We've teamed up to make it easier for students to access healthcare in their school!

WAIANAE COAST COMPREHENSIVE HEALTH CENTER

Together, we are your School-Based Health Center!

JUNIOR SEARIDER HEALTH CENTER

Waianae Intermediate School (WIS) is proud to partner with Waianae Coast Comprehensive Health Center (WCCHC) to provide a School-Based Health Center (SBHC) at WIS. WCCHC gives students an opportunity to be seen by a licensed health care provider without having to miss school. **The following 4-page registration form includes a parent/legal guardian-representative consent.**

STAFF CONTACT INFORMATION AND HOURS

Our staff includes licensed health care providers to assist students and we are available to communicate with the parent/legal guardian-representative of each child. We want to know your concerns and be able to keep you updated on the student's health.

Feel free to contact us during office hours.

JUNIOR SEARIDER HEALTH CENTER CONTACT INFORMATION

85-626 Farrington Highway

1st Floor, Building A

Waianae, HI 96792

PH. (808) 697-3523

Fax (808) 697-3545

HOURS OF OPERATION

SUMMER 2018	2018 – 2019 SCHOOL YEAR
OPEN FROM 8 AM – 1 PM: **June 12 – 22, July 2 – 13 and July 23 – August 3** CLOSED: Weekends, June 25 – 29, July 4 and July 16 – 20	**August 6, 2018 – May 31, 2019 *** **Monday – Thursday | 7:45 AM – 2:45 PM** **Friday | 7:45 AM – 1:45 PM** *** NOTE: Clinic hours subject to school calendar.**

Making it easy for students to receive health care right in their own school!

- We accept most health insurance plans
- Convenient one-stop medical care at your school
- Walk-ins are welcome
- Keeps students in school
- Eliminates parents' time away from work
- Flexible appointments are available
- Full-time board-licensed medical staff

Waianae Coast Comprehensive Health Center & Waianae Intermediate School

JUNIOR SEARIDER HEALTH CENTER
School-Based Health Center
REGISTRATION and CONSENT FORM

STUDENT

Last Name	First Name	Middle Initial
	☐Male ☐Female	
Date of Birth (mm/dd/yyyy)	Gender	
Address (Street)	City, State	Zip Code
Mobile Phone	Home Phone	Email

RACE (please check ONE):

- ☐ Native Hawaiian (Hawaiian/Part Hawaiian)
- ☐ American Indian/Alaska Native
- ☐ Asian (Japanese, Chinese, Vietnamese, Laotian, Filipino, etc.)
- ☐ Black/African American
- ☐ Hispanic/Latino (Puerto Rican, Mexican, Guatemalan, etc.)
- ☐ Other Pacific Islander (Tongan, Samoan, Micronesian, etc.)
- ☐ White/Caucasian (Including Portuguese)

CITIZENSHIP (please check ONE):

- ☐ U.S. Citizen by Birth
- ☐ Naturalized Citizen
- ☐ Immigrant
- ☐ Permanent/Alien

ETHNICITY (please check ONE):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

STUDENT HEALTH HISTORY

Allergies to food or medications

Disabilities

CURRENT MEDICATIONS:

Medication/Supplement	Dosage	Medication/Supplement	Dosage

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

☐ ADHD	☐ Depression	☐ Heart Murmur	☐ Kidney Disease	☐ Sickle Cell Disease
☐ Anemia	☐ Diabetes	☐ Hearing/Vision	☐ Latex Allergy	☐ Sexually Transmitted Diseases (STDs)
☐ Asthma	☐ Epilepsy	☐ Growth Problems	☐ Liver Disease	
☐ Bleeding Disorder	☐ Eating Disorders	☐ Hepatitis	☐ Pregnancy (Teens)	☐ Stomach Problems
☐ Cancer	☐ Esophageal Reflux	☐ High Cholesterol	☐ Seasonal Allergy	☐ Weight Problems
☐ Chronic Sinusitis	☐ Heart Disease	☐ HIV + /AIDS	☐ Seizure Disorder	☐ Other _____

Doctor/Pediatrician — Phone Number

Pharmacy of Choice — Phone Number

ALTERNATE CONTACT INFORMATION ***(if parent/legal guardian-representative is unavailable)*****:**

Print Name	Work/Home Phone	Mobile Phone	Email

PARENT OR LEGAL GUARDIAN-REPRESENTATIVE

☐ Yes ☐ No

Father's Name: Last Name First Name Middle Initial Lives with you

Father's Contact Information:

Home Phone Work Phone Mobile Phone Email

☐ Yes ☐ No

Mother's Name: Last Name First Name Middle Initial Lives with you

Mother's Contact Information:

