Southeast Schools- AultmanNow School Telemedicine Program **2018-2019**
Parent/Guardian Medical History/Consent Form

Student Information	Parent/Guardian Information
Date: _____ **Last Name:** _____ **First Name:** _____ **Address:** _____ _____ **City**: _____ **State:** _____ **Zip Code:** _____ **Date of Birth:** _____/_____/_____ **Sex**: _____**Male** _____ **Female** **Social Security Number**: _____ **Race/Ethnicity:** ___ **Hispanic** ___**Black** ____ **White** ___**American Indian** ____**Asian/Pacific Islander** ___**Other:** _____ **Preferred language:** _____ **Name of School:** _____ **Grade:** _____ ****Telemedicine Online Visit requires 3 Forms Completed:** _____ **Telemedicine Consent** _____ **HIPPA** _____ **FERPA**	**Mother:** **Last Name:** _____ **First Name:** _____ **Cell Phone Contact Number:** _____ **Email Address:** _____ **Father:** **Last Name:** _____ **First Name:** _____ **Cell Phone Contact Number:** _____ **Email Address:** _____ **Legal Guardian, If Applicable:** Relationship to student: ___Grandparent __Aunt/Uncle Other: _____ **Additional Emergency Contact Name & Number:** **Name:** _____ **#:** _____ **Relationship to student:** _____ **Home #:** _____ **Work#:** _____ **Cell #:** _____ **Other:** _____ ****Parent/Guardian will need mobile phone & Email address to participate with Telemedicine Online Visit**
Student Health Information	
Do you have a pediatrician or Family Doctor? ___Yes **Doctor Name**:_____ **Doctor Phone Number**: _____ **No Doctor** ____ **Dentist:** _____ **Hospital Preference:** _____ **Allergies**: _____ **Medication Allergies:**_____ **Food Allergies:**_____ **Do you take any medications?** Yes ____ No _____ **List of Meds**: _____ _____ _____ _____ **Which Pharmacy- Do You Use?** _____	**Does your child have medical issues? Yes or No** **Heart?** Y ___ N ____ **List** _____ **Breathing?** Y ___ N ___ **Asthma**? Y ____ N ___ **Brain/seizure disorders** Yes____ No ____ **Epilepsy?** Y ____ N ____ **Diabetes** Y____ N ____ **Bleeding problems** Y ____ N ____ **Skin Problems** Y _____ N _____ **Diagnosed Attention Deficit Disorder** Y ____ N ____ **Diagnosed Hyperactivity** Y ____ N ____ **Communicable Diseases?** Y ____ N _____ **Vision Problems? Wears Glasses** Y ____ N ___ **Hearing Problems?** Y ____ N ___ **Any Surgeries? Y**___ **N**____ **Please List:**_____ _____
Telemedicine Visit Tracking:	
Date: _____ **Time:** _____ **Doctor:**	**Sent Home?** Y ____ N ____ **Paid?** Yes ____ No ____
Date: _____ **Time:** _____ **Doctor:**	**Sent Home?** Y ____ N ____ **Paid?** Yes ____ No ____
Date: _____ **Time:** _____ **Doctor:**	**Sent Home?** Y ____ N ____ **Paid?** Yes ____ No ____
Date: _____ **Time:** _____ **Doctor:**	**Sent Home?** Y ____ N ____ **Paid?** Yes ____ No ____

Fax to Dunlap Family Physicians Prior to the Telemedicine Visit. Apple creek office Fax number: 330-698-2045 Orrville Office Fax is: 330-684-2045