HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY ENROLLMENT AGREEMENT

"THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER"

PLEASE KEEP A COPY FOR YOUR RECORDS.

In consideration of the mutual agreements hereafter set forth, faithfully, to be fully kept and performed by the respective parties hereto, it is agreed as follows:

Term 1. **Term Set for Contract** – I understand that the Hawaii National Guard Youth Challenge Academy (YCA) is a Residential Program and understand that all cadets must be in attendance for a required number of days. Cadets who fail to complete the required number of training days may become ineligible to complete/graduate the program. Dates of enrollment are set per class to cover the required number of training days as set forth in the memorandum of agreement with the National Guard Bureau.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 2. **Conditions of Enrollment** – I understand and agree that YCA retains the right to suspend or dismiss a cadet from YCA for conduct (on or off campus) that is prejudicial to the good order and discipline required by YCA, or for any violation of the YCA rules and regulations as set forth in the Cadet Student Manual. YCA bears no obligation to provide any academic work to complete a semester or any academic credit once a cadet is dismissed. All cadets are furnished with a copy of these regulations to which they will be bound, and ordered to both review and understand them fully.

Reasons for possible dismissal include but are not limited to the following:

- Drugs & Hallucinogens—Selling, Possession, Use Distribution of Drug Paraphernalia.
- Refusing to take a Urine Drug Screen/Breathalyzer Test
- Positive Results on a Urine Drug Screen/Breathalyzer Test
- Alcohol and/or Beer – Use of and/or Possession.
- Civil Law Violation Inside/Outside YCA
- Lying, Stealing, or Cheating of **ANY** Kind, On or Off Campus
- Physical or mental hazing of any kind
- Repeated Fighting in Barracks/on Campus
- Moral or Lewd Misconduct
- Vandalism – Willful Destruction of School Property (Room/Barracks, etc.)
- Making Unauthorized Telephone Calls
- Excessive Demerits/Class Absences
- Threatening YCA Faculty, Staff or Cadre
- Unauthorized Personnel in Cadet Barracks at and/or **ANYTIME**.
- Offenses affecting the Well Being of the YCA
- Female Cadet in Males' Room/Barracks or Male Cadet in Females' Room/Barracks
- Possession of Guns; Knives; Stun Guns; Paint Ball Guns, Rocket Fuel or Flammable Materials
- Self-Inflicted Wounds to include Tattoos/Branding, and/or Body Piercing
- Possession of Unauthorized Keys
- Leaving Facility without Permission
- Sexual Harassment of **ANY** Kind
- Racial Remarks of **ANY** Kind
- Gambling; Possession of Gambling Paraphernalia
- Stealing from YCA staff offices/desks/vehicles/purses, etc.
- Violation of the Tobacco use policy

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 3. **YCA Drug Policy** – I understand that every cadet will be given a urinalysis (UA) within 40-days of arrival at YCA and will be subject to random testing while enrolled at YCA. Anytime a UA result is positive, the parent or guardian has the right to request a second UA test be conducted at their own expense before the cadet is dismissed from the program. YCA will maintain physical custody of the cadet during this entire process.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 4. **Sexual Harassment** – I understand and agree that all cadets are required comply with YCA policies prohibiting any form of sexual harassment. I understand that if a cadet sexually harasses any other cadet, staff member or YCA volunteer they may be subject to immediate disciplinary actions. YCA Disciplinary actions include, but are not limited to, the loss of rank and/or position, being placed on a disciplinary detail, loss of favors or dismissal from the program. This policy does not limit or interfere with the potential for civil or criminal charges being brought by the victim.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 5. **Conditions for Authorized Leave** – I understand that cadets may be released from the academy on a temporary basis for any one or both of the following purposes: Wedding of Parent or Guardian or Death of Immediate Family Member (Parent or Guardian, Sibling, Grandparent or Great-Grandparent only) either Biological or Adopted. Released cadets must return within the designated time frame as determined by YCA to be appropriate for said event. Any deviations from course will result in possible disciplinary actions which may include, but are not limited to, the loss of rank and/or position, being placed on a disciplinary detail, loss of favors or dismissal from the program.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 6. **Statement of Non-Credit** – I understand that cadets are not given semester examinations, nor will they earn academic credits through YCA for the purpose of transference to other academic institutions. Upon successful graduation from YCA, graduates will receive a Certificate of Program Completion and a High School Equivalency Diploma, utilizing the Competency-Based Community School Diploma Program, known as C-BASE. Future requests for transcripts or copies of diplomas must be made through the Waipahu Community School for Adults, Hilo Campus.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 7. **Media Policy** – Unless specifically forbidden by the responsible enrolling party, it is YCA's policy that enrollment is deemed as consent to the photographing, videotaping and voice recording of cadets for use singularly or in conjunction with other images and/or recordings for advertising, publicity, commercial or other business purposes in markets both foreign and domestic.

