STUDENT'S INFORMATION

Mālama I Ke Ola HEALTH CENTER

FIRST NAME		**LAST NAME**
DOB		**GENDER**
INSURANCE		**PHONE NUMBER:**
GRADE	○ KIHEI ELEMENTARY ◉ LOKELANI INTERMEDIATE ○ MAUI HIGH	**EMAIL:**

PARENT/ LEGAL GUARDIAN CONSENT FOR STUDENT

I, the parent/legal guardian of said student, give consent for the student to receive services at Mālama I Ke Ola Health Center's (CCM) School-Based Health Center (SBHC), including medical (e.g., physical exams, or care for acute illness such as fever, evaluation of injuries, and referrals) and behavioral health services (e.g., screening, diagnoses, therapy, and referrals).

I understand this includes consent for telehealth visits which may encompass medical, behavioral health, or dental treatment and procedures, laboratory testing, diagnosis, and prescribed medication information in accordance with the judgment of CCM providers.

I understand that youth (14 years and older) may consent to their own outpatient behavioral health services and other services as allowable by law. CCM will encourage every student to involve his/her parents/legal guardian-representative 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) disease control for public health, (4) the student presents a danger to themself or others, or (5) child or elder abuse/neglect is suspected.

I understand that the SBHC is operated by CCM 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 CCM 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 CCM for consultation and continuity of care.

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 with 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 the alternative contact.

I understand that this consent will remain active while my child is enrolled in the participating Hawai'i Department of Education school identified on this form and receiving services through a CCM School-Based Health Center (SBHC). If my child transfers to another school, a new consent form must be completed before services can be provided at the new school site. I understand that I may withdraw or revoke this consent at any time by notifying CCM in writing.

CONSENT TO RELEASE INFORMATION

I give authorization for CCM to release copies of immunization records, physical exams, sports physical exams, and doctor's notes to the school in which the SBHC is operating.

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

HIPAA 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://www.ccmaui.org/resources/resources. 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.

CONSENT TO ADMINISTER MEDICATION

I understand that I will be contacted for my consent prior to any administration of medication or vaccine to my child, except in the event of an emergency. I understand and agree that my child may receive treatment or medication such as asthma inhalers, oxygen, epinephrine injection for allergic reactions, glucagon, or naloxone for opioid overdose, if deemed medically necessary and ordered by a licensed medical provider. I understand that medications will be administered by a licensed nurse, provider, or trained medical assistant.

Print Name of Parent/ Legal Guardian **Parent/ Legal Guardian Signature** **Date**