



# **R** Sick Child?

## **AultmanNow School-based Telemedicine Program Coming Soon!**

AultmanNow is a health care service that provides a convenient family practice provider – online – for your sick child while they are still at school. With your permission and the assistance of the school nurse, your child can be seen by a family practice provider by using telemedicine technology. Using your smart phone or computer, you are welcome to join the visit without leaving your home or office. At only \$10 a visit, AultmanNow brings affordable health care to your child's school, so that they can feel better, faster.

### **Who is eligible for a telemedicine visit?**

Rittman students who have a non-emergent medical condition and have completed the telemedicine enrollment requirements are eligible for a telemedicine visit.

### **How will I know if my sick child is having an online telemedicine visit?**

If your child is eligible for the telemedicine visit, you will be contacted by the school nurse prior to the visit.

Parents/guardians must enroll their child in the telemedicine school-based program. This includes completing a basic medical history form and signing three additional forms: telemedicine visit consent, HIPAA privacy and FERPA education authorizations.

### **Do I need to be present for my child's online provider visit?**

Parents/guardians are strongly encouraged to attend, but it is not required for the online visit. However, parents/guardians will be contacted prior to the child's telemedicine visit.

### **If I am unable to participate in the online visit, how will I know what is wrong with my child?**

A summary of the visit, the diagnosis and the recommended treatment will be provided by the school nurse. This information will be given to your child to take home with them as well as the provider's contact information, in case of questions.

### **How will I be billed for the telemedicine visit?**

After the visit, you will receive a \$10 bill from the school for the telemedicine visit.

### **What if the provider prescribes a medication for my child?**

The prescription will be electronically sent to the pharmacy of your choice. Medication pickup and payment will be the responsibility of the parent/guardian.

### **What if the provider orders lab work for my child?**

You will be encouraged to take your child to Aultman Orrville Hospital Outpatient Lab to complete the tests or another facility covered by your insurance.

### **What happens if my child has a medical condition that cannot be diagnosed by telemedicine?**

Parents will be informed that a face-to-face office visit will be necessary. The school nurse will work with the family practice medical group and parents to provide recommendations so that medical care is not delayed.

### **How do I get started?**

1. Read and review the telemedicine handouts.
2. Complete all forms.
3. Send completed forms to the Rittman school nurse prior to the telemedicine visit.

Contact Myra Pierce, Rittman school nurse, at 330-927-7462 or [ritt\\_mpierce@tccsa.net](mailto:ritt_mpierce@tccsa.net).





Dear Parents/ Guardians,

Rittman Exempted Village School District recognizes that in order for a student to be successful in school they must be healthy. To assist in ensuring the health of our students, we have been seeking an opportunity to connect students with non-emergent medical care that would provide convenience for parents/ guardians, by having a doctor's visit here at school. Telemedicine is a Skype-like HIPPA-approved medical visit that remotely connects the patient to a physician or nurse practitioner and allows assessment and diagnosis to be made. Telemedicine is being used in many platforms and in schools in other states. Rittman administration has pursued a contract with Aultman Orrville Hospital, to be **the very first school in Ohio** to offer telemedicine to students and staff, in our school clinics. Superintendent Ritchie guided this process and we will go live **Monday, April 16, 2018** for our students and staff.

The partnership between Rittman Exempted Village School and Aultman Orrville Hospital enables us to offer these visits for only \$10 per student visit. Aultman Orrville has provided our clinic with a tablet that has a specialized camera as well as attachments to enhance assessment. Attachments include a stethoscope for heart, lungs, and bowel sounds, an otoscope for ear and ear canal visualization, and a dermatoscope to examine the skin. A physician or nurse practitioner (provider) from Dunlap Family Physicians (DFP) will direct the school nurse to collect other vital signs and provide hands-on assessment of the student.

**Typical conditions (minor and non-urgent) might include**

- Cold/cough
- Rash
- Allergies
- Sinus infection
- Headache/ migraine
- Bronchitis, respiratory infection
- Pink eye
- Ear ache
- Sore throat
- Muscle strains

In order to participate, the parent/ guardian **MUST** complete a medical history form and 3 consent forms **per student**: HIPPA, Telemedicine Consent, and FERPA authorization, and return to the school nurse. If a student is sick, the school nurse will contact the parent/ guardian and, if they agree to a visit, will call DFP for an appointment time with a provider. DFP will email parent/ guardian a link if they wish to connect to the visit, so all 3 groups (parent/ guardian, school nurse and student, and DFP provider) could see each other on the screen. A hands-on assessment will be done by the school nurse, as directed by the provider, and the parent/ guardian is also a part of the visit. A diagnosis will be determined by the provider and, if necessary, a prescription will be called in to the pharmacy of parent/ guardian's choice. All this can be done without leaving work, home, or school! The student can go home or back to class as determined by the provider and nurse.

