Howard County Health Department

HOWARD COUNTY PUBLIC SCHOOL SYSTEM

HOWARD COUNTY HEALTH DEPARTMENT
SCHOOL-BASED WELLNESS CENTERS PROGRAM
TELEMEDICINE SERVICES

A partnership between the Howard County Health Department and the Howard County Public School System

What is telemedicine?

Telemedicine uses a secure, two –way video link between your school's health suite and their primary care provider or Howard County General Hospital to provide acute health services to your child. Equipment operated by the school nurse will send images and sounds to the provider. Your child can be seen and treated for pink eye, strep throat, rashes, ear infections, asthma flare ups, and other minor health conditions while they stay in school. Prescriptions, if needed, are sent to the pharmacy of your choosing.

How can my child receive telemedicine services?

Children must be enrolled in the Howard County School-Based Wellness Center located inside your school's health suite to receive telemedicine services. Please visit the school's website or contact your school nurse for information on how to enroll your child in this valuable program.

Will I know that my child is receiving telemedicine services?

Parents or guardians must enroll their children in the Howard County School-Based Wellness Center Program before the child can be seen. In addition, the school nurse will always call you before the child receives any telemedicine services. If the nurse is unable to reach you, your child will not receive telemedicine services and will be given the care routinely provided by school health staff. You may participate in the visit by remaining on the phone with the school nurse or if your child is receiving care by a Howard County General Hospital physician, the provider can give you access to view the visit through your smart phone or computer.

What if I can't participate in the visit? How will I know what is wrong with my child

A summary of the visit with the diagnosis and recommended treatment will be provided by the health provider treating your child. This summary will either be given to your child to take home with the contact information of the provider in case you have questions or if your child's primary care provider saw your child, he or she will contact you with the visit information.

How will I billed for the telemedicine visit?

If your child's health provider (one of those listed below) provides the telemedicine visit then he or she will bill your child's health insurer, including Medical Assistance. You may be charged a co-pay if required by your insurance company or have to pay in the same manner as if your child had been seen in the doctor's office. If your child's telemedicine provider is a Howard County General Hospital Pediatric Emergency Room physician, there is currently no charge for telemedicine visits.

Current Pediatric Providers participating in the Howard County Health Department telemedicine network (may be subject to change):

Columbia Medical Practice- Pediatrics
Ken Klebanow M.D. and Associates

If you have additional questions, please contact Sharon Hobson, School-Based Wellness Centers Program Administrator, at (410) 313-7238.

HOWARD COUNTY HEALTH DEPARTMENT
SCHOOL-BASED WELLNESS CENTERS PROGRAM
Parent/ Guardian Consent Form
SCHOOL-BASED WELLNESS CENTERS TELEMEDICINE PROGRAM

STUDENT INFORMATION	PARENT/GUARDIAN INFORMATION

Last Name: _____

First Name: _____

Address: _____

_____
City State Zip Code

Date of Birth: _____/_____/_____
Month Day Year

Sex: ❑ Male ❑ Female

❑ Transgender Male ❑ Transgender Female

❑ Non-Binary_____

Social Security Number (optional): _____-_____-_____

Race / Ethnicity: ❑ Hispanic ❑ Black ❑ White

❑ Native American ❑ Asian/Pacific Islander

❑ Other _____

Preferred Language: _____

Name of School: _____

Grade: _____

Health Insurance

Does your child have health insurance? ❑ Yes ❑ No

If yes, does your child have Medical Assistance? ❑ Yes ❑ No

Does he or she have private health insurance? ❑ Yes ❑ No

If your child does not have health insurance, would you like staff from the Howard County Health Department contact and assist you with applying for health insurance?
____ Yes ____ No

Mother

Last Name: _____First Name:_____

Contact Number(s): _____

E-mail Address: _____

Father

Last Name: _____ First Name:_____

Contact Number(s): _____

E-mail Address: _____

Legal Guardian, If Applicable

Last Name: _____First Name:_____
Relationship of legal guardian to student:

❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact Number(s): _____

E-mail address: _____

Additional Emergency Contact

Name: _____

Relationship to Student: _____

Home Tel: _____ Work Tel: _____

Cell: _____

Please turn this page over, read the information, and sign and date on the two lines indicated. Please give the completed form to the school nurse.

Thank you!

