Consent to Participate in Virtual Special Education Services & Telehealth/Teletherapy

Student Name: _____ School: _____

PURPOSE: The purpose of this form is to obtain your consent to participate in Special Education Services virtually and Telehealth/Teletherapy Consultation/Treatment in connection with one or more of the following services included on your student's Individualized Education Program (IEP).

☐Occupational Therapy
☐Physical Therapy
☐Speech Therapy
☐School Nurse and Health Services
☐Special Education Instruction
☐Adapted Physical Education
☐Audiology
☐Vision/Hearing Services
☐Counseling/Social Work Services
☐Other:

1. **Nature of Telehealth/Teletherapy/Virtual Services**:
   a. Telehealth, also referred to as teletherapy, is a means of providing care that is "face to face" but not "in person." It is the practice of delivering clinical healthcare services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. It allows care that is timely, convenient and personalized to your student's needs while also allowing social distancing. While some elements of telehealth visits may not be exactly like in-person visits, the therapist or provider is able to offer insights and recommendations based on your concerns similar to when your student is at school. These interactions may be one-to-one, without others present.
   b. Special education instruction may include instructional services that are specially designed to meet the unique needs of a child with a disability. These services may be provided in a virtual format.
   c. Details of your student's medical history or educational placement may be discussed through the use of interactive video, audio and telecommunication technology. In the course of these communications, certain information about your student may be collected.
   d. Choose a location that is quiet and private without distractions. This is a therapy session, and distractions can make the appointment challenging for everyone. Removing distractions will allow your student to focus fully on learning. Using the same space for every visit allows the therapist to know what equipment and furniture is available for treatment or services.

2. **Medical Information & Records**: All existing laws regarding your access to medical information and copies of school records apply to this telehealth consultation. Additionally, dissemination of any student identifiable images or information for this telehealth interaction to any other parties or entities shall not occur without your consent. You agree video, audio and/or photo recording may be taken of your student during the procedure(s) or service(s) for treatment purposes only. Please note, not all telecommunications are recorded and stored.

3. **Confidentiality**: Reasonable and appropriate efforts have been made to eliminate any confidential risks associated with telehealth consultation, and all existing confidentiality protections under state and federal law apply to information disclosed during this telehealth consultation.

4. **Rights:** Participation in telehealth/teletherapy is strictly voluntary. You may withhold or withdraw your

consent to the telehealth consultation at any time without affecting your student's right to future related services.

5. **Emergency Protocols:** In order to protect the health and well-being of the minor student, it is strongly recommended that a parent/guardian or another approved adult be present at the location where the student is receiving teletherapy services. At the beginning of each session, some clinicians (i.e. counseling/social work services), will attempt to confirm the address where the student receiving services is currently located and a phone number for the adult present. If there is a mental health or medical emergency during a session, and the clinician is unable to reach the adult at the location where the student is receiving teletherapy services or another emergency contact, the clinician may need to contact emergency authorities.

Emergency Contacts – Please list all adults (18 or older) that you give permission to be emergency contacts for the student while receiving teletherapy services:

Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____

Address where the student will most likely be located during services: _____
Any additional addresses (relative, neighbor, etc) where the student may be located during services?
_____

6. **Risks, Consequences & Benefits:** You have been advised of all the potential risks, consequences and benefits of telehealth. The therapist has discussed with you the information provided above.

By verbalizing/giving my consent, I certify: (1) that I have read this form and/or had this form explained to me; (2) that I fully understand its contents, including all risks and benefits; (3) that I have been given ample opportunity to ask questions and that my questions have been answered to my satisfaction.

Parent/Guardian: _____ Date: _____ Time: _____AM/PM

Parent/Guardian Phone Number(s): _____

☐Parent permission obtained verbally ☐Parent permission obtained directly or via electronic signature

Clinician/Provider's Signature: _____ Date: _____ Time: _____AM/PM