



General 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

Dear Parents and Guardians:

It is often the occasion during the course of an academic year that school officials are called upon to act on your behalf. Infrequently, this action can involve something as serious as emergency medical treatment for your child. More frequently, such action involves relatively mundane activities such as: coordinating with an airline representative, providing information relating to officials of the athletic conference of which HPA is a member, arranging for a tutor, or booking taxi transportation.

In order to facilitate all such relationships and interactions and also to assure those who do not work at HPA but who occasionally have contact with our school and our students, we have prepared this General Authorization Form for signature by the parents or guardians of our students. This form must be completed and returned to HPA. Copies of this form will be securely filed in the school's Business Office and will be available to appropriate school personnel as and when needed. Thank you in advance for completing and returning this form.

GENERAL AUTHORIZATION

The undersigned parent(s) or guardian(s) of [print name of student]: _____

Soc. Sec. No. (if applicable): _____ Date of birth: _____ Grade: _____

a student enrolled at Hawai'i Preparatory Academy in Kamuela, Hawai'i, USA (the "Student" and "HPA"), hereby execute(s) this General Authorization Form. I/we intend for this form to be construed broadly. This authorization shall be in full force and effect so long as my/our child or ward is (a) enrolled as a student at HPA, or (b) on the premises at HPA, or (c) engaged in activities sponsored by HPA, or (d) being served by HPA personnel or making use of HPA property or program(s). Without reservation or qualification, I/we authorize the following:

- (1) for any physician, nurse, emergency medical treatment technician, other medical or related technician, rescue squad member, other care-giving employee of any medical treatment facility, and any employee of HPA to consent to the rendering of medical or emergency care to the Student; this authorization shall encompass all emotional counselors (whether medical doctors or otherwise) and all non-custodial HPA personnel (including contract coaches and athletic trainers); further, procedures contemplated by this Authorization shall include, but not be limited to, surgery and the administration of local and/or general anesthetics;
- (2) for any HPA employee and his/her spouse, to transport the Student in an HPA-owned motor vehicle or vehicle titled in the name of an HPA employee or spouse, provided that such transportation relates to HPA's curricular or extracurricular program or is otherwise offered for the Student's benefit; this authorization shall cover, but not be limited to, academic and related travel, travel pertaining to community service or recreational activities, shopping trips, athletic trips, emergency transport, and transport to and from the airport; this authorization shall also apply to third parties not employed by HPA but who may, from time to time, be used to transport students for HPA-approved activities (e.g., field trips on the Big Island);
- (3) in the sole discretion for any senior official of HPA (director of health and wellness, director of residential life (Middle School), director of student life (Upper School), K-8 principal, Upper School principal, assistant headmaster, headmaster), to approve or to decline to approve any leave request involving residence by, or supervision of, the Student with anyone other than the undersigned parent(s) or guardian(s);
- (4) in order to determine the suitability of the Student to remain enrolled as an HPA student, to consent to psychological or educational testing and/or counseling or a tutorial program for the Student; in the case of such counseling or assessment activity or tutoring, the undersigned shall be responsible for such costs, provided they are reasonably incurred; and
- (5) in the sole discretion of any senior official of HPA, to consent to the Student's participation in HPA community service and related curricular or extracurricular activities and to interact on behalf of the Student and the undersigned with County of Hawai'i or State of Hawai'i or United States governmental authorities concerning any matter relating to adherence to Hawai'i or United States civil or criminal laws, including, but not limited to, INS and TSA rules and regulations.

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Student's Name: _____ Grade: _____

In all matters relating to the above authorizations, I/we understand that those acting on behalf of the undersigned or on behalf of the Student shall be released and held harmless from any damages, real or alleged, with respect to personal injury, property damage, death, or costs incurred, provided that the person so acting has not done so recklessly or with wanton disregard of the facts or circumstances or conditions then existing.

CUSTODIAL PARENT(S) OR GUARDIAN(S):

Signature of Parent 1: _____ Date: _____

Printed Name of Parent 1: _____

Signature of Parent 2: _____ Date: _____

Printed Name of Parent 2: _____

Signature of Witness 1: _____ Date: _____

Printed Name of Witness 1: _____

Signature of Witness 2: _____ Date: _____

Printed Name of Witness 2: _____

Note: If two parents have legal custody, each must sign, and each may witness the signature of the other. If only one parent or guardian has legal custody, this person must sign and have his/her signature witnessed by a third party.

STUDENT HEALTH INSURANCE INFORMATION

Name of Insurance Company: _____ Policy Number: _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____



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: _____

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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 physician'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!



