Mississippi Department of Education and the

University of Mississippi Medical Center School – Based Telehealth Authorization

Parent/Guardian authorization is required for students to participate in Picayune School District's School-Based Telehealth Program. The program is available at no cost, regardless of income or insurance status. This form must be completed and returned to your child's school in order to allow their participation in the program and receive medical evaluation and treatment by a UMMC provider.

STUDENT NAME:
DATE OF BIRTH: / /
SCHOOL: **GRADE**:

I, _____am the parent/guardian of the above-named student and I hereby give my consent to the Mississippi School-Based Telehealth Program, in coordination with the nurse or other authorized facilitator, to perform the telehealth examinations, treatments, and related services as may be necessary in accordance with the judgment of the telehealth providers without my being present. I understand that a telehealth connection is the process of delivering health care service by interactive video communications and/or by the electronic transmission of information from, in this case, my child's school, to a UMMC telehealth provider located at another site. I understand that additional verbal consent will be attempted to be obtained prior to scheduling a telehealth visit for my child. By signing below, I authorize the nurse or other authorized facilitator to schedule a telehealth visit for my child in the event that I cannot be reached and the nurse deems a telehealth visit is needed. I understand there is no charge for this service. I understand that my insurance information will be used solely for any prescriptions the telehealth provider may electronically send to my pharmacy of choice. I understand that this consent will remain valid through the current school year unless revoked by me. **I may revoke this consent for treatment at any time by requesting in writing that the district remove my child from services.** I understand that I will be notified of any services or treatment my child receives and my child's Primary Care Provider may receive information regarding the telehealth visit. I also understand that I should contact the nurse if I have questions regarding any necessary follow up care or instructions. It is my responsibility to notify the nurse of all updates or changes to my child's health conditions, medications, or insurance coverage.

☐ **I have read and understand the explanation of the services listed herein and my signature provides consent to receive services as part of School-based Telehealth Program.**

☐ I do NOT wish for my child to participate in the School-Based Telehealth Program.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____/_____/_____

Printed Name: _____ **Phone Numbers**: _____-_____-_____

Address: _____ _____-_____-_____

Student's Primary Care Provider:_____ **Provider's Phone** _____-____-____

Pharmacy: _____
Insurance Provider:_____Policy:_____ Group ID#: _____