (MM/DD/YY)	Male [ ] Female [ ]

I have read the Hazel Health Services Authorization on page 3 and 4 and: (Please check one box below)

☐ I give permission for my child to receive services from Hazel Health Services.

☐ I DO NOT give permission for my child to receive services from Hazel Health Services.

Parent/Guardian Signature (Required)	**Date**

Parent/Guardian #1 Name	Home Phone	Mobile Phone	Email
Parent/Guardian #2 Name	Home Phone	Mobile Phone	Email

HEALTH QUESTIONNAIRE

Is your child allergic to any medications?

[ ] No [ ] YES Please list:_____

Is your child on any medications?

[ ] No [ ] YES Please list:_____

Your child will be provided basic first aid and medical exams using remote medical practitioners via a telehealth application. Injury/illness assessment and intervention may include the use of the following over-the-counter medications. Age/weight appropriate medications are given.

Can the following medications be administered to your child at school?

MEDICATION (Condition for treatment)	YES	NO
Acetaminophen/Tylenol (Pain/Fever):	[ ]	[ ]
Benadryl/Diphenhydramine (Allergic Reaction):	[ ]	[ ]
Cetirizine/Zyrtec (Allergies/Allergic Reaction):	[ ]	[ ]
Bacitracin ointment/Neosporin (Cuts/Infections):	[ ]	[ ]
Children's Pepto (Upset Stomach):	[ ]	[ ]
Throat lozenge (Cough/Sore throat):	[ ]	[ ]
Sudafed (Decongestant):	[ ]	[ ]
Guiatuss DM/Robitussin DM (Cough):	[ ]	[ ]
Hydrocortisone cream (Inflammation):	[ ]	[ ]
Ibuprofen/Advil/Motrin (Pain/Fever):	[ ]	[ ]
Mylanta/Antacid (Stomach ache, age 12+):	[ ]	[ ]
Honey (Cough):	[ ]	[ ]

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_____ _____ _____
Child's Last Name Child's First Name Birthday (MM/DD/YY)

Does your child have any of the following health conditions or health concerns?

No Yes
[ ] [ ] Allergies, other than medications (food, seasonal) – *Please list:* _____
[ ] [ ] Asthma - *Date of last asthma attack* _____
[ ] [ ] Diabetes
[ ] [ ] High blood pressure
[ ] [ ] Sickle cell anemia
[ ] [ ] Acid reflux (Heartburn)
[ ] [ ] Infections - *Circle the ones he/she had: Ears / Bladder Other:* _____
[ ] [ ] Seizures - *Date of last seizure* _____
[ ] [ ] Anxiety
[ ] [ ] Depression
[ ] [ ] ADHD
[ ] [ ] Surgery - *Circle the ones he/she had: Appendix / Gallbladder / Tonsils / Ear tubes Other:*_____
[ ] [ ] Other *Please describe:* _____

Does your child have a primary care doctor?

[ ] No [ ] YES Child's Doctor_____ Phone_____

Optional Insurance Information

We do not bill your insurance nor require insurance information. However, to better coordinate your child's healthcare please provide the name of your insurance company.

Name of Insurance Company (Optional) _____

Hazel Health Services School Health Center Authorization

Understanding that my child may need healthcare treatment or healthcare screenings during school hours at school, I hereby authorize Hazel Health Services, and the School by and through the Hazel Health Services telehealth service, to administer such first aid or other medical examination and treatment as shall be deemed best under the circumstances, and I consent for my child to receive such treatment. I represent and warrant that I am an authorized legal representative of the child. I understand that the School will attempt to notify an authorized legal representative of the child in the event of an emergency requiring immediate medical care for my child and if the School is unable to notify an authorized legal representative of the child, it will have my child treated by a duly qualified medical practitioner. Any medical information provided to the School may be shared with Hazel Health and Hazel Health Services. This authorization applies to all school-sponsored programs.

1. PURPOSE. The purpose of this form is to obtain your consent for your child to participate in a telehealth consultation. This consent will authorize medical information about the child, including personally-identifiable medical information, to be disclosed to Hazel Health and Hazel Health Services and medical professionals, administrative staff, and employees of Hazel Health and Hazel Health Services for the purposes of treatment by and through a telehealth consultation. This disclosure will also authorize the use of written or recorded information containing the child's personally-identifiable medical information, including recordings of any telemedicine encounter with the child, for training and informational purposes by employees of the School or Hazel Health or Hazel Health Services and the use of personally-identifiable information by Hazel Health for the development and improvement of software, hardware, and related tools designed to improve services provided by medical professionals, administrative staff, contractors and employees of Hazel Health and Hazel Health Services.
2. NATURE OF TELEHEALTH CONSULTATION. During the telemedicine consultation, the following may occur:
   - **A.** Details of your child's medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of a mobile application with real-time, interactive video, audio and telecommunications technology.
   - **B.** Physical examination of your child may take place via a remote medical practitioner through the mobile application.
   - **C.** Non-medical personnel including school staff, Hazel Health Services employees and/or translators may be present to aid with language and technical implementation of the consultation.
   - **D.** Video, audio and/or photo recordings may be taken of the consultation.
3. MEDICAL INFORMATION AND RECORDS. All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Additionally, dissemination of any patient-identifiable images or information from this telehealth interaction will not occur without your explicit consent. I authorize Hazel Health Services services to disclose protected health information about students to school health designees, school nurses, physicians, Hazel Health or other health care providers for treatment purposes.
4. CONFIDENTIALITY. Reasonable and appropriate efforts have been made to eliminate any confidentiality risk associated with the telehealth consultation, and all existing confidentiality protections under federal law apply to information disclosed during this telehealth consultation.

5. RIGHTS. You may withhold or withdraw consent to telehealth consultation at any time without risking the loss or withdrawal of any program benefits to which you otherwise be entitled. You acknowledge that you have been advised of your right to receive a copy of this authorization as signatory to the authorization.

6. DISPUTES. I agree that any disputes arriving from the telehealth consult be resolved in California through binding arbitration. I understand that (except for Small Claims Court cases and claims subject to a Medicare appeals procedure) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Hazel Health and Hazel Health Services, any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of telehealth consultations including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration.
7. RISK, CONSEQUENCES AND BENEFITS. I am aware of any potential risk, consequences and benefits of telehealth. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above. I am choosing to enroll in Hazel Health Services and am not being forced to utilize this program.