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

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 or 404-574-2512.

Signature: _____ **DATE:** _____

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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; 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 arriving 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: _____

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Teacher: _____**Grade:**_____

Patient Information

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

Race: (Please circle one) American Indian/Alaskan Native, Black Hispanic/Latino, Black Non-Hispanic/Latino, White Hispanic/Latino, White, Non-Hispanic/Latino, Asian, 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 _____

DENTAL

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 ___

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 QUESTIONAIRE

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?

_____
_____
_____
_____
_____
_____
_____
_____
_____