PEARL HAVEN

A Program of HOʻŌLA NĀ PUA

Admission Packet

Please email completed packet to:

Elizabeth Porter, Program Director
Phone: (808) 900-8747
admissions@hoolanapua.org

Attach the following documents, if available:

- ☐ Admission Packet
- ☐ Court Documents
- ☐ Immunization Records
- ☐ Medical History
- ☐ Mental Health History
- ☐ Consent Forms
- ☐ School Records
- ☐ Discharge Summaries from Previous Placements

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Youth Name (first, middle, last): _____ DOB: _____

1. The entire packet must be completed prior to admission.

2. If medication is sent with the youth during intake, a full inventory sheet documenting medication, dosage, and quantity must be provided. Medication must be packaged separately from other property. Pearl Haven staff must be notified that medication is present when a youth is transferred to their custody.

3. All of the following documents are required for admission to ensure quality of care and meet licensing requirements.

    a. Court Documents (including most recent Dispositional and Permanency Hearing reports)

    b. Health and Medical History
        i. Immunizations
        ii. Current treatment needs and medications
        iii. Past Medical Procedures

    c. Mental Health Treatment History
        i. Any available psychological evaluation
        ii. Current treatment needs and medications
        iii. Prior counseling efforts
        iv. Prior Medications
        v. Prior Psychiatric hospitalizations

    d. Consent Forms

    e. School Records

    f. Discharge Summaries from previous placements

All questions regarding policy and consents must be resolved prior to admission into the program to ensure safe and appropriate care for all youth at Pearl Haven.

Parent/Guardian Name (printed): _____ Date: _____

Parent/Guardian Name (Signature): _____ Date: _____

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Mental Health Treatment History

Youth Name (first, middle, last): _____ DOB: _____

In order to develop the appropriate treatment plan for the youth, Pearl Haven must receive the following information prior to admission:

1) Current Psychological Evaluation: ☐ Included ☐ Not Included

If included, when is the evaluation dated? _____

Current diagnoses (DSM-V): _____

Past diagnoses: _____

2) Current Treatment Needs:

☐ Aggression towards peers	☐ PTSD/Trauma	☐ Physical Abuse
☐ Aggression towards staff	☐ Self-Harm	☐ Emotional Abuse
☐ Prior Substance Abuse	☐ Suicide Ideation	☐ Sexual Abuse
☐ Prior Running Away	☐ Gang Association	☐ Neglect
☐ CSEC/Trafficking/Exploitation	☐ Psychiatric Hospitalization	☐ Other: _____

3) Current Medication: List the psychotropic medications that you know are taken by the youth.

Medication name (generic or brand)	Dosage	Time of Day	# of Doses Per Day

Type of Consent **Included:**

☐ Parental Consent ☐ DHS ☐ Other: _____

Plan to Continue Medication:

☐ 14-day supply provided ☐ Prescription provided ☐ Other: _____

4) Prior Psychiatric Hospitalizations:

Date of Hospitalization	Length of Stay	Discharge Paperwork Included
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

Hospitalizations within the past 12 months require discharge paperwork prior to admission.

Hospitalizations within the past 90 days must be reviewed by the Pearl Haven Clinical Team prior to acceptance.

Parent/Guardian Name (printed): _____ Date: _____

Parent/Guardian Name (Signature): _____ Date: _____

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Consent for Treatment and Financial Agreement

Student Name:_____ D.O.B.:_____

Thank you for choosing Pearl Haven for your child's needs. It is our goal for our patients, parents, and placing agencies to understand the treatment services as well as their financial responsibility before treatment begins.

Youth is placed at Pearl Haven by:

☐ Court Order ☐ Parent/Guardian ☐ Other: _____

Treatment Services and Residential Care are paid by:

☐ Medical Insurance _____ ☐ Private Pay ☐ Other: _____

Financially responsible party for costs not covered by insurance: _____

All charges not paid by the youth's insurance company are your responsibility regardless of the reason for nonpayment.

