Southeast Local School District

9048 Dover Road, Apple Creek, OH 44606
330-698-3001 / Fax 330-698-5000

James J. Ritchie, Superintendent
Mark Dickerhoof, Treasurer

Waynedale High School
9050 Dover Road
Apple Creek, OH 44606
PH 330-698-3071
FAX: 330-698-1432

John R. Lea Middle School
9130 Dover Road
Apple Creek, OH 44606
PH 330-698-3151
FAX: 330-698-1922

Apple Creek Elementary
173 West Main Street
Apple Creek, OH 44606
PH 330-698-3111
FAX: 330-698-2922

Fredericksburg Elementary
160 West Clay Street
P.O. Box 249
Fredericksburg, OH 44627
PH 330-695-2741
FAX: 330-695-2116

Holmesville Elementary
8141 East Jackson Street
P.O. Box 8
Holmesville, OH 44633
PH 330-279-2341
FAX: 330-279-2023

Mt. Eaton Elementary
8746 Market Street
P.O. Box 268
Mt. Eaton, OH 44659
PH 330- 857-5313 / 359-5519
FAX: 330-857-3703

Dear Parents,

Southeast Local School District recognizes that in order for a student to be successful in school they must be healthy. To assist in ensuring the health of our students, we have been seeking an opportunity to connect students with non-emergent medical care that would provide convenience for parents by having a doctor's visit here at school. Telemedicine is a Skype-like HIPAA-approved medical visit that remotely connects the patient to a physician/nurse practitioner for an assessment and diagnosis. Southeast administration has pursued an agreement with Aultman Orrville Hospital to be **one of the first schools in Ohio** to offer telemedicine to students in our school clinics for only **$10 per visit** (invoiced by Southeast Local Schools).

Aultman Orrville has provided our clinic with a tablet with a specialized camera and attachments, including a stethoscope for heart/lung sounds, an otoscope for ear canal visualization, and a dermatoscope to examine the skin. A physician/nurse practitioner from Dunlap Family Physicians (DFP) will direct the school nurse to collect other vital signs.

Typical conditions (minor and non-urgent) might include:

- **Cold/Couth**
- **Rash**
- **Allergies**
- **Sinus Infection**
- **Bronchitis, respiratory infection**
- **Pink Eye**
- **Ear ache**
- **Sore throat/Fever**

In order to participate, the parent **MUST** complete a medical history form and three consent forms per student: HIPAA, Telemedicine consent, and FERPA authorization. If a student is sick, the school nurse will contact the parent and, if they agree to a visit, will call DFP for an appointment. DFP will send a link if a parent wishes to connect to the visit, so all three sites can see each other on the screen. A hands-on assessment will be done by the school nurse, as directed by the health provider, and the parent can also be part of the visit. A diagnosis will be determined by the health provider and, if necessary, a prescription will be called into the pharmacy of the parent's choice. All this can be done without leaving work, home or school! The student can go home or back to class as determined by the health provider and nurse.

If you have any questions, contact School Nurse Tara Jacobs at 330-698-3001. **Consent forms are included in this packet and can be turned in at a school office to the nurse's attention. Additional copies may be picked up at school or printed directly from the school website.**

Sick Child?

AultmanNow School-based Telemedicine Program Coming Soon!

AultmanNow is a health care service that provides a convenient family practice provider – online – for your sick child while they are still at school. With your permission and the assistance of the school nurse, your child can be seen by a family practice provider by using telemedicine technology. Using your smart phone or computer, you are welcome to join the visit without leaving your home or office. At only $10 a visit, AultmanNow brings affordable health care to your child's school, so that they can feel better, faster.

Who is eligible for a telemedicine visit?
Southeast Schools students who have a non-emergent medical condition and have completed the telemedicine enrollment requirements are eligible for a telemedicine visit.

How will I know if my sick child is having an online telemedicine visit?
If your child is eligible for the telemedicine visit, you will be contacted by the school nurse prior to the visit.

Parents/guardians must enroll their child in the telemedicine school-based program. This includes completing a basic medical history form and signing three additional forms: telemedicine visit consent, HIPAA privacy and FERPA education authorizations.

Do I need to be present for my child's online provider visit?
Parents/guardians are strongly encouraged to attend, but it is not required for the online visit. However, parents/guardians will be contacted prior to the child's telemedicine visit.

If I am unable to participate in the online visit, how will I know what is wrong with my child?
A summary of the visit, the diagnosis and the recommended treatment will be provided by the school nurse. This information will be given to your child to take home with them as well as the provider's contact information, in case of questions.

How will I be billed for the telemedicine visit?
After the visit, you will receive a $10 bill from the school for the telemedicine visit.

What if the provider prescribes a medication for my child?
The prescription will be electronically sent to the pharmacy of your choice. Medication pickup and payment will be the responsibility of the parent/guardian.

