Hawai'i Island Community Health Center

sbhc School Based Health Center

Aloha Parents and Guardians,

We are excited to share information about the School Based Health Center (SBHC) on your student's campus through a partnership with Hawaii Island Community Health Center (HICHC). SBHCs provide a range of services to help your child stay healthy, focused, and ready to learn.

The SBHC will offer primary care services provided by HICHC's healthcare team, including:

- well-child exams and physicals
- behavioral health therapy
- sick visits
- telehealth visits
- group counseling sessions
- vaccinations with parental consent
- preventative dental care

If your student has a primary care provider (PCP) outside of HICHC, they can stay with their PCP for all their routine care and still utilize HICHC's services for behavioral health, urgent care, or when their regular PCP is not available.

Benefits of the SBHC:

- services are provided on campus during school hours
- parents do not need to attend, but they are welcome to join, or participate via phone or telehealth
- less time away from school for students, and less time away from work for parents
- fewer unnecessary emergency room visits
- no one is turned away for lack of insurance or inability to pay
- we accept most insurance plans
- sliding fee scale discounts are available for uninsured patients

To enroll your child in SBHC services, simply complete the attached consent forms and return them in the enclosed envelope to the SBHC on your child's campus. Enrolling your child is optional but highly encouraged so that they can receive timely care during the school day. Consent forms are accepted throughout the school year.

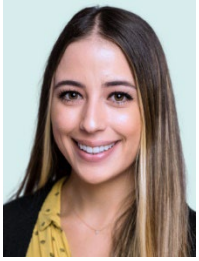
If you have any questions or concerns, please feel free to contact a member of the SBHC team directly at 808-326-7321. We look forward to working together towards a healthier school community.

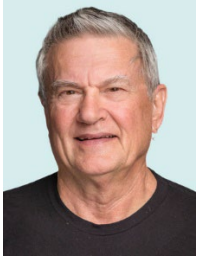
Mahalo,
Hawaii Island Community Health Center
School Based Health Center Staff & Providers


Steven Pine, DDS
Chief Dental Officer


Katherine Knezek May, Psych D, CSAC
Psychologist


Angela Lind, MD
Pediatrician


Cassandra Travers, APRN
Family Nurse Practitioner


Craig Stevenson, MD
Pediatrician


Ka'I Kiefer, APRN
Family Nurse Practitioner

Hawai'i Island Community Health Center

Today's Date: _____

SCHOOL BASED HEALTH CENTER REGISTRATION & CONSENT FORM

PATIENT INFORMATION

School Currently Attending: _____

Last Name: _____ MI: _____ First Name: _____ Birthdate: _____

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

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

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Preferred Method of Communication: ☐ Text ☐ Email ☐ Phone Call

Email Address: _____ ☐ *I do not have email*

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Not on birth certificate ☐ Choose not to disclose ☐ Unknown ☐ Uncertain

Do you need an interpreter? ☐ No ☐ Yes Preferred language: _____ Written language: _____

English fluency: ☐ Very good ☐ Good ☐ Not Good ☐ Not at all Form Confidence: ☐ Very good ☐ Good ☐ Not Good ☐ Not at all

Race (Please check **all** boxes that apply.)

☐ American Indian/Alaska Native ☐ Asian Indian ☐ Black/African American ☐ Chinese ☐ Filipino

☐ Guamanian/Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Vietnamese

☐ White ☐ Other: _____ ☐ Other Asian: _____ ☐ Other Pacific Islander ☐ Kosraen

☐ Marshallese ☐ Micronesian ☐ Samoan ☐ Tongan ☐ Unknown

Ethnicity

☐ Other Hispanic/Latino/a, or Spanish origin ☐ Cuban ☐ Puerto Rican

☐ Mexican, Mexican American, or Chicano/a ☐ Not Hispanic, Latino/a, or Spanish origin ☐ Unknown/Choose not to disclose

Homeless Status

☐ I am not homeless ☐ Doubling up/Couch surfing ☐ Street ☐ Unknown

☐ Homeless shelter ☐ Transitional housing ☐ Permanent supportive housing ☐ Other

Public Housing ☐ No ☐ Yes

Migrant/Seasonal Agricultural Worker Status (Parent/Guardian or Patient is a Migrant/Seasonal Agricultural Worker)

