

<b>Bandon SD</b>	<b>Brookings SD</b>	<b>Gold Beach SD</b>	<b>Coos Bay SD</b>	<b>Coquille SD</b>
<b>Myrtle Point SD</b>	<b>North Bend SD</b>	<b>Port-Orford SD</b>	<b>Powers SD</b>	<b>Reedsport SD</b>
<b>EI/ECSE</b>				

## Written Consent *for* Telehealth / Telepractice Services

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ I understand that— \_\_\_\_\_ (School District)

The purpose of this form is to obtain consent to participate in telehealth/ telepractice services provided by *the School District* in connection with the following services from the parent/guardian of the above student.

Services that may be provided through telehealth/telepractice services:

**Occupational Therapy** - is defined as the use of interactive audio and video, in real time telecommunication technology or store-and-forward technology, to deliver health care services when the occupational therapist and patient/client are not at the same physical location. Its uses include diagnosis, consultation, treatment, prevention, transfer of health or medical data, and continuing education.

**Physical Therapy** - means a physical therapy intervention, including assessment or consultation that can be safely and effectively provided using synchronous two-way interactive video conferencing, or asynchronous video communication, in accordance with generally accepted healthcare practices and standards.

**Nursing Services** - This means that the RN may assess their client, and evaluate the assistive person's continued ability to perform the delegated procedure on the client safely, via telecommunications technology.

**Speech Services** - The application of telecommunications technology to delivery of professional services at a distance for assessment, intervention, and/or consultation.

**School Psychology**- Provide psychological counseling for individuals, groups and families, consult with educators and parents with concerns around social development, behavioral and academic difficulties. Conduct assessment for purposes of identifying special needs and coordinate intervention strategies for management of individuals.

I understand that telehealth /telepractice includes treatment using interactive audio, video, or data communications.

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

I consent to my child participating in the online individual/group sessions and further agree that no one in my household will record these sessions.

I will respect the confidentiality of all participants in the telehealth /telepractice session.

The laws that protect the confidentiality of my medical information also apply to telehealth/telepractice. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential.

I understand that there are risks and consequences from telehealth/telepractice including, but not limited to, the possibility, despite reasonable efforts on the part of *the School District*, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. The School District will use one of the authorized telehealth/telepractice applications to provide service:

I understand that I am responsible for (1) providing the necessary computer or device, telecommunications equipment, and internet access for my telehealth/telepractice sessions whenever possible, (2) the information security on my computer or device, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth/telepractice session.

It is recommended that an adult facilitator be present in the room for assisting with technical difficulties, and/or keeping a child on task.

I have read, understand and agree to the information provided above. I give consent for my child to participate in telehealth/telepractice with the School District.

Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_