YCA policy states that unless specifically forbidden by the responsible enrolling party, all responsible parties release YCA, and any of its affiliated organizations, their directors, officers, agents, employees, customers, and appointed advertising agencies from all claims of any kind on account of such use.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 8. **Financial Responsibility** – Although YCA has no registration fees or established program costs, I acknowledge by my initials below that any undue expenses incurred by YCA as a result of damage, misuse of facilities or any other unforeseen circumstances due to negligence will be reimbursed by me as soon as possible upon receipt of such charges. All incomplete or non-paid fiscal responsibilities may result in cadet termination, suspension of training or withholding of graduation documents. In the event that recovery of financial obligations requires legal action, I agree to pay all collection expenses incurred by YCA to include court costs and attorney's fees, without relief from valuation or appraisement laws.

1. All payments must be made in money order or cashier's check, to the YCA and all fiscal responsibility concerns may be directed to the YCA business office, the Deputy Director for the appropriate academy or the Director of YCA.

When deemed necessary by YCA or their affiliates, a credit investigation of the parent and/or responsible party is authorized for the purpose of obtaining necessary financial information.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 9. **Transportation Policy** – I understand that cadets participate in organized off-site events for medical appointments, educational field trips and other training or functions. All off-site training missions are conducted with the highest regard for the safety and the well-being of each cadet in accordance with YCA and NGB standards. While participating in any off-site training/functions, cadets are required to follow all rules of conduct as specified in the YCA's rules and regulations SOP and the Cadet Student Manual. By enrolling in the YCA, I give consent to allow participation in all YCA sanctioned off-site training, and agree to voluntarily release and forever discharge YCA, its employees, agents, representatives, and volunteers from any and all claims of liability or damages incurred as a result there of, from the time of departure to the time of return to YCA facilities. It is understood that nothing in this policy is intended to, nor shall it be construed to, release any insurance company or third party agency from any obligation to pay under any liability insurance or other benefit.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 10. **Athletics Participation Policy** –All cadets are expected to participate in organized and intramural athletics while attending YCA. By the initials below, I acknowledge that injuries are a possibility, which could result in a permanent disability, paralysis or even death. Unless noted on the required physical examination form, cadets and/or parents/guardians attest and verify that the identified cadet is in good physical health and is capable of participating in such activity. By enrolling in the YCA, I give consent to allow participation in all YCA physical activities and agree to voluntarily release and forever discharge YCA, its employees, agents, representatives, and volunteers from any and all claims of liability or damages incurred as a result there of, whether on or off of YCA property. It is understood that nothing in this policy is intended to, nor shall it be construed to, release any insurance company or third party agency from any obligation to pay under any liability insurance or other benefit.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 11. **Occupational Welfare Policy** – Program participants receive training under program guidelines established by the National Guard Bureau, the Hawaii Department of Defense and the Hawaii Department of Education, however, cadets are not considered employees nor members of any of the aforementioned organizations. In regards to computing compensation benefits for a disability or death incurred while attending the YCA, participants shall be considered Federal employees under Subchapter I of Chapter 81 of Title 5, U.S. Code, for the purpose of compensation for work injuries; and for the purpose of Sections 1346(b) and Chapter 171 of Title 28, U.S. Code, and any other provision of law relating to the liability of the United States for tortious conduct of employees of the United States and shall, if granted, receive compensation under the entrance salary for a grade GS-2 federal employee.

1. The participants shall not be considered to be in the performance of duty while not at the assigned location of training or if they are found to be in violation of any program agreements or standing orders.

2. The entitlement of a person to receive compensation for a disability shall begin on the day following the date that the person's participation in the Program is terminated.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 12. **Representation or Warranties** – I understand that there are no representations or warranties upon which I have relied in deciding to enroll my cadet in the YCA, except as specifically contained within this agreement or written documents to which it may refer.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 13. **Permission Statement** – By my initials below, I hereby grant consent for YCA to provide my parent(s)/legal guardian(s) or sponsor(s) any information regarding academics and all other aspects of my involvement in the YCA program.

Cadet Initials _____

Term 14. **Legal Contract to Enrollment Agreement** – YCA and the undersigned parties are bound by the provisions of this Enrollment Agreement and all other written and signed agreements with YCA and terms contained therein as governed by the laws of the State of Hawaii and the National Guard Bureau. This agreement cannot be changed or modified without a mutually signed agreement between all parties involved.

CANDIDATE SIGNATURE	**DATE**
PARENT/GUARDIAN SIGNATURE	**DATE**
PARENT/GUARDIAN SIGNATURE	**DATE**

HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY

MEDICAL AID STATION INFORMATION

The Youth Challenge Academy Medical Aid Station (MAS) addresses and or assists daily with medical issues, which include:

- Conducting sick call twice daily and providing medical care to youth as needed.
- Responding in an on-call basis to deal with after hours, non-emergency medical issues.
- Overnight medical facilities are available in the Medical Aid Station, if needed.
    - Emergency situations are handled with support of the MAS staff and Emergency 911, as required.
- Coordinating cadets' off campus/out-of-town medical, dental, and/or counseling appointments.
- Maintaining and distributing prescription medications for cadets as prescribed by physicians.
- Coordinating with local medical/mental health care facilities to provide expedited services for cadets and assist with documentation required for insurance processing.
- Reviewing and maintaining copies of all cadet physical examination reports and immunization records as follows:
    - **All cadets are required to have an annual physical examination or sports physical on file in the MAS**.
- No cadet is admitted to the Academy until their physical examination is current and legible copies provided to the MAS.
    - Hawaii State Law, Hawaii Administrative Rules Title 11, and Department of Health, Chapter 157 requires all students to be immunized against the following illnesses:
        - Polio
        - Diphtheria
        - Tetanus
        - Mumps
        - Rubella (German measles)
        - Rubella (measles)
        - Pertussis
        - Hepatitis

Note: Hawaii Law requires the MAS to file reports on the status of immunizations with the Hawaii Department of Health. There may be medical fees, not limited to, but including Office Fees, Physician's fees, etc.

