WAIMĀNALO HEALTH CENTER

School-Based Health Center Student Registration

PATIENT INFORMATION

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Legal Sex (Please CHECK ONE)* ☐ Male ☐ Female ☐ Choose not to disclose

*Sex assigned at birth (Male and Female). Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.

Physical Address	City	State	Zip Code
Mailing Address	**City**	**State**	**Zip Code**

Please complete and indicate your preferred contact method by CHECKING ONE of the boxes below:

☐ Home Phone ☐ Cell Phone ☐ Day Phone ☐ E-Mail Address

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Do You Need An Interpreter? ☐ Yes ☐ No

Primary or Preferred Language: ☐ English ☐ Other: _____

Housing Status: ☐ **Not Homeless** ☐ **Homeless:** ☐ Doubling Up ☐ Shelter ☐ Street, Beach, Etc. ☐ Transitional ☐ Unreported

Ethnicity: ☐ Chicano ☐ Mexican American ☐ Not Hispanic/Latino ☐ Cuban ☐ Puerto Rican ☐ Not Reported ☐ Mexican ☐ Spanish (Or another Hispanic, Latino or Spanish Origin)

Farmer Status: ☐ N/A ☐ Migrant ☐ Seasonal

Active Military or Veteran: ☐ Yes ☐ No

Race (CHECK ONE below that best describes you):

☐ Native Hawaiian	☐ Fijian	☐ Chuukese	☐ Filipino	☐ Portuguese	☐ White
☐ Other Pacific Islander	☐ Marshallese	☐ I-Kiribati	☐ Chinese	☐ Puerto Rican	☐ Chamorro
☐ Samoan	☐ Micronesian	☐ Kosraean	☐ Japanese	☐ Other Asian	☐ African American/Black
☐ Tahitian	☐ Palauan	☐ Yapese	☐ Vietnamese	☐ Asian Indian	☐ Native American
☐ Tongan	☐ Pohnpeian	☐ Korean	☐ Laotian	☐ All Other (Please specify): _____	

PARENT/LEGAL GUARDIAN or GUARANTOR INFORMATION

Relationship of Guarantor to Patient (Check One): ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Please complete and indicate your preferred contact method by CHECKING ONE of the boxes below:

☐ Home Phone ☐ Cell Phone ☐ Day Phone ☐ Email Address

Employer/Occupation:	Family Size (includes self, spouse, & children under 18): _____	Family Income: $ _____ ☐ Monthly ☐ Annual

PRIMARY MEDICAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Stepchild ☐ Other: _____

Policy Holder Name	Date of Birth	☐ Male ☐ Female ☐ Unknown

Plan Name	Policy # / Subscriber #	Group #	Effective Date:	Expiration Date:

Home Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone

Student Name: _____ **DOB:** _____

EMERGENCY CONTACT INFORMATION		
Emergency Contact Name:		**Relationship:**
Work Phone	**Cell Phone**	**Email Address**

PARENT/LEGAL GUARDIAN CONSENT FOR STUDENT

I, the parent/legal guardian of said student, give consent for the student to receive all services at the Waimānalo Health Center (WHC) School-Based Health Center (SBHC), including medical (e.g., physical exams, or care for acute illness such as fever, vaccinations, physical exams, evaluation of injuries, and referrals) and behavioral health services (e.g., screenings, diagnoses, therapy, and referrals). I understand these health services will be provided to the student listed at the School-Based Health Center located at Waimānalo Elementary & Intermediate School. This document will be effective upon date signed, until the last active day of school, unless otherwise requested in writing to the School-Based Health Center.

I understand this includes consent for telehealth visits which may encompass necessary laboratory, diagnostic or medical treatment and procedures; and prescribed medication information in accordance with the judgment of WHC providers.

I understand that youth 14 years and above may consent to their own outpatient behavioral health services. WHC will encourage every student to involve his/her parents/legal guardian-representatives 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) the student presents a danger to themself or others, or (4) child or elder abuse/neglect is suspected.

I understand that the SBHC is operated by WHC 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 WHC 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 WHC as needed.

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 in 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 alternative contact. 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 the student's entire enrollment at the school indicated on this consent form or until I provide SBHC with written directions otherwise.

CONSENT TO ADMINISTER MEDICATION

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

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

CONSENT TO RELEASE INFORMATION

I give authorization for Waimānalo Health Center to release to the school indicated on this consent form, copies and/or updates of the student's immunization and/or sports physical exams s/he received at SBHC.

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

The Health Insurance Portability and Accountability 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 WHC's website, Notice of Privacy Practices. 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.

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

STUDENT HEALTH HISTORY

Student Name: _____ **DOB:** _____

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
- ☐ Epilepsy
- ☐ Eating Disorder
- ☐ Esophageal Reflux
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hearing/Vision
- ☐ Growth Problems
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV (+) / AIDS
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Pregnancy (Teens)
- ☐ Seasonal Allergies
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ Sexually Transmitted Infection (STI)
- ☐ Stomach Problems
- ☐ Weight Problems
- ☐ Other: _____
- ☐ Other: _____

Doctor/Pediatrician	Phone Number	Fax Number
Pharmacy of Choice	**Phone Number**	**Fax Number**

FOR OFFICE USE ONLY

Record # _____	**Valid ID:** ☐ Scan ID & Update NG Pt Picture	**Insurance:** ☐ Update Info & Scan Card	
Pt Status Type: ☐ SBHC Only	☐ Active ☐ Non-WHC Active	☐ Dental Patient Only	☐ Scheduled ☐ Inactive
Collected By: _____ Date: _____		Entered By: _____ Date: _____	