EDUCATIONAL PASSPORT

This form is for the purpose of enrolling the student in school. It is to be completed by the school/facility from which the student is leaving. This form is mandated by KRS158.137 and KRS 605.110(3)e and shall be presented, by the SSW or foster parent, to the receiving school or educational facility within two (2) days of enrollment. **Information contained on this Passport is subject to confidentiality laws.** Pursuant to provisions in the FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT Section 444(b) of the General Education Provisions Act (20U.S.C. 1232g(b)), the child's social services worker may request copies of educational records listed on this form. The school is to waive all fees, per 702 KAE 3:220

STUDENT NAME _____ STUDENT ID # _____

BIRTHDATE _____ GRADE _____ TOTAL CREDITS EARNED TO DATE _____

STUDENT WITHDRAWAL DATE _____

TRANSFERRING SCHOOL _____

(Include District Name) _____

_____

Phone _____ FAX _____

TOTAL DAYS ENROLLED AT TRANSFERRING SCHOOL _____

EMERGENCY CONTACT NAME/ADDRESS

_____ PHONE NUMBER _____

_____ RELATIONSHIP TO STUDENT _____

EDUCATION ADVOCATE ☐ Yes ☐ No If so, who? _____

RECORDS (List all records provided to the receiving school)			
Physical Exam	☐ Yes ☐ No	Vocational Test	☐ Yes ☐ No
Immunization Certificate Expiration Date _____	☐ Yes ☐ No	Graduation Plan/ Transition Plan	☐ Yes ☐ No
Tuberculin Skin Test	☐ Yes ☐ No	Official Transcript Record	☐ Yes ☐ No
Birth Certificate	☐ Yes ☐ No	Current Report Card	☐ Yes ☐ No
Social Security Card	☐ Yes ☐ No	Attendance Record	☐ Yes ☐ No
Psychological Evaluation	☐ Yes ☐ No	KY Performance Rating for Educational Progress (KPREP)	☐ Yes ☐ No
504 Plan	☐ Yes ☐ No	Individualized Learning Plan (ILP)	☐ Yes ☐ No
I.E.P.	☐ Yes ☐ No	**Current Classes**	**Withdrawal Date**
Most Recent State Achievement Test	☐ Yes ☐ No		
Special Health Needs	☐ Yes ☐ No		
Special Medications	☐ Yes ☐ No		

Person Providing Information _____ Date _____

Signature of School Official _____

1. Type of classroom setting: ☐ Mainstream ☐ Self-Contained ☐ Resource ☐ Other
Explain (if other) _____

2. Name of Teacher _____

If not attending school, what educational services is the student receiving and from whom? _____

_____

3. Total number of school changes (this year) NOT due to a grade promotion? What were reasons for changes? _____

_____

4. How many missed days of school this year? _____ **Reasons** _____

_____

5. Is this student performing at grade level? ☐ Yes ☐ No Explain _____

_____

6. Does this student have a/an: ☐ IEP ☐ Standardized Education Plan ☐ 504 Plan
If so, is this student on track to meeting the described goals? Explain _____

_____

_____

7. How motivated is this student to do well in school? (Circle one)
(Not motivated at all) 1 2 3 4 5 (Very motivated)

8. Areas in school where this student excels _____

_____

9. What are some behavior/motivation strategies that this student best responds to? _____

_____

_____

10. What are some behavior/motivation strategies this student does NOT respond well to? _____

_____

11. Date of last educational evaluation or assessment _____ **Results** _____

_____

_____

12. Extracurricular activities this student is involved/interested in? _____

_____

13. Any barriers to participation in extracurricular activities? _____

_____

14. Are there known socio-emotional issues impeding this student's school performance? Explain

_____

_____

15. Are there known environmental issues impeding this student's school performance? Explain

_____

_____

DPP-330
R. 7/2017

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department of Community Based Services
Division of Protection and Permanency

EDUCATIONAL ADVOCACY REQUEST FORM

CHILD INFORMATION		
Name (last, first)	Date of Birth	Gender ☐ Male ☐ Female

SPECIAL EDUCATION INFORMATION
☐ Student needs to be assessed for Individualized Education Plan (IEP)
☐ Student has an IEP
☐ Student's Evaluation in Progress