Physical Examination 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

- **New Students:** All new students are required to have a physical exam done within one year of school entry. This physical exam must be performed and the entire form completed by a U.S. licensed medical doctor (MD), doctor of osteopathy (DO), advanced practice registered nurse (APRN), or physician assistant (PA).
- **Returning Students:** Physical examinations are required of returning students entering grades 3, 6, 9, 10, 11, 12, and post graduate year. Returning students may have their physical exams completed by physicians licensed in other countries.
- **Athletic Participation:** This form is required for athletic participation.
- **Students with religious exemption** are required to submit a religious exemption form.

HPA may delay class entry to a student who has not met all the health requirements by the first day of school.

STUDENT INFORMATION

Student name: _____ Date of birth: _____ Grade: _____

HEALTH HISTORY

Height (in): _____ Weight (lbs): _____ Vision - RT: _____ LT: _____

Blood Pressure: _____ Resting Pulse: _____ Hearing - RT: _____ LT: _____

Tuberculosis (TB) Test - A TB test is required of all new students. Students returning from an area of high TB prevalence may be re-tested by school health staff upon their return to school. A chest x-ray is required if PPD result is >10 mm. A TB test for a new student must be completed by a US licensed qualified personnel or the test will be redone when the student arrives at school.

PPD - Date given: _____ Date read: _____ Result (mm): _____ X-ray date: _____ Results: _____

BCG - No Yes Date: _____

Illnesses - Mark all that apply and indicate date of occurrence(s).

- | | | |
|---|---|---|
| <input type="checkbox"/> Chicken Pox: _____ | <input type="checkbox"/> Concussion: _____ | <input type="checkbox"/> Diabetes: _____ |
| <input type="checkbox"/> Measles: _____ | <input type="checkbox"/> Epilepsy: _____ | <input type="checkbox"/> Anemia: _____ |
| <input type="checkbox"/> Mumps: _____ | <input type="checkbox"/> Depression: _____ | <input type="checkbox"/> Eating Disorder: _____ |
| <input type="checkbox"/> Rubella: _____ | <input type="checkbox"/> Mononucleosis: _____ | <input type="checkbox"/> STI: _____ |
| <input type="checkbox"/> Poliomyelitis: _____ | <input type="checkbox"/> Asthma: _____ | <input type="checkbox"/> Dizziness or syncope during or after exercise: _____ |
| <input type="checkbox"/> Diphtheria: _____ | <input type="checkbox"/> Eczema: _____ | <input type="checkbox"/> Chest pain during or after exercise: _____ |
| <input type="checkbox"/> Whooping Cough: _____ | <input type="checkbox"/> Heart Condition: _____ | |
| <input type="checkbox"/> Rheumatic Fever: _____ | <input type="checkbox"/> High Blood Pressure: _____ | |
| <input type="checkbox"/> Typhoid Fever: _____ | <input type="checkbox"/> Hepatitis: _____ | |

Injuries - Mark all that apply and indicate date of occurrence(s) and location of injury(ies).

- | | |
|---|--|
| <input type="checkbox"/> Injuries: _____ | <input type="checkbox"/> Dislocations: _____ |
| <input type="checkbox"/> Fractures: _____ | <input type="checkbox"/> Swelling: _____ |
| <input type="checkbox"/> Sprains: _____ | <input type="checkbox"/> Surgeries: _____ |
| <input type="checkbox"/> Strains: _____ | |

Hospitalizations - List dates and reasons: _____

Family history of heart disease or sudden death before age 50 - explain: _____

Clinical Findings

- | | |
|--------------------------|-------------------------|
| Posture/gait: _____ | Groin/genitals: _____ |
| Skin, hair, scalp: _____ | Anus/rectum: _____ |
| EENT: _____ | Back/extremities: _____ |
| Teeth/mouth: _____ | Glands: _____ |
| Neck/thyroid: _____ | Neurological: _____ |
| Heart: _____ | Psycho-social: _____ |
| Lungs/chest: _____ | Nutrition: _____ |
| Abdomen: _____ | Menses: _____ |

- CONTINUED ON PAGE 2 -

Student's Name: _____ Grade: _____

REQUIRED IMMUNIZATIONS for school entry in Hawai'i - Kindergarten-Grade 12. Required minimum intervals between vaccine doses must be observed. A copy of an immunization record may be attached. This record must be signed by a U.S. licensed medical doctor (MD), doctor of osteopathy (OD), advanced practice registered nurse (APRN), or physician assistant (PA), and must be in English or accompanied with an English translation.