Health, Medical, or Accident Insurance Requirement - I understand that medical insurance is required to participate in the Hawaii National Guard Youth Challenge (YCA) program. A copy of the **front and back** of each cadet or guardian's insurance card is required as evidence of insurance and will be kept on file in the MAS, Admissions Office and Charge of Quarters. If there is any change in medical insurance coverage for a cadet, the responsible party must notify YCA within 5 business days of the change.

YCA will not accept financial responsibility for injuries to a cadet regardless of cause. ***The cadet, parent, guardian or previously established responsible party is required to pay the physician, hospital or any other medical bills directly to the billing agency.***

There is no charge for consultation and treatment by the MAS Staff.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

NOTE: Cadets who are part of an HMO plan, or who have a previously established primary care physician will be seen by said agency for all non-emergency situations if at all possible. If a cadet is seen by a physician contracted through the MAS, clinic, or hospital there may be a charge for their services, which will be billed to the responsible party. The parent or guardian is responsible for coordinating necessary medical referral services while cadets are attending YCA.

HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY
MEDICAL AID STATION
Medical Treatment Authorization & Release of Information

FULL NAME of CADET: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ **DATE OF BIRTH**: _____ / _____ / _____

By my initials below, I hereby grant permission for my cadet to receive emergency medical treatment, non-emergency medical treatment, behavioral/mental health care and/or routine health care as deemed necessary by the MAS staff while enrolled as a cadet at YCA. Consent is granted for the MAS staff of YCA to act in my stead to select attending physicians, specialists, surgeons, psychiatrists, therapists, dentists, and medical facilities as necessary. I understand that I am financially responsible for services provided to my cadet and may receive a statement/bill from the above noted professionals or medical facilities. Consent is also given for all medical and mental health records to be released to the YCA medical staff upon request, along with the release of information concerning my cadet, to health care and/or mental health professionals as deemed necessary by the YCA medical staff.

This authorization will remain in effect during my Cadet's enrollment at Hawaii Youth Challenge Academy or until revoked by me in writing and that statement is received by the MAS staff.

Parent/Guardian Signature: _____ Parent/Guardian Initials _____ /_____ Cadet Initials _____

Privacy Policies – By my initials below, I understand that the cadet health record is kept on file in the MAS and contains their symptoms, examination/test results, diagnoses and treatment, a plan for future care or treatment and billing related information.

MAS Responsibilities:

- The MAS is required by law to maintain the privacy of a cadet's health information and to provide the patient and the parent/guardian a description of our privacy practices.

- The MAS may disclose health information about a cadet to doctors, nurses, technicians, or other medical personnel involved in taking care of the cadet. Examples would include, but are not limited to lab work, meals, x-rays, etc.

- The MAS may use and disclose health information about a cadet's treatment for physicians to bill and collect payment from insurance providers or third-party payers.

Example:

1. Giving the insurance company information about a cadet's x-rays for payment or reimbursement of charges.
2. Telling your health plan provider about treatment your cadet needs to determine whether your plan allows for coverage of such treatment; such as MRIs, physical therapy, etc.Members of the staff may use information in a cadet's health record to assess required care and outcomes in the youth's individual case. Results may also be used to evaluate service needs or treatment plans to improve the quality of care for all cadets that we serve. **Parent/Guardian Initials _____ /_____ Cadet Initials _____**

MEDICAL AID STATION
Policies & Cadet Physical Aptitude

Privacy Policies – You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your cadet's care. In some circumstances, we may deny your request to inspect and/or copy a cadet's records in accordance with The Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you are denied access, you may request that the denial be reviewed. If you feel the health information about your cadet is incorrect or incomplete, you may request to have that information amended. You have a right to request an amendment for as long as the information is kept by or for the MAS.

You have a right to request a restriction or limitation on the health information we use or disclose about your cadet. We are not required to comply with your request, however, we do our best to uphold your desires unless release of the medical record information is determined to be necessary for the treatment of your cadet.

We may also use and disclose health information for the following types of entities including, but not limited to:

- Public Health or Legal Authorities charged with preventing or controlling disease, injury, etc.
- Military Command Authorities
- Health Oversight Agencies
- National Security and Intelligence Agencies
- Protective Services for the President and others

We reserve the right to change or revise this notice as needed. The change or revision to this notice will be effective for information we already have about your cadet, as well as any information we receive in the future. The most current notice will be posted in the MAS and will include the effective date.

Parent/Guardian Initials _____ Cadet Initials _____

Physical Aptitude – To the best of my knowledge, my cadet is in good physical condition and participation in the program will not have an adverse effect on his/her health and well-being*.

