



### **ATTENTION: Parents/Guardians in the Putnam County School System**

The Putnam County School System, in partnership with Satellite Med and Intellectual Care, is pleased to announce the launch of the Onsite Medical Clinic at Prescott South Middle School, Monterey High School, and Cookeville High School. The Onsite Medical Clinic utilizes state-of-the-art technology to provide an efficient and accurate telemedicine solution for treating the physical and mental health needs of all students and faculty of the Putnam County School System.

*In order for your child to receive access to the Onsite Medical Clinic, all required paperwork must be completed.* Once enrolled, and at the parent's discretion, students will be able to receive medical advice, diagnosis, and treatment at school. For students with TennCare, CoverKids, or other insurances, Satellite Med will submit claims to the insurance provider as if the student was seen in person. Standard co-pays apply. For students without insurance, all services will remain at Satellite Med's cash prices.



**BELOW IS A LIST OF COMMONLY ASKED QUESTIONS REGARDING OUR SERVICES.**

**What is telemedicine?** Telemedicine is the use of technology by healthcare providers to treat patients remotely. Our telemedicine solution is a secure, two-way video connection between our Board-Certified healthcare providers at Satellite Med and our nurse at Prescott South Middle School. Our onsite nurse helps our providers conduct the visit with your child by screening, examining, and monitoring their vitals and immediate needs. This, along with special digitized equipment, gives the healthcare provider the ability to examine the child's ears, eyes, nose, throat, lungs, skin, etc. without physically being in the room with the child.

**What can be treated via telemedicine?** Since launching our telemedicine product in 2014, we have been able to treat 98% of all medical illnesses that present at our clinics. The remaining 2% have been referred to be seen in-person at Satellite Med. Below is a list of most commonly treated illnesses.

- Skin concerns (cuts/abrasions/rashes)
- Sore throat
- Earache
- Pink eye
- coughs/colds
- Flu-like symptoms
- Ortho/injuries
- Urinary problems

**We DO NOT treat chest pain, shortness of breath, or signs of a stroke. If you experience any of these symptoms, please call 911 or go to your closest ER or Satellite Med.**

**Who can be seen at the Onsite Medical Clinic?** All students and faculty in the Putnam County School System are eligible for enrollment in the Onsite Medical Clinic.

**How are the services paid for?** For students with TennCare or CoverKids insurance coverage, Satellite Med will submit claims to the insurance company (standard copays apply). For students without insurance, services will be provided based on Satellite Med's cash prices.

**How does this help me?** For parents, it's never a good thing when the school calls and tells you your child is sick. Especially if you work for a living, it may be impossible for you to leave your workplace immediately. With your permission, your child can have a telemedicine visit without leaving the school. Not only does this add convenience to your busy day, but it gives you the peace of mind knowing your child will be okay should an illness arise.

**Will I be contacted before my child is seen at the Onsite Medical Clinic?** Yes, the school nurse will always call the parent/guardian before your child is seen via telemedicine. If the parent/guardian cannot be reached, your child will not be seen via telemedicine, even if they have enrolled.

**What if my family doctor is not at Satellite Med?** No problem! We aren't trying to become your family doctor, but we are trying to improve your access to getting care when you need it most. If you would like to have your visit details forwarded to your family doctor, we will gladly do so for continuity of care and at no additional cost.

**How will I know what happened during the visit?** Our nurse or the school nurse will notify you regarding your child's visit and you will be informed of all findings, treatments, and recommendations.

**IF YOU WOULD LIKE YOUR CHILD TO HAVE ACCESS TO THE ONSITE MEDICAL CLINIC, PLEASE COMPLETE THE ENCLOSED FORMS AND RETURN THEM TO YOUR SCHOOL. THANK YOU!**

**Consent for Evaluation and Treatment**  
**(Consent to Treat)**  
**Satellite Med Onsite Medical Clinic**

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Please read carefully and sign this consent authorization in order for your child to receive health care services at the Satellite Med Onsite Medical Clinic.