EARLY CHILDHOOD INTERVENTION INFORMATION
☐ Child needs to be assessed for First Steps
☐ Child is enrolled in First Steps
☐ Child has an Intensive Family Service Plan (IFSP)

_____
Resident School District/Early Intervention Local Lead Agency

PLACEMENT INFORMATION
Placement/ Facility (check one)
☐ Foster/Adoptive Home ☐ Residential ☐ Other _____

_____
Placement/Facility Name

_____
Address (Street, City, State Zip Code)

_____
Telephone (including area code)

Kentucky
UNBRIDLED SPIRIT

REQUEST INFORMATION Request For: (check one)		
☐ Permission Granted Permission Reason: ☐ Parent is not available ☐ Parent requests foster parent act on their behalf	☐ Replacement Replacement Reason: ☐ Advocate no longer wishes to serve ☐ Advocate has a conflict of interest ☐ Advocate no longer available ☐ Child's placement changed	☐ Withdrawal Withdrawal Reason: ☐ Student has been adopted ☐ Moved from district ☐ Parents now available ☐ Student graduated ☐ Unspecified

In accordance with 707 KAR 1:002(43)(e), *Parent means: a foster parent if the biological or adoptive parents grant authority in writing for the foster parent to make educational decisions on the child's behalf, and the foster parent is willing to make educational decisions required of parents under 707 KAR Chapter 1, and has no interest that would conflict with the interests of the child*, the birth parent for the above mentioned child, has agreed to allow the foster parent to make educational decisions for the child. The birth parent has been informed that they may rescind this agreement at any time. The status of this agreement will be reassessed during regularly scheduled Case Planning Conferences.

_____ _____

Signature of Parent Date Signature of Parent Date

_____ _____

SSW Signature Date FSOS Signature Date

Terry Holliday, Ph.D.,
Commissioner

Kentucky Department of Education
500 Mero Street, 1st floor, Capital Plaza Tower
Frankfort, KY 40601
(502) 564-4770 | www.education.ky.gov

Steven L. Beshear
Governor

Teresa C. James
Commissioner

Department for Community Based Services
275 E. Main, Mail Stop 3W-A
Frankfort, KY 40621
(502) 564-3703 | www.chfs.ky.gov/dcbs

May 24, 2013

Dear Colleagues:

The enactment of the Uninterrupted Scholars Act (Public Law 112-278) on January 14, 2013 has provided a unique opportunity for further collaboration between federal, state, and local education and welfare agencies. The Act amended the Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g; 34 CFR Part 99, to permit educational agencies and institutions to disclose a student's education records, without parental consent, to a case worker or other representative of a state or local child welfare agency or tribal organization authorized to access a student's case plan "when such agency or organization is legally responsible, in accordance with State or tribal law, for the care and protection of the student." In certain types of judicial proceedings that involve the parent, the Act also allows educational agencies and institutions to disclose a student's educational records pursuant to a court order without requiring additional notice to the parent by the educational agency or institution.

Representatives of the Kentucky Department of Education and the Department of Community Based Services (DCBS), with input from the Kentucky School Boards Association, have been working together to plan the effective and uniform implementation of the Act. Each agency is aware of and understands the importance of protecting the privacy of education records without jeopardizing the ability to fully serve the educational needs of students in foster care.

An Educational Passport, a form provided by the caseworker, will be used to streamline the disclosure of records. DCBS workers will provide local school districts with proof that the agency has legal custody or is otherwise legally responsible for the care and protection of the child for whom records are sought. The Kentucky School Boards Association has prepared a form that districts may use to document disclosures made under the Act.

Federal guidance on the Act is forthcoming, but some interim observations are appropriate. The Act does not exclude or make exception for special education records. In addition to the Act, Kentucky regulation provides that parents may grant authority in writing for a foster parent to make educational decisions on the child's behalf. Parents may document this granting of authority using DCBS Form DPP-330. The Act does not grant access to educational records to welfare agencies that are not legally responsible for the care and protection of the student. Recent Kentucky legislation, HB 54, eliminates

the FERPA parental consent requirement for release of education records to officials performing their duties and requiring education records pursuant to KRS Chapter 600-645. Finally, please note that, under 707 KAR 3:220(4) (7), there is a mandatory waiver of fees for the school records of a pupil who qualifies for free or reduced price lunches, and a student in foster care qualifies for free lunches.

