

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



**WAIANAЕ COAST
COMPREHENSIVE
HEALTH CENTER**



Hale Ola Kino Maika'i

Together, we are your School-Based Health Center!

Hale Ola Kino Maika'i

Waianae High School (WHS) is proud to partner with Waianae Coast Comprehensive Health Center (WCCHC) to provide a School-Based Health Center (SBHC) at WHS. 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 your child's health.

Feel free to contact us during office hours.

HALE OLA KINO MAIKA'I CONTACT INFORMATION

85-251 Farrington Highway
2nd Floor, Building B
 Waianae, HI 96792
PH. (808) 697-3520
 Fax (808) 697-3521

HOURS OF OPERATION

SUMMER 2018	2018 – 2019 SCHOOL YEAR
<p>OPEN FROM 8 AM – 1 PM: July 22 – August 3</p> <p>CLOSED: Weekends and the remainder of Summer</p>	<p>August 6, 2018 – May 31, 2019 *</p> <p>Monday, Wednesday, Friday 7:45 AM – 2:45 PM Tuesday and Thursday 7:45 AM – 1:45 PM</p> <p>* NOTE: Clinic hours subject to school calendar.</p>

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 High School

**Hale Ola Kino Maika'i
SCHOOL-BASED HEALTH CENTER
REGISTRATION and CONSENT FORM**

STUDENT

Last Name	First Name <input type="checkbox"/> Male <input type="checkbox"/> Female	Middle Initial
Date of Birth (mm/dd/yyyy)	Gender	
Address (Street)	City, State	Zip Code

Mobile Phone	Home Phone	Email
RACE (please check ONE): <input type="checkbox"/> Native Hawaiian (Hawaiian/Part Hawaiian) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian (Japanese, Chinese, Vietnamese, Laotian, Filipino, etc.) <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino (Puerto Rican, Mexican, Guatemalan, etc.) <input type="checkbox"/> Other Pacific Islander (Tongan, Samoan, Micronesian, etc.) <input type="checkbox"/> White/Caucasian (Including Portuguese)		CITIZENSHIP (please check ONE): <input type="checkbox"/> U.S. Citizen by Birth <input type="checkbox"/> Naturalized Citizen <input type="checkbox"/> Immigrant <input type="checkbox"/> Permanent/Alien ETHNICITY (please check ONE): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino

STUDENT HEALTH HISTORY

Allergies to food or medications	Disabilities
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CURRENT MEDICATIONS:

Medication/Supplement	Dosage	Medication/Supplement	Dosage

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

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

Doctor/Pediatrician	Phone Number
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Pharmacy of Choice	Phone Number
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ALTERNATE CONTACT INFORMATION (if parent/legal guardian-representative is unavailable):

Print Name	Work/Home Phone	Mobile Phone	Email
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PARENT OR LEGAL GUARDIAN-REPRESENTATIVE

Father's Name: _____ Yes No
Last Name First Name Middle Initial Lives with you

Father's Contact Information:

Home Phone Work Phone Mobile Phone Email

Mother's Name: _____ Yes No
Last Name First Name Middle Initial Lives with you

Mother's Contact Information:

Home Phone Work Phone Mobile Phone Email

Legal Guardian-Representative's _____ Yes No
Name: 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 (Complete this section only if you do not have medical insurance)

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 High 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 High School. It is not part of, or directly operated by Waianae High 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 High 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 my child 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. My child 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 High School copies and/or updates of my child's immunization and/or Sports Physical Exam s/he received at the 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 High 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 High School. It is not part of, or directly operated by, Waianae High 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 High 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

Hale Ola Kino Maika'i

WHS School-Based Health Center

2nd Floor, Teacher's Lounge, Building B