☐ Migratory agricultural worker in last two years ☐ Seasonal agricultural worker in last two years ☐ Neither

Are you visually impaired? ☐ No ☐ Yes Are you hard-of-hearing? ☐ No ☐ Yes

Are you an organ donor? ☐ No ☐ Yes Do you work in health care? ☐ No ☐ Yes

PARENT/LEGAL GUARDIAN 1

Name: _____ Relationship: _____

Phone: _____ ☐ Home ☐ Mobile ☐ Work Birthdate: _____

Street Address/City/State/Zip Code: _____

Preferred Language: _____ Is an interpreter needed for this contact? ☐ No ☐ Yes

May we speak to this person regarding your care? ☐ No ☐ Yes Is this person the patient's legal guardian? ☐ No ☐ Yes

Does this person live in the same household? ☐ No ☐ Yes May we notify this person in case of an emergency? ☐ No ☐ Yes

PARENT/LEGAL GUARDIAN 2

Name: _____ Relationship: _____

Phone: _____ ☐ Home ☐ Mobile ☐ Work Birthdate: _____

Street Address/City/State/Zip Code: _____

Preferred Language: _____ Is an interpreter needed for this contact? ☐ No ☐ Yes

May we speak to this person regarding your care? ☐ No ☐ Yes Is this person the patient's legal guardian? ☐ No ☐ Yes

Does this person live in the same household? ☐ No ☐ Yes May we notify this person in case of an emergency? ☐ No ☐ Yes

ALTERNATE EMERGENCY CONTACT (if Parent/Guardian are unavailable)

Name: _____ Relationship: _____

Phone: _____ ☐ Home ☐ Mobile ☐ Work Birthdate: _____

Street Address/City/State/Zip Code: _____

Preferred Language: _____ Is an interpreter needed for this contact? ☐ No ☐ Yes

May we speak to this person regarding your care? ☐ No ☐ Yes Is this person the patient's legal guardian? ☐ No ☐ Yes

Does this person live in the same household? ☐ No ☐ Yes May we notify this person in case of an emergency? ☐ No ☐ Yes

FINANCIAL INFORMATION

Your responses to the questions below help us obtain grants so we can continue providing health care, and may help you qualify for benefits, such as Sliding Fee Scale, or discounts on medication or services. If you would like to learn more, check this box: ☐ and one of our eligibility specialists will reach out to you.

Family Size: _____

Monthly Gross Family Income:

☐ No income ☐ $100–499 ☐ $500–999 ☐ $1,000–1,499

☐ $1,500–1,999 ☐ $2,000–2,499 ☐ $2,500–2,999 ☐ $3,000–3,499

☐ $3,500–3,999 ☐ $4,000–4,499 ☐ $4,500–4,999 ☐ Other (specify): _____

HEALTH CARE PROVIDER INFORMATION

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

Dentist: _____ Phone Number: _____

Preferred Pharmacy: _____ Phone Number: _____

☐ My child does not have a Primary Care Provider.

☐ My child does not have a Dentist.

MEDICAL INSURANCE/GUARANTOR INFORMATION

☐ Check here if your child does NOT have health insurance (Skip the rest of this page, and go to the next.)

