Student Information/Health Authorization Form

Return form by June 30, 2010 to: HPA Enrollment, 65-1692 Kohala Mountain Road, Kamuela, Hawai'i 96743 -or- Fax: 808-881-4045

INSTRUCTIONS

This form must be completed by a parent/guardian each school year.

STUDENT INFORMATION

Name:______________________________ Sex: ☐ Male ☐ Female

Grade:________ Date of Birth: ______________ School attended last year: ______________________

Student's Cell Phone:____________________ Student's E-mail: ______________________

PARENT / GUARDIAN INFORMATION

Parent 1:______________________________ Relationship to Student: ______________

Address:______________________________ City: ______________________

State:____________________ Zip: ______________ Country: ______________

Phone 1: ______________ Phone 2:______________ Phone 3: ______________

Fax: ____________________ E-mail: ______________________________

Parent 2:______________________________ Relationship to Student: ______________

Address:______________________________ City: ______________________

State:____________________ Zip: ______________ Country: ______________

Phone 1: ______________ Phone 2:______________ Phone 3: ______________

Fax: ____________________ E-mail: ______________________________

Student lives with (check all that apply): ☐ Parent 1 ☐ Parent 2 ☐ Both Parents

EMERGENCY CONTACTS

In the event the parents/guardians cannot be reached, the school will call the people listed below. People listed should be individuals who can: 1) give permission to administer health care; 2) pick up your child if your child is ill; AND 3) give advice about caring for your child.

Contact 1:______________________________ Relationship to Student: ______________

Phone 1: ______________ Phone 2:______________ Phone 3: ______________

Fax: ____________________ E-mail: ______________________________

Contact 2:______________________________ Relationship to Student: ______________

Phone 1: ______________ Phone 2:______________ Phone 3: ______________

Fax: ____________________ E-mail: ______________________________

STUDENT'S HEALTH CARE PROVIDERS

Physician's Name: ______________________________ Phone: ______________________

Address:______________________________ Fax:______________________

Dentist's Name: ______________________________ Phone: ______________________

Address:______________________________ Fax:______________________

Orthodontist's Name: ______________________________ Phone: ______________________

Address:______________________________ Fax:______________________

HEALTH INSURANCE (REQUIRED)

Health insurance is required of all students. ATTACH A COPY OF INSURANCE CARD (FRONT AND BACK). If not currently insured, a student insurance plan is available for purchase through the school (see Financial Form). ***A student who arrives at school with no health insurance will be enrolled in the HMSA Student Plan and the cost will be billed to the student's account.***

Name of Insurance Company: ______________________________ Policy Number: ______________

Name of Subscriber:______________________________ Subscriber's Date of Birth: ______________

- CONTINUED ON PAGE 2 -

FOR HPA USE: Received by: ______________ Date: ______________ Logged by: ______________ ☐ Copy to VC or US & original to HS

Student's Name:______________________________ Grade:__________

HEALTH INFORMATION (REQUIRED)

In order to provide safe and appropriate care to your child, all medications and health conditions/concerns must be noted. Attach additional paper if necessary.

Allergies: ☐ None ☐ Yes – If yes, describe: ______________________________

____

Medications: ☐ None ☐ Yes – If yes, describe: ______________________________

____

Note: If student is taking any medications, an Administration/Storage Form must be completed.

Sports or physical education concerns/restrictions: ☐ None ☐ Yes – If yes, describe: ______________________________

____

Other health concerns or instructions (include any special social/emotional/psychological support needs): ☐ None ☐ Yes – If yes, describe:

____

____

HEALTH AUTHORIZATION AND INFORMATION VERIFICATION

Read carefully, initial each statement, and sign below. ***Note: Parent and witness signatures are required.***

I hereby verify that I have read the information included on this form and that to the best of my knowledge the information provided here is complete and correct. I understand that while enrolled at Hawai'i Preparatory Academy, my child may require nursing, medical, surgical, mental health, or dental care. For each statement below, initial in the appropriate box.

Consent given	***Consent withheld***	***NOTE: Consent is presumed to be given when no initials appear.***
Initial one box: YES	NO	*1. I hereby give permission for school health personnel to administer, or arrange to have administered at a physican's office, any missing TB test and/or immunizations that are required for my child to enter school in Hawai'i. I understand that my child may be retested for TB upon return to school if my child has spent time in an area of high TB prevalence.*
Initial one box: YES	NO	*2. I hereby authorize and give my consent to the HPA staff, including health personnel, to administer to my child any first aid, nursing care, and counseling deemed necessary or appropriate in the opinion of the said person.*
Initial one box: YES	NO	*3. I hereby authorize and give consent to any licensed physician, or dentist to perform or administer to my child medical, surgical, or dental treatment deemed necessary or appropriate in the opinion of the said person. I will promptly pay for or require my insurance company to pay for any services so performed.*
Initial one box: YES	NO	*4. I understand that for purposes of providing quality health care to my child, information regarding my child's health and health care may need to be shared between health providers and school health staff. I further understand that health conditions which may affect my child's ability to participate fully in the HPA curricular and co-curricular programs may need to be shared with other HPA faculty and staff. I hereby authorize and give consent for this sharing of information as deemed appropriate by health providers and HPA health staff.*

I understand that in the event of emergency care or surgery, a reasonable attempt will be made to contact me or my named emergency contacts before relying upon this authorization. I understand that I may revoke this authorization at any time by giving written notice of my revocation to Hawai'i Preparatory Academy's Health Services Department.

Signature of Parent 1:______________________________ Date: __________

Printed Name of Parent 1:______________________________

Signature of Parent 2:______________________________ Date: __________

Printed Name of Parent 2:______________________________

Signature of Witness: ______________________________ Date: __________

Printed Name of Witness: ______________________________Phone: __________

Signature of Upper School Student:______________________________ Date: __________

IMPORTANT – Parent and witness signatures required!

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