

To Parent(s) and/or Guardian(s):

The Telemedicine Clinic gives your child an opportunity to be seen by a licensed healthcare provider without having to leave the school. An explanation of services offered by the Telemedicine Clinic is listed below. You do not have to be present for your child to be seen; however, a consent form must be signed by you in order for any services to be rendered.

### Description of Services

- Primary care services via telemedicine to ProMedica Pediatric and Adolescent Center
- Care for acute illness and minor injuries such as strep throat, ear infections, rash, and influenza
- Preventative care such as immunizations
- Insurance enrollment assistance for adolescents that are uninsured or underinsured
- On-site behavioral health counseling

Your insurance will be billed for services provided in the clinic. If you do not have insurance, services will be provided on a sliding fee scale that is based on the student's income. Please contact us if you have any questions or concerns at the following number: 517-279-5477.

**Crisis interventions and emergency care do not require consent. Life-saving interventions MAY be initiated without prior consent.** Services NOT provided at ProMedica School Telemedicine Clinics include prescribing and dispensing contraception, abortion counseling, and long-term psychotherapy.

**Current Michigan Law mandates (requires) confidential services to be available to minors in these areas: pregnancy, sexually transmitted infections (STI), human immunodeficiency virus (HIV) testing and counseling, behavioral health counseling, and substance abuse counseling.**

### Contact Information

Our staff is here to assist you, and we are available to communicate with the parents of each student. We want to know your concerns and be able to keep you updated on your student's health. State law mandates full confidentiality in certain circumstances. The telemedicine works with, and is not meant to replace, your family doctor. Feel free to contact us during office hours.

**Cardinal Connect**

Kelli Hills, BSN  
275 N. Fremont St.  
Coldwater, MI 49036  
517-279-5295

**Oriole Connect**

Mari-Lynn Marquart, BSN  
18 Colfax St.  
Quincy, MI 49082  
517-279-5297

**Viking Connect**

Jessica McKinley, BSN  
450 E. Grant St.  
Bronson, MI 49028  
517-279-5296

**Legg Telemedicine**

Tara Coats, BSN  
175 Green St.  
Coldwater, MI 49036  
517-279-5458

**Mental Health Provider**

Shannan Lester, LMSW  
517-279-5270

**Mental Health Provider**

Katelyn Hamlin, LLSW  
517-279-5275

**Mental Health Provider**

Rebekah Clancy, LPC  
517-279-5208

**Mental Health Provider**

Alan Reifert, LLP  
517-279-5459

The School Clinics link via telemedicine to the ProMedica Pediatric and Adolescent Clinic under the direction of Dr. Edelwina Dy



### ENROLLMENT & CONSENT FORM

#### STUDENT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Graduation Year: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Student Gender: \_\_\_\_\_ Email: \_\_\_\_\_ Student Cell: \_\_\_\_\_

#### PARENT / GUARDIAN INFORMATION – *Date of Birth Required*

Father: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone (H/C) \_\_\_\_\_ (W) \_\_\_\_\_  
 Mother: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone (H/C) \_\_\_\_\_ (W) \_\_\_\_\_  
 Guardian: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: (H/C) \_\_\_\_\_ (W) \_\_\_\_\_  
 Alternative Contact: \_\_\_\_\_ Phone (H/C) \_\_\_\_\_ (W) \_\_\_\_\_

#### HEALTH INFORMATION

- List any allergies your child may have and any medications your child should not take: \_\_\_\_\_  
\_\_\_\_\_
- List any medications your child currently takes and why: \_\_\_\_\_  
\_\_\_\_\_
- Family Physician/Pediatrician: \_\_\_\_\_ or None Dentist: \_\_\_\_\_
- If we need to call in a prescription, which pharmacy would you like us to call? \_\_\_\_\_
- Medical Problems:** Please check all that apply for your child:
 

<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Headaches	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Depression	<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Hay Fever/Allergies	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> ADD/ADHD	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Vision or Hearing Problem		

#### INSURANCE - \*POLICY HOLDER DATE OF BIRTH REQUIRED\*

**INSURANCE:** Name of Insurance Company: \_\_\_\_\_  
**Please fill out** Address: \_\_\_\_\_  
**Information and** City/State/Zip Code: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_  
**provide copy of** Policy/ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
**card front & back** Policy Holder Name: \_\_\_\_\_ \*Policy Holder Date of Birth: \_\_\_\_\_  
 Place of Employment: \_\_\_\_\_

**MEDICAID:** Please Check One  Meridian Health  United Healthcare  Other \_\_\_\_\_  
 ID# \_\_\_\_\_ Group # \_\_\_\_\_

**NO HEALTH INSURANCE** - Request application for MI Child/Medicaid or financial assistance

\*Please note some commercial insurance companies do not cover the telemedicine facilitation fee. Contact your insurance company to see if your plan covers this service. This charge is not applied to vaccines or sports physicals. If you have questions please call 279-5477.

**Consent for School Telemedicine Clinic Services**

**Student's name:** \_\_\_\_\_

I, the parent/guardian of said student, give consent for my child to receive all services at the Telemedicine Clinic. I understand that this consent form is valid for as long as the student is enrolled in Coldwater, Quincy or Bronson Community Schools or until I provide the clinic staff with written directions otherwise.

All healthcare information is confidential. By signing the consent form, you are giving the telemedicine clinic permission to communicate and share medical information with your child's primary care doctor. Communication regarding your child's medical condition will be on an as-needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to healthcare services due to inability to pay. As in any health clinic, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing purposes.

Confidentiality between the student, parents and the health clinic is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions.

I am the legal guardian of the above named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact.

\_\_\_\_\_  
Signature of Parent / Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date