WAIMĀNALO
HEALTH CENTER

Member status	Active
☐ New ☐ Renewing	☐ Active ☐ Inactive

Data entry

Rec'd:

Entered:

Student Application

Waimānalo Health Center's

Kū I Ka Māna Mentoring Program

SY 2018 (Spring Program)

(Child 1) First Name: **Middle Name:** **Last Name:**

Home Address: **City:** **Zip Code:**

Gender: o Female o Male **Birthdate:** **Age:** **Grade:** **Phone #**

School Name:

(Child 2) First Name: **Middle Name:** **Last Name:**

Home Address: **City:** **Zip Code:**

Gender: o Female o Male **Birthdate:** **Age:** **Grade:** **Phone #**

School Name:

Lives with (Please Circle):

Both Parents Mother Father Sibling Grandparents
Aunt/Uncle Guardian Other

Family Size:

Ethnicity (Circle all that apply):

African American Filipino Japanese Chinese Caucasian Micronesian

Pacific Islander Portuguese Hawaiian/Part Hawaiian Tongan Samoan

Hispanic Native American Other (please specify):_____

Parent/Guardian Information: (please print)

Head of Household First Name: **Last Name:** **Work Phone & Mobile:**

Employer: **Occupation:** **Email Address:**

Other Parent/Guardian First Name: **Last Name:** **Work Phone & Mobile:**

Employer: **Occupation:** **Email Address:**

Emergency Contact First & Last Name: **Relationship to Student:** **Contact Phone #:**

Emergency Contact First & Last Name: **Relationship to Student:** **Contact Phone #:**

(Child 1) Medical Problems/Allergies:

Medications:

(Child 2) Medical Problems/Allergies:

Medications:

Physician:

Physician Phone #:

Preferred Hospital or Clinic:

Hospital Phone #:

Insurance Company:

Insurance Policy #:

Parent or Guardian Signature: **Child's Signature** **Date:**