REGISTRATION & CONSENT FORM
SCHOOL-BASED HEALTH CENTER

This document is be completed by the parent or legal guardian for consent of healthcare services to be provided to the student listed at the School-based Health Center. 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.

STUDENT INFORMATION

LAST NAME **FIRST NAME** **MIDDLE INITIAL** **BIRTHDATE** mm/dd/yyyy

☐ Male ☐ Female

GENDER **SCHOOL ATTENDING / SCHOOL-BASED HEALTH CENTER LOCATION**

ADDRESS (STREET) **CITY** **STATE** **ZIP CODE**

MOBILE PHONE **HOME PHONE** **E-MAIL**

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**

MEDICATION/SUPPLEMENT **DOSAGE** **MEDICATION/SUPPLEMENT** **DOSAGE**

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 or legal guardian is unavailable)*

FIRST & LAST NAME **MOBILE/HOME PHONE** **WORK PHONE** **E-MAIL**

REGISTRATION & CONSENT FORM
SCHOOL-BASED HEALTH CENTER

PARENT OR LEGAL GUARDIAN INFORMATION

MOTHER'S INFORMATION

☐ Yes ☐ No

LAST NAME | FIRST NAME | BIRTHDATE | LIVES WITH YOU

MOBILE/HOME PHONE | WORK PHONE | E-MAIL

FATHER'S INFORMATION

☐ Yes ☐ No

LAST NAME | FIRST NAME | BIRTHDATE | LIVES WITH YOU

MOBILE/HOME PHONE | WORK PHONE | E-MAIL

LEGAL GUARDIAN INFORMATION

☐ Yes ☐ No

LAST NAME | FIRST NAME | BIRTHDATE | LIVES WITH YOU

MOBILE/HOME PHONE | WORK PHONE | E-MAIL

MEDICAL INSURANCE / GUARANTOR INFORMATION

HEALTH INSURANCE PLAN | POLICY NUMBER | GROUP NUMBER

NAME (Last Name, First Name, Middle Initial) | BIRTHDATE | EMPLOYER

ADDRESS | CITY | STATE | ZIP CODE

MOBILE/HOME PHONE | WORK PHONE | E-MAIL

FINANCIAL INFORMATION (To be completed only if student does not have medical insurance)

☐ Yes ☐ No

NUMBER OF PEOPLE IN HOUSEHOLD | GROSS MONTHLY FAMILY INCOME | ARE YOU HOMELESS

IF YOU ARE HOMELESS, PLEASE CHECK ONE: ☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street

REGISTRATION & CONSENT FORM
SCHOOL-BASED HEALTH CENTER

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 School-Based Health Center indicated on page 1 of this consent form, including medical (e.g. 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 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 the WHC telehealth providers.

I understand that youth 14 years 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 Wahiawa Health Center in cooperation with the school that is indicated on page 1 of this consent form; it is not part of, or directly operated by the School. I understand that 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 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 billing purposes. I agree to pay my portion of the students' costs, if any, associated with the 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 the school that is indicated on page 1 of this consent form or until I provide SBHC staff 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 a 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 Wahiawa Health Center to release to the school that is indicated on page 1 of this consent form, copies and/or updates of the student's immunization and/or Sports Physical Exam s/he received at SBHC.

ACKNOWLEDGEMENT OF HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

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, https://wahiawahealth.org/wp-content/uploads/2024/12/WH-Notice-of-Privacy-Practices-rev-12.3.24.pdf. 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