What if the provider orders lab work for my child?
You will be encouraged to take your child to Aultman Orrville Hospital Outpatient Lab to complete the tests or another facility covered by your insurance.

What happens if my child has a medical condition that cannot be diagnosed by telemedicine?
Parents/guardians will be informed that a face-to-face office visit will be necessary. The school nurse will work with the family practice medical group and parents to provide recommendations so that medical care is not delayed.

How do I get started?
1. Read and review the telemedicine handouts.
2. Complete all forms.
3. Send completed forms to the Southeast Schools school nurse prior to the telemedicine visit.

Contact Tara Jacobs, Southeast school nurse, at soea_tjacobs@tccsa.net.

FORM A: Informed Consent for Telemedicine Services

STUDENT NAME:____________________	DATE OF BIRTH:
LOCATION OF STUDENT:____________________	
PRIMARY CARE PHYSICIAN:____________________	LOCATION:____________________
STUDENT'S PHARMACY:____________________	LOCATION:____________________

Introduction

Southeast Local School District ("Southeast") has established a program to offer students medical care through telemedicine. The goal of the telemedicine program is to enable healthcare practitioners located at Aultman Orrville Hospital to provide consultations and related services, through telemedicine, to students located at each of Southeast's six locations. Practitioners may include physicians, primary care practitioners and/or licensed nurse practitioners, specialists, and/or subspecialists.

Expected Benefits of Telemedicine Services:

- Improved access to medical care by enabling a student to remain in his/her school while the Practitioner consults from Practitioner's distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks of Telemedicine Services:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the Practitioner and consultant(s).
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By signing this form, I understand and acknowledge the following:

1. I understand that I have the right to withhold or withdraw my consent to use telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

2. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. You are encouraged to ask the Presenting Practitioner to explain the alternatives to your satisfaction.

3. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located at a different location than me, and details of my medical history, examinations, x-rays, and tests may be discussed with the medical practitioner who is at a different location than me.

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 have received a copy of Aultman Orrville Hospital's Notice of Privacy Practices.

Consent to the Use of Telemedicine

As the Legally Authorized Representative of the student, I consent for the undersigned student to receive Telemedicine consultation services. I understand that confidentiality between the student and the Practitioners will be ensured in specific instances in accordance with the law, and that students will be encouraged to involve their parents or guardians in counseling and medical care decisions. Telemedicine consultation services may include, but are not limited to:

- Prescribing of medications
- Medically prescribed, basic laboratory tests for strep throat (Rapid strep and throat culture)
- Referrals for service not provided at the school-based wellness center
- Health education and risk prevention counseling

I understand that if this form is not signed by the Legally Authorized Representative and returned to Southeast, then no telemedicine services will be offered to the applicable student.

I further understand and agree that this informed consent for telemedicine services will suffice as informed consent for future telemedicine services rendered to student at Southeast.

Student ID#:____

Student:____
Date:_______________
(please print and sign name)

Legally Authorized
Representative:____________________________________ Date:________

Legally Authorized Representative's Relationship to
Student:__________________________

Unless this box is checked ☐ and initialed _________, you hereby permit Southeast and Aultman Orrville Hospital to provide the student with telemedicine services without you being present or participating.

Please FAX signed form to (330) 684-2075 and place original in Permanent Student Record.

FORM B: HIPAA AUTHORIZATION

AUTHORIZATION FORM

Student Authorization for Use and Disclosure of Protected Health Information

Student Name:________________________________ Date of Birth__________________

Student ID#:________________________________

By signing this form, I hereby authorize Aultman Orrville Hospital ("Orrville Hospital") to disclose health information about me to any employee of the Southeast Local School District ("Southeast") and my parents/authorized representatives for treatment, payment, or healthcare operations. I understand that any health information disclosed by Orrville Hospital to Southeast Local School District pursuant to this Authorization may be incorporated into my student education records and may be accessed by others who are legally permitted to view such records.

This authorization permits Orrville Hospital to use and/or disclose protected health information about me, including, without limitation, all notes of physicians, nurses, psychologists, counselors, and other persons who have provided or who are providing health care to the undersigned individual, all radiology and pathology records, and other sensitive information (including HIV/STD information, genetic testing information, mental health information, and alcohol and drug abuse information). Notwithstanding the broad scope of the above disclosure request, the undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act ("HIPAA").

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Aultman Orrville Hospital, ATTN: Medical Records Department at 832 South Main Street, Orrville, OH 44667. I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this Authorization. Orrville Hospital will not condition my treatment or payment for my treatment on whether I provide authorization for the requested use or disclosure. I also understand I have the right to a copy of this Authorization.

I understand that information used or disclosed pursuant to this Authorization may be used or disclosed by the recipient and may no longer be protected by federal or state law.

