



Child's Name: \_\_\_\_\_  
 Parent/Guardian Name: \_\_\_\_\_  
 School: \_\_\_\_\_  
 Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Dear Parent(s)/Legal Guardian(s),

Congratulations! Your child's school will participate in the **Kids'-Doc-On-Wheels (KDOW) School Based Health Care Telehealth Clinic** for the 2018-2019 school year. **KDOW** will provide medical services for students through an onsite medical team (i.e. school nurse, staff assistant and virtual provider) with the iCare Counter, a telehealth station. The goal is to provide on-site access to medical care and services similar to that of a pediatric office. **KDOW** accepts all Medicaid and most private insurance plans. This program is not intended to replace your primary physician, but can be considered an additional service. If your child does not have a primary care physician (a medical provider your child sees regularly), **KDOW** can become your child's Primary Care Provider (PCP)!

**\*\*Please select ONE program option for your child.\*\***

**Full KDOW Program:**

- KDOW will become your child's PCP
- Primarily seen on the unit with Telehealth as a supplement
- Access to mobile Behavioral Health Services, mobile Dental Services, and Telehealth Services
  - Behavioral Health Services provided by Licensed Behavior Specialist through KDOW
  - Dental Services provided by Help-A-Child-Smile
- We provide all services done in a traditional Pediatrician's Office
  - Well Exams (Child Health & Development Interactive System (CHADIS) questionnaire required for ages 0-5 & 11-18 years old)
    - CHADIS is a web-based screening, diagnostic and management system that administers and analyzes child pre-visit. CHADIS improves the diagnosis and management of health, developmental and behavioral issues, helping Clinicians address parents' concerns about their child's health and development. CHADIS questionnaire can be completed online at <https://www.site.chadis.com/>
  - Sick Visits
  - Sports Physicals
  - Vaccines
  - Flu Shots and more
- During School breaks our unit will be located at convenient locations in your local community. There is also availability after school hours. For after school hour access, please call 404-574-2512.

**My Child's School Based Health Care Telehealth Clinic:**

- If the school nurse identifies a student that requires medical attention, the parent/guardian will be offered the option of a telehealth visit.
  - Primarily seen by a provider virtually with the mobile unit as a supplement
  - Per Georgia law, patients seen via Telehealth only must have an **in person visit on the mobile unit once a year.**
- Services Provided through Telehealth are as follows:

**Chronic Illness Management**

- Allergy
- Asthma
- ADHD
- Elevated BMI/ Obesity

**\*\*\*In order for child to receive Telehealth services while in school, a consent form has to be on file!\*\*\***

**As the parent/legal guardian of a student, you give permission for your child to utilize the program by:**

- Signing the registration form to authorize child's participation.
- Providing Copy of front and back of insurance card
- Returning the consent form back to the school nurse or other designated school personnel

We're confident you and your child will greatly enjoy the experience and compassionate care of **KDOW**. If you have any questions please contact KDOW at [contact@kidsdoconwheels.org](mailto:contact@kidsdoconwheels.org) or 404-574-2512.

**Signature:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



Child's Name: \_\_\_\_\_  
 Parent/Guardian Name: \_\_\_\_\_  
 School: \_\_\_\_\_  
 Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

**WHAT TYPE OF MEDICAL INSURANCE DO YOU CURRENTLY HAVE?**

PLEASE PROVIDE PROOF OF INSURANCE OR MEDICAID YOU MAY BE HELD FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED. PLEASE LIST ALL INSURANCE COVERAGE THE CHILD IS ELIGIBLE FOR.

Name of Policy Holder/Guarantor \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Name of Insurance /Medicaid \_\_\_\_\_ ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Secondary Insurance Name \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_

Please check if applicable: \_\_\_\_\_ Not Insured

**CONSENT/REFUSAL FORM FOR THE USE OF TELEHEALTH**

PURPOSE: The purpose of this form is to enroll your child into the Kids'-Doc-On-Wheels, Inc. (KDOW) telemedicine program in connection with the following procedure(s) and/or services: **Medical Services, Dental Services, and Behavioral Health Services.**

1. NATURE OF TELEHEALTH CONSULT: During the telemedicine consultation:
  - a. Details of your child's medical history, examinations, x-rays, and test will be discussed with our healthcare professionals through the use of interactive video, audio, and telecommunication technology.
  - b. A clothed physical examination of your child may take place.
  - c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
  - d. Video, audio, and/or photo recordings may be taken of your child during the procedure(s) or service(s).
- e. Parent(s)/Legal guardian(s) will have the option of being present for the evaluation in person by phone or via link ([www.kidsdoconwheels.org](http://www.kidsdoconwheels.org); [www.emdanywhere.com](http://www.emdanywhere.com)) that is sent from the telemedicine system to allow them to participate using a desktop or smartphone. If you are unable to participate, you will receive a timely follow-up communication from a KDOW representative regarding the child's medical evaluation and treatment.
2. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to your child's medical information and medical records, apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
3. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telemedicine consultation.
4. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your child's right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
5. DISPUTES: You agree that any dispute arising from the telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.
6. RISKS, CONSEQUENCES, & BENEFITS: You have been advised of all the potential risks, consequences, and benefits of telemedicine. Your child's healthcare practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation during regularly scheduled school meetings. All your questions have been answered, and you understand the written information provided above.

