



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/notice-of-privacy-practice/>. 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

**Hawaii State Department of Education
PHYSICAL EXAMINATION FOR ATHLETES**

Student's Name _____ M/F _____ Date of Birth ____/____/____ Grade _____
 (Print) Last First MI Month Day Year
 Address _____ Home Phone _____ Student Resides With _____
 Street No. City State Zip Code
 Fall Sport _____ Winter Sport _____ Spring Sport _____
 Father's/Guardian's Name _____ Bus. Phone _____ Cell or Pager _____
 Mother's/Guardian's Name _____ Bus. Phone _____ Cell or Pager _____
 Emergency Contact _____ Bus. Phone _____ Cell or Pager _____
 Name & Relationship _____
 Emergency Contact _____ Bus. Phone _____ Cell or Pager _____
 Name & Relationship _____
 Emergency Contact _____ Bus. Phone _____ Cell or Pager _____
 Name & Relationship _____
 Health and/or Insurance Carrier _____ Policy # _____

The student and parent/guardian consent and authorize school officials through an Athletic Health Care Trainer (AHCT), qualified coach/staff, or physician as determined by the school, to provide any first aid and/or emergency care as well as follow-up first aid or medical treatment that may be reasonably necessary for the student as determined by a school official in the course of athletic practice, competition or travel.

The student and parent/guardian further consent and authorize the school's AHCT to provide appropriate therapeutic modalities in order to return student to athletic competition, such care to be conducted under the direction of a physician.

The student and parent/guardian further consent and authorize the school's AHCT to administer baseline and/or post injury concussion management assessment in order to manage a concussion or suspected head trauma, such care to be conducted under the direction of a physician.

The student and parent/guardian hereby consent to the release of medical information by physician to school to obtain information regarding the medical history, records of injury or surgery, serious illness, and rehabilitation results of the student from his/her physician(s). We understand that the purpose of this request for medical information is to assist the school in the management or rehabilitation of an injury/illness. This information is confidential and except as provided in this release will not be otherwise released by the parties in charge of the information. This release remains valid until revoked by the adult student or parent/guardian in writing.

Signature of Student _____ Signature of Parent/Guardian _____ Date _____
 (parent/guardian fill out back side of this form)

To be completed by Physician only

Height _____ feet & inches Weight _____ lbs Blood Pressure ____/____ Pulse _____ bpm
 Vision: R 20/____ L 20/____ Corrected: Yes No Pupils: Equal ____ Unequal ____
 Asthma _____ (Medication Used) Diabetes _____ (Medication Used) Allergies _____ (Medication Used)

MEDICAL	NORMAL	COMMENTS	INITIALS
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart/Murmurs			
Pulses			
Lungs			
Abdomen			
Skin			
Genitalia			
MUSCULOSKELETAL			
Neck			
Back/Spine			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Calf/ankle			
Foot/toes			
Other			

Parent/Guardian and Student to fill out before Physical Examination

Explain "Yes" answers below. Circle question you don't know the answer to.

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	25. Do you cough, wheeze or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over the counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had discomfort, pain or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told you that you have: (circle all that apply) High blood pressure A heart murmur High Cholesterol A heart infection	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps, or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
14. Has a family member died while exercising?	<input type="checkbox"/>	<input type="checkbox"/>	38. Do you have any hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>
15. Does anyone in your family have Marfan Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	39. Do you have a hearing device?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you have a family member with hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	41. Has a doctor told you that you, or does someone in your family have sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had an injury, like sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, list affected area: _____	<input type="checkbox"/>	<input type="checkbox"/>	42. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you had any broken or fractured bones or dislocated joints? If yes, list affected area: _____	<input type="checkbox"/>	<input type="checkbox"/>	43. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, list affected area: _____	<input type="checkbox"/>	<input type="checkbox"/>	44. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	45. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	46. Would you like to lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	47. Would you like to gain weight?	<input type="checkbox"/>	<input type="checkbox"/>
24. Has a doctor ever told you that you have asthma or wheezing?	<input type="checkbox"/>	<input type="checkbox"/>	48. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
EXPLAIN "YES" answers here: (Add additional pages if necessary)			49. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
			50. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
			51. Do you feel depressed?	<input type="checkbox"/>	<input type="checkbox"/>
			52. Do you have a history of multiple or long nosebleeds?	<input type="checkbox"/>	<input type="checkbox"/>
			53. MALES ONLY: Do you ever have or had swelling of your testicles or groin?	<input type="checkbox"/>	<input type="checkbox"/>
			FEMALES ONLY		
			54. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
			55. How many periods have you had in the last 12 months?	_____	

I hereby verify to the best of my knowledge that the answers which have been provided to the above questions are correct.

Signature of Student _____ Signature of Parent/Guardian _____ Date _____

Clearance: (Place a check in appropriate box below)

- Cleared for all sports
- Cleared after completing evaluation/rehabilitation for _____
- Not cleared for:
 - Collision (Football)
 - Contact (Baseball, Basketball, Cheerleading, Judo, Softball, Soccer, Volleyball, Wrestling)
 - Non contact Strenuous Moderately Strenuous Non-strenuous

Reason not cleared: _____

Physician's Recommendation _____

Name of Physician _____ **Date of Physical Exam** _____

Address _____ **Telephone** _____

Signature of Physician _____ **Fax Number** _____