# MCES Launches *Telemedicine –*

# “In-School” Medicine

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| ***MCES* Parents!***Telemedicine*allows your kids to see a Pediatrician while still in school! |
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* *24/7 Kid Doc’s* new medical program allows parents to **enroll** their children to use *Telemedicine* to diagnose and treat their sick children, while still in school.
* *Telemedicine* makes healthcare more **convenient**, keeping kids in school and parents at work.
* With the parents’ permission, diagnoses will be made by a Pediatrician or NP thru HIPAA video conferencing & remote diagnostic equipment.
* Parents may **enroll** for **free** by:

Calling *24/7 Kid Doc* **1-844-303-8006** or

by contacting your school nurse for an enrollment package.



 *24/7 Kid Doc, Inc.*

 **1-844-303-8006**

 [**www.247KidDoc.com**](http://www.247KidDoc.com)

## **Telemedicine Process:**

1. Sick student is sent to the School Nurse.
2. School Nurse determines if *Telemedicine* visit is necessary.
3. Parent will be notified of sick child and asked for permission to use *Telemedicine*.
4. School Nurse will schedule *Telemedicine* visit for the same day.

###  **How do I Enroll my Child?**

* Call *24/7 Kid Doc* @ **1-844-303-8006**
* See your School Nurse
* Request a Free Enrollment Package
* Complete the Enrollment Package
* Send package back to *24/7 Kid Doc*
1. School Nurse will take student’s blood pressure, pulse and temperature.
2. *Telemedicine* Medical Provider will diagnose your child and, if necessary, send prescription to family pharmacy.
3. School Nurse will call parent with follow-up instructions from the provider.
4. Student will be sent back to class or wait for parent pick up.
5. Student’s medical insurance is billed.



 **Patient/Student Enrollment**

By completing this form, I consent in advance to my child having access to all-­‐available services of *Telemedicine* if my child remains enrolled in Montgomery County Schools. *24/7 Kid Doc, Inc.* *Telemedicine* services include: diagnosis and treatment of common illnesses and injuries, preventive health screenings, health education and referrals.

**Students must have parental permission to use Telemedicine.**

Student’s Name (First, Middle, Last):

DOB: SSN: Age: Gender: M F School:

Mailing Address: City: Zip:

Primary Phone: Parent Email:

Mother/Guardian: Phone: \_\_

Father/Guardian: Phone: \_\_

Who does the child live with most of the time? \_\_

In Case of Emergency, please tell us a Local Friend or Relative (not living at same address) whom we could contact.

Name: Relationship: Phone #:

Person Responsible for the Bill:

Is the Patient covered by insurance? YES or NO.

*Please fill in all the following:*

**Primary Insurance**: Name of Insurance Company: Copay Amount:

Insurance ID #: Group #: \_

Name of Subscriber: DOB: SSN:

Patient’s Relationship to Subscriber: SELF SPOUSE CHILD OTHER:

**Secondary Ins**. Name of Insurance Company: Copay Amount:

Ins. ID #: Group #: \_

Name of Subscriber: DOB: SSN:

Patient’s Relationship to Subscriber: SELF SPOUSE CHILD OTHER:

Primary Care Doctor/Clinic: \_\_\_\_\_\_\_

Pharmacy: Town: \_



**Patient/Student Enrollment** -­‐ pg. 2

 **Consent Form**

**Child’s Name: DOB:**

HIPAA/FERPA: All students have health issues that must be handled in a confidential manner. *24/7 Kid Doc* will share confidential information only in the following situations:

* When the student’s education is affected
* When addressing a student’s healthcare needs
* When safety is an issue
* And other situations specified by law

For example, *24/7 Kid Doc* may discuss the student’s medication and other health care needs with the appropriate staff members who will administer the student’s medication and provide care to the student while the student is at school.

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# I, the undersigned,

* give permission and consent for my child to have treatment through and by *24/7 Kid Doc*. I understand the nature of this treatment, the way it is provided, and the details and limitations of Telemedicine.
* give permission for *24/7 Kid Doc* to receive information from the school about my child’s healthcare history.
* agree to release all records related to this treatment to the Primary Care Provider
* agree that all I will be responsible for all costs associated with said treatment and that I will provide any insurance information as requested. All costs and fees not covered by insurance will be my responsibility.
* As Parent/Guardian of the above student, I:
	+ authorize the release of any information necessary to process insurance claims for payment of benefits *24/7 Kid Doc.*
	+ authorize payment of benefits to *24/7 Kid Doc* for services rendered.
	+ have provided details of all insurance policies that cover my child.

The information above and on the proceeding page is true and complete to the best of my knowledge.

Parent/Guardian name PRINTED: Parent/Guardian SIGNATURE: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **No Telemedicine Services can be provided without this and the following page completed and signed.**

 **(Next)**

 **Patient/Student Enrollment** -­‐ pg. 3

 **Medical History**

**Students must have parental permission to be seen by *24/7 Kid Doc*.**

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Student’s Last Name First Middle

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth Gender School

**Does your child have any of the following conditions or other health concerns?**

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 Allergies, other than medications (such as bee stings or peanuts) – *Please list*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Asthma – *Date of last asthma attack: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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Seizures – *Date of last seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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Vision Problems

Hearing Problems

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Sickle Cell Anemia

Heart Problems – *Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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Bleeding Disorders

Orthopedic (bone or joint) Problems Anxiety/Depression

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Operations and/or Hospitalizations – *Dates (details below): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_

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Diseases in Siblings

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* **If you checked ANY of the above conditions, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Is your child on any medications?**

No

## Yes – Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your child allergic to any medications?**

No

## Yes – Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*In signing this form, I am stating the following:*

* + *The information that I have provided is accurate and up-to-date.*
	+ *I will update MY Health-e-Schools with any changes as soon as possible.*

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**Parent/Guardian Signature Date**