Home Phone Work Phone Mobile Phone Email

Legal Guardian-Representative's Name: ☐ Yes ☐ No

Last Name First Name Middle Initial Lives with you

Legal Guardian-Representative's Contact Information:

Home Phone Work Phone Mobile Phone Email

STUDENT MEDICAL INSURANCE (Please complete the information below)

Name of Health Insurance Plan Policy Number Group Number

Guarantor: Last Name First Name Middle Initial

Address City State Zip Code

Guarantor Date of Birth Guarantor Employer

Guarantor's Contact Information:

Home Phone Work Phone Mobile Phone Email

FINANCIAL INFORMATION (<u>Complete this section only if you do not have medical insurance</u>)

Number of People in Household: _____ Gross Monthly Family Income: $_____

Are you homeless? ☐ Yes ☐ No If yes, please check one: ☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street

PARENT/LEGAL GUARDIAN-REPRESENTATIVE CONSENT FOR STUDENT TO RECEIVE SERVICES AT THE SCHOOL-BASED HEALTH CENTER

I, the parent/legal guardian-representative of said student, **give consent for the student to receive all services at Waianae Intermediate School's School-Based Health Center** including medical (e.g. vaccinations, physical exams, evaluation of injuries, and referrals) and behavioral health services (e.g. screenings, diagnoses, therapy, and referrals).

I understand that youth 14 and above may consent to their own outpatient behavioral health services. SBHC staff 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 services. I understand that the student's healthcare information is confidential, but that in certain instances, law allows or requires use and disclosure to others including if (1) you or the student authorizes the release of information, (2) a court so orders, (3) the student presents a danger to the student or others, or (4) child or elder abuse/neglect is suspected.

I understand that SBHC is operated by WCCHC in cooperation with Waianae Intermediate School. It is not part of, or directly operated by Waianae Intermediate School. I understand that SBHC is operated by WCCHC 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 WCCHC 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 health services due to inability to pay. As in any health center, there may be a charge depending on the service provided. When available, insurance will be billed. I understand that SBHC may release information regarding treatment to third party payers for billings purposes. I agree to pay my portion of the student's costs, if any, associated with services received.

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 also 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 Waianae Intermediate School or until I provide SBHC staff with written directions otherwise.

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

CONSENT TO ADMINISTER MEDICATION

I agree to the student receiving any medication(s) required for his/her care at the School-Based Health Center. I understand that medications, or a generic equivalent, will only be administered by a Medical Assistant or Registered Nurse per a Doctor's or Nurse Practitioner's order. The student may receive all medications offered at the School-Based Health Center, except for the following:

_____

Preferred Pharmacy (Name & Location):

_____

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

CONSENT TO RELEASE INFORMATION

By signing below, I give authorization for Waianae Coast Comprehensive Health Center to release to Waianae Intermediate School copies and/or updates of the student's immunization and/or Sports Physical Exam s/he received at SBHC.

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

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 our sponsoring center's website, http://www.wcchc.com/Home/Privacy. 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-Representative	Signature of Parent/Legal Guardian-Representative	Date
Print Name of Student	Signature of Student	Date

STUDENT CONSENT REGARDING SERVICES AT THE SCHOOL-BASED HEALTH CLINIC

I agree to receive services through the Waianae Coast Comprehensive Health Center's (WCCHC) School-Based Health Center (SBHC) at Waianae Intermediate School. I understand these services include evaluation, therapy, and referrals. I understand the presence of risks and benefits to treatment and not receiving treatment, alternative treatment options, and options for a second opinion. I understand that I may ask the SBHC for more information about my options. The 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 am therefore eligible to obtain behavioral health services on my own from the SBHC.

I understand that the SBHC is operated by WCCHC in cooperation with Waianae Intermediate School. It is not part of, or directly operated by, Waianae Intermediate School. I understand that the SBHC is operated by WCCHC and certain records about my treatment shall be kept in written and computerized form and may be reviewed by other providers at WCCHC as needed.

I understand that my healthcare information is confidential but that in certain instances 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) I present a danger to myself or others, or (4) abuse/neglect is suspected. I understand that information will continue to be treated in a confidential manner. I understand that confidentiality between myself and the SBHC is assured. I understand that I can ask for more information about confidentiality.

I understand that no student will be denied access to health services due to inability to pay. As in any health center, there may be a charge depending on the service provided. When available, insurance will be billed. I understand that the SBHC may release information regarding treatment to third party payers for billings 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 Waianae Intermediate School or until I provide the SBHC staff with written directions otherwise.

Print Name of Student Consenting to Services	Signature of Student Consenting to Services	Date

Return completed registration form (4 pages) to

Junior Searider Health Center

Wai'anae Intermediate School

Teacher's Workroom, Building A