Atrium Health
Levine Children's

ENROLLMENT AND CONSENT FORM

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____
(mm/dd/yyyy)

Address: _____ City/State/Zip: _____

School Name: _____ Grade: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian: _____ Date of Birth: _____
(mm/dd/yyyy)

Address: _____ City/State/Zip: _____

Relationship to Patient: _____ Phone: (H) _____ (W) _____ (C) _____

Alternate Contact: _____ Phone: (H) _____ (W) _____ (C) _____

Alternate Contact: _____ Phone: (H) _____ (W) _____ (C) _____

Alternate Contact: _____ Phone: (H) _____ (W) _____ (C) _____

RELEASE OF INFORMATION

In treating your child at the Atrium Health Levine Children's Virtual Clinic, his/her information will be used and shared to provide care or conduct health care operations. For example, we may use your child's information to coordinate care with other providers, including the school nurse; we may share information with school personnel about how to administer medications or accommodate your child's condition; we may use the information to evaluate how the services were delivered and whether this program is effective; and, we may share the information with the school and others if there is imminent harm or a public health situation. We may also receive information from other providers and pharmacies, such your child's health history and medication list. We will keep a copy of this information in your child's record. For more information about how your child's information may be used or disclosed, please review our Atrium Health Notice of Privacy Practices available on our website AtriumHealth.org under the Privacy Practices link at the bottom of the page for more information. A paper copy may be available at the school clinic.

I acknowledge that a copy of the Atrium Health Notice of Privacy Practices has been made available to me.

Parent/Guardian signature: _____ Date: _____

FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT

All persons have health issues that must be handled in a confidential manner. School staff will share confidential information only in the following situations: when it is educationally relevant for a student's academic progress, when necessary to address potential health care needs, to ensure the safety of the patient, other students/staff and/or school personnel, or other situations specified by law. I give permission for designated school personnel (including the school nurse) to share information from the school with Atrium Health Levine Children's Clinics about my child's health history if appropriate, and/or other emerging health concerns.

Parent/Guardian signature: _____ Date: _____

TELEMEDICINE SERVICE

The purpose of the Atrium Health Levine Children's Virtual Clinic is to provide care to your child in certain situations, such as when he/she is sick while at school. By signing below, you are acknowledging that you understand the risks and benefits of your child receiving treatment through the Atrium Health Levine Children's Virtual Clinic and you give consent for us to treat your child, virtually by telemedicine. Telemedicine is the use of electronic information and communication technologies by a health care provider (using interactive audio, video, or data communications) to deliver services to your child when he/she is at school and the provider is located at a different place. Not every condition can be treated by the Atrium Health Levine Children's Virtual Clinic. If your child's treatment provider believes your child would be better serviced by in-person treatment you will be notified and referred to an in-person setting for further care. If your child's condition is determined to be emergent, the school and/or the provider may send him/her to the hospital.

Telemedicine encounters are still subject to the requirements of the HIPAA Privacy Rule that apply to Protected Health Information (outlined in the Release of Information section above). If you text or email us with patient information in an unsecured manner, you understand the risks of doing so (see our Guidelines for Email under the above Privacy Practices link for examples) and give us permission to respond to you in a similar, unsecured manner. There is the risk that treatment provided by telemedicine could be disrupted due to technical failures.

CONSENT FOR SERVICES

I, the parent/guardian of said student above, give consent for my child to receive services at Atrium Health Levine Children's Virtual Clinic as described in this document. I understand that this Consent Form will be good until my child leaves/graduates school or until I provide the Clinic staff with written directions otherwise. I understand that this consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on this consent prior to the revocation. Any request for revocation must be in writing and sent to Atrium Health Levine Children's Virtual Clinic at the School address.

By signing below, I agree as legal custodian of my child that I have read, accepted and agreed to be bound by this consent, notice and acknowledgement in relation to the services, including telemedicine services, provided to my child. I understand that if I do not sign this document, my child will not be able to receive treatment as a part of the program.

Parent/Guardian signature: _____ Date: _____