Patient's relationship to Subscriber/Member: ☐ Child ☐ Other: _____

Health Insurance Company: _____ Policy #: _____ Group #: _____

Subscriber's Employer: _____ Policy #: _____ Group #: _____

Subscriber Name (Last, First, MI): _____ ☐ Male ☐ Female Date of Birth: _____

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

SECONDARY MEDICAL INSURANCE/GUARANTOR INFORMATION

Patient's relationship to Subscriber/Member: ☐ Child ☐ Other: _____

Health Insurance Company: _____ Policy #: _____ Group #: _____

Subscriber's Employer: _____ Policy #: _____ Group #: _____

Subscriber Name (Last, First, MI): _____ ☐ Male ☐ Female Date of Birth: _____

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

DENTAL INSURANCE INFORMATION

Patient's relationship to Subscriber/Member: ☐ Child ☐ Other: _____

Health Insurance Company: _____ Policy #: _____ Group #: _____

Subscriber's Employer: _____ Policy #: _____ Group #: _____

Subscriber Name (Last, First, MI): _____ ☐ Male ☐ Female Date of Birth: _____

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

STUDENT HEALTH HISTORY

List any disabilities: _____

List all medication (including dosage and frequency): _____

List all supplements taken (including dosage and frequency): _____

List past surgeries (type/date): _____

List history of hospitalization (reason/date): _____

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

- ☐ ADHD/ADD
- ☐ Anemia
- ☐ Allergies
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Bladder Problems
- ☐ Bone Disorders
- ☐ Brain Injury
- ☐ Cancer/Malignancy
- ☐ Cerebral Palsy
- ☐ Chemo/Radiation
- ☐ Cystic Fibrosis
- ☐ Chronic Sinusitis
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Esophageal Reflux (GERD)
- ☐ Ear Ache/Infections
- ☐ Headache
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hearing Problems
- ☐ Growth Problems
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV (+)/AIDS
- ☐ Immune Disorder
- ☐ Kidney Disease
- ☐ Nerve/Muscle Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Obesity
- ☐ Scoliosis
- ☐ Premature Birth
- ☐ Rheumatic Fever
- ☐ Pregnancy
- ☐ Seasonal Allergies
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ Sexually Transmitted Disease (STD)
- ☐ Stomach Problems
- ☐ Speech Disorder
- ☐ Substance Use
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ TMJ Problems
- ☐ Ulcers
- ☐ Urinary Tract Infection (UTI)
- ☐ Vision Problems
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

If your child has allergies, please check all that apply:

- ☐ Peanut/tree nuts
- ☐ Eggs
- ☐ Wheat/Gluten
- ☐ Soy
- ☐ Metals
- ☐ Milk
- ☐ Latex/Rubber
- ☐ Animal/Dander
- ☐ Dyes/Colorants
- ☐ Pollen/Dust
- ☐ Berries
- ☐ Antibiotics/Amoxicillin
- ☐ Anesthetics
- ☐ Acrylics
- ☐ Other: _____

Please check/list any other concerns you have about your child:

- ☐ Dental: _____
- ☐ Medical: _____
- ☐ Behavioral: _____

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, diagnostic testing, care for acute illness such as fever, evaluation of injuries, and referrals); dental (e.g., exams, cleanings, x-rays, photographs, sealants, fluoride, 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 request additional information about services minors can access by their own consent.

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 understand that 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 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 in writing.

CONSENT TO RELEASE INFORMATION

I give authorization for HICHC to release appointment information and copies of immunization records, sports physical exams, and medical office visit notes to the school in which the SBHC is operating. I authorize HICHC SBHC staff to communicate with school health personnel regarding my child's medical care.

Please initial: _____

CONSENT TO ADMINISTER MEDICATION

I understand that HICHC staff will attempt to contact me for my consent prior to any administration of medication to my child, *except in the event of an emergency*. I understand and agree that my child may receive emergency treatment or medication such as an asthma inhaler, oxygen, epinephrine injection for allergic reactions, glucagon, or naloxone for opioid overdose, if deemed medically necessary 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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Hawai'i Island Community Health Center (HICHC) keeps a record of health care services we provide you. You may ask to see and receive a copy of that record. You may also ask to correct that record.

HICHC will not disclose your record to others unless you direct us to do so, or unless the law authorizes or requires us to do so. You may see your record, or get more information about it by contacting us.

HICHC's Notice of Privacy Practices describes in detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Hawai'i Island Community Health Center Notice of Privacy Practices.

PATIENT ACKNOWLEDGEMENT

Signature of Patient (or Authorized Representative)	Date
Print Name of Authorized Representative	Relationship to Patient

I have read the Patient's Rights & Responsibilities: ☐ Yes ☐ No Please initial: _____

This form will be retained in your medical record.

CONSENT TO LEAVE VOICE AND SMS MESSAGES

I understand that my health care information is protected. I understand that if I would like messages to be left for me when I'm not immediately available, I need to expressly give permission to HICHC to leave detailed messages containing specifics related to my care, referrals, or appointments.

☐ I prefer ***not*** to receive voice messages related to my care.

Please note that if you opt not to receive messages, we ask that you pay close attention to calls received, and return any calls from the health center to avoid delays in your care.

☐ I give my permission for voice and SMS messages to be left for me at the following number: _____

If you'd like a digital copy of HICHC's Notice of Privacy Practices, you can access it by using this link: https://bit.ly/HICHC_Privacy or by scanning this QR code with your smartphone: →