Child Health Survey Form

Childs Name		
Grade Level (Kindergarten, 1st, etc.)		
Gender	o Male	o Female
Name of Primary Care Provider if available:		
If translation services are needed for your child's visit, please list language:		

Does your child have any of the following conditions?	**Yes (If no leave blank)**	**If so, how much time did the condition keep your child out of school? None, A little, Most of the time?**
Asthma		
Diabetes		
Behavioral Conditions (ADD, ADHD)		
Other: Please Indicate		

How would you rate how well the problem below, was controlled during the last 4 weeks?	**Completely controlled**	**Well controlled**	**Somewhat controlled**	**Poorly controlled**	**Not controlled at all**
Asthma					
Diabetes					
Behavioral Conditions (ADD, ADHD)					
Other please indicate					

Please list any allergies your child has: Ex. Food, Medication.	

List all medication your child has been prescribed.	**Dosage**	**Times per day**

Any information you could provide us to help serve your child better, please write here.	

CoxHealth

Virtual Visits Clinic Authorization for Consent to Treat a Minor

Parent/Guardian authorization is required for all students participating in the school-based telehealth. The following form must be completed, signed, and returned to your child's school in order for them to participate in the project and receive related medical evaluation and treatment.

Child's Name: _____

Date of Birth: ___/____/____

Name of Child's School: _____

Upon notification, I, _____, the _____ of the minor child listed above, hereby
(name of parent/guardian) (relationship to child)

requests and authorizes _____ to facilitate treatment and health care for my child, to be
(name of child's school)

provided by CoxHealth licensed medical providers via telehealth connection, and made possible by grant funding from Missouri Foundation for Health and Children's Miracle Network. I understand that a telehealth connection is the process of delivering health care services by interactive video communications and/or by the electronic transmission of information from, in this case, my child's school, to a telehealth provider located at another site. I authorize treatment including, but not limited to, primary care services, immunizations, vision services, specialist care, care for chronic diseases such as diabetes and asthma, and the treatment of common illnesses. I consent for my child's school nurse or other facilitator to receive protected health information about my child in order to carry out the treatment of my child as part of this visit and to remain in the room, where necessary to aid in the visit. I accept responsibility for all charges that might result from any medical treatment under this authorization and, as applicable; I authorize CoxHealth to release information regarding treatment to third party payers or others for the purpose of receiving payment for services. I understand I have the right to revoke this consent at any time. Revocation must be made in writing and presented to the school named above. I understand that this consent will be effective for one (1) year from the date of my signature and that I will be notified prior to each individual telemedicine visit involving my child.

☐ **I have read and understand the services listed herein and my signature provides consent for my child to receive services provided as part of the school-based telehealth program.**

☐ I do NOT wish for my child to participate in the School based telehealth project

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Address: _____

Phone Number(s): _____

I authorize the following people to participate in any Telehealth visits my child may have:

_____
printed name relationship

_____
printed name relationship