DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

SCHOOL HEALTH SERVICES TELEHEALTH PROGRAM CONSENT FORM

Under the School Health Services Telehealth Program, I understand that:

1. My child will be participating in appointments conducted by video (videoconferencing) or phone call (teleconferencing) with Children's National Hospital and other physicians and health care providers such as behavioral health providers. The healthcare provider may determine that an in-person follow-up visit or that urgent care or emergency services is required.

2. In a telehealth visit, my child will not be in the same room as the healthcare provider, who will be located at another site. I also understand that I have the option to refuse a telehealth appointment for my child. Instead, I can take my child for an in-person visit with their healthcare providers.

3. Limitations to telehealth services may include interruptions, unauthorized access and technical difficulties. I also understand that the healthcare provider can discontinue my child's telehealth visit if the healthcare provider determines the videoconferencing/teleconferencing connections are notsuitable.

4. In addition to my child's health care team and provider, individuals who operate the video equipment and are trained to maintain the confidentiality of all information obtained may also be present. I further understand that my child has the right to request the following: (1) to omit specific details of my child's medical history/physical examination; (2) ask non-medical personnel to leave the examination room; or (3) end a visit at any time.

5. Any interview or photograph made of my child will only be used for medical purposes andmaintained by the provider and health suite staff as confidential medical records, consistent with federal and DC laws and regulations.

6. By signing this consent, I authorize the School Health Services health suite staff to release any relevant medical information about my child's medical condition and medical care to the provider, its physicians and healthcare providers. I also authorize the provider or its healthcare personnel to release any and all information to my child's health insurance plan or any other agent that may be responsiblefor paying medical bills associated with the visit. I am further authorizing the School Health Services Telehealth Program to release specific medical information to school officials and DC Health, either because it is required by law or by regulation, or because it is necessary to protect my child's health and safety.

7. Enrollees in MedStar Family Choice, AmeriHealth, Care First, or HSCSN will not receive a bill for any of the services provided through telehealth. All charges associated with this program are at the discretion of the insurance company. Any copay that is required for primary care visits could apply for this service. I understand that any monies or benefits for providing telehealth will be

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assigned and transferred to the provider, including benefits/monies from my health plan, Medicaid, or other third parties who are financially responsible for my child's medical care. I authorize the release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes.

8. This consent will be valid for the duration of the student's enrollment in the school. I also understand that I have the right to withdraw my consent at any time by giving the health suite staff a signed and dated letter withdrawing my consent.

9. If I am not satisfied with the services rendered at any time, I may file a complaint with the Ombudsman team via phone: (202) 724-7491 or via email: healthcareombudsman@dc.gov. I can also communicate with the Children's School Services team at TelehealthCSS@childrensnational.org. Complaints should also be submitted via the School Health Services Program portal at: dchealth.force.com/studenthealthservices/s/.

10. Now that I have read (or have had read to me) this document carefully, I hereby enroll my child to participate in the School Health Services Telehealth Program, by filling out and signing the attached consent form under the terms described above and within the consent form below.

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SCHOOL HEALTH SERVICES TELEHEALTH PROGRAM CONSENT FORM

Please complete the following form to allow your child to receive medical services from the School Health Services Telehealth Program. By providing this information, you confirm that you understand and consent to the conditions under which your child will receive telehealth services.

Student's Personal Information | To be completed by parent/guardian/student.				
Student Last Name:	**Student First Name:**			**Date of Birth:**
School or Child Care Facility Name:		**Gender:** ☐ Male ☐ Female ☐ Non-Binary		
Home Address:	**Apt:**	**City:**	**State:**	**Zip:**
Ethnic Designation: *(check all that apply)*	☐ Hispanic/Latino ☐ Other	☐ Non-Hispanic/Non-Latino ☐ Prefer not to answer		
Race: *(check all that apply)*	☐ American Indian/ Alaska Native ☐ Asian	☐ Native American/ Pacific Islander ☐ White	☐ Black/ African American ☐ Prefer not to answer	
Parent/Guardian/Spouse/Other Name:		**Parent/Guardian/Spouse/Other Phone:**		
Parent/Guardian/Spouse/Other Email:		**Parent/Guardian/Spouse/Other Alternate Phone:**		
Emergency Contact Name:		**Emergency Contact Phone:**		
Insurance Type: ☐ Medicaid ☐ Private ☐ None		**Insurance Name/ID #:**		
Primary Care Provider Name, Organization, and Phone Number *(if available)*				

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I give permission to the signing licensed health care professional to share the health information on this form and health information resulting from telehealth visits with the student's school and appropriate DC Government agencies for coordination between relevant agencies and health care providers for follow-up purposes. I also authorize the release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes. In addition, I hereby acknowledge and agree that the District, the school, its employees, and agents shall be immune from civil liability for acts or omissions under DC Official Code § 38-651 (DC Law 17-107), except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and submitted before the student can participate in telehealth visits.

Signature of Parent/Guardian/ Student 18 or older: _____

Date: _____

Print name of Parent/Guardian/ Student 18 or older: _____

Minor's Health Consent Services

22-B DCMR §600 provides that a person who is eighteen (18) years of age or older may consent to the provision of healthservices for himself, or herself, or their child or spouse.

Additionally, within the District of Columbia, a minor of any age may consent to health services which he or she requests for the prevention, diagnosis, or treatment of the following medical situations: (a) Pregnancy or its lawful termination; (b) Substance abuse, including drug and alcohol abuse; or (c) A mental or emotional condition and sexually transmitted disease.

Student Signature: _____

Date: _____

Print Name of Student: _____

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