HAWAI'I KEIKI

Healthy and Ready to Learn

UH Mānoa Nursing with Hawai'i Department of Education

NURSING
UNIVERSITY of HAWAI'I at MĀNOA

www.nursing.hawaii.edu/hawaiikeiki

2018-2019

Dear Parents/Guardians,

Did you know that Waiakea High School has added a Nurse to your school health room to work with the School Health Assistant (SHA) in supporting your child's health and education? Waiakea High School is staffed with a Hawai'i Keiki advanced practice registered nurse (APRN). When your child is sick at school, this APRN can treat your child and decide—if your child needs to go home or can stay in school.

The APRN can:

* Care for your child's allergies, asthma, and other medical conditions.
* Give your child medication when needed.
* Offer advice about health topics to you and your children.

Why is this important? Because keeping your child in school keeps them in class, which keeps them learning.

There's no cost to you for any services your child may receive. However, we need your insurance information in case we need to bill them for certain services. Students without health insurance can still get care from the APRN at no cost.

But before a Hawai'i Keiki APRN can care for your child, we need your permission. Please review the enclosed consent form, sign it, and return it to Christina Gaspar, APRN.

Remember that a Hawaii Keiki APRN doesn't replace the care your child gets from the doctor or clinic. Also, even though you've signed the consent form, we won't treat or give medications to your child without talking to a parent or guardian first.

If you have any questions about the consent form or the Hawai'i Keiki APRN, please contact Christina Gaspar.

Thank you for keeping your child healthy and learning.

Christina Gaspar
APRN

(808) 974-4888
cgaspar@ucera.org

Office Hours
School days 8am-2pm

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What is a School Nurse Practitioner?

Nurse Practitioners (NP) have advanced education and are licensed by the State of Hawaii to provide high-quality health care services with parental consent.

Available Health Services

- Diagnosing and treating common pediatric illnesses or injuries
- Prescribing medication and other treatments
- Performing check-up exams
- Working with health care providers to manage your child's care
- Preventing and controlling communicable disease and other health problems

Hawai'i Keiki School Health Program
Parental Consent Form

University Clinical, Education & Research Associates
677 Ala Moana Boulevard, Suite 1003 • Honolulu, HI 96813-4100 • phone: (808) 469-4900 • fax: (808) 536-7315

Office Use Only

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____/_____/_____
Month Day Year

Sex: ❑ Male ❑ Female Grade_____
Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian
❑ Asian/Pacific Islander ❑ Other _____
Student Mailing Address:

_____

_____ _____ _____
City State Zip Code

Who is the student's regular doctor or nurse practitioner?
Name:_____
Telephone:_____
Address: _____

_____

PARENT/GUARDIAN INFORMATION

Mother
Last Name:_____First Name: _____

Home:_____Cell:_____Work:_____

Father
Last Name:_____First Name: _____

Home:_____Cell:_____Work:_____

Legal Guardian *If Applicable*
Last Name:_____First Name: _____
Home:_____Cell:_____Work:_____
Relationship of legal guardian to student
❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Additional Emergency Contact
Name:_____
Relationship to Student: _____
Home:_____Cell:_____Work:_____

INSURANCE INFORMATION

Does your child have Medicaid?
❑ No ❑ Yes: Medicaid # _____

Does your child have Quest?
❑ No ❑ Yes: Quest # _____

Which Plan?
❑ Alohacare Quest ❑ Ohana Quest
❑ HMSA Quest ❑ United Health Care Quest
❑ Kaiser Quest

Does your child have coverage through your employer or any other type of health insurance?
❑ No ❑ Yes: Health Plan: _____
Member ID/Group Number: _____
Subscriber Date of Birth:_____/_____/_____
Month Day Year

If your child does not have health insurance, would you like someone to contact you to enroll into health insurance?
❑ No ❑ Yes What is the best time to contact you? _____

PARENTAL CONSENT FOR SCHOOL HEALTH SERVICES

I have read and understand the services listed on the next page (School Health Services) and my signature provides consent for my child to receive services provided by the Nanaikapono Elementary School Health Center and Hawai'i Keiki School Health Program.

NOTE: By law, parental consent may not be required for the provision of certain health care services, including but not limited to the application of first aid treatment, the provision of services where the health of the student appears to be endangered, and certain treatment and services as set forth under Chapter 577A of the Hawaii Revised Statutes. Parental consent is not required for students who are 18 years or older or for students who are parents or legally emancipated.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PARENTAL CONSENT FOR RELEASE OF HEALTH RECORDS/INFORMATION

I have read and understand this consent for the release of health records and information as described on page 2 of this form.
My signature indicates my consent to the release health records and information as specified.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

Hawai'i Keiki School Health Program
Parental Consent Form

Nanakuli-Waianae Complex Area Schools, Hawaii DOE School District
University Clinical, Education & Research Associates
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SCHOOL HEALTH SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of the Hawaii Keiki School Health Program, as part of the school health program approved by the State of Hawai'i Department of Education and University of Hawai'i School of Nursing and Dental Hygiene. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. Hawai'i Keiki school health services may include, but are not limited to:

1. Screening for vision (including eye glasses), hearing, asthma, obesity, Tuberculosis and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including screening, evaluation, diagnosis, treatment, and referrals.
6. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, & HIV, as age appropriate.
7. Referrals for service not provided at the Hawai'i Keiki School Health Center.
8. Annual health questionnaire/survey.