We look forward to continuing to work together, at the state and local levels, to improve the educational outcomes of some of Kentucky's most vulnerable students.

Sincerely,

Terry Holliday, Ph.D.
Commissioner
Kentucky Department of Education

Teresa C. James
Commissioner
Department for Community Based Services

Clay County Public Schools

2019-2020 Student Enrollment Form (Please print & use a pen)

Date

tudent Information

tudent's Full Legal Name _____ Middle (Full)

ender ☐M ☐F ___/___/___ Student SS# _____

Ex: 02/02/2002

lome Phone 606 Grade _____ Homeroom: (completed by school) _____

thnicity

Ethnicity: (Check One) ____Hispanic/Latino ____Non Hispanic/Latino

Race: (Must check one–may check more than one) ____American Indian/Alaskan ____Asian ____White ____Black ____Native Hawaiian/Other Pacific Islander

11 Address _____ Apt# _____ City Big Creek State Ky Zip 40914

lailing Address (If different) _____ Apt# _____ City _____ State _____ Zip _____

rent/Guardian may be asked to provide proof of residency (deed, mortgage receipt, rent receipt, rental agreement, utility bill, etc.) at the time of enrollment.

ransportation: Student will ☑Ride Bus twice daily ☐ Ride Bus once daily ☐a.m. ☐p.m. ☐Will not ride the bus

arent/Guardian

guardians live in the primary home with the student)

emale Guardian Name Alex Relationship to student Foster Parent

Last First Middle (Full)

ork Phone (606) _____ Cell Phone (____) _____

nail _____ @ _____ Date of Birth 7-30-09

ale Guardian Name _____ Relationship to student _____

Last First Middle (Full)

ork Phone (____) _____ Cell Phone (____) _____

nail _____ @ _____ Date of Birth _____

ther Parent/Guardian Information *(For Divorce / Separation / Shared Custody—this guardian does NOT live in the primary me with student)*

ame _____ Relationship to student Foster Parent

First Middle (Full)

ailing Address _____ Apt# _____ City _____ State _____ Zip _____

ousehold Telephone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

nail _____ @ _____ Date of Birth _____

ther Children Under Age 18 Living in the Home (include all children regardless of age)

First Name	Middle (Full)	Last Name	Birthdate	Gender	Relation to Student	School Attending
			7-30-09		Foster Parent	
			9-12-2002		Brother	

Emergency Contact Information (other than parent/guardian)

In case of an accident or emergency of any kind, when parent/guardian cannot be located please call and/or release my child to one of the following individuals. Emergency contacts must be at least 18 years of age and listed below in order to pick up your child.

1. Name: _____ Relationship to child: _____

   Home phone: _____ Work phone: _____ Cell phone: _____

2. Name: _____ Relationship to child: _____

   Home phone: _____ Work phone: _____ Cell phone: _____

3. Name: _____ Relationship to child: _____

   Home phone: _____ Work phone: _____ Cell phone: _____

4. Name: _____ Relationship to child: _____

   Home phone: _____ Work phone: _____ Cell phone: _____

Student Previous School Information

Last School Attended _____ City, State, Zip _____

Grade _____ School Year _____

Is your child presently under an expulsion order from any other school district? ☐Y ☐N

Is your child presently under consideration for expulsion? ☐Y ☐N

Is your child presently involved in the Juvenile Justice system? ☐Y ☐N

English Language Learner Information (All new students should fill out a Home Language Questionnaire)

Does the student speak a language other than English? ☐Y ☑N What language? _____

Primary Language of Household: ☐English ☐Spanish ☐Other _____

Special Services Information

Is your child receiving special education services? ☑Y ☐N

Does your child have a current 504 plan? ☐Y ☐N Is it in: ☐Academics ☐Health

Was your child in any Gifted/Talented Programs? ☐Y ☐N Please list: _____

Is Mom or Dad military? ☐Y ☐N

Medical Information

Is your child taking any medications regularly? ☐Y ☑N If yes, please list: _____

Student Medication Request Release Agreements are available at the school office. This form must be completed for any medication a student will need to take during school hours.

