



"We Put Wheels On Wellness!"
www.kidsdoconwheels.org

Child's Name: _____
Parent/Guardian Name: _____
Registration Site: _____
Child's School: _____
Teacher: _____ Grade: _____
Pharmacy: _____ Phone #: _____

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

Congratulations! Your child's community program will participate in the **Kids'-Doc-On-Wheels (KDOW) Community Based Healthcare Telehealth Clinic**. KDOW will provide medical services for students through an on-site medical team (i.e. school nurse, staff assistant and virtual provider) with the iCare Center, a telehealth station. This program is designed 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 doctor, but can be considered an additional service. If your child does not have a primary care doctor (a medical provider your child sees regularly), KDOW can become your child's **Primary Care Provider (PCP)**!

My Child's Community Based Healthcare Telehealth Clinic:

Please read page 4 for more details on the telehealth examination process before signing.

As your child's community based clinic, KDOW will provide the following services:

- Every child will receive a virtual health assessment to determine baseline health measures
- If a staff member identifies a child that requires medical attention, the parent/guardian will be offered the option of a telehealth visit
- Primarily seen by a provider virtually (online) with the mobile unit as an additional service
- Per Georgia law, patients seen via telehealth must have an in-person visit with one of our providers once a year
- Services provided through telehealth are as follows:

Sick Visits

- Ear Infections
- Sinus Infections
- Watery eyes
- Common cold
- Rash

Chronic Illness Management

- Allergies
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Elevated BMI/Obesity

YES! I agree to participate in my child's Community Based Healthcare Telehealth Clinic.

Signature: _____ Relationship to Patient: _____

No, I do not want my child to have access to a doctor throughout the day via their community telehealth clinic.

Signature: _____ Relationship to Patient: _____

WITNESS: _____ DATE: _____ TIME: _____

Full KDOW Program:

If you would like for KDOW to become your child's primary care provider and receive all the services listed, please check the box below.

In addition to the telehealth program, your child will have access to KDOW's full list of services which include the following:

- KDOW will become your child's Primary Care Provider
- We provide all services done in a traditional Pediatrician's Office: Sick Visits, Sports Physicals, Vaccines, Flu Shots and more!
- Mainly seen in the privacy of the mobile unit in addition to telehealth at the community program
- Access to Mobile Behavioral Health Services (counseling), Mobile Dental Services, and Telehealth Services
- Behavioral Health Services provided by Licensed Behavioral Specialist through KDOW
- Dental Services provided by Help-A-Child-Smile

YES! I want KDOW to become my child's primary doctor.

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

Returning the consent form back to the school nurse, front office, or other designated community program personnel.

In order for your child to receive Telehealth services while at their community program, a consent form must be on file!



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Patient Information

Child's Full Name (First, Middle, Last) _____ Date of Birth _____ Sex: M F
Race (Please circle one) American Indian/Alaskan Native, Black/African American, White/Caucasian, Asian,
Native Hawaiian/Other Pacific Islander Mixed Race (please specify : _____)
Ethnicity (Please circle one) Hispanic/Latino, Non-Hispanic/Latino
Address _____ Apt # _____
City _____ State _____ Zip _____
Home Phone # _____ Cell Phone # _____ Work Phone # _____
Consent to receive texts (Please circle) Yes No
Email Address _____ Primary Language _____

Does your child have a primary care doctor? Yes No
Primary Care Doctor _____ Phone Number _____

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 _____

What Type of Medical Insurance Do You Currently Have?

Please circle one: Medicaid Private Insurance No Insurance

Please provide proof of insurance/Medicaid or 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 provide a copy of front and back of insurance card along with this form ~

General Health History

Is your child up to date on their immunizations? __Yes __No __Unsure

Has your child's hearing and vision been screened recently? __Yes __No If so, when? Date: _____

Does the patient have any allergies to medications, food and /or anything else? List all that apply and the type of reaction(s).

If any, please list daily medication names and dosages:

Any health problems currently being treated? __ Yes __ No

If yes, explain _____ Where treatment is/was received? _____

Has your child seen a doctor within the last year? __ Yes __ No If so, when? Last date seen _____

Where? _____ Why? _____

Has your child used a hospital emergency room in the last year? __ Yes __ No If yes, how many times? _____

Where? _____ Why? _____

Was your child in the hospital overnight in the last year? __ Yes __ No

Where? _____ Why? _____ How Long? _____



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Parent/Guardian Name: _____
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Teacher: _____ Grade: _____
Pharmacy: _____ Phone #: _____

Family History

Child's Mother ___ In good health ___ Unknown Medical problems/Reason for death (if deceased)
Child's Father ___ In good health ___ Unknown _____
Child's Siblings ___ In good health ___ Unknown _____
Other Family Members ___ In good health ___ Unknown _____

Dental Health History

When was your child's last dental visit? Date _____ Has your child had a recent injury to their teeth or jaw? Yes ___ No ___
Does your child have dental problems? Yes ___ No ___ Does your child have a finger or thumb sucking habit? Yes ___ No ___
Has your child had a toothache recently? Yes ___ No ___

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 ___
Obesity/Elevated BMI Yes ___ No ___
Menstrual Problems Yes ___ No ___
Menstruation Started Age _____

Other Problems (Please specify)

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? (Please explain in detail)



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TELEHEALTH CONSENT/REFUSAL INFORMATION

The purpose of this form is to enroll your child into the Kids'-Doc-On-Wheels, Inc. (KDOW) telehealth 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; 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.

****After reading the above statement thoroughly, please sign page 1 to consent for telemedicine services. If you have any questions please call us at 404-574-2512.****

Additional Information:

What happens after we sign up?

A member of our Community Outreach Team will call you to answer any and all of your questions and set up your child's first appointment. We will then schedule your child for their baseline virtual health assessment with a doctor.

Does my child need to change their regular healthcare provider?

No, your child may keep their doctor. We work with and communicate with your child's healthcare providers, specialists or mental health providers. KDOW is an added service to help support your child's already existing primary care team.

Can I fill out one consent form for all of my children?

No. Each child will need their own consent form.

Do I have to be present for my child to be seen?

No. With a signed consent form you are not required to be present, but we encourage you to attend, if you are available (both virtually or in-person).

How will I know what the provider says during the visit?

After each visit, (1) the provider will call you to discuss everything that took place, (2) your child will bring home a 'Report Card' detailing the visit information, and (3) this information is also available online in your Patient Portal.

What happens to my child's care during the school breaks?

During school breaks our mobile unit will be located at convenient locations in your local community (ex: parks, shopping centers, apartment complexes, etc). There is also availability after school hours. For after school hour access, please call 404-574-2512. Please visit our website at www.kidsdoconwheels.org for the school break schedule.

Is there anything else I need to fill out to have my child seen by KDOW?

In most cases, the answer is no. However, you may need to fill out an online questionnaire if your child needs a well exam between the ages of 0-5 & 11-18. This is called the Child Health & Development Interactive System (CHADIS) questionnaire. Completing CHADIS before your child's well exam helps the provider better assess your child's health and wellness. It also helps address any concerns you may have about your child's health and development. The CHADIS questionnaire can be found and completed online at <https://www.site.chadis.com/>.

Allergy Testing - If your child needs to have an allergy test performed, an additional consent form will be sent home to be completed.

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