

## PARENT/LEGAL GUARDIAN CONSENT FOR STUDENT

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I, the parent/legal guardian of said student, give consent for the student to receive all services at the Waimānalo Health Center (WHC) School-Based Health Center (SBHC), including medical (e.g., physical exams, or care for 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 these health services will be provided to the student listed at the School-Based Health Center located at Waimānalo Elementary & Intermediate School. 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.

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 WHC providers.

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

I understand that the SBHC is operated by WHC in cooperation with the State of Hawaii Department of Education and the host school from which the SBHC is operating. It is not part of, or directly operated by the host school. I understand that the 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 healthcare services due to inability to pay. As in any health center, there may be a charge depending on the service(s) provided. When available, insurance will be billed. I understand that SBHC may release information regarding treatment to third party payors for billing purposes. I agree to pay my portion of the student's costs, if any, associated with services rendered. Billing information will be sent via U.S. Mail, as payments will not be accepted at the SBHC site.

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 new legal guardian-representative. I 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 alternative contact. I 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 is valid for the student's entire enrollment at the school indicated on this consent form or until I provide SBHC with written directions otherwise.

### CONSENT TO ADMINISTER MEDICATION

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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 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

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I give authorization for Waimānalo Health Center to release to the school indicated on this consent form, copies and/or updates of the student's immunization and/or sports physical exams s/he received at SBHC.

### ACKNOWLEDGEMENT OF HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

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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 WHC's website, [Notice of Privacy Practices](#). 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.

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Print Name of Parent/Legal

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Guardian Parent/Legal Guardian Signature

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Date



**STUDENT HEALTH HISTORY**

**Student Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

List Allergies to Food or Medication:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Disabilities:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List All Medications (including dosage and frequency):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List All Supplements Taken (including dosage and frequency):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check any of the following that apply to the student's health history:

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

\_\_\_\_\_  
Doctor/Pediatrician

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Pharmacy of Choice

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

**FOR OFFICE USE ONLY**

<b>Record #</b> _____	<b>Valid ID:</b> <input type="checkbox"/> Scan ID & Update NG Pt Picture	<b>Insurance:</b> <input type="checkbox"/> Update Info & Scan Card
<b>Pt Status Type:</b> <input type="checkbox"/> SBHC Only	<input type="checkbox"/> Active	<input type="checkbox"/> Non-WHC Active
<input type="checkbox"/> Dental Patient Only	<input type="checkbox"/> Scheduled	<input type="checkbox"/> Inactive
Collected By: _____	Date: _____	Entered By: _____
		Date: _____