CONSENT FOR SERVICES
2019-2020 School Year

School: _____ Grade: _____

I hereby give consent for my child,

_____

Last Name First Name Date of Birth

to receive health care services (Services) provided by the Bienville Parish Hospital Service District No. 2., doing business as Bienville Family Clinic ("BHSD"). I understand that these Services will be performed when my child is at school during school hours, and that visits will be performed through a live audio-video connection, known as Telehealth/Telemedicine, where a provider at Bienville Family Clinic, with the assistance of the School RN, will examine the child through the use of specialized audio and video (camera) equipment and a private, legally-compliant internet connection. It will be my responsibility to notify BHSD staff of any changes in guardianship, my child's living or custody arrangements, and contact numbers.

I understand that BHSD personnel may manage and provide for my child's KidMed Visit if my child is brought to Bienville Family Clinic by parent or guardian, or through Telehealth/Telemedicine at my child's school only if parent or guardian is present during the appointment. I further understand that health care at school may consist of both preventive care services, including but not limited to: health screenings and immunizations, nutrition services, and wellness care, as well as treatment for illnesses. An attempt will be made to notify me so that I can attend all scheduled health care appointments for my child, either in-person, or through the use of a speakerphone installed at my child's school campus. I understand that I will receive a follow-up notice from BHSD if additional health care Services are recommended for my child. I understand that a visit summary may be provided to my child's regular primary care provider in order to ensure continuity of care. Finally, I understand that although my child will be treated at school, my child's treatment will be provided under the supervision and care of BHSD and not by the school or School Board. I further understand that although school nurses or other school personnel may assist BHSD in my child's treatment (e.g. by taking vitals, administering medication and shots, etc.), any such treatment is provided under the direction and care of the BHSD. As a condition of my child's participation in the SBHC, I hereby release the School Board for any claims or damages resulting from my child's treatment by BHSD. Finally, I grant the Bienville Parish School Board consent to provide BHSD with any personally identifiably information needed in order for BHSD to provide treatment for my child.

_____ _____

Parent/Guardian Signature (student under age 18) Date

_____ _____

Student Signature (if 18 or older or emancipated) Date

SERVICES WILL NOT BE PROVIDED WITHOUT CONSENT AS REQUIRED BY LAW.