HOWARD COUNTY HEALTH DEPARTMENT
SCHOOL BASED WELLNESS CENTER TELEMEDICINE PROGRAM
Parent/ Guardian Consent Form

Child's Name: _____ **School:** _____

SCHOOL-BASED WELLNESS CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals contracting with the Howard County Health Department (HCHD) which may include the primary health care provider I specified when enrolling my child in the HCHD School Based Wellness Center Program (SBWC) if the provider is part of the HCHD SBWC telemedicine network or another licensed health professional. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Wellness Center telemedicine services may include, but are not limited to:

- Medical care and treatment, including diagnosis of acute and chronic illness and disease
- Prescribing of medications and if ordered by licensed health provider and medically-indicated, the dispensing of acetaminophen, ibuprofen, hydrocortisone cream 1% , and albuterol via inhaler or nebulization on-site
- 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

X_____ _____

Signature of Parent/Guardian **Date**

HOWARD COUNTY HEALTH DEPARTMENT'S
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on this form authorizes the release of medical information for the Howard County Health Department School-Based Wellness Center to contact other providers that have examined my child to release any medical or other information to assist in the management of my child's health. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be given to the Howard County Public School System either because it is required by law or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, such as proof of immunization. Failure to provide this information may result in the student being excluded from school.

I consent to the release from the Howard County Health Department School Based Wellness Center to the Howard County Public School System and from the Howard County Public School System to the Howard County School-Based Wellness Center, of medical information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law regulations on confidentiality:

Information Required by Law or School System:
- New entrant exam
- Immunization record
- Vision and hearing screening results
- Tuberculin test results

Information to Protect Health and Safety:
- Conditions which may require emergency medical treatment
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law)
- Conditions which limit a student's daily activity
- Health insurance coverage

PARENT/ GUARDIAN CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:
I, the undersigned, voluntarily consent to treatment of my child by the provider contracting with the Howard County Health Department to provide medical services at the School-Based Wellness Center (HCHD SBWC). I also voluntarily consent to the use and disclosure of my child's protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. I authorize payment directly to this health care provider for services for which the provider accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

X_____ _____

Signature of Parent/Guardian **Date**

Time Period During Which Release of Information is Authorized:

From: Date that form is signed **To**: Date that student is no longer enrolled in the School-Based Wellness Center

Please make sure you have signed your name and dated the two lines at the top and bottom of this page.

HOWARD COUNTY HEALTH DEPARTMENT
SCHOOL-BASED WELLNESS CENTERS PROGRAM
Medical and Family History Questionnaire

Child's Name:	Today's Date:

FAMILY HEALTH INFORMATION

Does any of the child's family members (parents, sisters, brothers, grandparents)have or had the following:

Health Problem	Yes	No	Which Family Member?
Asthma			
Diabetes			
Mental Health/ Psychiatric Problem			
Sickle Cell			
Other:			

Who is the student's regular health provider?

Name: _____ **Office Telephone:** ( ) ____ - _____

Address: _____

When was your child's last physical or well child exam? _____
Date/Month

Please provide the name and phone number of your pharmacy.
Name: _____ **Phone Number:** ( ) ____ - _____

CHILD'S HEALTH INFORMATION

Please place a check in the box for any health problems your child has had.

- ☐ **Asthma**
- ☐ **Attention Deficit Disorder**
- ☐ **Bleeding Problems**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **Ear Infection** (frequent)
- ☐ **Epilepsy/Seizures**
- ☐ **Headache** (frequent)
- ☐ **Hearing**
- ☐ **Heart Problems/Murmur**
- ☐ **Rheumatic Fever**
- ☐ **Sickle Cell Anemia**
- ☐ **Tuberculosis**
- ☐ **Vision**
- ☐ **Other:** _____
- ☐ **Allergies (List all, including medicines):**

If your child has been hospitalized, please provide the date(s) and reason(s):

PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS YOUR CHILD TAKES: _____

_____

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
AND YOUR HEALTH INFORMATION
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Safeguarding Your Protected Health Information

The Maryland Department of Health and Mental Hygiene (DHMH) is committed to protecting your health information. In order to provide treatment or to pay for your healthcare, DHMH will ask for certain health information and that health information will be put into your record. The record usually contains your symptoms, examination and test results, diagnoses, and treatment. That information, referred to as your health or medical record, and legally regulated as health information may be used for a variety of purposes. DHMH is required to follow the privacy practices described in this Notice, although DHMH reserves the right to change our privacy practices and the terms of this Notice at any time. You may request a copy of the new notice from any DHMH agency. It is also posted on our website at http://www.dhmh.state.md.us/.

How DHMH May Use and Disclose Your Protected Health Information

DHMH employees will only use your health information when doing their jobs. For uses beyond what DHMH normally does, DHMH must have your written authorization unless the law permits or requires it. The following are some examples of our possible uses and disclosures of your health information.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations:

For treatment: DHMH may use or share your health information to approve, deny treatment and to determine if your medical treatment is appropriate. For example, DHMH health care providers may need to review your treatment plan with your healthcare provider for medical necessity or for coordination of care.

To obtain payment: DHMH may use and share your health information in order to bill and collect payment for your health care services and to determine your eligibility to participate in our services. For example, your health care provider may send claims for payment of medical services provided to you.

For health care operations: DHMH may use and share your health information to evaluate the quality of services provided, or to our state or federal auditors.

Other Uses and Disclosures of health information required or allowed by law:

Information purposes: Unless you provide us with alternative instructions, DHMH may send appointment reminders and other materials about the program to your home.

Required by law: DHMH may disclose health information when a law requires us to do so.

Public health activities: DHMH may disclose health information when DHMH is required to collect or report information about disease or injury, or to report vital statistics to other divisions in the department and other public health authorities.

Health oversight activities: DHMH may disclose your health information to other divisions in the department and other agencies for oversight activities required by law. Examples of these oversight activities are audits, inspections, investigations, and licensure.

Coroners, Medical Examiners, Funeral Directors and Organ Donations: DHMH may disclose health information relating to a death to coroners, medical examiners or funeral directors, and to authorized organizations relating to organ, eye, or tissue donations or transplants.

Research purposes: In certain circumstances, and under supervision of our Institutional Review Board or other designated privacy board, DHMH may disclose health information to assist medical research.

Avert threat to health or safety: In order to avoid a serious threat to health or safety, DHMH may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

Abuse and Neglect: DHMH will disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or some other crime. DHMH may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Specific government functions: DHMH may disclose health information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

Families, friends or others involved in your care: DHMH may share your health information with people as it is directly related to their involvement in your care or payment of your care. DHMH may also share health information with people to notify them about your location, general condition, or death.

Worker's Compensation: DHMH may disclose health information to worker's compensation programs that provide benefits for work-related injuries or illnesses without regard to fault.

Patient Directories: The health plan under which you are enrolled does not maintain a directory for disclosure to callers or visitors who ask for you by name. You will not be identified to an unknown caller or visitor without authorization.
Lawsuits, Disputes and Claims: If you are involved in a lawsuit, a dispute, or a claim, DHMH may disclose your health information in response to a court or administrative order, subpoena, discovery request, investigation of a claim filed on your behalf, or other lawful process.
Law Enforcement: DHMH may disclose your health information to a law enforcement official for purposes that are required by law or in response to a subpoena.

You have a Right to:

Request restrictions: You have a right to request a restriction or limitation on the health information DHMH uses or discloses about you. DHMH will accommodate your request if possible, but is not legally required to agree to the requested restriction. If DHMH agrees to a restriction, DHMH will follow it except in emergency situations.
Request Confidential Communications: You have the right to ask that DHMH send you information at an alternative address or by alternative means. DHMH must agree to your request as long as it is reasonably easy for us to do so.
Inspect and copy: You have a right to see your health information upon your written request. If you want copies of your health information, you may be charged a fee for copying, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.
Request amendment: You may request in writing that DHMH correct or add to your health record. DHMH may deny the request if DHMH determines that the health information is: (1) correct and complete; (2) not created by us and/or not part of our records; or (3) not permitted to be disclosed. If DHMH approves the request for amendment, DHMH will change the health information and inform you, and will tell others that need to know about the change in the health information.
Accounting of disclosures: You have a right to request a list of the disclosures made of your health information after April 14, 2003. Exceptions are health information that has been used for treatment, payment, and operations. In addition, DHMH does not have to list disclosures made to you, based on your written authorization, provided for national security, to law enforcement officials or correctional facilities. There will be no charge for up to one such list each year.
Notice: You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request.

For More Information
This document is available in other languages and alternate formats that meet the guidelines for the Americans with Disabilities Act. If you have questions and would like more information, you may contact: **Antigone Vickery, Deputy Health Officer – 410-313-6300.**

To Report a Problem about our Privacy Practices
If you are a resident of a DHMH facility and believe your privacy rights have been violated, you may file a complaint.

- You can file a complaint with the Department of Health and Mental Hygiene, Resident Grievance System Central Office at 1-800-RGS-7454.
- You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may call the Department of Health and Mental Hygiene for the contact information.

DHMH will take no retaliatory action against you if you make such complaints.
Effective Date: This notice is effective on April 14, 2003.

(Provider programs must ensure that they try to get this acknowledgement signed)

Acknowledgement of receipt of this notice:

_____ _____
Patient or Authorized Representative **Date**

If unable to get acknowledgement, specify why: _____

Signature of DHMH representative