Known Medical Problems: _____

Special Medical Instructions: _____

If your child has a severe allergy that could result in anaphylactic shock, we must receive a physician statement stating so and a sufficient supply of their prescribed medication to be kept at the school for your child's use in the event of an emergency.

Physician name: _____ Phone (_____) _____

Parent/Guardian Signature _____ Date 8-12

(Do not sign this form if any of the statements are incorrect)

Name _____ DOB _____ Grade _____ CLAY COUNTY

School Based Health Consent for Services
Grace Health, Inc.

Please read carefully: In order for us to see your child in school based clinics, all pages of this form must be completed by the child's parent or legal guardian, signed and dated in ink in the appropriate places. Students should return the completed form to their teacher or nurses' station. Consent is for the 2019-20 school year and may be withdrawn at any time. Make sure to put student's Name, DOB, and Grade on each page.

Child's School: C County School

Student's Last Name _____ First Name _____ MI: _____ DOB: 7-3-08

Social Security Number: _____ Gender: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☒ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Homeless? ☐ Yes ☐ No Migrant Worker? ☐ Yes ☐ No

Ethnicity: Are you Hispanic or Latino? ☐ Yes ☐ No

Primary Language: _____ Religion Preference: (optional) _____

Mailing Address: 6

City: Big Creek State: Ky Zip Code: 40914

Physical Address (If Mailing Address is a P.O. Box):

Home / Cell Phone Number: 606 -

In Case of Emergency, Please Contact:

Name of Mother/ Legal Guardian: _____

Mother's Social Security Number: _____ Mother's Date of Birth: _____

Home Phone Number | Cell Phone Number | Work Phone Number | e-mail address

Name of Father/ Legal Guardian: _____

Father's Social Security Number: _____ Father's Date of Birth: _____

Home Phone Number | Cell Phone Number | Work Phone Number | e-mail address

If Immediate Family is Not Available, Please Contact: (this is the only person we can share student info with)
Name and Relationship to Child: _____

Home Phone Number | Cell Phone Number | Work Phone Number

Name_____ DOB_____ Grade_____ CLAY COUNTY

Student's Medical History

The following information will aid the School Nurse in making an accurate assessment of your child in case of illness or emergency. Please check the appropriate space if your child has ever had any of the following:

- ☐ Measles
- ☐ Mumps
- ☐ Anemia
- ☐ Birth Defects
- ☐ Diabetes
- ☐ Chicken Pox
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Sleep Problems
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Unexplained Weight Loss
- ☐ Unexplained Tiredness
- ☐ Persistent Cough
- ☐ Unexplained Weight Gain
- ☐ Leukemia
- ☐ Stomach or Bowel Problems
- ☐ Joint or Muscle Pain or Stiffness
- ☐ Exposed to Tuberculosis
- ☐ Shortness of Breath
- ☐ Head, Eyes, Ears, Throat Problems
- ☐ Blood Transfusions
- ☐ Anaphylactic Episodes
- ☐ Chest Pain

If you answered yes to any of the above, please explain: _____

Student's Medications taken on a regular basis: _____

****You will be asked to complete a separate Medication Consent form if you desire the School Nurse to administer this medication in the School.**

Student's Doctor: _____ Address: _____

Student's Dentist: _____ Address: _____

Student's Pharmacy: _____ Address: _____

- Any Operations (reason/date): _____
- Any Hospitalizations (reason / date): _____
- Any serious injuries or illnesses (describe): _____

When was the last time your child was seen by a doctor?