Vaccine # of Doses Vaccine Abbreviations

- DTP or DTaP 5 DTP=Diphtheria-Tetanus-Pertussis; DTaP=Diphtheria-Tetanus-acellular Pertussis
- Polio 4 Polio=OPV or IPV; OPV=Oral Polio Vaccine; IPV=Inactivated Polio Vaccine
- MMR 2 MMR=Measles-Mumps-Rubella (Two doses of measles required with at least one being MMR)
- Hepatitis B 3 Hep B=Hepatitis B (Required for school entry for all students born after December 31, 1992)
- Varicella 1-2 Chicken Pox (Required for all new students with no history of chicken pox disease, and for any student entering grade 7 with no history of chicken pox disease. Two doses required if first dose given on or after 13th birthday.)
- Meningococcus Recommended. Please discuss with your primary care physician for his/her recommendation.

IMMUNIZATIONS - Please list complete history from birth.

	- B A S I C -			- B O O S T E R -		
	M/D/Y	M/D/Y	M/D/Y	M/D/Y	M/D/Y	M/D/Y
Diphtheria						
Tetanus						
Pertussis						
Polio						
Varicella						

	- B A S I C -		
	M/D/Y	M/D/Y	M/D/Y
Mumps			
Measles			
Rubella			
Hepatitis A			
Hepatitis B			
Meningococcus			

OTHER CONCERNS

Any health conditions that should be called to our attention (e.g. allergies, medications): _____

Physical restrictions/reasons: _____

Sports/PE restrictions/reasons: _____

Diet restrictions/reasons: _____

Recommendations for modified physical activity programs: _____

Additional Notes/Comments: _____

PHYSICIAN INFORMATION

Signature of examiner: _____ Print name: _____

Address: _____ U.S. license #: _____

Phone: _____ Fax: _____ Date of exam: _____



Financial Form for Day Students

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

INSTRUCTIONS

Please initial next to each item you wish your child to enroll in. *If you do not make a selection, your child will not be enrolled in that program.*

STUDENT INFORMATION

Name: _____ Grade: _____

LUNCH for Grades K-8 (Note: For students in grades 9-12, the cost of lunch is included with tuition.)

- Initial your selection { Annual payment plan:
 - Grades K-3 \$690/year
 - Grades 4-5 715/year
 - Grades 6-8 740/year
- Monthly payment plan (Grades K-8): August - \$35, September - \$105, October - \$105, November - \$105, December - \$40, January - \$105, February - \$105, March - \$40, April - \$105, May - \$60

AFTER SCHOOL PROGRAM for Grades K-6

- Initial your selection { Annual payment plan \$850/year
- Semester payment plan 450/semester
- Monthly payment plan (Grades K-8): August - \$55, September - \$120, October - \$120, November - \$120, December - \$60, January - \$120, February - \$120, March - \$55, April - \$120, May - \$90
- Daily payment plan 13/day

OTHER ITEMS

- Initial your selection { Yearbook for Grades K-8 \$35
- Yearbook for Grades 9-12 75

STUDENT BANK ACCOUNT for Grades 6-12

- Initial your selection { YES. Open/continue my student bank account. I permit my child to charge his/her student bank account under the stated student bank guidelines.
- NO. I do not wish to open/continue a student bank account. I understand that my child will be responsible for paying cash for any and all expenses incurred at school. These expenses will include, but are not limited to, books, school supplies, dances, athletic events, and other items that students normally are allowed to charge.

INSURANCE PLANS (Note: Payments must be received before your child is deemed enrolled in any insurance plan.)

Accident Plan - Refer to the Health Services Enrollment Information or the brochure for more information on the Accident Plan. *To enroll, please initial below and sign and return the Student Accident Plan Authorization Letter (provided with the brochure).*

- Initial your selection { YES. I wish to enroll in the Student Accident Plan.
- NO. I do not wish to enroll in the Student Accident Plan.

Health Plan - All students must be covered by health insurance. Refer to the Health Services Enrollment Information for more information on the health plan.

- Initial your selection { YES. I wish to RE-ENROLL in the HMSA Student Plan (for students already enrolled in Student Plan).
- YES. I am interested in enrolling; please send me the brochure and enrollment material..
- NO. I am not interested in enrolling my child in the HMSA Student Plan.

AUTHORIZATION

I authorize HPA to charge my child's student bank account for the optional items I have elected above.

Signature of Parent 1: _____ Date: _____

Printed Name of Parent 1: _____

Signature of Parent 2: _____ Date: _____

Printed Name of Parent 2: _____