Norton Healthcare School Telehealth Consent Form

By completing this form and returning to your child's school, you understand the school nurse will provide this information to Norton Healthcare.

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Gender: _____ Phone #: _____

Parent Email: _____ School Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Relationship: _____

Parent Email: _____ Phone #: _____

Emergency Contact Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Relationship: _____ Phone Number: _____

Primary Care Provider & Pharmacy Information:

Primary Care Provider Name: _____ Phone #: _____

Pharmacy Name: _____ Phone #: _____

Insurance Information:

Norton Healthcare will bill any third party insurance plan using the information provided in this enrollment form for all services provided to students and staff. In the event student or staff does not have insurance or is self-pay, Norton offers a financial assistance program. I agree to the assignment of all third-party benefits to Norton Healthcare and agree to pay Norton Healthcare for all charges not covered by third-party payors. I agree that this document shall remain in full force and effect during the 2026-2027 *school year unless specifically revoked by me in writing. Any sums not paid by a third-party payor are my obligation.*

Insurance Plan Name: _____

Member ID: _____ Group ID: _____

Subscriber Name (person who is responsible for insurance policy) Subscriber Date of Birth

_____ _____

Insurance Plan Address: _____

City: _____ State: _____ Zip Code: _____

Medical and Surgical History: Does your child have any of the following conditions or other health concerns? Check all that apply.

Medical History

- ☐ Allergies
- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bone or Joint Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Hearing/Vision Problems
- ☐ Stomach or Bowel Problems
- ☐ Seizures/Stroke/Neurological Problems

Other Medical Conditions (please explain) and list any conditions: _____

_____

If you have checked **ANY** of the above conditions, please explain: _____

_____

Surgical History

- ☐ Appendix
- ☐ Gallbladder Removed
- ☐ Heart Surgery
- ☐ Tonsils Removed

Other Surgeries (please explain) and list any previous surgery: _____

_____

If you have checked **ANY** of the above surgeries, please explain: _____

_____

Medications - Please list any current medications.

1. Medication Name: _____ Dose: _____
How Often Taken?: _____ Why is the medication taken?:_____

2. Medication Name: _____ Dose: _____
How Often Taken?: _____ Why is the medication taken?:_____

If your child takes additional medication, please attach a separate page.

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Consent for Treatment – please select an option below.

☐ If the school nurse is unable to contact me by telephone when my child is ill, I give permission to have a Norton Healthcare provider examine my child, which includes testing for strep throat/flu/covid as needed and/or sending prescription medications to the pharmacy identified on this form.

☐ The school nurse must contact me by telephone and receive verbal consent before a Norton Healthcare provider may examine my child, which includes testing for strep throat/flu/covid as needed and/or sending medications to the pharmacy identified on this form.

MyNortonChart:

I authorize Norton Healthcare to create a MyNortonChart account for my child and me. This will allow me to view a visit summary from my visit and to securely message the provider if I have questions after my visit.

HIPAA Policies:

I acknowledge that I have reviewed the Notice of Privacy Practices (HIPAA Policy) found at NortonHealthcare.com. I agree to release all records related to this visit to my primary care provider. Norton Healthcare may leave messages with, discuss treatment plan, and Release of Information with the Emergency Contacts entered.

Authorize for Release of Medical Information:

I hereby authorize the release of medical information as necessary to my primary care provider listed on the medical information form. Unless otherwise indicated, this authorization extends to such psychiatric, alcohol or drug abuse, and HIV related diagnosis information, if any, as may be contained in the clinic records. I understand that I have the authority to release the above reference medical records. Further, I release Norton Healthcare and any related corporations or affiliates from any liability resulting from the release of these medical records and agree to indemnify and hold them harmless from any such liability.

Summary

I consent to my child being examined by Norton Healthcare Providers and nurses through a secure face-to-face video visit, which includes peripheral devices and tests deemed necessary for the treatment of my child's condition. I understand that I could instead request an in-office visit with the provider.

I acknowledge the medical and surgical history information provided on my child is accurate and up to date. I will notify the provider during my visit if this information has changed

I acknowledge the risks, benefits and alternatives to my child receiving care via video visit and understand that if my child's condition or technology used for the video visit limit the provider's ability to provide a treatment plan, my child will be referred to the appropriate provider.

Parent Guardian Name PRINTED: _____

Parent/Guardian SIGNATURE: _____

Date: _____