________________________________ Date: __________________

Student Signature

________________________________ Date: __________________

Legally Authorized Representative Signature

If signed by a Legally Authorized Representative, provide your name and describe your authority to act for the individual below (e.g., parent, legal guardian, healthcare power of attorney, etc.).

____

010-8612-1548/2/AMERICAS

FORM C: FERPA AUTHORIZATION

Student Name:______________________________ Date of Birth________________

Student ID#:______________________________

The purpose of this Authorization is to permit Southeast Local School District ("Southeast") to provide all personally identifiable information contained in the student's educational records (including any health-related or other information in the records maintained by the Orrville school nurse) to (i) my parents and/or Legally Authorized Representatives (unless restricted by law) and (ii) Orrville Hospital so that Orrville Hospital can provide telemedicine treatment services to me.

The Family Educational Rights and Privacy Act ("FERPA") is a Federal Law that protects the privacy of student education records. In accordance with FERPA, Southeast will disclose information from education records with the student's, or student's Legally Authorized Representative's, written consent.

By signing this document, I am giving consent that Southeast officials may provide and discuss the entire contents of my educations records, including personally identifiable information from such records, with Orrville Hospital representatives. I understand that I may revoke consent at any time in writing Tara Jacobs, RN, 9050 Dover Road, Apple Creek, Ohio 44606. I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this Authorization.

______________________________ Date: ________________

Student Signature

______________________________ Date: ________________

Legally Authorized Representative Signature

If signed by a Legally Authorized Representative, provide your name and describe your authority to act for the individual below (e.g., parent, legal guardian, healthcare power of attorney, etc.).

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6. TECHNICAL OPERATIONS

Southeast Schools- AultmanNow School Telemedicine Program
Parent/Guardian Medical History/Consent Form

2018-2019

Student Information	Parent/Guardian Information
Date: ____________ Last Name: ____________ First Name: ____________ Address: ____________ ____________ City: ________ State: ______ Zip Code: ________ Date of Birth: _____/_____/_____ Sex: ____Male ____ Female Social Security Number: ____________ Race/Ethnicity: ___ Hispanic ___Black ___ White ___American Indian ___Asian/Pacific Islander ___Other: ____________ Preferred language: ____________ Name of School: ____________ Grade: ________ **Telemedicine Online Visit requires 3 Forms Completed: ______ Telemedicine Consent ______ HIPPA ______ FERPA	Mother: Last Name: ____________ First Name: ____________ Cell Phone Contact Number: ________ Email Address: ____________ Father: Last Name: ____________ First Name: ____________ Cell Phone Contact Number: ________ Email Address: ____________ Legal Guardian, If Applicable: Relationship to student: ___Grandparent __Aunt/Uncle Other: ________ Additional Emergency Contact Name & Number: Name: ________ #: ________ Relationship to student: ________ Home #: ________ Work#: ________ Cell #: ________ Other: ________ **Parent/Guardian will need mobile phone & Email address to participate with Telemedicine Online Visit

Student Health Information	
Do you have a pediatrician or Family Doctor? ___Yes Doctor Name: ____________ Doctor Phone Number: ____________ No Doctor ____ Dentist: ____________ Hospital Preference: ____________ Allergies: ____________ Medication Allergies: ____________ Food Allergies: ____________ Do you take any medications? Yes ____ No ____ List of Meds: ____________ ____________ ____________ ____________ Which Pharmacy- Do You Use? ____________	Does your child have medical issues? Yes or No Heart? Y ___ N ___ List ____________ Breathing? Y ___ N ___ Asthma? Y ___ N ___ Brain/seizure disorders Yes____ No ____ Epilepsy? Y ____ N ____ Diabetes Y____ N____ Bleeding problems Y ____ N ____ Skin Problems Y _____ N _____ Diagnosed Attention Deficit Disorder Y ____ N ____ Diagnosed Hyperactivity Y ____ N ____ Communicable Diseases? Y ____ N ____ Vision Problems? Wears Glasses Y ____ N ___ Hearing Problems? Y ____ N ___ Any Surgeries? Y___ N____ Please List:________ ____________

Telemedicine Visit Tracking:	
Date: _______ Time: ______ Doctor:	Sent Home? Y ____ N ____ Paid? Yes ____ No ____
Date: _______ Time: ______ Doctor:	Sent Home? Y ____ N ____ Paid? Yes ____ No ____
Date: _______ Time: ______ Doctor:	Sent Home? Y ____ N ____ Paid? Yes ____ No ____
Date: _______ Time: ______ Doctor:	Sent Home? Y ____ N ____ Paid? Yes ____ No ____

Fax to Dunlap Family Physicians Prior to the Telemedicine Visit. Apple creek office Fax number: 330-698-2045 Orrville Office Fax is: 330-684-2045