Hawai'i Island Community Health Center

SCHOOL-BASED HEALTH CENTER REGISTRATION & CONSENT FORM

This document should be completed by the parent/legal guardian authorized to provide consent for health care services to be provided to the student listed below at the School-Based Health Center. This document will be effective upon the date signed and throughout the student's enrollment in the State of Hawaii Department of Education system, unless otherwise requested in writing.

Please fill in all information requested, as it helps us to better serve you.

Please be assured that patient information is confidential, and is only used for Hawai'i Island Community Health Center purposes.

First Name: _____ Middle Initial: _____ Last Name: _____

Birthdate: _____ Sex at Birth: ☐ Male ☐ Female School Currently Attending: _____

Mailing Address: _____ City: _____ State/Zip: _____

Street Address:* _____ City: _____ State/Zip: _____

Home Phone: _____ Cell Phone: _____ * *Required for prescriptions*

Please select preference for appointment reminders: Preferred Phone: ☐ Home ☐ Cell Preferred Method: ☐ Voice ☐ Email ☐ Text

Patient's Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed

Race:
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Asian
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Native American Indian/Alaskan Native
- ☐ More than one race

Ethnicity:
- ☐ Latino/Hispanic
- ☐ Not Latino/Hispanic

Would you like to have an interpreter?
☐ Yes ☐ No

Primary Language:
- ☐ English
- ☐ Spanish
- ☐ Marshallese
- ☐ Russian
- ☐ Filipino
- ☐ Chinese
- ☐ Japanese
- ☐ Sign Language
- ☐ Other

Patient's Employment Status: ☐ Employed ☐ Unemployed ☐ Part-Time Student ☐ Full-Time Student

Primary Care Physician/PCP/Pediatrician: _____ Phone Number: _____

Dentist: _____ Phone Number: _____

Preferred Pharmacy: _____ Phone Number: _____

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PATIENT INFORMATION

Farm Worker Status: ☐ Migrant ☐ Seasonal ☐ Not a Farm Worker

Public Housing: ☐ Yes ☐ No

Disabled: ☐ Yes ☐ No

Homeless: ☐ No ☐ Transitional Housing ☐ Homeless Shelter ☐ Street ☐ Other

Refugee Status: ☐ Yes ☐ No If "Yes," what is your country of origin? _____

HOUSEHOLD AND FINANCIAL INFORMATION

Please complete the information requested below. Your responses will help us receive grant funding to provide health care services for our community, and may also help you qualify to receive additional benefits, such as a Sliding Fee Scale discount, or other discounts on medication or services.

Be assured that your personal, identifiable information is never reported.

Family Size: _____

Monthly Gross Family Income: ☐ No income ☐ $100-500 ☐ $500-1,000 ☐ $1,500-2,000

☐ $2,500-3,000 ☐ $3,500-4,000 ☐ $5,500-6,000 ☐ Other (specify): _____

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): _____

Please check any of the following that apply to the Student's health history:

- ☐ ADHD/ADD
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Chronic Sinusitis
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Esophageal Reflux
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ 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)
- ☐ Stomach Problems
- ☐ Weight Problems
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

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PARENT/LEGAL GUARDIAN #1

Last Name: _____ First Name: _____ Birthdate: _____

Relationship to Student: _____ Cell Phone: _____ Home Phone: _____

Same Household as Patient? ☐ Yes ☐ No Email Address: _____ Preferred Language: _____

PARENT/LEGAL GUARDIAN #2

Last Name: _____ First Name: _____ Birthdate: _____

Relationship to Student: _____ Cell Phone: _____ Home Phone: _____

Same Household as Patient? ☐ Yes ☐ No Email Address: _____ Preferred Language: _____

ALTERNATE EMERGENCY CONTACT *(If Parent/Guardian is unavailable)*

Last Name: _____ First Name: _____ Birthdate: _____

Relationship to Student: _____ Cell Phone: _____ Home Phone: _____

Preferred Language: _____

PERSON RESPONSIBLE FOR PAYMENT/GUARANTOR

☐ Parent/Legal Guardian #1 ☐ Parent/Legal Guardian #2 ☐ Self/Patient (for Patients 18+ years old)

PRIMARY MEDICAL INSURANCE

Insurance Company: _____ Subscriber ID #: _____

Patient's Relationship to Subscriber/Member: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Subscriber/Member Name (First/Last): _____ DOB: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State/Zip: _____

SECONDARY MEDICAL INSURANCE

Insurance Company: _____ Subscriber ID #: _____

Patient's Relationship to Subscriber/Member: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Subscriber/Member Name (First/Last): _____ DOB: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State/Zip: _____

Hawai'i Island Community Health Center

SCHOOL-BASED HEALTH CENTER REGISTRATION & CONSENT FORM

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), including medical (e.g., physical exams, or care for 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 State of Hawaii Department of Education and the host school from which the SBHC is operating. It is not part of, or directly operated by the host school.

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 new 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 is valid for any SBHC operated by HICHC while the student is enrolled in a participating State of Hawaii Department of Education school, or until otherwise requested.

CONSENT TO RELEASE INFORMATION

I give authorization for HICHC to release copies of immunization records, physical exams, sports physical exams, and doctor's notes to the school in which the SBHC is operating.

ACKNOWLEDGEMENT OF HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA 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 understand that I will be contacted for my consent prior to any administration of medication or vaccine to my child, *except in the event of an emergency.* I understand and agree that my child may receive treatment or medication such as asthma inhalers, oxygen, epinephrine injection for allergic reactions, glucagon, or naloxone for opioid overdose, if deemed medicallynecessary and ordered by a licensed medical provider. I understand that medications will be administered by a licensed nurse, provider, or trained medical assistant.

Print Name of Parent/Legal Guardian	Parent/Legal Guardian Signature	Date

Hawai'i Island Community Health Center

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). 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 State of Hawaii Department of Education and the host school from which the SBHC is operating. It is not part of, or directly operated by the host school.

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 is valid for my entire enrollment in the State of Hawaii Department of Education public school system.

Print Name of Student	Student Signature	Date