



# 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 Hawaii'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 may 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)

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

PRINT NAME :

Date:

**HUI HO'OLA MAIKA'I STAFF ONLY:**

Reviewed By:

Date:

New

Updated

Registration Card

Kapaa

Waimea

MEDICAL CLEARANCE (MC):

YES

NO

Date Medical Clearance Received

IF YES:

Gave MC to Client

Faxed MC to Doctor listed below

Date Medical Clearance Received  
Noted on Registrant Card

Doctor:

Medical Clearance Filed In Client Chart

Date Faxed: