Hawai'i Island Community Health Center

SCHOOL-BASED HEALTH CENTER REGISTRATION & CONSENT FORM

This document should be completed by the parent or legal guardian authorized to provide consent for healthcare services to be provided to the student listed below at the School-Based Health Center. This document will be effective upon the date signed, until the last active day of school, unless otherwise requested in writing to the School-Based Health Center.

STUDENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL

BIRTHDATE (mm/dd/yyyy) | ☐ Female ☐ Male GENDER | SCHOOL

STREET ADDRESS | CITY, STATE | ZIP CODE

MOBILE PHONE | HOME PHONE | E-MAIL ADDRESS

RACE (please check ALL that apply):

- ☐ Native Hawaiian
- ☐ American Indian/Alaska Native
- ☐ Asian (please circle - Asian Indian, Chinese, Filipino, Japanese, Korean, Laotian, Vietnamese, Other)
- ☐ Black/African American
- ☐ Hispanic/Latino (please circle - Mexican, Puerto Rican, Other)
- ☐ Other Pacific Islander (please circle - Chamorra, Guamanian, Kosraen, Marshallese, Micronesian, Samoan, Tongan, Other)
- ☐ White/Caucasian (Including Portuguese)

ETHNICITY (please check ONE):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

STUDENT HEALTH HISTORY

LIST ALLERGIES TO FOOD OR MEDICATION:

LIST DISABILITIES:

LIST ALL MEDICATIONS (INCLUDING DOSAGE AND FREQUENCY):

LIST ALL SUPPLEMENTS TAKEN (INCLUDING DOSAGE AND FREQUENCY):

CHECK ANY OF THE FOLLOWING THAT APPLY TO THE STUDENT'S HEALTH HISTORY:

- ☐ ADHD/ADD
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Chronic Sinusitis
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Eating Disorder
- ☐ Esophageal Reflux
- ☐ Heart Disease
- ☐ Heart Murmer
- ☐ Hearing/Vision Problems
- ☐ Growth Problems
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV (+) / AIDS
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Pregnancy
- ☐ Seasonal Allergies
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ Sexually Transmitted Disease (STD's)
- ☐ Stomach Problems
- ☐ Weight Problems
- ☐ Other:
- ☐ Other:

PEDIATRICIAN / PRIMARY CARE DOCTOR / CLINIC | PHONE NUMBER

PREFERRED PHARMACY | PHONE NUMBER

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PARENT OR LEGAL GUARDIAN INFORMATION

MOTHER'S INFORMATION

LAST NAME _____ FIRST NAME _____ BIRTHDATE _____ *Lives with you?* ☐ YES ☐ NO

MOBILE PHONE _____ HOME PHONE _____ E-MAIL ADDRESS _____

FATHER'S INFORMATION

LAST NAME _____ FIRST NAME _____ BIRTHDATE _____ *Lives with you?* ☐ YES ☐ NO

MOBILE PHONE _____ HOME PHONE _____ E-MAIL ADDRESS _____

LEGAL GUARDIAN INFORMATION

LAST NAME _____ FIRST NAME _____ BIRTHDATE _____ *Lives with you?* ☐ YES ☐ NO

MOBILE PHONE _____ HOME PHONE _____ E-MAIL ADDRESS _____

ALTERNATE EMERGENCY CONTACT (IF PARENT/GUARDIAN IS UNAVAILABLE)

LAST NAME _____ FIRST NAME _____ BIRTHDATE _____ *Lives with you?* ☐ YES ☐ NO

MOBILE PHONE _____ HOME PHONE _____ E-MAIL ADDRESS _____

MEDICAL INSURANCE / GUARANTOR INFORMATION

HEALTH INSURANCE COMPANY _____ POLICY NUMBER _____ GROUP NUMBER _____

SUBSCRIBER NAME (LAST, FIRST, MI) _____ BIRTHDATE _____ EMPLOYER _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

MOBILE PHONE _____ HOME PHONE _____ E-MAIL ADDRESS _____

SECONDARY MEDICAL INSURANCE / GUARANTOR INFORMATION

HEALTH INSURANCE COMPANY _____ POLICY NUMBER _____ GROUP NUMBER _____

SUBSCRIBER NAME (LAST, FIRST, MI) _____ BIRTHDATE _____ EMPLOYER _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

MOBILE PHONE _____ HOME PHONE _____ E-MAIL ADDRESS _____

FINANCIAL INFORMATION (To be completed only if student does NOT have medical insurance)

NUMBER OF PEOPLE IN HOUSEHOLD _____ GROSS MONTHLY FAMILY INCOME _____ SOURCE _____

Are you homeless? ☐ YES ☐ NO

If you are homeless, please check one: ☐ Transitional Housing ☐ Shelter ☐ Doubling Up ☐ Street

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PARENT / LEGAL GUARDIAN CONSENT FOR STUDENT

I, the parent/legal guardian of said student, give consent for the student to receive services at the Hawai'i Island Community Health Center (HICHC) School-Based Health Center (SBHC) indicated on page 1 of the consent form, including medical (e.g. vaccinations, physical exams, acute illness such as fever, evaluation of injuries, and referrals), dental (e.g. screenings, evaluations, and referrals), and behavioral health services (e.g. screenings, diagnoses, therapy, and referrals.)

