Dear Parent(s):

Bowling Green Independent School District is excited to announce an affiliation with Graves Gilbert Clinic to provide school based health services. A licensed or a certified provider will be based in each individual school in order to provide nursing services such as medication administration, basic first aid, assessment of symptoms and performance of special needs care.

In addition, an Advanced Practice Registered Nurse (APRN) will be located in Bowling Green High School and be available to perform telehealth visits for students and staff. This new telehealth program will allow the provider to see and talk to your child and school medical personnel by means of live video conferencing with your consent. You may also join your child and medical personnel and be present during the exam. The program is designed to allow availability of primary medical services to your child when they have a healthcare need such as a fever or an illness. This partnership offers quick and easy access to medical care, minimizing exposure to other illnesses, while decreasing student absenteeism and work time lost for parents.

The telehealth consultation does not replace your child's primary care provider or specialist. The program is being offered to expand student healthcare options while increasing student attendance and fostering academic success.

Graves Gilbert Clinic will be able to directly bill your insurance carrier for telehealth services rendered by a licensed provider. You will be responsible for required copays and any prescriptions that may be required.

What is telehealth and how will it work?

- Medical personnel will be physically present in all seven (7) of the Bowling Green Independent Schools. Telehealth services will be provided by Ashley Allen, APRN who will be physically located at the high school. Services will be available through the school nursing office during regular school hours.
- School nurses will continue to provide basic first-aid and over-the-counter medications (with signed school district permission forms) to all students.
- If a child needs care beyond basic first aid, the parent or guardian will be contacted with the option of treatment by the APRN. Typical telehealth visits may include, but is not limited to, the evaluation of common cold symptoms, temperatures of short duration, urinary symptoms, bug bites and stings.
- Using interactive computer programs, the APRN can talk face-to-face with your child and school medical personnel. The provider will then direct the assessment of your child. This may include laboratory testing such as flu and strep.
- Parents wishing to participate in the visit will be able to come to the school and be present with your child. If you're unable to participate, you may request a clinic summary of your child's visit.
- Following the telehealth visit, the provider may send prescriptions to your preferred pharmacy and you will be notified by school medical personnel.

- The APRN will also be available for students who stay home sick and are unable to get a same day appointment with their family health care provider. By simply contacting the school and asking to speak with the school nurse, they will have the opportunity to be seen for a same day appointment.
- If your child is seen by the APRN, GGC will bill your insurance. Those with private/commercial insurance will bill the copay to the parent or guardian.
- If your child requires hands on care, or this is an emergency, your child may need to go directly for treatment elsewhere. You will be notified immediately if this is the case.

How do I give consent for my child to be seen by the Nurse Practitioner?

School medical personnel can evaluate your child and determine if they would benefit from a telehealth visit following evidenced based protocols approved by School Health Service Director, Amy Gearlds, D.O. Before your child can be assessed by a provider, your consent is required. In order to assist in the evaluation of your child, please complete the attached consent form and medical questionnaire and return both to the school office if you wish to participate.

If you do not wish for your child to participate in the telehealth program, your child can still see school medical personnel for basic first aid. If you decide later that you would like to participate in the telehealth program, forms can be obtained from the school for completion prior to a visit taking place.

LOOKING FORWARD TO A HEALTHY SCHOOL YEAR.

Sincerely,

Chris Thorn, CEO

ATTACHMENTS:

- New Patient Information Questionnaire
- Consent for Over The Counter Medications
- Consent for Telehealth Consultation
- Notice of Privacy Practices

GRAVES GILBERT CLINIC

Student Health Questionnaire

Students Legal Name: _____ Phone: _____

Parent/Legal Guardian: _____ Phone: _____

Pediatrician or Family Doctor: _____

Preferred Pharmacy: _____

Insurance Carrier: _____ Policy Number: _____ Eff. Date:_____
Subscribers Name: _____ Date of Birth: _____
Subscribers Address: _____

1. Past Medical Diagnosis, Hospitalizations, and/or Surgeries:

_____
_____

2. Current Medications: Name and Dosage (Include vitamins, herbs, supplements, and oil)

_____
_____

3. Doctor Diagnosed Asthma: ☐ Yes ☐ No

Triggers: ☐Pollens ☐Dust ☐Animals ☐Foods
☐Exercise ☐Heat ☐Illness ☐Scents/Perfume
☐Smoke ☐Seasonal ☐Others: _____

4. Doctor Diagnosed Allergy: ☐ Yes ☐ No

Allergy to: _____

5. Medication Needed at School: ☐Yes ☐No If yes, explain: _____

6. Medical Procedures Needed at School: ☐ Yes ☐No If yes, explain: _____

Family History:
Check any of the following that parents, grandparents, siblings, aunts, uncles, or cousins may have had:

☐ Asthma ☐Childhood cancers ☐Heart Attack less than 35
☐ High Cholesterol ☐ Sickle Cell Disease/Trait
☐ Other: _____

Please list any other individuals who you give permission for us to communicate with about your child's medical condition.