Doctor's Name	Reason	Date

Student's allergy to FOOD, MEDICATIONS, OR ENVIRONMENTAL POLLENS? ☐ Yes ☐ No

IF YES, PLEASE LIST: _____

Have there been any recent upsets in the family that might affect your child? ☐ Yes ☐ No

If you answered yes please explain: _____

Family Medical History:

Please check the appropriate space if any of the child's blood relatives (mother, father, brother, sister) has any of the following conditions:

- ☐ HIV/AIDS
- ☐ Alcohol/Drug Addiction
- ☐ Alzhemier's
- ☐ Arthritis
- ☐ Asthma
- ☐ Birth Defects
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ COPD/Emphysema/Bronchitis
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Heart Attack/Stroke
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease/Hepatitis
- ☐ Mental Illness
- ☐ Osteoporosis
- ☐ Sickle Cell
- ☐ Thyroid Disorder
- ☐ Tuberculosis/TB
- ☐ Other: _____

Name _____ DOB _____ Grade _____ CLAY COUNTY

Immunization Status:

Is your child up to date on immunizations? ☐ Yes ☐ No

Where is the child's immunization record on file? _____

Yes, I give permission for school nurse to request a copy of immunization record

Other:

Do you have concerns about your child's health? ☐ Yes ☐ No

Is your child exposed to second hand smoke? ☐ Yes ☐ No

Does your child smoke and/or use tobacco products? ☐ Yes ☐ No

Does your child drink alcohol? ☐ Yes ☐ No

The following list of medications will be on hand at the Satellite School Clinic to be administered by the School Nurse after she has evaluated your child's complaint.

- Acetaminophen (Generic name for Tylenol)
- Claritin for allergies
- Refresh Plus Eye Drops/ Refresh
- Tums for indigestion
- Diphenhydramine (Generic for Benadryl)
- Tussin DM
- Solarcaine spray for burns and scrapes
- Imodium for diarrhea
- Ibuprofen (Generic name for Advil)
- Orajel/ Orasol
- Zofran for nausea
- Triple antibiotic ointment
- Hydrocortisone 1% Cream
- Hydrogen Peroxide (for wound cleansing)
- Simethicone for gas

If you prefer we do not administer a medication listed above please list below.

_____

We are a Federally Qualified Health Center and are required to obtain the following information. This information will be kept confidential.

Household Size ↓	Yearly Income Amount—*Circle the box that represents your household income.*			
Family Size	Below	Between	Between	Above
1 →	$12,490	$12,491 - $18,735	$18,736 - $24,980	$24,981+
2 →	$16,910	$16,911 - $25,365	$25,366 - $33,820	$33,821+
3 →	$21,330	$21,331 - $31,995	$31,996 - $42,660	$42,661+
4 →	$25,750	$25,751 - $38,625	$38,626 - $51,500	$51,501+
5 →	$30,170	$30,171 - $45,255	$45,256 - $60,340	$60,341+
6 →	$34,590	$34,591 - $51,885	$51,886 - $69,180	$69,181+
7 →	$39,010	$39,011 - $58,515	$58,516 - $78,020	$78,021+
8 →	$43,430	$43,431 - $65,145	$65,146 - $86,860	$86,861+

Is anyone in your household on our sliding fee scale? ☐ Yes ☐ No

If YES, who? _____

Grace Health offers a Sliding Fee Discount to un-insured and under-insured students and staff. If you think you might qualify please let your school nurse know so she can have an outreach worker contact you.

Name_____ DOB_____ Grade_____ CLAY COUNTY

Please complete the following insurance information for your student. This information is required for the student's health record to be complete but will ONLY be billed if services are provided by the Nurse Practitioner.

****School nurse visits are not billed to insurance****

Medical Card/Managed Care Organization (MCOs)
Insurance Company: _____ Policy Number: _____

Health Insurance- Please Fully Complete and Please attach copy of insurance card
Insurance Company: _____ Policy Number: _____
Group Number: _____
Send Medical Claims to Address on Card: _____
Name on Insurance Card: _____

Policy Holder Information:
Name of Primary Insured (policy holder): _____
Relationship to Patient: _____
Social Security Number of Primary Insured (policy holder): _____
Gender: _____ Policy Holder's Date of Birth: _____
Mailing Address: _____

Grace Health School Based Health

Assignment of Benefits / Consent for Treatment

I consent to the customary tests (for example blood glucose testing), procedures that may be deemed necessary for treatment of my child's condition by Nurses and Family Nurse Practitioners members of the Medical Staff and Employees of Grace Health. Consent is hereby given for such visits to the school nurse, examination, treatment, and procedures.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment.

I authorize payment of medical benefits to the supplier for services provided by Grace Health.