☐ **YES**

☐ **NO** Please specify: _____

Has your cadet been diagnosed with any mental illness to include, but not limited to, anxiety, depressions, ADD, or ADHD?*

☐ **NO**

☐ **YES** Please Specify: _____

Please list all medications your cadet is currently taking on a regular basis including medications for mental illness*:

_____

_____

Please list anything (medications, foods, latex, etc.) to which your cadet may be allergic*: _____

_____

** You must inform YCA of any changes in physical condition or status of general health and fitness.*

Parent/Guardian Initials _____ /_____ Cadet Initials _____

HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY
MEDICAL AID STATION
Responsible Party Payment Information

ALL INFORMATION ON THIS PAGE MUST BE COMPLETED!!!!

PARENT/GUARDIAN/RESPONSIBLE PARTY INFORMATION:

(Note: Responsible Party will be billed if insurance does not pay).

Name of Father/Guardian: _____

Address: _____

Home Telephone #: (____) _____ - _____ Office #: (____) _____ - _____ Cell #: (____) _____ - _____

Name of Mother/Guardian: _____

Address:

_____

Home Telephone #: (____) _____ - _____ Office #: (____) _____ - _____ Cell #: (____) _____ - _____

RESPONSIBLE PARTY IS: (Check one) ☐ FATHER ☐ MOTHER ☐ GUARDIAN ☐ OTHER

MEDICAL INSURANCE INFORMATION: Please complete the following information pertaining to the individual whose name appears on the insurance card AND provide a copy of the FRONT *and* BACK of the INSURANCE CARD.

Adult Carrying Insurance: _____ Relationship to Cadet: _____

Adult's Date of Birth: _____ / _____ / _____ Adult's Social Security #: _____ - _____ - _____

Adult's Employer: _____ Employer's Telephone #: (____) _____ - _____

Employer's Address: _____

Name of Insurance Company: _____ Telephone #: (____) _____ - _____

Address: _____ City: _____ State: Zip code: _____

Policy #: _____ Certificate #: _____ Group #: _____

_____ _____

CANDIDATE SIGNATURE **DATE**

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY
CUSTODY INFORMATION

CADET LAST NAME: _____

CADET FIRST NAME: _____

CADET DATE OF BIRTH: _____ / _____ / _____

CADET SOCIAL SECURITY NUMBER: _____ - _____ - _____

CADET IDENTIFYING MARKS (Scars, Birthmarks, Tattoos, etc.): _____
_____

Primary Nationality	Gender	Height	Weight	Hair Color	Eye Color

CUSTODIAL PARENT(S)/GUARDIAN (S)*: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____

SECOND PARENT(S)/GUARDIAN(S)*: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____

SECONDARY CONTACT: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____

RELATION TO CADET: _____

If you complete the 2nd Parent information, please mark yes or no to the following questions.

1. PLEASE SEND MAILINGS CONCERNING CADET INFORMATION & GRADES: YES _____ NO _____
2. SECOND PARENT IS ALLOWED VISITATION AT THE ACADEMY ONLY: YES _____ NO _____
3. SECOND PARENT IS ALLOWED FULL PASS PRIVILEGES: YES _____ NO _____

**Note: In cases of divorce we will require a copy of legal custody paperwork.*

"THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER"

PARENT/GUARDIAN INTERVIEW QUESTIONNAIRE

NAME: _____ (Check One) Parent:☐ Guardian:☐

APPLICANT NAME: _____ **Age of today:** ___ **Gender:** ___

FAMILY:

1. Are there any family dynamic issues we should be aware of (e.g. family members he/she should not be seeing nor having any correspondence with and why? _____

_____

_____

_____

2. How is your child at home? How's the relationship between child and other family members? _____

_____

_____

_____

3. Does your child engage in helping with chores? Does your child have a curfew? If not, why?

_____

_____

_____

4. Are you in control of your child when it comes to discipline? Explain: _____

_____

_____

_____

5. Why would your child be interested in Youth Challenge Academy? Or is it you? Explain: ____

_____

_____

_____

FAMILY INCOME (for statistics):

Less than $15,000 ☐	$15,000-$25,000 ☐	$25,000-$35,000 ☐	$35,000-$45,000 ☐	Over $45,000 ☐

SCHOOL:

1. Does your child have any special needs that we should be aware of? IEP/504? _____

_____

_____

2. What is your child's academic strength and or interest (e.g. math, reading, writing, etc.) Explain: _____

_____

_____

3. What type of characteristic does your child have (e.g. shy, talkative, opinionated, helpful, etc.) Explain: _____

_____

_____

LEGAL:

1. Does your child have a Probation Officer? If yes, why? _____

_____

_____

_____

_____

2. Does your child have any pending charges or court dates? If yes, what is it and when? _____

_____

_____

_____

_____

3. Probation Officer name and contact information:

_____

SELF:

1. Does your child have a boyfriend or girlfriend? If yes, list their name: _____

_____

2. Do you know of your child knows someone in the program or has applied for next cycle? If yes, please state name and information: _____

_____

3. Do you have any relatives applying for next cycle or friends of the family? If yes, please list the names: _____

_____

4. Is there any concerns you would like to share about your child that we haven't asked you? Everything that is shared is confidential: _____

_____

_____

_____

SURVEY:

How did you hear about HINGYCA: _____

What do you think about HINGYCA: _____

Would you recommend HINGYCA to others: _____

What district are you from: _____

By signing below, you have agreed that all answers given in the nest of you knowledge and honesty and should any information is falsified, your child will not be considered an applicant for this program. Any questions or concerns please address it at this time.