I hereby authorize Pearl Haven to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper medical care.

I authorize and consent to routine and emergency treatment for my child when deemed necessary by the licensed treatment provider. I understand that if the treatment needs of my child change then the needed treatment will be completed, and I am responsible for any additional costs involved. In the event of a medical emergency, and I cannot be reached, I authorize the licensed treatment provider to provide emergency medical treatment and use his or her discretion in authorizing any medical decisions for my child.

I will make all payments of treatment expenses which are not covered by the child's insurance. In the event legal action should become necessary to collect an unpaid balance due for treatment services rendered to my child, I/we agree to pay reasonable attorney's fee or other such cost as the Court determines proper.

Purpose, Limitations and Risks

The purpose of treatment is to reduce distress through a process of personal change. Moreover, the process of treatment services usually involves working through tough personal issues that can result in some emotional or psychological pain for the client. Attempting to resolve issues that brough forth involvement in therapy may result in changes that were not originally intended. Treatment may result in decisions about changing behaviors, relationships or virtually any other aspect of the client's life. At times, a decision that is considered positive for one family member may be viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that treatment or other services will yield positive or intended results.

If participation in group or family treatment services and activities, unless the plan of care specifies individual treatment only occurs, understand that during these sessions, other members of the group or family session will hear or see information that would otherwise be considered Protected Health Information. Though the staff member will keep all information confidential, (except as required by law), other members of the group or family treatment session are not bound by the rules of HIPAA or other rules or laws that require confidentiality.

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Treatment process and rights

Treatment will begin with one or more sessions devoted to an initial assessment so that a good understanding of the issues, background information, and any other factors that may be relevant can be acquired. When the initial assessment process is complete, a Treatment plan will be developed. Clients have the right and the obligation to participate in the development and review/revision of the treatment plan. Clients and their Parent/Guardian have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdrawal.

Parent/Guardian Name (printed): _____ Date: _____

Parent/Guardian Name (Signature): _____ Date: _____

Phone Number: _____

Address: _____

Street Address City State Zip Code

Copy must be placed in youth case file and documented in individual treatment plan.
This consent remains active until the youth exits the program or the agency withdraws consent.

PEARL HAVEN
A Program of HOʻŌLA NĀ PUA

Informed Consent for Telemedicine Services

(Page 1 of 2)

Youth Name (first, middle, last): _____ DOB: _____

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The inability to have direct, physical contact with the patient is a primary difference between telemedicine and direct in-person service delivery. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, buy may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgement error;
- It may not be appropriate if you are having a crisis, acute psychosis, or suicidal/homicidal thoughts.

Please initial after reading this page: _____

PEARL HAVEN
A Program of HOʻŌLA NĀ PUA

Informed Consent for Telemedicine Services

(Page 2 of 2)

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I will not record the telemedicine services provided and the provider shall not record the telemedicine services unless it is deemed clinically necessary and my consent to record is documented.
3. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
4. I understand that I have the right to inspect all information obtained in the course of telemedicine interaction and may receive copies of this information for a reasonable fee.
5. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.
6. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

Parent/Guardian Name (printed): _____ Date: _____

Parent/Guardian Name (Signature): _____ Date: _____

Copy must be placed in youth case file and documented in individual treatment plan.
This consent remains active until the youth exits the program or the agency withdraws consent.

PEARL HAVEN
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Consent for Athletic Participation and Community Event Participation

Youth Name (first, middle, last): _____ DOB: _____

I understand that Peral Haven offers youth the opportunity to participate in high school athletics, school and community events. I understand that youth have the opportunity to participate in activities that may attract media attention that cannot be controlled by Pearl Haven.

I approve of her participation in the sports and/or community events she may choose and release Pearl Haven from responsibility for breach of confidentiality in these circumstances.

I give my permission for the youth to fully participate in the Pearl Haven athletic programs and community events.

