ENROLLMENT TELEHEALTH CONSENT FORM
FOR MADISON HIGH SCHOOL-BASED HEALTH CENTER

Student's Name: Last First Middle Initial Date of Birth: ID # (Office Use Only)

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Madison High School-Based Health Center will from hereafter be referred to as "SBHC."

1. I understand that my child's health care provider wishes to engage in a telehealth visit or series or visits. I understand that these encounters will not be the same as direct health care provider visits because my child will not be in the same room as the health care provider. Instead, they will communicate using two-way simultaneous audio-visual technology.

2. I understand that my child has the right to refuse to participate in any telehealth encounter at any time or to end it at any during the encounter. I understand that if he/she does not wish to participate in a telehealth encounter I will need to either make an appointment for an in-person visit at the SBHC, with his/her primary care provider, or seek care for him/her at the nearest emergency department if we believe symptoms warrant that level of care. I further understand that my child's provider may not be able to accommodate an in-person visit the same day and there may be a delay in care if an in-person visit is chosen.

3. I understand that my child's health care provider can discontinue the telehealth encounter if he or she believes that this technology does not meet the standard of care necessary to address my child's medical concerns. If that happens, I understand that I will need to either make an appointment for an in-person visit at the SBHC, with his/her primary care provider, or seek care at the nearest emergency department if we believe that symptoms warrant that level of care.

4. I understand how the technology will be used to conduct telehealth encounters at the SBHC. I also understand that, with this technology, there is a risk of interruption and technical difficulties. If this occurs, attempt will be made to end and restart the visit. If the visit is unable to reconnect within **ten (10) minutes**, my child will call his/her provider to discuss the matter at **(318) 574-5371** since a reschedule may be required.

5. I have had the opportunity to ask questions about telehealth encounters and the technology. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language that I understand.

6. This consent will remain valid for **twelve (12) months** from the date of my first telehealth visit.

Signature of Parent/Legal Guardian: _____

Date

Signature of Student: _____

Date