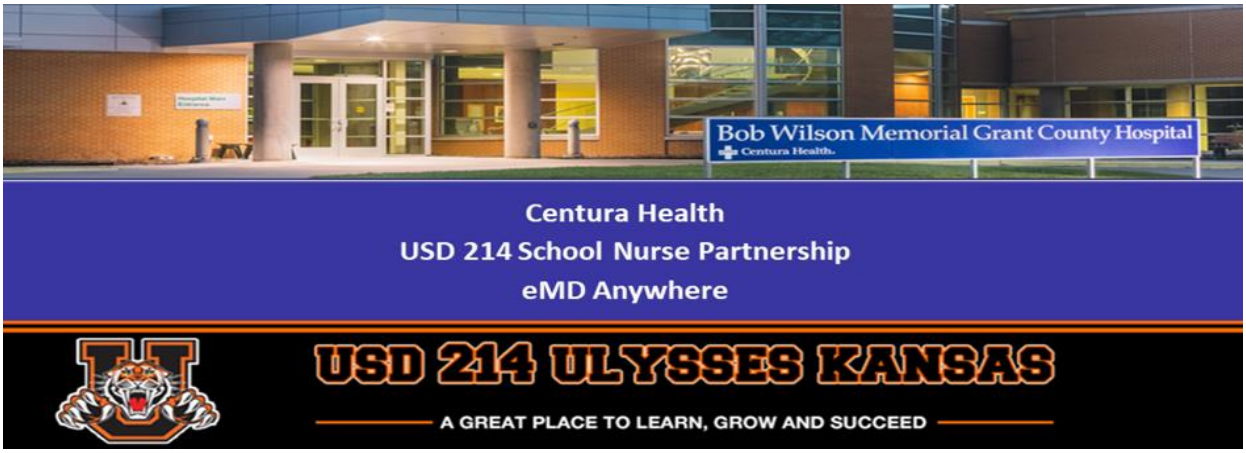

Dear Parent / Guardian,

In partnership with **USD 214, eMD** will provide a limited range of medical services for our students, faculty and staff through a **Bob Wilson Memorial Hospital Advanced Practice Provider** via a Telemedicine Station. **eMD** can provide medical services for your child similar to a regular office visit, accepting most insurance types for the medical services provided. The goal of this program is to provide immediate access to medical care similar to that of an urgent care clinic. This program is not intended to replace your primary physician and should be considered a supplemental medical care service. If your child does not have a primary care physician, **eMD** can provide primary care services or assist in locating a pediatric provider in your area.

Here's how the medical service will work for children enrolled in the service.
When the school nurse identifies an illness that requires medical attention, the nurse will notify the parent/guardian and offer the option of arranging a telemedicine visit with a **Bob Wilson Memorial Hospital Advanced Practice Provider.**
Prior to medical evaluation, the school nurse will make reasonable attempts to notify the student's parent/guardian with the contact information on file. If the school nurse is unable to make contact and the appropriate forms are on file, the school nurse will determine whether to proceed with treatment based upon your child's symptoms and medical complaints.
As the parent/legal guardian of a student, you give permission for your child to utilize this program by:

- o Signing the registration form to authorize your child's participation;
- o Copy of front and back of insurance card;
- o Returning the registration form and this completed form to the school nurse.

We're confident you and your child will greatly enjoy the experience and compassionate care of one of our **Bob Wilson Memorial Hospital Advanced Practice Providers.** They will provide excellent care for both our students and faculty. The NP will work closely with each school nurse to provide medical services, both in person and via a mobile telemedicine station that is established in each school-based clinic.

It is important to note several key points:

- Only the students enrolled in the school-based clinic and telemedicine program will be eligible to receive school-based treatment. Parents/guardians must complete and return the appropriate enrollment form that is being sent home and update insurance information as needed.
- Prior to a clinical or telemedicine medical evaluation, the school nurse will make reasonable attempts to notify the student's parent/guardian with the information they have on file. If the school nurse is unable to make contact, and the appropriate forms are on file, the school nurse will determine whether to proceed with treatment based upon the child's symptoms and medical complaints.
- Parents/guardians will have the option of being present for the evaluation. If you are unable to participate, they will receive timely follow-up communication regarding the child's medical evaluation and treatment.