Parent/Guardian Name (printed): _____ Date: _____

Parent/Guardian Name (Signature): _____

Photograph/Media Consent

As part of a normalized high school and adolescent experience, Pearl Haven provides youth pictures of themselves, their team, and their peers participating in activities and events.

Photographs and video may be used as part of sports practice to review team performance or for a commemorative slide show at the end of a sports season or graduation ceremony.

Additionally, notification and permission is required if a youth would like to provide their picture for use in a publication or website posting.

Parent/Guardian Name (printed): _____ Date: _____

Parent/Guardian Name (Signature): _____

Copy must be placed in youth case file and documented in individual treatment plan.
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Use of Electronic Devices and Communication Procedures

Youth Name (first, middle, last): _____ DOB: _____

Communication with permanent connections is an essential component of youth success. Based on this youth's assessments and risks, it is required for her safety that she only be authorized to make contact with specific persons authorized by her placing agency (see *Youth Authorized Contact List*).

Letters and phone call will follow established policy to ensure youth safety.

Youth will use computers for educational activities and develop age-appropriate skills with such devices. The youth is not authorized to possess an electronic device capable of independent communication at this time.

Specific risk factors are listed as follows (*check all that apply*) and will be fully addressed in the youth's needs and services plan upon entry.

- ☐ Prior Substance Abuse (serious or significant)
- ☐ Prior Running Away
- ☐ CSEC/Trafficking/Exploitation
- ☐ PTSD/Trauma
- ☐ Prior Self Harm
- ☐ Prior Suicide Gesture and/or Attempt
- ☐ Prior Psychiatric Hospitalization
- ☐ Gang Association

Parent/Guardian Name (printed): _____ Date: _____

Parent/Guardian Name (Signature): _____

Copy must be placed in youth case file and documented in individual treatment plan.
This consent remains active until the youth exits the program or the agency withdraws consent.

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Consent and Acknowledgement of Youth Search Procedures and Use of Safe Physical Management

Youth Name (first, middle, last): _____ DOB: _____

Placing Agency: _____

Youth safety is an essential component of effective treatment. This agency provides written consent for Pearl Haven to implement searches to ensure the wellbeing of this youth, based on their history, risk factors and individual treatment plan. Searches will include body and living area searches conducted in a safe and respectful way as described in Pearl Haven Policy 600.123. Pearl Haven will utilize these search procedures to ensure the health, safety, and welfare of the youth, staff, campus, and surrounding community.

Pearl Haven will utilize approved Safe Nonviolent Physical Management Techniques to ensure the health, safety, and welfare of the youth, staff, and campus and surrounding community. This document serves as written consent for Pearl Haven to utilize Safe Nonviolent Physical Management Techniques to protect youth from immediate harm including attempt to run away from the program should such an attempt present a physical harm to the youth.

Based on this youth's history, risk factors, and individual treatment plan, she poses an imminent danger to herself and/or others.

Specific risk factors are listed as follows (*check all that apply*) and will be fully addressed in the youth's needs and services plan upon entry.

- ☐ Prior Substance Abuse (serious or significant)
- ☐ Prior Running Away
- ☐ CSEC/Trafficking/Exploitation
- ☐ PTSD/Trauma
- ☐ Prior Self Harm
- ☐ Prior Suicide Gesture and/or Attempt
- ☐ Prior Psychiatric Hospitalization
- ☐ Gang Association

Parent/Guardian Name (printed): _____ Date: _____

Parent/Guardian Name (Signature): _____ Date: _____

Copy must be placed in youth case file and documented in individual treatment plan.
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Youth Approved/Unapproved Contact List