Name: _____ Relationship: _____ Contact #:_____

Name: _____ Relationship: _____ Contact #:_____

It is the guardian's responsibility to notify the school health office in writing if above contacts change.

Parent/Legal Representative Printed Name: _____

Parent/Legal Representative Signature: _____

Date: _____ Relation: _____

VALID FOR SCHOOL YEAR 2019-2020

Over-the-Counter Medication

Student's Name: _____ Grade: ____ **ALLERGIES:_____**

Student's Age: ____ Date of Birth: _____ School: _____

Please indicate below the medications you permit to be administered to your child.

This form will keep us from having to call you each time your child needs something different related to occasional basic medical needs. It will also help us get your child back to class quickly. Thank you for allowing us to care for your child.

☐ **Acetaminophen**	☐ **Antibiotic ointment**	☐ **Eye drops/wash**	☐ **Aloe Vera**
☐ **Calamine lotion**	☐ **Ibuprofen**	☐ **Oragel**	☐ **Cough Drops**
☐ **Loratidine (Allergy)**	☐ **Antacid Tablet**	☐ **Hydrocortisone Cream**	☐ **Anti- Nausea**
☐ **Lip Ointment**	☐ **Sunscreen**	☐ **NONE OF THE ABOVE**	

- I authorize the nursing and medically trained staff at Bowling Green Independent School District and Graves Gilbert Clinic to provide over the counter medication as noted above and as needed to my child.
- I understand that it is my responsibility to directly notify the nursing staff in writing at the school where my child is enrolled of any changes in my child's OTC medication needs.
- I understand that in the event of an adverse reaction any OTC medication, the medication will be halted, and I will be notified by the nursing staff at the school.
- I understand that this permission form will be kept on file in my child's student health record and will not be changed without written notification.
- I understand that this document's confidentiality is governed by FERPA (Family Education Rights to Privacy Act) and that all rules under such Act will be followed by all parties.
- I understand that a generic equivalent may be administered to my child.
- I expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administration of the above medication.
- I understand that I must provide to the school nursing staff a signed physician's order/statement in order to exceed the recommended dosage guidelines (as printed on the bottle/packaging) when administering the indicated medications.
- Of my own free will, I consent to care which may include screenings such as vision, hearing, first aid, over the counter medication as indicated above, and any other health service given to my child. I also authorize the release of medical information about my child to Medicaid/KCHIP to determine payment for services.

_____ _____

Parent/Guardian Signature *Date*

_____ _____

Printed Name *Relationship*

CONSENT VALID FOR SCHOOL YEAR 2019-2020 Amended from KYBE 09.2241. AP. 21

CONSENT FOR SCHOOL BASED TELEHEALTH CONSULTATION AGREEMENT FOR TREATMENT

I request and consent to having my child _____ examined and evaluated by medical providers affiliated with Graves Gilbert Clinic by means of interactive/video. This telemedicine consultation may be used to help diagnose, manage, or treat my child.

In addition, I understand and agree to the following:

- The consulting health care provider or specialist *will be* at a different location from my child. The school nurse or other qualified practitioners will be present with the child in the room to assist in the examination and evaluation. I may attend electronically or in person as well if I provide information allowing me to be reached in a timely manner.
- Additional technical personnel may be present during the consultation as needed to operate the telemedicine equipment.
- This telemedicine consultation program is not replacement for my child's primary or specialty care, and is being provided to enhance the school based health service
- The results of the examination will become a part of the child's medical record, which could include video and/or audio recording of the session as deemed appropriate by the consulting provider or specialist. The consulting provider or specialist will send the results of the teleconferenced visit to your child's primary care provider.
- The consulting provider or specialist may recommend additional tests and treatment, and it is my responsibility to follow-up on such recommendations.
- Although the equipment and resources are designed to protect patient confidentiality and to provide accurate and timely transmissions, the risk remains for technical difficulties, interruptions, and unauthorized access.
- Your child's school and Graves Gilbert Clinic will attempt to reach you before the telemedicine visit takes place, however, in the event we are unable to contact you, you give your permission for the telemedicine visit to take place, and Graves Gilbert Clinic will send you a summary of the visit and recommendations that were made.
- Telehealth consultations may be billed to my insurance when appropriate. I authorize direct payment to the clinic the benefits provided under any health care plan or medical expensed policy due to me or payable by the plan. I further authorize the clinic to release any information required by any third party payer regarding any claim for payment.

Please indicate whether you want to be notified of a telemedicine visit before it happens.

☐ **YES** ☐ **NO** **Contact Number:** _____

I acknowledge receipt of Graves Gilbert Clinic's Notice of Privacy Practices.

Child's Name: _____ Date of Birth: _____

Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature: _____

Relation: _____ Date: _____ Time: _____

CONSENT VALID FOR SCHOOL YEAR 2019-2020