_____ _____

PRINT FULL NAME OF PARENT/GUARDIAN **DATE**

_____

SIGNATURE OF PARENT/GUARDIAN

HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY
EMERGENCY CONTACT INFORMATION

CANDIDATE: _____

PARENT/LEGAL GUARDIAN:

	FATHER/MALE GUARDIAN	MOTHER/FEMALE GUARDIAN
NAME:		
ADDRESS:		
CITY, STATE, ZIP CODE:		
HOME PHONE:		
WORK PHONE:		
CELLULAR PHONE:		
EMAIL:		
STATE JOINT OR SOLE CUSTODY, IF APPLICABLE:		

	EMERGENCY CONTACT #1	EMERGENCY CONTACT #2
NAME:		
RELATIONSHIP:		
HOME PHONE:		
WORK PHONE:		
CELLULAR PHONE		
EMAIL:		

AUTHORIZED FOR PICK UP, OTHER THAN PARENT/GUARDIAN
(at least 21 years old with ID)

	DESIGNATED ADULT #1	DESIGNATED ADULT #2
NAME:		
HOME PHONE:		
WORK PHONE:		
CELLULAR PHONE:		

HAWAII NATIONAL GUARD
YOUTH CHALLENGE ACADEMY

P.O. Box 5210 Hilo, HI 96720
(808) 430-4184 (808) 969-1504-fax

CONSENT TO ADMINISTER MEDICATION

I affirm I am the parent and/or legal guardian of_____
(Name of Minor)

DOB of Minor: _____

As the parent and/or legal guardian, I hereby authorize HINGYCA—Medical Department, and/or its agents to administer medication including over the counter (OTC) medication as well as medication prescribed by his/her Physician to my son/daughter.

_____
(Name of Minor)

I hereby consent and authorize the administration of OTC medication that may be considered advisable or necessary, in the opinion of the HINHYCA—Medical Department to my son/daughter.

_____
(Name of Minor)

I affirm that I have red and understand the **Consent to Administer Medication Form**.

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____

Date: _____ Primary Phone: _____

ADOPT A HIGHWAY

State of Hawaii Department of Transportation

Release Form for Adopt-A Highway Participants Under Age Eighteen

Date _____

I, a member of the Hawaii National Guard Youth Challenge Academy (Adopt-A-Highway group) have attended the roadside safety training program as a prerequisite to participation in the Adopt-A-Highway Program.

I do hereby release and discharge the State of Hawaii, Department of Transportation, and their officers, agents and employees, from all claims, demands and causes of action of every kind whatsoever for any damages and, or, injuries which may result from my participation in the Adopt-A-Highway and other voluntary activities on or near the highway rights-of-way.

I further agree to hold harmless the State of Hawaii, Department of Transportation, and their officers, agents and employees, from liability for any damages or injuries resulting from any acts or failure to act on my part during my participation in said voluntary activities on or near the highway rights-of-way.

Name: _____
Print or Type Name of minor Signature

Parent or Guardian: _____
Print or Type Name Signature

Address: _____

_____

_____

(Sign and submit this form to the DOT before participation)

RELEASE OF CLAIMS

This Release of Claims is made on _____, 20_____, by _____ (Name of Participant), whose date of birth is _____, and whose address is _____ (Street Address/P. O. Box #) (Town/City) (State) (Zip Code).

In consideration of the permission granted to me by the County of Hawai'i, State of Hawai'i, to participate in Service to Community (Description of Activity) program at All Hawaii County Facilities (Name and Address of Facility) (hereafter "Facility") from _____ (Dates of Activity), 20_____, to _____, 20_____,

I hereby release the County of Hawai'i, its agents, independent contractors, and employees from all actions, causes of action, damages, claims or demands, which I, my heirs, personal representatives, or assignees may have against the County of Hawai'i, and other above-named parties for all injuries, known or unknown, which may incur by my participation in the above-described activity or by my use of the above-described Facility.

I do further agree that I shall indemnify and save harmless the County of Hawai'i, or any of its officers or employees, either jointly or severally, from any and all claims, demands, damages, loss of service, or expense for property damage and for personal injuries or actions brought by a third party resulting or arising from my participation in the above-described activity or my use of the Facility.

I, the undersigned, have read this Release and understand all of its terms. I execute it voluntarily and with full knowledge of its significance.

IN WITNESS WHEREOF, I have executed this Release at Youth Challenge Academy, Hilo Campus, Hawaii National Guard (Place of Execution) on the day and year first written above.