I understand that I may be billed separately for services provided by clinic providers for treatment related services. I hereby authorize payment directly to the professional providing these services which would otherwise be payable to me. ***Visits to the school nurse are not billed.**

Authorize for Release of Medical Information for Billing Purpose Only

I hereby authorize the release of medical information as necessary for settlement of this claim. Unless otherwise indicated, this authorization extends to such psychiatric, alcohol or drug abuse, and HIV related diagnosis information, if any, as may be contained in the clinic records. I understand that I have the authority to release the above reference medical records. Further, I release Grace Health and any related corporations or affiliates from any liability resulting from the release of these medical records and agree to indemnify and hold them harmless from any such liability. This constitutes permission to release medical information regarding sexually transmitted disease, if applicable, to Third Party Payor pursuant to KRS 214.420.

Name _____ DOB _____ Grade _____ CLAY COUNTY

I have read the above and underst [illegible] applies to me. I verify I have received a Notice of Privacy Practices (45 CFR 164.520 (2) (ii

Date _____ Signature of Parent/Legal Guardian _____

Best Number (to reach you) _____ Em [illegible] Portal, for child's health record) _____

Date _____ Sig [illegible]

If parent/legal guardian signs with (X) or authorized person gives verbal consent, two signatures with names, addresses, and telephone numbers must be entered below.

Date	Phone Number	Witness Name	Address
Date	Phone Number	Witness Name	Address

CONSENT FOR WELL-CHILD EXAMS

As part of overall health care for children, the school requires Kindergarten and 6th Grade Well Child Exams and it is recommended that all children have a Well Child Exam on a yearly basis. The Nurse Practitioner can complete the exam if you want to get your child's check-up through the school clinic. **All you need to do is sign below giving permission if you would like us to complete your child's Well Child Exam or School Grade Entry Exam.**

If your child has already had a well-child exam or the required school check-up at their primary care physician's office, please forward a copy of it to the school as soon as possible. Well Child exams are billable and will be billed to your insurance/medical card. Although, for private insurance NO COPAY will be billed to you because the children's well-child exams are covered 100% by insurance. So it will be **NO COST** to you.

All of the exam can be completed at the school clinic including any required immunizations (shots) if they are available at the time of the exam. **If the required immunizations are not available at the time of exam,** the school nurse will help you schedule an appointment with your child's physician or the health department.

☑ Yes, I would like for Grace Health to complete my child's exam at school.

☐ My child has already had their required school exam or the well-child exam.

☐ I give my permission for Grace Health to [illegible] the well-child exam from _____
(Location of Exam)

Parent/Guardian Signature: _____

Best Phone Number to reach you: _____

Name_ DOB 7-30-01 Grade_ CLAY COUNTY

Grace Health/Kentucky TeleHealth Network

TELEMEDICINE INFORMED CONSENT FORM

PATIENT INFORMATION

Patient Name:	DOB:
Site Where Patient is Seen via Telehealth: Clay County Schools	
Consulting Provider Name Seeing Patient via Telehealth:	Provider Location:

INTRODUCTION

Your child is 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:

Your child will be introduced to the provider and anyone else who is in the room with the provider. Your child may ask questions of the provider or any telemedicine staff in the room with you, if they are unsure of what is happening. If your child is not comfortable with seeing a provider on videoconference 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 child's care, but that no results can be guaranteed or assured.
5. I agree that I am responsible to the _____ 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 child's care.

I hereby authorize Grace Health to use telemedicine in the course of my child's diagnosis and treatment.
(Agency or Physician Name)

Signature of Patient (or authorized person) _ Date/Time _

If authorized signer, relationship to patient _

Witness _ Date/Time 8-12-19

Kentucky Telehealth Board – Sept 2016

GraceHealth

Clay School-Based Dental Consent Form

ır Parent or Guardian,

ıse review, sign, and return this permission slip to your child's school to participate in the school-based dental gram during the 2019-2020 school year through a partnership with Clay County Board of Education and Grace ılth. These services are administered by Dr. Ben Hensley. Please check the appropriate box and return to your d's school. If yo [illegible] call Alesia Anderson at 606-526-9005 ext. 6015.

