Alamogordo Public Schools – Consent Form to Participate in Telehealth Consultation/Treatment Services

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Parent/Guardian authorization is required for all students participating in school-based telehealth services at Alamogordo Public Schools ("APS"). The following form must be completed, signed, and returned to your child's school to allow them to participate in tele-health-based services at APS not limited to medical consultations, evaluations, and/or treatment.

Child's Name: ______________________________________

Child's Date of Birth: __/__/____

Name of Child's School: ______________________________________

I, ________________, the ________________ of the minor child listed above, hereby requests and
{Name of parent/guardian} {Relationship to Child}
authorizes _________________ to facilitate treatment and healthcare for my child, to be provided
{Name of the Child's School}
by GCRMC Urgent Care, licensed medical providers, via a telehealth connection. I understand that a telehealth connection is the process of delivering health care and health care related services by interactive video communications and/or electronic transmission of information, in this case, my child's school, to a telehealth provider located at another physical location. I authorize treatment for, but not limited to, primary care services, specialist care, care for chronic diseases such as diabetes and asthma, and the treatment of common illnesses. I consent for my child's school nurse to receive protected health information about my child to carry out the treatment of my child as part of their telehealth visits and to remain in the room, where necessary to aid in the visits. I accept all responsibility for all charges that might result from any medical treatment stemming from this authorization. As applicable, I authorize GCRMC Urgent Care to release information regarding treatment to third-party payers or others for the purpose of receiving payment for services.

I am aware that there are potential risks to telehealth, including but not limited to, interruptions, unauthorized access, and technical difficulties. I understand that either the healthcare provider or I can discontinue my child's telehealth visit if it is felt that the videoconferencing connections are not adequate for the situation.

I understand that APS will operate under the guidelines under the Family Educational Rights and Privacy Act ("FERPA), state statutes and regulations, and state and APS policies and

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procedures to ensure confidentiality regarding the release of student information. No information will be released without prior approval from the parent, except as provided by law.

By providing my signature below, I understand that granting consent for the release of personally-identifiable information from my child's education records is voluntary and may be revoked at any time. Revocation must be made in writing and presented to the school named above. I understand that this consent will be effective for the current school year. I understand that I will be notified prior to each individual telemedicine visit involving my child.

- **I have read and understand the services listed herein and my signature provides consent for my child to receive services provided as part of APS's telehealth program.**

Parent/Guardian Signature: ____
{Parent or Legal Guardian must sign if student is under 18 years of age}

Date: ____________________

Address: ____

Phone Number(s) ______________________________

Further, I authorize the following people to participate in any telehealth visits my child may have:

________________________________	______________________________
Printed Name	Relationship
________________________________	______________________________
Printed Name	Relationship