Norton eCare School Telehealth Consent Form

By completing this form and returning to your child's school, you understand the school nurse will provide this information to Norton Healthcare.

Patient Information:

First Name: ______________________ Middle Initial: ______ Last Name: ________________________

Date of Birth: ____________________ Gender: ___________ Phone #: __________________________

Parent Email: ____________________________________ School Name: ____________________________

Home Address: ____

City: ____________________________ State: ____________ Zip Code: _________________________

Parent/Guardian Information:

First Name: ______________________ Middle Initial: ______ Last Name: ________________________

Date of Birth: ___________________________ Relationship: _____________________________________

Parent Email: ____ Phone #: ___________________

Emergency Contact Information:

First Name: ______________________ Middle Initial: ______ Last Name: ________________________

Relationship: _____________________________ Phone Number: __________________________________

Primary Care Provider & Pharmacy Information:

Primary Care Provider Name: ___________________________________ Phone #: ___________________

Pharmacy Name: ________________________________ Phone #: _________________________________

Insurance Information:

Norton Healthcare will bill any third party insurance plan using the information provided in this enrollment form for all services provided to JCPS students and staff. In the event JCPS student or staff does not have insurance or is self-pay, Norton offers a financial assistance program. I agree to the assignment of all third-party benefits to Norton Healthcare and agree to pay Norton Healthcare for all charges not covered by third-party payors. I agree that this document shall remain in full force and effect during the 2023-2024 school year unless specifically revoked by me in writing. Any sums not paid by a third-party payor are my obligation.

Insurance Plan Name: ____

Member ID: ________________________________ Group ID: _________________________________

Subscriber Name (person who is responsible for insurance policy) Subscriber Date of Birth

____ ____________________________

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Insurance Plan Address: ____

City: ____________________________ State: ____________ Zip Code: _________________________

Medical and Surgical History: Does your child have any of the following conditions or other health concerns? Check all that apply.

Medical History

- ☐ Allergies
- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bone or Joint Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Hearing/Vision Problems
- ☐ Stomach or Bowel Problems
- ☐ Seizures/Stroke/Neurological Problems

Other Medical Conditions (please explain) and list any conditions: _________________________________

____

If you have checked **ANY** of the above conditions, please explain: _________________________________

____

Surgical History

- ☐ Appendix
- ☐ Gallbladder Removed
- ☐ Heart Surgery
- ☐ Tonsils Removed

Other Surgeries (please explain) and list any previous surgery: ____________________________________

____

If you have checked **ANY** of the above surgeries, please explain: __________________________________

____

Medications - Please list any current medications.

1. Medication Name: __________________________________ Dose: ___________________________
How Often Taken?: ___________________________ Why is the medication taken?:______________

2. Medication Name: __________________________________ Dose: ___________________________
How Often Taken?: ___________________________ Why is the medication taken?:______________

If your child takes additional medication, please attach a separate page.

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Consent for Treatment – please select an option below.

☐ **If the school nurse is unable to contact me by telephone when my child is ill, I give permission to have a Norton Healthcare provider examine my child**, which includes testing for strep throat/flu/covid as needed and/or sending prescription medications to the pharmacy identified on this form.

☐ **The school nurse must contact me by telephone and receive verbal consent before a Norton Healthcare provider may examine my child**, which includes testing for strep throat/flu/covid as needed and/or sending medications to the pharmacy identified on this form.

MyNortonChart:

I authorize **Norton Healthcare** to create a **MyNortonChart** account for my child and me. This will allow me to view a visit summary from my visit and to securely message the provider if I have questions after my visit.

HIPAA Policies:

I acknowledge that I have reviewed the **Notice of Privacy Practices (HIPAA Policy)** found at NortonHealthcare.com. I agree to release all records related to this visit to my primary care provider. **Norton Healthcare** may leave messages with, discuss treatment plan, and Release of Information with the Emergency Contacts entered.

Authorize for Release of Medical Information:

I hereby authorize the release of medical information as necessary to my primary care provider listed on the medical information form. Unless otherwise indicated, this authorization extends to such psychiatric, alcohol or drug abuse, and HIV related diagnosis information, if any, as may be contained in the clinic records. I understand that I have the authority to release the above reference medical records. Further, I release **Norton Healthcare** and any related corporations or affiliates from any liability resulting from the release of these medical records and agree to indemnify and hold them harmless from any such liability.

Summary

I consent to my child being examined by Norton Healthcare Providers and JCPS nurses through a secure face-to-face video visit, which includes peripheral devices and tests deemed necessary for the treatment of my child's condition. I understand that I could instead request an in-office visit with the provider.

I acknowledge the medical and surgical history information provided on my child is accurate and up to date. I will notify the provider during my visit if this information has changed

I acknowledge the risks, benefits and alternatives to my child receiving care via video visit and understand that if my child's condition or technology used for the video visit limit the provider's ability to provide a treatment plan, my child will be referred to the appropriate provider.

Parent Guardian Name PRINTED: ____

Parent/Guardian SIGNATURE: ____

Date: ______________________________________