_____
Participant's Signature Telephone No.

If Participant is under 18 years of age:

_____
Signature of Parent or Guardian Telephone No.

_____ _____
Printed Name of Witness (age 18 or older) Witness's Signature Telephone No.
(All signatures require a witness) *(All signatures require a witness signature)*

5/23/06

WYMAN TEEN OUTREACH PROGRAM®

TOP® Club Registration and Parent/Guardian Consent Form

Name of Teen: _____

Name of Parent/Guardian: _____

Address: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

Medication Allergies: _____

Other Health Considerations: _____

Teen Outreach Program® TOP Consent Form

Your son or daughter has been chosen to participate in the Teen Outreach Program®, replicated in Hawai'i and owned by Wyman Center, Inc. (Wyman). During the time your child will spend in the Teen Outreach group, young people will explore their own physical and emotional growth and development, their goals for the future, and their goals for close and productive relationships with others. This program has been evaluated nationally and has shown very positive results for young people. This unique program will involve your child in volunteer work in the community. This work may occur off school grounds. The program promotes progress in school and avoidance of behaviors which may hinder your child's most successful growth and achievement.

Please initial all consents and sign at the bottom

Consent to Participate in the Teen Outreach Program® I, the undersigned, am the Parent or Legal Guardian of the child named below who is to participate in the Teen Outreach Program® provided by Youth Challenge Academy through funding from the State of Hawai'i Department of Health Maternal and Child Health Branch. I am aware that there are potential hazards and risks involved in some programs. I am willingly allowing the child mentioned above to participate in all aspects of the program (including field trips and transportation) under the supervision of Teen Outreach Program® facilitators. Teen Outreach Program® facilitators will accompany off site activities. I agree to hold harmless and indemnify the State of Hawai'i, and/or its employees, agents, or lessors from any and all claims by myself, my teen, my heirs, my family, or my assigns.

☐ Yes ☐ No

Consent to Use Photographs. I give my consent to the Department of Health to use videos and/or photographs of my teen for brochures, to display in photo albums, in advertisements, or for other publicity purposes. If my teen's photo is used, he/she will only be identified by first name.

☐ Yes ☐ No

Consent to Participate in Surveys & Data Collection I give my consent for my child to participate in Wyman surveys. In compliance with Children's Online Privacy Protection Act (COPPA), Wyman provides the following information to survey participants. Wyman Center, Inc. operates a secure environment to collect and store information from student participants in its Teen Outreach Program®.

Wyman collects the following types of information directly from TOP® participants through online surveys:
-Opinions about their experience in TOP®
-Demographics- Zip code, ethnicity, gender, most frequent guardian, parents' education level
-School records - Grade in school, absences, truancy, suspension, course failure, graduation and schooling plans
-Health information- Pregnancy, parenting

I understand Wyman uses the participants' responses to improve the Teen Outreach Program®. I understand that survey and data collection is voluntary and that my child may choose to participate or discontinue participation at any point in the process without risk of losing Wyman's services. I am also aware Wyman will not require my child to disclose more information than is reasonably necessary to participate in Teen Outreach Program® as a condition of participation. I am aware Wyman will use and may share responses with third parties to market Teen Outreach Program® to increase awareness and funding and that **Wyman will not disclose my child's identifying information to third parties or program staff.** I also understand that the associated risks for my child to participate in this survey are minimal and will not exceed any discomfort that may be found in any daily life situations when answering routine survey questions. For a sample report on how Wyman compiles and reports this data, go to www.wymantop.org.

☐ Yes ☐ No

Child's Name

Parent or Guardian Signature
OR Teen Signature if 18 & Over or emancipated

Print Name

Date

Please submit the filled Release and Waiver Form in hard copy with your original signature(s) to:

Keaukaha One Youth Development
RISE 21st Century After School Program
67 Keokea Loop, Hilo, HI 96720
Ph. (808)895-8666. Email: keahi.koyd.rise@gmail.com

Assumption of Risk, Release and Waiver

I, _____(the undersigned) understand that there are risks involved in my participation in service- learning activities, projects, and programs on land as well as sea, on land administered by or through Keaukaha One Youth Development ("KOYD") or RISE 21st Century After School Program ("RISE") by the State of Hawai'i, including the Department of Transportation, and its Harbors Division, beginning on the date of my signature below and continuing until my completion of the program, including the risk of PROPERTY DAMAGE, PERSONAL INJURY, OR DEATH. I understand that KOYD, RISE, the State of Hawai'i, including the Department of Transportation, and its Harbors Division as well as their officers, agents, employees, or representatives does not provide liability insurance, or otherwise indemnify me or anyone else who may participate in these programs, projects and activities, for any injuries or any other liabilities arising from my participation, including transportation to and from the sites of service.

Therefore, in consideration of my participation, I assume all risks and responsibilities in relation to my participation in service-learning activities, projects, on land administered by or through KOYD and/or RISE, I release, agree to defend, hold harmless, and indemnify KOYD, RISE and, the State of Hawai'i, the Department of Transportation, Harbors Division and their other entities, as well as their officers, agents, employees, or representatives from and against all liabilities, claims, demands or causes of actions, including claims for property damage, personal injury, or death CAUSED BY THE PASSIVE OR ACTIVE NEGLIGENCE OF MYSELF AND/OR KOYD, RISE, THE STATE OF HAWAI'I, DEPARTMENT OF TRANSPORTATION, HARBORS DIVISION AND OTHER ENTITIES, AS WELL AS THEIR OFFICERS, AGENTS, EMPLOYEES, OR REPRESENTATIVES for any hidden, latent or obvious defect in equipment, or caused by any other activities of mine, or anyone else who may be a participant in the above-mentioned activities, including transportation to and from the sites of service.