Name/Relationship to Youth	Address	Phone Number	Type of Contact Please Circle all that apply	Approved Contact Yes or No
			Phone ☐ Mail ☐ In-Person ☐	
			Phone ☐ Mail ☐ In-Person ☐	
			Phone ☐ Mail ☐ In-Person ☐	
			Phone ☐ Mail ☐ In-Person ☐	
			Phone ☐ Mail ☐ In-Person ☐	
			Phone ☐ Mail ☐ In-Person ☐	
			Phone ☐ Mail ☐ In-Person ☐	
			Phone ☐ Mail ☐ In-Person ☐	
			Phone ☐ Mail ☐ In-Person ☐	
			Phone ☐ Mail ☐ In-Person ☐	

Parent/Guardian Name (printed): _____ Date:_____

Parent/Guardian Name (Signature):_____ Date:_____

Copy must be placed in youth case file and documented in individual treatment plan.
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Medical Enrollment Checklist

- ☐ **Negative TB Test:** must be from within the past 12 months. Mandatory before patient can physically step foot on PH campus.
- ☐ **Physical:** must be from within the past 12 months.
    - Physician Information Form
- ☐ **Immunization Record:**
- ☐ **Medical Consent Forms:** the following forms are included in intake packet.
    - Authorization for Medical Records & Psychological Services
    - Authorization for Routine and/or Diagnostic Procedure, Emergency Surgery or Medical Treatment, and for Medical and Psychological Records.
    - Informed Consent For Telemedicine
    - Over the Counter Medications Consent Form
    - Mental Health Treatment History Form
    - Flu Vaccine Consent or Declination Form
- ☐ **Medical Insurance Card:** copy of the card. Please verify that the patient's insurance covers routine (not just emergent) care in the state of Hawaii.
- ☐ **Current Medication List:** medication name, dose, and instructions. A copy of the patients current MAR (Medication Administration Record) would be sufficient.
- ☐ **Neuropsych Evaluation:** must be from within the past 12 months.
- ☐ **Psychiatrist Progress notes:** 4 most recent notes. This will help our psychiatrist get up to date on the case and help with the transition of care.
- ☐ **COVID-19 Vaccine Card:** copy of the card. If unvaccinated, a consent or declination form is required.
- ☐ **Medical Records:** only required for current health problems or chronic conditions (ex. Asthma)

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PHYSICIAN INFORMATION

Youth's Name_____ Date of Birth _____

Physician's Information

Agency Name:
Name of Physician:
Address:
Telephone:
Email

_____ _____
Signature of Parent/Guardian Date

Please provide information on any current standing orders for the youth on diet restrictions/concerns below (if none, please document):

_____ _____
Signature of Physician Date

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OVER THE COUNTER MEDICATIONS CONSENT FORM

Youth Name: _____ **Date:** _____

Over the Counter Medication Option: Pearl Haven can provide and monitor the self-administration of over-the-counter medication with Guardian consent. By signing below, you are giving consent to Pearl Haven staff to monitor in the self-administration of the following over the counter medications according to directions on bottle.

Allergies (please state if there are none):

_____

_____

_____

MEDICATION	DIRECTIONS FOR USE
ANAPHYLACTIC AGENT	
Epi Pen 0.3 mg (Epinephrine)	Emergency treatment in anaphylaxis, i.e. bee stings. IM in thigh, may repeat if needed.
ACNE PREPARATION	
Benzoyl Peroxide Gel 5%, 10% (Oxy 5%, 10%, PersaGel)	Apply sparingly to clean face, chest, back, 1-2 times daily.
ANTACID OF CHOICE	
Generic Antacid Tablet	1-2 tabs or 30 ml every 4-6 hours as needed for stomach upset.
ANTI-ALLERGIC/DECONGESTANT	
Diphenhydramine 25 mg (Benadryl) *causes drowsiness	25 mg every 4-6 hours as needed for allergies or rash; 25-50mg for sleep.
Medicidin-D	One tab every 6 hours as needed for allergies, runny nose, congestion, itchy eyes, cold s/s. ***Caution**: contains Tylenol
Contact, Dayquil, Dristan, or other decongestant	Use as directed.
Nasal Spray (Sodium Chloride 0.65%)	Nasal Moisturizer: 1-2 sprays in each nostril as needed

