PLEASE KEEP A COPY FOR YOUR RECORDS

HAWAII NATIONAL GUARD JOB CHALLENGE ACADEMY MEDICAL AID STATION
Medical Treatment Authorization, Consent to Speak & Release of Information

FULL NAME OF ASSOCIATE: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ **Date of Birth:** _____/_____/_____

Consent for Medical Treatment and Communication

By my signature below, I hereby grant permission for my child to receive emergency medical treatment, non-emergency medical treatment, behavioral/mental health care, and/or routine health care as deemed necessary by the medical staff while enrolled as a candidate/associate.

I further consent to the medical staff of JCA acting on my behalf to select attending physicians, specialists, surgeons, psychiatrists, therapists, dentists, and medical facilities as necessary. This consent also includes the authorization for medical staff to communicate with these professionals regarding my child's health and treatment as required including to receive emails, voicemails, phone-calls, and/or test messages for appointment reminders and other healthcare communications.

I understand that I am financially responsible for services provided to my child and may receive a statement/bill from professional physicians or medical facilities.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORAMTION

I authorize medical doctors and/or facility (doctor office, dental office or Emergency Facility) to release/obtain the protected health information of my child listed above to the Hawaii National Guard Job Challenge Academy (HJCA) medical staff upon request. Information to be disclosed includes:

Discharge Summary, ER reports, history & Physical, Laboratory results, consults, X-ray/imagining reports, operative reports, entire records and/or other for the purpose of; individual request, legal purposes, insurance, physician follow-up at JCA and/or other.

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

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

"This institution is an equal opportunity employer"

Revised 7/2024

HILO BENIOFF MEDICAL CENTER
HONOKA`A HOSPITAL
KA`U HOSPITAL
Y. OKUTSU STATE VETERANS HOME

HAWAII HEALTH SYSTEMS CORPORATION

Patient Label

Patient Name:

Date of Birth:_____/_____/_____

COMMUNICATION CONSENT FORM

Consent to Email, Voicemail, Phone-call and/or Text Message for Appointment Reminders and Other Healthcare Communications:

Patients in our East Hawaii Region may be contacted via phone, email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, enrollment in our patient portal, and to provide general health reminders/information.

_____(***Patient initials***) I consent to receive voicemail, email, and/or text messages from the practice at my cell phone and any number forwarded or transferred to that number.

_____(***Patient initials***) I do NOT consent to any of the forms of contact stated above.

Patient/Guardian Signature:_____Date:_____Time: _____

Staff Signature:_____Date:_____Time: _____

Hawaii National Guard Job Challenge Academy

HILO CAMPUS

P.O Box 5210 Hilo, HI 96720

Phone: (808) 430-4184 Fax: (808) 969-1504

This certificate is not valid unless all fields are complete

Information (Please Print)

Last Name	**First Name**	**Birthdate (MM/DD/YYYY)**
Parent or Guardian Name:	**Telephone (Home or Mobile)**	
Street Address:	**City and State**	
Youth Challenge Campus & Class:	**Gender:** **M( ) F ( )**	

Date of Dental Screening: _____

Treatment NEEDS (Check ONE only based on screening results, prior to treatment services provided):

( ) NO obvious Problems – Youth's hard and soft tissues appear visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

( ) REQUIRES Dental care – tooth decay or a white spot lesion is suspected in one or more teeth, or gum infection is suspected.

( ) URGENT Dental Care – obvious tooth decay is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

Tooth decay: visible decay cavity or hole in a tooth with brown or black coloration, or a retained root.
Whit Spot lesion: a demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gum line. It is considered as an early indicator of tooth decay, especially in primary (baby) teeth.
Gum infection: Gum (gingival) tissue is red, bleeding or swollen.

SCREENING PROVIDER (Check ONE only):

( ) DDS/DMD ( ) RDH ( ) MD/DO ( ) PA ( ) RN/ARNP	
Provider Name (please print):	**Provider Business Phone:**
Provider Business Address:	
Signature & Credentials of Provider or Recorder:	
Date Signed:	
***Recorder: An authorized provide (DDS/DMD, RDH, MD/DO, PA, RN/ARNP) may transfer information onto this form from another health document. The other health document should be attached to this form**	