I agree to participate in my child's School Based Health Care Telehealth Clinic.

Signature: \_\_\_\_\_ If signed by someone other than the patient, indicate relationship: \_\_\_\_\_

I refuse to participate in my child's School Based Health Care Telehealth Clinic.

Signature: \_\_\_\_\_ If signed by someone other than the patient, indicate relationship: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_



Child's Name: \_\_\_\_\_  
 Parent/Guardian Name: \_\_\_\_\_  
 School: \_\_\_\_\_  
 Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

**Patient Information**

Child's Full Name (First, Middle, Last) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F

Race: \_\_\_\_\_ Mixed Race (please specify : \_\_\_\_\_)

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Email Address \_\_\_\_\_ Primary Language \_\_\_\_\_

Does your child receive special services? Explain \_\_\_\_\_ Consent to receive texts (Please circle) Yes No

Emergency Contact Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Phone Number \_\_\_\_\_

Name of individual who can make medical decisions for your child in your absence:

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Phone Number \_\_\_\_\_

**GENERAL HISTORY**

**Does the patient have any allergies to medications, food and /or anything else?**

List here \_\_\_\_\_ Reactions \_\_\_\_\_

List here \_\_\_\_\_ Reactions \_\_\_\_\_

List here \_\_\_\_\_ Reactions \_\_\_\_\_

\_\_\_\_\_ **Please List Daily Medication Names and Dosages:**

Pharmacy Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**Any Health Problems Under Treatment?** \_\_\_ Yes \_\_\_ No

If yes, explain \_\_\_\_\_ Where treatment was received? \_\_\_\_\_

**Has your child seen a doctor in the last year?** \_\_\_ Yes \_\_\_ No

**If yes, how many times?** Please Circle: 1 time 2 times 3 times 4 or more times

Where? \_\_\_\_\_ Why? \_\_\_\_\_

**Has your child used a Hospital Emergency Room in the last year?** \_\_\_ Yes \_\_\_ No

**If yes, how many times?** (Please Circle): 1 time 2 times 3 times 4 or more times

Where? \_\_\_\_\_ Why? \_\_\_\_\_

**Was your child in the hospital overnight in the last year?** \_\_\_ Yes \_\_\_ No

Where? \_\_\_\_\_ Why? \_\_\_\_\_ How Long \_\_\_\_\_



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Is your child up to date on their immunizations?  Yes  No  Unsure

Has your child's hearing and vision been screened recently? If so, when?  Yes  No Date: \_\_\_\_\_

**Family History**

	In good health	Unknown	Medical problems / Reason for death (if deceased)
Child's Mother			
Child's Father			
Child's Siblings			
Others			

**ILLNESS HISTORY**

Anemia Yes \_\_\_ No \_\_\_  
 Asthma Yes \_\_\_ No \_\_\_  
 Bleeding Disorders Yes \_\_\_ No \_\_\_  
 Cancer Yes \_\_\_ No \_\_\_  
 Diabetes Yes \_\_\_ No \_\_\_  
 Heart Murmur Yes \_\_\_ No \_\_\_

Allergies Yes \_\_\_ No \_\_\_  
 Menstrual Problems Yes \_\_\_ No \_\_\_  
 Menstruation Started Age \_\_\_\_\_  
 Obesity/ Elevated BMI Yes \_\_\_ No \_\_\_  
 Other Problems Yes \_\_\_ No \_\_\_  
 Please Specify \_\_\_\_\_

When was your child's last dental visit? \_\_\_\_\_  
 Does your child have dental problems?  
 Yes \_\_\_ No \_\_\_  
 Has your child had a toothache recently?  
 Yes \_\_\_ No \_\_\_

**DENTAL**

Has your child had a recent injury to the teeth or jaws  
 Yes \_\_\_ No \_\_\_  
 Does your child have a finger or thumb sucking habit?  
 Yes \_\_\_ No \_\_\_

**BEHAVIORAL HEALTH QUESTIONNAIRE**

Does your child have behavior issues at home or school?

Yes \_\_\_ No \_\_\_

Does your child seem to be hyper and require constant redirection?

Yes \_\_\_ No \_\_\_

Does your child have a hard time with school or homework?

Yes \_\_\_ No \_\_\_

Does your child seem sad often?

Yes \_\_\_ No \_\_\_

Has your child ever threatened/or tried to harm him/her self or others?

Yes \_\_\_ No \_\_\_

Is your child constantly involved in conflict with peers or authority figures?

Yes \_\_\_ No \_\_\_

Is there anything else you would like us to know concerning your child's health?

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