LAKE CUMBERLAND
Schoolhouse Health
A Service of Lake Cumberland Regional Hospital

Dear Parents and Guardians,

In coordination with Lake Cumberland Regional Hospital (LCRH), Lake Cumberland Medical Associates (LCMA), is pleased to share information with you about Lake Cumberland Schoolhouse Health, **a new partnership with Pulaski County, Somerset Independent, and Science Hill Independent Schools** to contract with eighteen school nurses beginning this fall with the 2021-2022 academic year.

School nurses in these districts, working collaboratively with providers at Lake Cumberland Medical Associates, will continue to provide nearly all the same services as before, such as medication monitoring and dispensing and acute, or sick, visits. Extending the partnership formed in 2019 when Lake Cumberland Medical Associates unveiled Schoolhouse Mobile Care, these nurses will have the ability to coordinate well-child visits, sick visits, and physicals via telemedicine with parental consent.

Telemedicine capabilities in each school nursing office will allow nurses the opportunity to connect to a physician or advanced practice provider at Lake Cumberland Medical Associates to share information, discuss acute issues or treatment, and even process prescriptions; potentially saving parents' time and money on a second trip to the doctor's office.

LCMA will also continue to offer visits on a rotating schedule via the Schoolhouse Mobile Care unit. Through combined efforts of Schoolhouse Health and Mobile Care, children will be able to receive high quality health care services on-site, without missing school. This collaboration promotes positive outcomes for every child's health and education.

Important things to know:
- Healthcare Providers are board certified and follow evidence-based practice guidelines.
- Parents/guardians must sign a consent allowing healthcare to be provided to the child.
- Parents/guardians do not have to be present for care to be provided, although they are welcome if they so choose. All insurances are accepted.

Please complete the attached forms and return them to your child's school or teacher at your earliest convenience. In order for your child to see the school nurse, pages 1, 2 and 3 must be signed. Thank you.

We look forward to continuing to serve you and your student during the upcoming academic year!

Robert Parker
CEO, Lake Cumberland Regional Hospital

J. Barry Dixon, MD
President, Physician Services
Medical Director, Lake Cumberland Medical Associates

LAKE CUMBERLAND MEDICAL ASSOCIATES
SCHOOLHOUSE HEALTH & MOBILE CARE REGISTRATION AND CONSENT FORM

SECTION 1: PATIENT INFORMATION

Please complete the following information about your child:

Patient's Name: _____School: _____Date of Birth:_____Gender:___

Primary Language:_____Ethnicity:_____Grade:_____

Street Address: _____

Mother's Name: _____ Father's Name: _____ Child's Legal Guardian: _____

Parent/Guardian Home Phone: _____Cell Phone_____Work Phone_____
Email _____

Emergency Contact Name and Phone Number (Other than Parent/Guardian):_____

Child's Primary Care Provider/Physician:_____
Child's Dentist_____
Child's Pharmacy Name and Location: _____

MEDICAL INSURANCE INFORMATION

Insurance Co. Name and Phone Number:_____
Insurance Co. Address:_____
ID Number:_____ Group Number:_____
Policy Holder Name and DOB_____
Policy Holder Address and Relationship to Patient:_____

PATIENT HEALTH HISTORY

Please label below with **C** for child, **M** for mother, **F** for Father, **S** for sibling and **G** for grandparent.
Does your child or the child's immediate family have a history of:

____No problems	____Urinary Problems	____HIV/AIDs	____Diabetes
____Ear Tubes	____Frequent Sore Throats	____Ear Infections	____Mood Disorder
____Hepatitis A	____Hepatitis B	____Hepatitis C	____ADHD
____Heart Murmur	____Congenital Heart Defect	____High Blood Pressure	____Anxiety
____Hernia	____Eye Problems	____Wears Glasses	____Behavioral
____Depression	____Tonsils/Adenoids Removed	____Anemia	____Developmental
____Thyroid Problems	____Kidney Disease	____Stomach Issues	____Seizures/Date of last seizure_____

____ Asthma: Inhaler needed at school: Y* N Asthma Triggers:_____
____Other (please list): _____

Allergies:
Does your child have any medication allergies? _____Yes* _____No
Please list medication and type reaction (rash, breathing difficulty, swelling, etc.)

_____
_____

Is your child allergic to environmental factors (bees, latex, nuts, food, etc.)? ____Yes* ____No
Please list environmental allergens with type of reaction (rash, lips swelling, can't breathe, etc.)

Name of Allergen	**Type of Reaction**
_____	_____
_____	_____

***Contact the school nurse if your child needs an inhaler and/or Epi-Pen, Diastat, Glucagon during school hours. The parent/guardian is responsible for bringing the inhaler, Epi-Pen and/or medical supplies (glucometer, etc.) to school and for notifying the school of any changes regarding the medication. A permission for Prescribed Medication Form will need to be completed by the prescribing provider.**

Medications

Does your child currently take any medications? ____Yes ____No
Please list any medications with current dose (how much and how often):_____
_____
_____
_____
Medication to be administered at school: ___Yes ___ No
Name, Dose and Time of Medication to be administered at school _____
_____

Please check any of the following OTC medications that you will allow your child to be given. All doses will be given according to child's age and weight.