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ANTI-DIARRHEAL	
Loperamide HCL 2 mg (Imodium)	Take two tabs initially, then one pill after each unformed stool; max 8 mg per day. STOP AFTER 48 HOURS
ATHLETES FEET/FUNGAL	
Clotrimazole 1%, Lotrimin 1%, Lamisil 1%, Tinactin Cream or Powder	Apply twice daily until gone and then 1 week longer
CONSTIPATION	
Generic Brand Stool Softener	Use as directed.
COUGH/SORE THROAT	
Guaifenesin 100mg/5ml or Mucinex	10-20 ml every 4 hours as needed for cough (2 teaspoons)/1 tablet of Mucinex Q12H PRN congestion
Throat Lozenges or Cough Drops of Choice	As needed
EYE DROPS	
Visine, Optopic Sterile Irrigant, Sterile Water	Apply 1-2 drops each eye as needed for itching or minor irritation
MOSQUITO REPELLANT OF CHOICE	
Off, Repel, etc.	Apply as needed
PAIN RELIEVERS	
Acetaminophen 325mg (Tylenol)	1-2 tabs every 4-6 hours as needed for pain (325mg-650mg). Do not take more than 12 tablets in 24 hours.
Ibuprofen 200 mg (Advil, Motrin)	Two tablets every 4-6 hours as needed pain (400mg)
Naproxen Sodium 220mg (Aleve)	2 caplets for first dose, then 1 caplet every 8-12 hours for pain, not to exceed 2 caps in 8-12H; or 3 in 24H
Menstrual Complete (Acetaminophen 500mg, Caffeine 60mg, Pyrilamine maleate 15mg)	2 caplets every 6 hours as needed, not to exceed 6 caplets per day (*Contains Tylenol)
Oral Pain Reliever of Choice (Orajel, Orabase, Ambesol, Campho-phenique)	Apply to cold/canker sores as needed, tooth for pain.

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TOPICAL CREAMS/OINTMENTS	
Hydrocortisone Cream 1% (Cortaid)	Apply thin film to rash two-three times per day
Caladryl Lotion, Calamine Lotion, Benadryl Gel	Apply as needed to bug bites for itching
Triple Antibiotic Ointment (Neosporin, Bacitracin)	Apply to wound 2-3 times per day as needed
Muscle Rub of Choice (i.e. Icy Hot/Biofreeze)	Apply to sore muscles as needed
Abreva (Docosanol)10% Cream	Apply to external cold sores, up to 5 times per day until healed. (Not for use inside mouth).
Calmoseptine Cream	Apply to skin irritations as needed
Sunblock (at least SPF 15)	Apply as needed
Cranberry Soft gels 300mg	1 soft gel three times a day with water at meal times, increase fluid intake to 6-8 glasses per day
VITAMINS OF CHOICE (Multivitamin and Vitamin C)	1 each daily
Lice Treatment	Apply on hair and scalp, as needed

Guardian *(Printed)*		**Guardian Signature**		**Date**	

Physician *(Printed)*		**Physician Signature**		**Date**	

HOʻŌLA NĀ PUA

Referral and Permission Form

Please complete with as much accurate information as you have available. Call/email with any questions Hoʻōla Nā Pua, 808-445-3131, **starfish@hoolanapua.org**

REFERRAL SOURCE

Referring Agency OR Individual: _____

Point of Contact/Title: _____

Phone: _____ Email: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Legal Name:_____

Phone: _____ Email: _____

EMERGENCY CONTACT PERSON

Name:_____ Phone: _____

Relationship to Client: _____

PERSONAL DATA

Client Legal Name: _____ DOB: _____

Phone: _____ Email: _____

Current Address: _____

_____

_____

Permanent Address: _____

_____

_____

CSEC ASSESSMENT

This person has been identified as:

