Goodside Health

2022–23 Goodside Health SchoolMed Consent Form

Goodside Health ("GSH") has partnered with your district to bring SchoolMed on-demand telehealth services to your school! Through our partnership, your child can be assessed, diagnosed, and treated for a range of conditions that may include, but are not limited to: strep, flu, sore throat, headache, skin rash, pink eye, upset stomach, the common cold, and others as appropriate. To see a list of medications that may be administered during a SchoolMed visit, see Attachment A. GSH medical providers can treat all students regardless of residency or insurance status. Translation services are available. SchoolMed visits are provided at no- to low-cost for families with Medicaid, CHIP, and Tricare. Copayments and deductibles may apply for marketplace, private, and commercial insurance plans. For those without health insurance, the Goodside Cares program provides financial support for SchoolMed visits. To participate in this program, please complete this form.

PROGRAM REGISTRATION

I consent for my child to participate in the GSH in-person and telemedicine program ☐ **Yes** ☐ **No**

I agree to the Terms and Conditions and acknowledge receipt of the Notice of Privacy Practices (https://goodsidehealth.com/terms-conditions/) *(by opting out, we cannot treat your child)* ☐ **Yes** ☐ **No**

If yes to both, please answer the following questions.

In partnership with your school district, GSH may offer additional services such as mental health screenings and Whole Child Physicals. If these additional services are authorized by your school district and GSH, **would you like your child to have access to these services and programs?** (*Please note, in order to participate in optional services, you must consent to the program and agree to Terms & Conditions.)*

I consent to screening for mental/behavioral health by a GSH healthcare provider. ☐ **Yes** ☐ **No**

I consent for GSH to share parent/guardian and student information with mental health partners if, based on screening results, my child Is determined to be at increased risk for mental/behavioral health conditions. ☐ **Yes** ☐ **No**

STUDENT INFORMATION

First Name _____ **Last Name** _____

Date of Birth (MM/DD/YYYY) _____ **Grade Level** _____

District _____ **School Campus** _____

MEDICAL HISTORY

Does your child currently take daily medications? ☐ **Yes** ☐ **No**

If yes, please list current daily medications:

_____

Does your child have any known allergies? ☐ **Yes** ☐ **No**

If yes, please list known allergies:

_____

Does your child have any known medical conditions? ☐ **Yes** ☐ **No**

If yes, please list known conditions:

_____

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PRIMARY CARE PHYSICIAN & PHARMACY

Does your child have a primary care physician? ☐ Yes ☐ No

If "**Yes**", please provide the information below to maintain continuity of care:

Name of Primary Care Physician/Practice

Preferred Pharmacy

Pharmacy Zip Code

Do you consent to share your health record with your primary care physician? ☐ Yes ☐ No

PATIENT INSURANCE

Does your child have health insurance? ☐ Yes ☐ No

If "**Yes**", then what type of insurance?

- ☐ **Medicaid**
- ☐ **CHIP**
- ☐ **STAR**
- ☐ **Private Insurance**

Medicaid Information, if applicable

Member ID

Private Health Plan/Insurance Information, if applicable

Health Plan/Insurance Name

Policy Number

PARENT/GUARDIAN CONSENT

By completing this form, I am confirming that I would like my child to participate in the district telemedicine program, operated by Pediatric Urgent Care, PA dba Goodside Health or Goodside Health of Florida, Inc. (GSH) and agree for them to have access to these enhanced medical services at school. I affirm that I have provided accurate patient information in full. I authorize GSH to collect information related to patient health insurance from available third-party resources should any information be inaccurate or incomplete. This consent/authorization may be withdrawn in writing at any time.

Parent/Guardian Printed Name

Parent/Guardian Date of Birth (MM/DD/YYYY)

Relationship to Student

Email

Cell Number

We'd like to keep in touch with you by sending text alerts and test results to your cell phone number.
Do you authorize us to text you? ☐ Yes ☐ No

Parent/Guardian Signature

Today's Date

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ATTACHMENT A

Medications that may be administered during a SchoolMed Visit may include:

1) Acetaminophen

2) Ibuprofen

3) Ondansetron

4) Diphenhydramine

5) Calcium carbonate antacid