If you have any questions contact Myra Pierce 330-927-7462. Additional forms may be picked up at school or printed directly from the school website.

Sincerely,

Myra Pierce RN, BSN

Rittman School Nurse



Student Information	Parent/Guardian Information
Date: _____ Last Name: _____ First Name: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____ Date of Birth: ____/____/____ Sex: ___ Male ___ Female Social Security Number: _____ Race/Ethnicity: ___ Hispanic ___ Black ___ White ___ American Indian ___ Asian/Pacific Islander ___ Other: _____ Preferred language: _____ Name of School: _____ Grade: _____  **Telemedicine Online Visit requires 3 Forms Completed: _____ Telemedicine Consent _____ HIPPA _____ FERPA	Mother: Last Name: _____ First Name: _____ Cell Phone Contact Number: _____ Email Address: _____ Father: Last Name: _____ First Name: _____ Cell Phone Contact Number: _____ Email Address: _____ <u>Legal Guardian, if Applicable:</u> Relationship to student: ___ Grandparent ___ Aunt/Uncle Other: _____ Additional Emergency Contact Name & Number: Name: _____ #: _____ Relationship to student: _____ Home #: _____ Work#: _____ Cell #: _____ Other: _____  **Parent/Guardian will need mobile phone & Email address to participate with Telemedicine Online Visit
Student Health Information	
Do you have a pediatrician or Family Doctor? ___ Yes Doctor Name: _____ Doctor Phone Number: _____ No Doctor ___ Dentist: _____ Hospital Preference: _____ Allergies: _____ Medication Allergies: _____ Food Allergies: _____ Do you take any medications? Yes ___ No ___ List of Meds: _____ _____ _____ _____ Which Pharmacy- Do You Use? _____	Does your child have medical issues? Yes or No Heart? Y ___ N ___ List _____ Breathing? Y ___ N ___ Asthma? Y ___ N ___ Brain/seizure disorders Yes ___ No ___ Epilepsy? Y ___ N ___ Diabetes Y ___ N ___ Bleeding problems Y ___ N ___ Skin Problems Y ___ N ___ Diagnosed Attention Deficit Disorder Y ___ N ___ Diagnosed Hyperactivity Y ___ N ___ Communicable Diseases? Y ___ N ___ Vision Problems? Wears Glasses Y ___ N ___ Hearing Problems? Y ___ N ___ Any Surgeries? Y ___ N ___ Please List: _____ _____
Telemedicine Visit Tracking:	
Date: _____ Time: _____ Doctor: _____	Sent Home? Y ___ N ___ Paid? Yes ___ No ___
Date: _____ Time: _____ Doctor: _____	Sent Home? Y ___ N ___ Paid? Yes ___ No ___
Date: _____ Time: _____ Doctor: _____	Sent Home? Y ___ N ___ Paid? Yes ___ No ___
Date: _____ Time: _____ Doctor: _____	Sent Home? Y ___ N ___ Paid? Yes ___ No ___



**FORM A: Informed Consent for Telemedicine Services**

STUDENT NAME: _____	DATE OF BIRTH: _____
LOCATION OF STUDENT: _____	
PRIMARY CARE PHYSICIAN: _____	LOCATION: _____
STUDENT'S PHARMACY: _____	LOCATION: _____

**Introduction**

Rittman Exempted Village School District ("Rittman") has established a program to offer students medical care through telemedicine. The goal of the telemedicine program is to enable healthcare practitioners located at Aultman Orrville Hospital to provide consultations and related services, through telemedicine, to students located at each of Rittman's three locations. Practitioners may include physicians, primary care practitioners and/or licensed nurse practitioners, specialists, and/or subspecialists.

**Expected Benefits of Telemedicine Services:**

- Improved access to medical care by enabling a student to remain in his/her school while the Practitioner consults from Practitioner's distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

**Possible Risks of Telemedicine Services:**

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the Practitioner and consultant(s).
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

**By signing this form, I understand and acknowledge the following:**

1. I understand that I have the right to withhold or withdraw my consent to use telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
2. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. You are encouraged to ask the Presenting Practitioner to explain the alternatives to your satisfaction.
3. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located at a different location than me, and details of my medical history, examinations, x-rays, and tests may be discussed with the medical practitioner who is at a different location than me.

4. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
5. I have received a copy of Aultman Orrville Hospital's Notice of Privacy Practices.

**Consent to the Use of Telemedicine**

As the Legally Authorized Representative of the student, I consent for the undersigned student to receive Telemedicine consultation services. I understand that confidentiality between the student and the Practitioners will be ensured in specific instances in accordance with the law, and that students will be encouraged to involve their parents or guardians in counseling and medical care decisions. Telemedicine consultation services may include, but are not limited to:

- Prescribing of medications
- 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

I understand that if this form is not signed by the Legally Authorized Representative and returned to Rittman, then no telemedicine services will be offered to the applicable student.

I further understand and agree that this informed consent for telemedicine services will suffice as informed consent for future telemedicine services rendered to student at Rittman.

Student: \_\_\_\_\_

Date: \_\_\_\_\_  
*(please print and sign name)*

Parent: \_\_\_\_\_ Date: \_\_\_\_\_

OR

Guardian/Legally Authorized Representative: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_

Legally Authorized Representative's Relationship to Student (e.g., legal guardian, healthcare power of attorney, etc.)  
 \_\_\_\_\_

Unless this box is checked  and initialed \_\_\_\_\_, you hereby permit Rittman and Orrville Hospital to provide the student with telemedicine services without you being present or participating.

**Please FAX signed form to (330) 684-2075 and place original in Permanent Student Record.**



**FORM B: HIPAA AUTHORIZATION**

**AUTHORIZATION FORM**  
**Student Authorization for Use and Disclosure of Protected Health Information**

Student Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

By signing this form, I hereby authorize Aultman Orrville Hospital ("Orrville Hospital") to disclose health information about me to any employee of the Rittman Exempted Village School District ("Rittman") and my parents/authorized representatives for treatment, payment, or healthcare operations. I understand that any health information disclosed by Orrville Hospital to Rittman pursuant to this Authorization may be incorporated into my student education records and may be accessed by others who are legally permitted to view such records.

This authorization permits Orrville Hospital to use and/or disclose protected health information about me, including, without limitation, all notes of physicians, nurses, psychologists, counselors, and other persons who have provided or who are providing health care to the undersigned individual, all radiology and pathology records, and other sensitive information (including HIV/STD information, genetic testing information, mental health information, and alcohol and drug abuse information). Notwithstanding the broad scope of the above disclosure request, the undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act ("HIPAA").

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Aultman Orrville Hospital, ATTN: Medical Records Department, 832 South Main Street, Orrville, OH 44667. I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this Authorization. Orrville Hospital will not condition my treatment or payment for my treatment on whether I provide authorization for the requested use or disclosure. I also understand I have the right to a copy of this Authorization.

I understand that information used or disclosed pursuant to this Authorization may be used or disclosed by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_  
Student Signature Date: \_\_\_\_\_

\_\_\_\_\_  
Parent OR Guardian/Legally Authorized Representative Signature Date: \_\_\_\_\_

If signed by a Legally Authorized Representative, provide your name and describe your authority to act for the individual below (e.g., parent, legal guardian, healthcare power of attorney, etc.)

\_\_\_\_\_

**FORM C: FERPA AUTHORIZATION**

Student Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

The purpose of this Authorization is to permit Rittman Exempted Village School District ("Rittman") to provide all personally identifiable information contained in the student's educational records (including any health-related or other information in the records maintained by the Rittman school nurse) to (i) my parents and/or Legally Authorized Representatives (unless restricted by law) and (ii) Orrville Hospital so that Orrville Hospital can provide telemedicine treatment services to me.

The Family Educational Rights and Privacy Act ("FERPA") is a Federal Law that protects the privacy of student education records. In accordance with FERPA, Rittman will disclose information from education records with the student's, or student's Legally Authorized Representative's, written consent.

By signing this document, I am giving consent that Rittman officials may provide and discuss the entire contents of my education records, including personally identifiable information from such records, with Orrville Hospital representatives. I understand that I may revoke consent at any time in writing to Myra Pierce, School Nurse, 50 Saurer Street, Rittman, OH, 44270. I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this Authorization.

\_\_\_\_\_  
Student Signature Date: \_\_\_\_\_

\_\_\_\_\_  
Parent OR Guardian/Legally Authorized Representative Signature Date: \_\_\_\_\_

If signed by a Legally Authorized Representative, provide your name and describe your authority to act for the individual below (e.g., parent, legal guardian, healthcare power of attorney, etc.).

\_\_\_\_\_