☐ **At-risk** of Commercial Sexual Exploitation Children

Check Risk Factors: ☐runaway ☐homeless ☐ gang affiliation ☐ older boyfriend
☐in foster care ☐history of sexual abuse ☐ arrest history
☐substance abuse history ☐send or receives nude pictures

☐**CSEC Confirmation**

Was a Screening/Identification Survey or Tool used? (Select one): ○ YES ○ NO

If yes, name of Screening/Identification Survey or Tool used:

_____

If your child suffers from any illnesses, disabilities (learning or behavioral), or allergies (e.g. food, medicines, bee stings) that may impact him/her while they participate in our program please share them below.

Hoʻōla Nā Pua Consent for Services Permission Form

I, (we)_____, _____, the undersigned parent(s) or guardian(s) of _____ (child's name), do hereby give my/our consent for said minor to participate services with Hoʻōla Nā Pua (HNP.

I understand that all HNP services are voluntary. All services are free of charge. It is understood that this consent is subject to revocation by the undersigned at any time expect to the extent that action has already been taken on that consent.

The information shared with our providers is treated with the utmost respect. All interactions and personal records of clients are confidential. Disclosure of confidential information is only made with a client's (parent/guardian's if client is a minor) written consent. However, ethically we are required to disclose specific information as it pertains to safety. Exceptions include: a) when required by court order; b) when there is knowledge of, or good reason to believe a child is being abused or neglected; c) when it is believed there is imminent danger of harm or violence to your child or others, and d) for quality assurance reviews, licensing, accreditation, and/or audit.

In case of an emergency involving my child, I understand that efforts will be made to contact me. In the event I cannot be reached, permission is hereby given to the medical provider to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

With appreciation of the dangers and risks associated with programs and activities including preparations for and transportation to and from the activity, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against Hoʻōla Nā Pua, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

By signing below, I am verifying that I am the legal parent or guardian of the aforementioned minor and have the legal right to consent for said minor to receive services from Hoʻōla Nā Pua.

_____

Parent/Legal Guardian Name Printed *(if child is under the age of 18)*

_____ _____

Parent/Legal Guardian Signature Date

_____

Parent/Legal Guardian Name Printed *(if child is under the age of 18)*

_____ _____

Parent/Legal Guardian Signature Date

STATE OF HAWAIʻI
DEPARTMENT OF EDUCATION

CONSENT FOR RELEASE OF INFORMATION

Student's Name: _____ Date of Birth: _____
Last Name First Name Middle Initial

Grant permission to the Hawaiʻi Department of Education, _____
Name of DOE School or Office

_____
Address City State Zip Code

_____
Department of Education Contact Phone Number Fax Number

To: ☐ RELEASE ☐ RECEIVE (Check one)

the following document(s)/information, on the above named student, except that which is legally not subject to disclosure by law, and is covered under the Hawaiʻi Revised Statutes, §325-101 Infections and Communicable Diseases (HIV Infection, ARC, and AIDS); §329-68 Uniform Controlled Substances Act (Protection of records; divulging confidential information prohibited) and §329-B6 Substance Abuse Testing (Test Results) **to or from the agency or person listed below:**

_____
Name of Agency or Person Phone Number

_____
Address City State Zip Code

Specify document(s)/information authorized for release or receipt:

For the purpose of:

This personal document(s)/information will be transmitted to the agency or person named above only on the condition that it not be shared with another agency or other person(s) without the written consent of the parent(s), or legal guardian(s), or eligible student (an "eligible student" means a student who has reached 18 years of age or is attending a postsecondary institution at any age).

_____ _____
Parent/Legal Guardian or Eligible Student Signature Date

_____ _____
PRINTED Name of Parent/Legal Guardian or Eligible Student Phone Number

_____
Address City State Zip Code

DISTRIBUTION: School Parent Agency

eCSSS, OITS-IAS
Form HAR 34
Rev. 11/11, RS 12-0504