I understand this includes consent for telehealth visits which may encompass medical, behavioral health or dental treatment and procedures, laboratory testing, diagnosis, and prescribed medication information in accordance with the judgment of HICHC providers.

I understand that youth 14 years and older may consent to their own outpatient behavioral health services and other services as allowable by law. HICHC will encourage every student to involve his/her parents/legal guardian-representative in health care decisions. I understand that I may receive more information about minor consent for services.

I understand that the student's health information is confidential, but that in certain instances, law allows or requires disclosure to others including (1) you or the student authorizes the release of information, (2) a court so orders, (3) disease control for public health, (4) the student presents a danger to themself or others, or (5) child or elder abuse/neglect is suspected.

I understand that the SBHC is operated by HICHC in cooperation with the school that is indicated on page 1 of this consent form. It is not part of, or directly operated by the school that is indicated on page 1 of this consent form.

I understand that the SBHC is operated by HICHC and certain records about the student and the student's treatment shall be kept in written and computerized form and may be reviewed by other providers at HICHC for consultation and continuity of care.

I understand that the student may be seen by a trainee/student who is identified as such and that all services provided will be supervised by a licensed provider. I have the right to refuse services by a trainee/student.

I understand that no student will be denied access to healthcare services due to inability to pay. As with any health center, there may be a charge depending on the service(s) provided. When available, insurance will be billed. I understand that SBHC may release information regarding treatment to third party payors for billing purposes. I agree to pay my portion of the student's costs, if any, associated with services rendered. Billing information will be sent via U.S. Mail, as payments will not be accepted at the SBHC site.

I am the parent/legal guardian-representative of the student. I understand that if guardianship or representation changes, a new consent must be signed by the legal guardian-representative.

I understand that by providing an alternative contact, if I cannot be reached, medical information regarding the student may be shared between the medical provider and the alternative contact.

I understand that this consent form is valid for the student's entire enrollment at the school that is indicated on page 1 of this consent form or until I provide SBHC staff with written directions otherwise.

CONSENT TO RELEASE INFORMATION

I give authorization for Hawai'i Island Community Health Center to release to the school that is indicated on page 1 of this consent form, copies and/or updates on the student's immunization and/or sports physcial exams received at SBHC.

ACKNOWLEDGEMENT OF HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

The Health Insurance Portability and Accoutability Act (HIPAA) of 1996 requires all physicians and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed, and how a patient may obtain access to their personal health information. A copy of this policy is located at the School-Based Health Center or can be obtained from HICHC's website. You must sign below, indicating that you have received notification on how to obtain a copy of our HIPAA policies prior to the student receiving services.

CONSENT TO ADMINISTER MEDICATION

I agree to my child receiving any medications(s) required for his/her care at the School-Based Health Center, unless otherwise indicated below. I understand that medications, or a generic equivalent, will only be administerd by a trained Medical Assistant or Registered Nurse according to a Doctor's or Nurse Practitioner's orders.

☐ **Please check this box if you want the provider to call you <u>before</u> administering any medications.**

PRINT NAME OF PARENT/LEGAL GUARDIAN	PARENT/LEGAL GUARDIAN SIGNATURE	DATE

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SCHOOL-BASED HEALTH CENTER REGISTRATION & CONSENT FORM

STUDENT CONSENT

I agree to receive services through the Hawai'i Island Community Health Center's (HICHC) School-Based Health Center (SBHC) at the school that is indicated on page 1 of the consent form. I understand these services include medical, dental and behavioral health services.

I understand these services may include evaluation, treatment, therapy, and referrals. I will be provided information regarding risks and benefits of treatment and of not receiving treatment, any alternative treatment options, and options for a second opinion. SBHC staff will encourage every student to involve his/her parents/legal guardian-representatives in health care decisions.

I confirm that I am at least fourteen (14) years of age and therefore eligible to obtain behavioral health services and other legally allowable services on my own from SBHC.

I understand that the SBHC is operated by HICHC in cooperation with the school that is indicated on page 1 of this consent form. It is not part of, or directly operated by the school that is indicated on page 1 of this consent form.

I understand that the SBHC is operated by HICHC and certain records about my treatment shall be kept in written and computerized form and may be reviewed by other providers at HICHC for consultation and continuity of care.

I understand that information will be treated in a confidential manner. I understand that the confidentiality between myself and the SBHC is assured. I understand that I can ask for more information about confidentiality at any time.

I understand that my healthcare information is confidential but that in certain situations the law allows or requires disclosure to others such as parents/guardians, school, law enforcement, government agencies, other medical providers, social services, and insurance companies if (1) I authorize the release of information, (2) a court so orders, (3) disease control for public health, (4) I present a danger to myself or others, or (5) abuse/neglect is suspected.

I understand that no student will be denied access to health services due to inability to pay. As with any health center, there may be a charge depending on the service(s) provided. When available, insurance will be billed. I understand that the SBHC may release information regarding treatment to third party payors for billing purposes.

I understand that I may be seen by a trainee/student who is identified as such and that all services provided will be supervised by a licensed provider. I have the right to refuse to be seen by a trainee/student.

I understand that this consent form is valid for my entire enrollment at the school that is indicated on page 1 of this consent form or until I provide SBHC staff with written directions otherwise.

PRINT NAME OF STUDENT	STUDENT SIGNATURE	DATE