**I hereby voluntarily give my consent for \_\_\_\_\_ to receive health care services offered by the Satellite Med Onsite Medical Clinic.**

I understand that students ***are not required to pay for any First-Aid services*** provided by the Putnam County School System nurses (examples: band-aids, antibiotic ointment). However, if the child experiences significant cuts/abrasions, rashes, sore throat, pink eye, fever, head lice, earache, cough, cold, flu-like symptoms, or other acute symptoms, you will be contacted first. If you choose to use the Onsite Medical Clinic, charges will be billed to your insurance company. If you are uninsured, your charges will be based on Satellite Med's cash prices. **The Putnam County School System is in no way responsible for any charges or bills that your child may incur.**

I understand that if my child requires medical treatment that is beyond the scope of the Satellite Med Onsite Clinic, the nurse will initiate a referral to Satellite Med or the health care facility of your choosing. I am assured that I, as parent/guardian, will be contacted by phone before any billable service is provided, and no services will be performed, including transportation or transfer to another medical provider or facility, will occur without verbal permission unless lifesaving treatment is necessary.

In case of emergency, I understand the school will call 911 and will render emergency care within the scope of the training and licensure of the staff until an ambulance arrives and care is transferred to Emergency Medical Services.

I understand that confidentiality between staff and students is assured. Only the Satellite Med Onsite Medical Clinic staff will have access to medical records; however, the school nurse may help inform parents/guardians of their child's illness by phone or in person. Health records will not be shared without the parent's permission, except to file insurance or other payment related documentation or as may be required by law. I understand that the Satellite Med Onsite Medical Clinic will adhere to the confidentiality and care standards as outlined in the Health Insurance Portability and Accountability Act (HIPAA). A summary of these rules can be found in the clinic or online.

I understand that by signing this form, my child can be treated during the school year for all the years they are enrolled within the Putnam County School System. I understand that I can withdraw this consent authorization only by written document delivered to the staff of the Onsite Medical Clinic.

I hereby certify that I have read and understand this consent authorization and accept the terms contained herein.

Parent/Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **MEDICAL CONSENT FORM FOR PCSS STUDENTS**

Parent/Legal Guardian Name: \_\_\_\_\_

Parent's DOB: \_\_\_\_\_

Parent's Social Security Number:  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home/Cell Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Do you have Insurance?  Yes  No **(\*Please include copy of insurance card)**

Name of Insurance: \_\_\_\_\_

Insurance Group #: \_\_\_\_\_

Policy #: \_\_\_\_\_

Student's Full Name: \_\_\_\_\_

Student's Date of Birth: \_\_\_\_\_

Student's Social Security Number:  
\_\_\_\_\_

Grade: \_\_\_\_\_

Does your child have Insurance?  Yes, same as Parent/Legal Guardian  
 Yes, but different than Parent/Legal Guardian  No Insurance

Name of child's Insurance: \_\_\_\_\_

Insurance Group #: \_\_\_\_\_

Policy #: \_\_\_\_\_

**\*(PLEASE INCLUDE COPY OF INSURANCE CARD)\***

## STUDENT INFORMATION

Last Name	FIRST NAME	BIRTHDATE
DATE OF LAST PHYSICAL	Primary Care Provider	

Chronic Illnesses (Please list any ongoing medical conditions your child may have, including Asthma, ADHD, and Diabetes)	
1	
2	
3	

Medication List	Dosage
1	
2	
3	

Allergies	
1	
2	
3	

Surgical History (If yes, please explain when and where surgery occurred.)	
No	
Yes	

Family History							
Patient's Father		Deceased		Cause of death		age at death	
		Alive					
Patient's Mother		Deceased		Cause of death		age at death	
		Alive					

Family Chronic Illnesses (Please list any ongoing medical conditions that are prevalent in your family, including Heart Disease, Depression/Anxiety, and Diabetes.)	
1	
2	
3	

**EMERGENCY CONTACT INFORMATION**

I, \_\_\_\_\_, hereby give permission for the following individuals to act on my behalf if I am not present for the visit or cannot be contacted by telephone, and give permission to allow treatment of my child at the Satellite Med Onsite Medical Clinic.

Permission given to:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Permission given to:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

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