Dear Parent(s)/Guardian(s):

In light of the COVID-19 pandemic and subsequent school closure, Ocean Academy would like to begin offering our school psychiatrist's services to your child on a telemedicine basis.

If your child is already an existing patient of Dr. Senese, this would replace the actual face-to-face visits with your child and you, until such time as the school reopens. This will ensure continuity of care with your child's treatment and medications.

We are currently in the process of setting up telemedicine visits via doxy.me for videoconferencing. This is a free, secure, encrypted program that is compliant with HIPAA requirements. No special software or hardware is needed. For more information, please go to doxy.me/patients and read the Frequently Asked Questions.

We will provide this service if you--as a parent/guardian-- specifically consent to it in writing. You do have the right not to accept telemedicine if you decide. Please indicate below if you accept or decline this service, sign and date, and return to us as soon as possible. If your child is 12 years old or older, they will need to sign and date as well.

If you are not currently a patient of Dr. Senese--but would be interested in scheduling an appointment with her--please contact me.

Please feel free to contact me (currently, email is best--but you can also leave a message on my voicemail and I will get back to you as soon as possible) and I will be happy to answer any questions/concerns you may have.

Stay well--we will all get through this together.
Sincerely,

Cindy Zumbo BSN, RN, CSN

Cindy Zumbo, BSN, RN, CSN--NJ
Ocean Academy School Nurse

## TELEMEDICINE PARENT/GUARDIAN PERMISSION FORM

I, __________________________, give permission for my child ____________________________

(Parent Name) (Name of Child)

to continue receiving psychiatric care from Dr. Karen Senese via telemedicine videoconferencing utilizing doxy.me.

Print Parent/guardian name ______________________________ Date____________________

Parent/guardian signature_________________________________ Date____________________

If your child is 12 years of age or older, they must print and sign below

Print Child's name ________________________________________ Date____________________

Child's signature__________________________________________ Date____________________

If you do not wish to receive this service, please indicate below, sign and date.

I, __________________________, **DO NOT** give permission for my child

(Parent Name)

____________________________ to continue receiving psychiatric care from Dr. Karen Senese

(Name of Child)

via telemedicine videoconferencing utilizing doxy.me.

Print Parent/guardian name______________________________ Date____________________

Parent/guardian signature _______________________________ Date____________________

If your child is 12 years of age or older, they must print and sign below

Print Child's name ________________________________________ Date____________________

Child's signature__________________________________________ Date____________________