I declare that the information provided by me is correct and made in good faith.

PHOTO/VIDEO RELEASE: I understand that my classroom and field work and photo/video likeness may be selected for use in reporting, program materials, and outreach. In this event, I will make no monetary or other claim against KOYD, RISE, the State of Hawai'i, the Department of Transportation, Division of Harbors and other entities, as well as their officers, agents. employees, or representatives for such use. Unless initialized below, I hereby

give my permission for the release of my work and likeness for program use. I do agree to and will uphold the terms of this agreement.

_____I do NOT allow my photo or video likeness used by any of the institutions or programs mentioned in this agreement. (Initial) _____

It is your own responsibility to make this decision known to site leaders and participants in activities, where photographing, taping, or filming may take place.

Participant signature	Date	Print name
Parent or Guardian Signature (if participant is under 18)	Date	Print Parent/Guardian Name
Participant email Parent/Guardian Email		Phone
Address while in Hawai'i	City	State Zip
Emergency contact: Name, relationship, and phone number		

Authorized Official Signature	Date	Print name

2043055 V1

Family Tree Project, LLP

Initial Client Information

Client Name: _____ Birth Date:_____/_____/_____

Male/Female (Circle one) Today's Date: _____/_____/____

Address:_____
_____ Phone: (H) _____
Phone: (W)_____

Guardian Contact Name: _____
Email:_____

Relationship:_____

Language spoken at home:_____
Insurance Information:

Policy holder:_____ Insurance Co. _____

Insurance ID:_____ Policy holder Birthdate:_____

Has your child ever been in treatment before?_____

If so, where and when? _____

Is your child currently on medication? _____

If so, please identify:_____

Please print legal name clearly:_____

Parent/Guardian Signature: _____

Authorization to Release/Obtain Information

I, _____ hereby agree that the Family Tree Project, LLP,
(Parent/Guardian)
_____ Release _____ Obtain (client/parent /legal guardian initials on line) information about me, the consumer, to/from the following individual:
(initial) (initial)

From/To: Youth Challenge Academy-OAHU Campus
1787 Shangrila St.
Kapolei, HI 96707
Phone: (808) 673-7530

Youth Challenge Academy-HILO Campus
PO Box 5210
Hilo, HI 96720
(808) 369-0948

The form in which this information will be shared (check appropriate): x Written x Verbal x Phone

For the person(s) providing consent
This consent has been freely, voluntarily and without coercion.
I was able to ask questions and receive answers about this release.
I hereby authorized obtaining the information as specified above and further understand that: Those who receive this information cannot disclose it to others without further consent, unless permitted by Federal or State law.

I also understand that I may revoke this consent at any time either verbally or in writing, except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event or condition upon which this consent expires)

Consent expires on this day (check one): x One year from signing _____ Other Date: _____
(Consent cannot be of greater length than one year)

_____ _____
Print name of client providing consent Date

_____ _____
Signature of client providing consent Signature of Parent or Guardian

_____ _____ _____
Signature of Staff/Agency Witness Title of Witness Date

This consent is withdrawn effective ____/____/____ Withdrawal requested: _____ Verbally _____ In Writing

Signature of Client:_____

**Original copy to Client's file (Family Tree Project)* **Copy to Provider(s)/client*

Family Tree Project, LLP

Consent for Evaluation and/or Treatment

Child Form

Name:

Date of Birth:

1. Consent to Evaluate/Treat: I voluntarily consent that my child will participate in a mental health evaluation and/or treatment by staff from Family Tree Project, LLP. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered

    The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Hawaii State Law for Mental Health Counseling. In addition to following the Hawaii Administrative Code, Family Tree Project, LLP, also follows ethics and requirements regulated by the American Counseling Association and the National Board of Certified Counselors.

2. Benefits to Evaluation/Treatment: Evaluation and treatment may be administered through psychological interviews, psychological assessment or testing, and psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. Charges when Applicable*: Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. If fees are applicable, I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees, when applicable will be agreed upon prior to the service with the responsible party. Clients have a right to terminate treatment at any time.

4. Confidentiality, Harm, and Inquiry: Information from my child's evaluation and/or treatment is contained in a confidential medical record at Family Tree Project, LLP. I consent to disclosure for use by Family Tree Project, LLP, staff for the purpose of continuity of my child's care. Per Hawaii State law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.

6. Expiration of Consent: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_____ _____

Signature of legal guardian for minor under age 18 Date

_____ _____

Signature of witness Date

Note: Hawaii State Law (HRS 577-26e) allows minors of any age who profess to seek treatment for Drug and/or Alcohol abuse without parental consent.

Family Tree Project, LLP

Consent for Evaluation and/or Treatment

Adult Form

Name:

1. Consent to Evaluate/Treat: I voluntarily consent that I will participate in a mental health evaluation and/or treatment by Family Tree Project, LLP, staff from Family Tree Project, LLP. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered

    The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Hawaii State Law for Mental Health Counseling. In addition to following the Hawaii Administrative Code, Family Tree Project, LLP, also follows ethics and requirements regulated by the American Counseling Association and the National Board of Certified Counselors.

2. Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. Charges when applicable: Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. If fees are applicable, I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees, when applicable will be agreed upon prior to the service with the responsible party. Clients have a right to terminate treatment at any time.
4.
5. Confidentiality, Harm, and Inquiry: Information from my evaluation and/or treatment is contained in a confidential medical record at the Family Tree Project, LLP, and I consent to disclosure for use by the Family Tree Project, LLP, staff for the purpose of continuity of my care. Per Hawaii State law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

6. Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

7. Expiration of Consent: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

_____ _____
Signature of client Date

_____ _____
Signature of witness Date

Family Tree Project, LLP

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Understanding Your Protected Health Information (PHI)
When you visit us, a record is made of your symptoms, examinations, test results, diagnoses, treatment plan, and other mental health or medical information. Your record is the physical property of the mental health care provider. The information within belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing disclosures to others. In using and disclosing your PHI, it is our objective to follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA) and requirement of state law.

Your Mental Health and/or Medical Record Serves as:

- A basis for planning your care and treatment.
- A means of communication among the health professionals who may contribute to your care.
- A legal document describing the care you received.
- A means by which you or a third party payer can verify that services billed were actually provided.
- A source of information for public health officials charged with improving the health of the nation.
- A source of data for facility planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Responsibilities of (Family Tree Project, LLP)
We are required to:

- Maintain the privacy of your PHI as required by law and provide you with notice of legal duties and privacy practices with respect to the PHI that we collect and maintain about you.
- Abide by the terms of this notice currently in effect. We have the right to change our notice of privacy practices and to make the new provisions effective for all protected health information that we maintain, including that obtained prior to the change. Should our information practices change, we will post new changes in the reception room and provide you with a copy.
- Notify you if we are unable to agree to a requested restriction.
- Use or disclose your health information only with your authorization except as described in this notice.

Family Tree Project, LLP

Your Protected Health Information (PHI) Rights

You have the right to

- Review and obtain a paper copy of the notice of information practices and your health information upon request. A few exceptions apply. Copy charges may apply.
- Request and provide written authorization and permission to release PHI for purposes of outside treatment and health care. This authorization excludes psychotherapy notes and any audio/video tapes that may have been made with your permission for training purposes.
- Revoke your authorization in writing at any time to use, disclose, or restrict health information except to the extent that action has already been taken.
- Request a restriction on certain uses and disclosures of PHI, but we are not required to agree to the restriction request. You should address your restriction in writing to the Privacy Officer by asking for the name of Privacy Officer, address, and phone. We will notify you within 10 days if we cannot agree to the restriction.
- Request that we amend your health information by submitting a written request with reasons supporting the request to the Privacy Officer. We are not required to agree with the requested amendment.
- Obtain an accounting of disclosures of your health information for purposes other than treatment, payment, health care operations, and certain other activities for the past six years but not before April 14, 2003.
- Request confidential communications of your health information by alternative means or at alternative locations.

Disclosures for Treatment, Payment, and Health Operations

Family Tree Project, LLP will use your PHI, with your consent, in the following circumstances:

Treatment: Information obtained by a nurse, physician, psychologist/counselor, dentist, or other member of your health care team will be recorded in your record and used to determine the management and coordination of treatment that will be provided for you.

Disclosure to others outside the agency: If you give us written authorization, you may revoke it in writing at any time but that revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not use or disclose your health information without your authorization, except to report a serious threat to the health or safety of a child and/or vulnerable adult.

For payment, if applicable: we may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identities you, as well as your diagnosis to obtain reimbursement for your health care or to determine eligibility or coverage.

For health care operations: Members of the mental health staff or members of the quality improvement team may use the information in your health record to assess the performance and operations of our services. This information will be used in an effort to continually improve the quality and effectiveness of the mental health care and services we provide.

We may use or disclose your PHI in the following situations without your authorization: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse/neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners and organ donation, research, or workers' compensation. Under the law, we must make disclosures to you when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements.

For More Information or to Report a Problem

If you have questions and would like additional information, please ask your clinician. He/she will provide you with additional information or put you in contact with the designated Privacy Officer. If you are concerned that your privacy rights have been violated or you disagree with a decision we have made about access to your health information, you may contact the Privacy Officer. We respect your right to privacy of your health information. There will be no retaliation in any way for filing a complaint with the Privacy Officer of our agency or the U.S. Department of Health and Human Services.

Family Tree Project, LLP

HIPAA Privacy Authorization for Use and Disclosure of Personal Health Information

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations as amended from time to time.

You may refuse to sign this authorization.

By my signature below, I acknowledge that I have received and read the Notice of Health Information Privacy Practices. I have been provided a copy of, read and understand (Family Tree Project) HIPAA Privacy Notice containing a complete description of my rights, and the permitted uses and disclosures of my protected health information under HIPAA. Further, I acknowledge that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and is no longer protected under HIPAA.

Name _____
Last First MI

Address: _____
Street City State Zip

Date of Birth:_____

Client Signature: _____ Today's Date:_____

Parent/Guardian Signature (if client under 18)_____

For office use only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained.

Reason: _____

_____ _____
Clinician Signature Date

Individual HIPAA Provider Number of Clinician Completing Form: _____

HIPAA Organization Number of Clinician Completing Form: _____