**Mail or fax form to:**
Leeward Community College
Student Health Center
96-045 Ala Ike, Pearl City, HI 96782-3393
(808) 455-0515 Fax (808) 455-0267

## AUTHORIZATION AND CONSENT FOR TB SKIN TEST (PPD)/MMR

NAME ______________________________________________ UH STUDENT ID # ____________________
Last (Family Name) First Middle

DATE OF BIRTH ____/_____/____ SEX: F ☐ M ☐

PARENT/LEGAL GUARDIAN NAME: ________________________________ RELATIONSHIP ______________

PHONE: (H)(______)______________ (W)(______)________________ (CELL)(______)______________
Area Code Area Code Area Code

Please answer the following: circle response

| | |
|---|---|
| History of positive TB skin test | YES NO |
| Previous treatment for TB | YES NO |
| Previous chest x-ray for TB | YES NO |
| Received MMR or Varicella vaccine in the past 4 weeks | YES NO |
| History of an immune system problem | YES NO |
| Currently taking immunosuppressant or steroid medications (such as prednisone, cortisone or anti cancer drugs) | YES NO |

If any of the above is yes, you may not be eligible to receive PPD. Please follow-up with your health care provider for further evaluation.

**AUTHORIZATION AND CONSENT FOR TREATMENT OF MINORS** - To be completed by a parent or guardian if the student will be under the age of 18 when seeking health services from Leeward Community College.

I, the parent/legal guardian of (PRINT STUDENT NAME)________________________________, in consideration of the services provided by Student Health Center, hereby voluntarily and knowingly authorize and give my express consent to the administration of TB skin test (PPD)/MMR to comply with the Health Clearance requirements. I understand that the PPD needs to be examined in 2–3 days to be valid.

**SIGNATURE OF PARENT/LEGAL GUARDIAN**______________________________DATE:________________

**University of Hawai'i at Manoa**
**Leeward Community College**
**96-045 Ala Ike, Pearl City HI 96782-3393**
**(808) 455-0515**

I Type ______

# HEALTH INSURANCE INFORMATION SHEET

## 1) PATIENT INFORMATION

| NAME: Last First Middle | | UH 10# ------------------------------------------- |
|---|---|---|
| DATE OF BIRTH: / / | SEX: ☐M ☐F | |

| Local Address | City: | State: | Zip Code: | Phone: ( ) |
|---|---|---|---|---|
| Permanent address: | City: | State: | Zip Code: | Phone: ( ) |

| Occupation: | |
|---|---|
| Employer. | |
| Address: | Phone: ( ) |

| EMERGENCY CONTACT: | Phone: (H) ( ) | Phone: (W) ( ) |
|---|---|---|

## 2) PRIMARY INSURANCE COMPANY

| Name of Insurance: | Policy or ID# : | Group # : |
|---|---|---|

| Subscriber: | Plan #: | Cov. Code: |
|---|---|---|

| Address: | City: | State: | Zip: |
|---|---|---|---|

| Phone: ( ) | Effective Date: | Expiration Date: |
|---|---|---|

Relationship to subscriber: child (c) spouse (p) self (s) other (o)

## 3) SECONDARY INSURANCE COMPANY

| Name of Insurance: | Policy or ID#: | Group # : |
|---|---|---|

| Subscriber: | Plan #: | Cov. Code: |
|---|---|---|

| Address: City: State: Zip: | Effective Date: | Expiration Date: |
|---|---|---|
| Relationship to Subscriber child (s) spouse (p) self (s) other (o) | Insurance Company Phone: ( ) | |

INSURANCE CARRIER:
I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME. TO THE UNIVERSITY OF HAWAII AT MANGA, UNIVERSITY HEALTH SERVICES AS INDICATED ON THE CLAIM. I understand I am financially responsible for any balance not covered by my insurance carrier.

______________________________ ______________
Signature of Patient (Parental signature required if under 18) Date

## Acknowledgement of Receipt of Notice of Privacy Practices

Leeward Community College
96-045 Ala Ike
Pearl City, HI 96782-3393

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To be read and signed by patient:
I acknowledge that I have received a copy of the LCC Notice of Privacy Practices.

Name (print) Signature Date

LCC Staff (for refusal to acknowledge)

I. Explain how you requested patient's acknowledgement

2. Explain reason why patient refused (if known)