Questions?
If you have further questions or concerns, please contact **Kristy Meier** at **(620)356-1261** or **Katrina Benyshek** at **(620)356-1690.**

eMDAnywhere

PATIENT REGISTRATION

Patient's Name (First, Middle, Last):_____ Nickname:_____

DOB:_____ SSN:_____ Sex: M or F School:_____

Race: (circle) Caucasian African American Native Alaskan Hispanic/Latino American Indian Asian/Pacific Islander Other_____

Mailing Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone:_____ Email: _____

Marital Status: (circle) Single Married Divorced Separated Widowed Minor/Child Student: Y or N Full-time or Part-time

Fathers Name & Phone:_____ DOB:_____SSN:_____

Mothers Name & Phone:_____ DOB:_____SSN:_____

Legal Guardian & Phone:_____ DOB:_____SSN:_____

In Case of Emergency, please tell us a Local Friend or Relative (not living at same address) whom we could contact.

Name:_____ Relationship:_____ Ph:_____

Primary Care Provider and other relevant Clinicians: _____

Person Responsible for the Bill:_____ DOB:_____SSN:_____

Is the Patient covered by insurance? YES or NO.

Pharmacy of choice:_____

Pharmacy Phone Number: _____

Please Fill in all of the following:

Primary Insurance Name of Insurance Company: _____ CoPay Amount: _____

Ins. ID Number: _____ Group Number: _____

Name of Subscriber:_____ DOB:_____ SSN:_____

Patient's Relationship to Subscriber: SELF SPOUSE CHILD OTHER:_____

Secondary Ins. Name of Insurance Company: _____ CoPay Amount: _____

Ins. ID Number: _____ Group Number: _____

Name of Subscriber:_____ DOB:_____ SSN:_____

Patient's Relationship to Subscriber: SELF SPOUSE CHILD OTHER:_____

The above information is true and complete to the best of my knowledge.

I, the undersigned (please check the below statements):

- o give permission and consent to have treatment through and by eMD Anywhere, LLC. I understand the nature of this treatment, the way it is provided, and the details and limitations of this form and style of treatment.
- o acknowledge that I have been offered a copy of the Notice of Privacy Practices
- o agree that all I will be responsible for all costs associated with said treatment and that I will provide any insurance information as requested. All costs and fees not covered by insurance will be my responsibility. Additionally, I authorize the release of any information necessary to process insurance claims for payment of benefits to eMD Anywhere, LLC, and authorize the payment of insurance benefits to eMD Anywhere, LLC for services rendered.
- o agree to release all records related to this treatment to the parties listed above: (ex: Primary Care Provider)
- o I have read the "School Based Clinics & Telemedicine Program" Letter describing eMD Telemedicine Services in the school clinic.

_____ _____

Signature of Parent or Legal Guardian Date of Signature

_____ _____

Signature of School Nurse (if verbal permission is obtained from the Parent or Legal Guardian) Date / Time

eMD Anywhere Student Health Questionnaire

Students must have parental permission to be seen by eMD Anywhere.

_____ _____ _____

Student's Last Name First Middle

Does your child have any of the following conditions or other health concerns:

Yes / No Allergies, other than medications (such as bee stings or peanuts) - If **YES**, *Please list*

_____

_____

Yes / No Asthma - Date of last asthma attack _____

Yes / No Seizures - Date of last seizure _____

Yes / No Vision Problems

Yes / No Hearing Problems

Yes / No Sickle Cell Anemia

Yes / No Heart Problems - If **YES**, Please List _____

_____

Yes / No Bleeding Disorders

Yes / No Orthopedic (bone or joint) Problems

Yes / No Anxiety/Depression

Yes / No Operations and/or Hospitalizations - Dates (details below)

_____

_____

_____

Yes / No Diseases in Siblings

Other - Please Explain: _____

_____

_____

Is your child on any medications?

- o No
- o Yes - *Please list* _____

Is your child allergic to any medications?

- o No
- o Yes - *Please list* _____

In signing this form, I am stating the following:

- *The information that I have provided is accurate and up-to-date.*
- *I will update eMD Anywhere with any changes as soon as possible.*

If you would like to speak with our medical provider about any of your child's health, please contact Ulysses Family Physicians at (620) 356-1261.

_____ _____

Signature of Parent or Legal Guardian Date of Signature

_____ _____

Signature of School Nurse (if verbal permission is obtained from the Parent or Legal Guardian) Date/Time