ıdent's Name: [illegible] Date of Birth: 7-30-07

Vo, I do not give [illegible] d to participate in the school-based dental program. My child is ady receiving dental care from Dr. _____ Phone Number _____.

Yes, I give permission for my child to participate in the school-based dental program and authorize payment of tal benefits to the supplier for services provided by Grace Health.

If yes, please fill out the following information, where applicable:

ool: _____ Grade: _____ Gender ☐Male ☐Female

ent's Name: _____ Phone: _____

dress: _____ City: _____ State _____ Zipcode: _____

DICAID#: _____ Social Security #: _____

e: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White

lative Hawaiian or Other Pacific Islander ☐More than 1 race Migrant? ☐Yes ☐No

you Hispanic or Latino? ☐ Yes ☐No Primary Language: _____

neless Status? ☐Yes ☐ No Religion? _____

ıtal Insurance Company: _____

icy#: _____ ID: _____

ırance Billing Address: _____

ne of Primary Insured: _____ SSN: _____

e of Birth of Primary Insured: _____

ergency Contact _____ Phone _____

DICAL HISTORY:

s your child have any allergies? ___Yes ___No If yes, please list: _____

e any Medicines? ☐Yes ☐No If yes please

_____

eding Problems? ☐Yes ☐No Heart Murmur? ☐Yes ☐No Diabetes ☐Yes ☐No Asthma? ☐Yes ☐No

umatic Heart Disease? ☐ Yes ☐No Congenital Heart Disease? ☐Yes ☐No Seizures? ☐Yes ☐No

following information helps us determine if your child is at risk for developing cavities:

oride Exposure: ____drinking water ____supplements ____toothpaste ____applied at doctor or dentist e

ary Foods or Drinks (juice, soft drinks, energy/sports drinks, medicinal syrups): ___ Primarily at ltimes ___ Frequently between meals ___ Bottle or sippy cup with anything other than water at bedtime

s child's primary caregiver, mother, or sibling have a history of cavities?

_Never ____Yes, over 24 mos ago ____ Yes, in the last 7-23 months ____Yes, within the last 6 months

s your child have a dentist where he/she receives regular dental care? ___Yes ___No

cial Health Care Needs (developmental, physical, medical or mental disabilities that prevent or limit ormance of adequate oral health care by themselves or caregivers) ___Yes ___No

your child undergone chemo/Radiation therapy? ___Yes ___No

s your child have a history of Eating Disorders? ___Yes ___No

s your child take medications that cause dry mouth? ____Yes ____No

s your child have a history of drug/alcohol abuse? ____Yes ____No

GraceHealth

Student's Name: _____ Date of Birth: _____

s there anything we should know about your child's health or oral health? If so please list below:

_____

_____

_____

Ve are a Federally Qualified Health Center and are required to obtain the following information. This nformation will be kept confidential

Household Size ↓	Yearly Income Amount—*Circle the box that represents your household income.*			
Family Size	Below	Between	Between	Above
→	$12,490	$12,491 - $18,735	$18,736 - $24,980	$24,981+
→	$16,910	$16,911 - $25,365	$25,366 - $33,820	$33,821+
→	$21,330	$21,331 - $31,995	$31,996 - $42,660	$42,661+
→	$25,750	$25,751 - $38,625	$38,626 - $51,500	$51,501+
→	$30,170	$30,171 - $45,255	$45,256 - $60,340	$60,341+
→	$34,590	$34,591 - $51,885	$51,886 - $69,180	$69,181+
→	$39,010	$39,011 - $58,515	$58,516 - $78,020	$78,021+
→	$43,430	$43,431 - $65,145	$65,146 - $86,860	$86,861+

Student's Name: _____ Date of Birth: _____

TREATMENT CONSENT, TRANSPORTATION, & RELEASE OF RECORDS CONSENT

By signing this form and returning it to your child's teacher, you authorize school personnel to release your child's nformation to the participating dentist(s) in order to bill the child's medical card or private insurance.

authorize the release of any medical or other information necessary to process this claim. I also request payment accepts assignment. I authorize payment of dental benefits to Grace received Grace Health's Privacy Practices.

_____

Signature of Parent/Guardian Print Name Date