HAWAI'I KEIKI AND STATE OF HAWAI'I DEPARTMENT OF EDUCATION FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH RECORDS/INFORMATION PARENTAL CONSENT FOR RELEASE OF HEALTH RECORDS/INFORMATION UNDER FERPA

My signature on the reverse side of this form (on page 1) authorizes release of my child's health records/information by the State of Hawai'i Department of Education as described in the paragraph below. Such records/information may be protected from release by federal and state laws, including the Family Educational Rights and Privacy Act (FERPA), which protects the privacy of students' educational records, including health records/information in some instances.

By signing this consent, I am authorizing my child's Hawaii Keiki School Health Program-related health records and information to be released by the State of Hawai'i Department of Education to the following parties for the purposes of providing medical treatment to my child, allowing providers providing services to my child to obtain payment for such services, and allowing certain other administrative activities relating to the provision of care:

- The University of Hawaii
- UCERA (the non-profit organization that provides Hawaii Keiki services in conjunction with the University of Hawaii)
- Any third party health care providers providing services to my child under the Hawaii Keiki School Health Program or through referrals from the Hawaii Keiki School Health Program
- Any third party payers who may pay or reimburse providers for health care treatment or services

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

Student: First Name_____ Last Name_____ Date of Birth_____

UCERA

University Clinical, Education & Research Associates
677 Ala Moana Boulevard, Suite 1003 • Honolulu, H/96813-4100 • phone: (808) 469-4900 • fax: (808) 536-7315

1. Consent for Treatment

I wish to receive medical care and treatment at University Clinical, Education & Research Associates (UCERA). Accordingly, I consent to the procedures that may be performed during this office visit, including emergency treatment. I authorize consent to any of the following: imaging, laboratory procedures, other diagnostic procedures, medical or surgical treatment, or other clinical services that my physician, physician assistant, or nurse practitioner believes are advisable to evaluate or treat me, and to other services rendered under the general and special instructions of my physician.

I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that this office has not made any guarantees to me as to the results of treatments or examinations. I am also aware that I should ask my physician any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.

2. Disclosure of Information for Payment Purposes

I understand that my medical information will be sent to my insurance carrier for billing purposes for any treatment I may receive at this office including treatment for Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnoses, and/or drug, alcohol or other substance abuse.

I understand that according to law, I may choose to pay out-of-pocket for certain services if I do not want my health information regarding those services to be provided to my insurance company. I agree to notify this office of my wishes regarding payment before these services are provided. I also understand that if I fail to pay in full for the services, the information will be sent to my insurance company.

3. Information to Other Providers

I understand that this facility may share my information electronically or on paper with other providers in the course of my treatment, for making arrangements for my continuing care, or upon request when seeking care from other providers. If I prefer that this medical facility not use or share my information, I may submit a written request for consideration per this facility's Notice of Privacy Practices.

4. Financial Agreement

I understand that I will receive a bill from UCERA. I understand and agree to pay all charges for services rendered and that I am obligated to pay for services in accordance with the regular rates and terms of UCERA. UCERA has a right to charge a Late Payment Fee and for a Returned Check Fee.

If I choose to pay all charges myself, I will notify this office prior to receiving services.

Should the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fees, collection expenses and interest at the statutory rate on all delinquent accounts, whether or not the account is referred to a collection agency.

5. Medicare Coverage

I certify that the information I have given in applying for payment under Medicare is correct. I authorize the Social Security Administration to release information about my Medicare effective dates and Medicare claim number to UCERA. I authorize any holder of medical or related information about me to release any information needed to process this or a related Medicare claim to the Social Security Administration or its intermediaries. I request that payment of benefits be made on my behalf to UCERA for any services provided in this office.

6. Assignment of Benefits

I hereby authorize assignment of the medical insurance benefits I am due to UCERA for application to bills for medical services and supplies received. I further authorize UCERA to receive direct payment from all such benefit payments. I agree to remain responsible and liable for payments of all amounts due UCERA and not received from my insurance carrier(s). I understand UCERA is submitting claims on my behalf as a courtesy. I shall not revoke this assignment for any reason.

7. Patient's Rights and Responsibilities

My signature below confirms that I have received the information on my Rights and Responsibilities as a patient and I have received a copy of this facility's NOTICE OF PRIVACY PRACTICES.

MINORS OR INCAPACITATED PERSONS- The patient is (please check & complete):

- ☐ A minor _____ years of age.
- ☐ Incapacitated and unable to sign for the following reason(s):_____

I have read this consent, received a copy of this facility's Notice of Privacy Practices, and am the patient or the patient's duly authorized representative. On my own behalf (or on behalf of the patient), I accept and agree to be bound by all of these TERMS AND CONDITIONS OF SERVICE.

_____ _____ _____

Patient or Representative's Signature Print Name Date

REPRESENTATIVE: Please describe your authority to act on behalf of the patient:_____