Hui Ho'ola Maika'i Program

INDIVIDUAL CLIENT REGISTRATION FORM

CLIENT INFORMATION

LAST NAME: ____ FIRST NAME: ____ MIDDLE INITIAL: ____ MAIDEN NAME: ____

MAILING ADDRESS: ____ CITY: ____ STATE: ____ ZIP CODE: ____

RESIDENCE ADDRESS: ____ CITY: ____ STATE: ____ ZIP CODE: ____

HOME PHONE: ____ WORK PHONE: ____ OTHER PHONE: ____

DATE OF BIRTH: ____ ☐ FEMALE ☐ MALE E-mail ____

ETHNICITY: (SELECT ONLY ONE) ____ PLEASE LIST IF YOU SELECTED OTHER: ____

PRIMARY LANGUAGE: ○ English ○ Hawaiian ○ Other Marital Status (Select One) ____

Homeless: ____ IF HOMELESS - INDICATE DATES: FROM: ____ TO: ____

FAMILY INCOME (YEARLY): ____ FAMILY SIZE: ____

EMERGENCY CONTACT INFORMATION

(List person we may contact in case of emergency (If possible, someone from outside the home)

NAME: ____ RELATIONSHIP: ____ PHONE: ____

PARENT/GUARDIAN INFORMATION

(COMPLETE THIS SECTION ONLY IF CLIENT IS UNDER 18 YEARS OLD)

RELATIONSHIP TO CLIENT: ☐ PARENT ☐ GUARDIAN

Last Name: ____ First Name ____ E-Mail Address ____

Mailing Address: ____ City: ____ State: ____ Zip Code: ____

Residence Address: ____ City: ____ State: ____ Zip Code: ____

Home Phone: ____ Cell Phone: ____ Date of Birth: ____

Employer ____ Work Phone: ____

Waiver and Consent Agreement

I consent to participate voluntarily in Ho'ola Lahui Hawai'i's Programs. I am aware that this program includes health screenings which include but is not limited to monitoring of blood pressure, weight, body fat and body mass index. I understand that by signing this form, I agree for myself, my heirs, executors and administrators to release, indemnify and hold harmless all Ho'ola Lahui Hawaii committee members, its affiliates, officers, directors, employees, volunteers and all sponsoring businesses and organizations and their agents and employees from any and all activities, whether it results from negligence of any of the above or from any other cause. I further agree that this consent and waiver agreement shall be applicable to any owner of a facility and/or property at or upon which the program is held. I am solely responsible for my own health and safety. I represent that I am physically fit and able to participate in this program. I am hereby, advised to consult my physician before participating in this program. Consultation with a physician my be required. Furthermore, I hereby grant full permission to any and all of the foregoing to use my name, my voice and or my picture or likeness in any broadcast, telecast, advertising, promotion or other account of this event for any purposes whatsoever. I understand that there will be a $20.00 service charge for all returned checks. I have read, understand and agree to the terms of this agreement and have, of my own free will, signed below to indicate so.

I have read/received a copy of the "Client's Rights and Responsibilities & Grievance Procedures handbook."(Click the link above to read and initial here)

Signature of Client **(OR)** (Parent/Guardian Signature for Client if UNDER 18 years old)

PRINT NAME :

Date:

I have read/received a copy of the "HIPAA Notice of Privacy Practices."(Click the HIPAA link to read and initial here)

HUI HO'OLA MAIKA'I STAFF ONLY:

Reviewed By:

Date:

☐ New ☐ Updated

☐ Registration Card ☐ Kapaa ☐ Waimea

MEDICAL CLEARANCE (MC): ☐ YES ☐ NO

IF YES:

☐ Gave MC to Client

☐ Faxed MC to Doctor listed below

Date Medical Clearance Received

Date Medical Clearance Received Noted on Registrant Card

Doctor:

☐ Medical Clearance Filed In Client Chart

Date Faxed: