February 21, 2020

Dear Parents of Hancock County Students:

It is with confidence that we introduce you to a new program that we have implemented in all of our schools “SCHOOL-BASED HEALTH SERVICES”. SCHOOL-BASED HEALTH SERVICES has been in place in other areas for 10-12 years and this program meets all KY state guidelines for treatment and recordkeeping. FAMILY HEALTH CARE has been participating for 7 years and we, at Hancock County, are happy to be a front runner in our area, offering these services.

After a lengthy process of meetings, reference checks and screening applicants to fill this role, On January 23, 2020, our Administrative Board unanimously approved and we have entered into a contract with Family Health Care. Beginning on April 6, 2020, Family Health Care will have placed a Nurse in each of our Facilities and a Nurse Practitioner in our District as well.

For each student whose parent or guardian has signed an Authorization for Treatment, these nurses will be able to assess your child and treatment can be administered under the care of a Nurse Practitioner. Family Health Care Services Proviced include:

- PREVENTATIVE HEALTHCARE
- HEALTHCARE MAINTENANCE
- IMMEDIATE MEDICAL ATTENTION
- ADDITIONAL SERVICES AVAILABLE

Please refer to the attached brochure for more information. You will also find an Authorization Form... please sign and return as soon as possible - remember, your child cannot be treated without an authorization in the student’s file.

It is our desire to keep your child healthy and in the classroom. SCHOOL-BASED HEALTH SERVICES will also prevent you, the parent, from having to leave work. Family Health Care will not be a substitute for your Current Primary Care Provider, they are here to bridge a gap in services and to make it easier for students and parents.

Thank you for your prompt participation.

Respectfully,

Kyle Estes
Superintendent

Equal Education and Employment Institution M/F/D
CONSENT FOR SCHOOL HEALTH SERVICES

SCHOOL: ___________________________ TEACHER: ___________________________

STUDENT'S FULL NAME: ___________________________

STUDENT'S SOCIAL SECURITY # ___________________________ BIRTHDATE: ___________

MALE ______ FEMALE ______ RACE: ___________________________

ADDRESS: ___________________________ CITY: ___________________________ ST: ______ ZIPCODE: ______

ANY KNOWN DRUG ALLERGIES: NO ___ YES ___ IF YES, PLEASE LIST: ___________________________

MEDICAL INSURANCE: _______________ POLICY #: ___________________________

PRIMARY CARE PROVIDER: ___________________________ PHONE #: ___________________________

MOTHER'S NAME: ___________________________ PHONE #: ___________________________

FATHER'S NAME: ___________________________ PHONE #: ___________________________

EMERGENCY CONTACT: ___________________________ PHONE #: ___________________________

PLEASE LIST ANY OPERATIONS, HOSPITALIZATIONS OR SERIOUS INJURIES OR ILLNESS: ___________________________

PLEASE LIST ANY OF THE STUDENT'S FAMILY MEMBERS HEALTH PROBLEMS:

MOTHER: ___________________________ FATHER: ___________________________ GRANDPARENTS: ___________________________

My child may be given the following OTC medicines:

Cough Syrup ___ Orage __ Children's Robitussin ___ Antibiotic Ointment ___ Antacid (Tums/Rolaids)

Ibuprofen ___ Tylenol ___ Calamine Lotion ___ Eye Drops ___ Throat Spray/Lozenge

Antifungal Cream ___ Cough Drops ___ Benadryl ___ Muscle Rub ___ Children's Pepto Bismol

I release this information to Medicaid/K-Chip for billing purposes for visits to the school health clinic. I understand that no guarantees are being made as to the effects of any exam or treatment on my child. I further understand that I will not be billed for any services that my child receives at the school clinic during the school session. I acknowledge receipt of the Notice of Privacy Practices (NPP) and Bill of Rights. I request that payment of authorized medical insurance benefits be made to FHCA on my behalf for services rendered to my child. I have read this statement and understand that my signature indicates that I do consent and assign benefits as stated above. I also authorize FHCA staff providing services at the school clinic to provide health information from my child's medical record and from the designee of the school and my child's physician only as needed under the guidelines of HIPAA and FERPA consistent with Federal Laws for the purpose of providing safe and appropriate school health services and programs. I consent to care which may include screening, assessments, lab tests, treatment, first-aid, over the counter and prescription medication, telemedicine and any other health service given to my child by staff or agents of FHCA. I authorize the school health clinic staff to release medical information about my child that impacts learning environment to her/his primary care provider, school principal/guidance counselor or designee. In case you are going to have clinical visits using videoconferencing technology, you will be able to see and hear the provider and they will be able to see and hear you, just as if I were in the same room. Since 1994, the technology has connected tens of thousands of patients and providers in Kentucky. The information may be used for diagnosis, therapy, and follow-up either in- Or not by the provider. I may ask questions of the provider or any telemedicine staff in the room with me, if I am unsure of what is happening. If I am not comfortable with seeing a provider on videoconference technology, I may request the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are being implemented to insure videoteleconference is secure, and no part of the encounter will be recorded without your written consent. Possible Risks: There are potential risks associated with the use of telemedicine which include, but may not be limited to: A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision. Technology problems may delay medical evaluation and treatment for an encounter. In rare instances, security protocols could fail, causing breach of privacy of personal medical information. By signing this Form, I understand the following: 1.) I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent, except as noted above. 2.) I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. 3.) I also understand that if the provider believes I would be better served by a traditional face-to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit. 4.) I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. 5.) I release the School District/Board of Education and Family Health Care Associates from any liability related to the administration of medication or treatment so long as Reasonable and Customary Care is provided. Parent Consent to the Use of Teleremedicine: I have read and understand the information provided above regarding telemedicine, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care. I hereby authorize FHCA to provide any services listed above in the course of my diagnosis and treatment.

Parent/Legal Guardian Signature: ___________________________ Date: ___________