__Ibuprofen tablets or children's liquid
__Loratadine/Allegra/Benadryl tablets, capsules or liquid
__Phenylephrine Decongestant (Sudafed PE tablets or liquid)
__Acetaminophen tablets or children's liquid
__Antibiotic ointment
__Cough drops
__Aloe Vera
__Anti-Acid (Tums)
__Orajel
__Anti-itch spray/Calamine Lotion
__Cough syrup
__Hydrocortisone/Benadryl cream

CONSENT

Please read carefully, COMPLETE FORM, SIGN, and DATE. Student should return this form to their school. Please notify the school if there are any health changes or a change in guardianship. Consent will not expire until your child leaves the school or the clinic is notified in writing that you wish to revoke such consent.

I give consent for _____ _____
Student's Full Name **Birthdate**

to receive all services offered by the Lake Cumberland Medical Associate's Schoolhouse Health & Mobile Care located at the student's school. All services include:

- Illness assessment and treatment
- Tests for strep and influenza
- Basic wound care, including suture/suture removal
- School and sports physicals and age appropriate screenings
- Immunizations which require a separate consent to be signed

On behalf of and as the parent and/or legal guardian of the above-named minor patient, I give permission and my consent to Lake Cumberland Medical Associates for any medical treatment necessary, including, without limitation, the performance of influenza and rapid strep tests that the Healthcare Provider may determine is medically necessary. I authorize the release of any medical information necessary to process the claim(s) associated with these services. I authorize payment of medical benefits paid directly to Lake Cumberland Medical Associates, 350 Hospital Way, Somerset, KY 42503, 606.451.2756. I also understand that any portion of the fee not paid by my insurance company will become my personal obligation and will be paid promptly by me.

_____ _____ _____
Parent/Guardian Signature Print Name Date

EXHIBIT B

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This Authorization for Release of Protected Health Information Form ("Authorization") allows for the release of protected health information to _____ ("School District") by employees of Lake Cumberland Physician Practice, LLC or Lake Cumberland Regional Hospital, LLC (with such employees being referred to herein as "Practice Personnel"), who render services to the student listed below ("Student"). The purpose of this Authorization is to allow Practice Personnel who provide services to the School District to communicate with the School District, the School District's personnel involved in the operation, administration, or management of the School District's programs for administering state-mandated physicals to its students, regarding the Student's protected health information and participation in School District's applicable programs. Practice Personnel will not condition treatment on whether this authorization is signed; however, the School District may not permit a Student to participate in any applicable School District program regarding the provision of state-mandated physicals if the Student and his/her parents or legal guardians have not signed this Authorization.

I hereby authorize Practice Personnel providing services to the School District to release to each other and to the School District oral and written information related to the Student's medical or physical condition. This protected health information may concern the Student's medical status, medical condition, injuries, prognosis, and any other related personal identifiable health information. I understand that the Student's health information is protected by the federal regulations under either the Health Information Portability and Accountability Act of 1996 (HIPAA) or the Family Educational Right and Privacy Act of 1974 (FERPA). This Authorization is expressly made on the following conditions:

 This Authorization will remain in effect until the Student no longer receives services by Practice Personnel through the School District's clinic and healthcare services program(s), except to the extent relied upon for disclosures made prior to expiration or revocation.

 This Authorization may be revoked at any time by providing written notification to: _____[1]. Any such revocation shall not affect disclosures made in reliance on this Authorization by Practice, Practice Personnel or School District prior to the receipt of the revocation.

 The Student and/or the Student's legal guardians are not required to sign this Authorization, but if it is not signed, the Student may be unable to receive care from Practice Personnel at the School District location.

 The Student and Parent/Guardian shall receive a complete copy of the signed Authorization, and a copy of this Authorization and any revocation of it will be kept by the School District.

 The undersigned understands and agrees that medical or health information disclosure by Practice Personnel pursuant to this authorization may be subsequently disclosed by the recipient and may no longer be protected by applicable law.

 If I have questions about disclosure of my health information, I may contact Kathy Monroe at (606) 678-3200.

Student _____ Parent/Guardian _____
Signature *Signature*

Student _____ Parent/Guardian _____
Printed Name *Printed Name*

Relationship to Student _____ Date _____

Kentucky TeleHealth Network: TELEMEDICINE INFORMED CONSENT FORM

Patient Name: _____ DOB: _____
Site Where Patient is Seen via Telehealth: _____
Consulting Provider Name Seeing Patient via Telehealth: _____
Provider Location:_____

You are going to have a clinical encounter using videoconferencing technology. You will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room. Since 1994, the technology has connected tens of thousands of patients and providers in Kentucky. The information may be used for diagnosis, therapy, follow-up and/or education.

Expected Benefits:
 Improved access to care by enabling a patient to remain within the facility and obtain services from providers at distant sites.
 Patient remains closer to home where local healthcare providers can maintain continuity of care.
 Reduced need to travel for the patient or other provider.

The Process:
You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider or any telemedicine staff in the room with you, if you are unsure of what is happening. If you are not comfortable with seeing a provider on Video conference technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are being implemented to insure that this videoconference is secure, and no part of the encounter will be recorded without your written consent.

Possible Risks:
There are potential risks associated with the use of telemedicine which include, but may not be limited to:
 A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision.
 Technology problems may delay medical evaluation and treatment for today's encounter.
 In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By Signing this Form, I understand the following:
1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that if the provider believes I would be better served by a traditional face-to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit.
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 agree that I may be responsible to the practice for charges resulting from the services rendered using videoconferencing technology at their prevailing rates.

Patient Consent to the Use of Telemedicine:
I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care.
I hereby authorize _____ to use telemedicine in the course of my diagnosis and treatment. (Agency or Physician Name)
Signature of Patient (or authorized person) _____
Date/Time _____.
If authorized signer, relationship to patient _____
Witness _____ Date/Time _____