Student Health Advocates LLC

Enrollment Form

Student Information:

Last/Sur Name: _____ First/Given Name: _____ Middle/Other: _____

Date of Birth: _____ Nationality: _____ Gender:_____

Home Address: _____

Name of US School attending: _____

Parent/Legal Guardian Contact Information:

Parent #1's Name: _____ Parent #2's Name: _____

Parent #1's Email Address: _____ Parent #2's Email Address: _____

Parent #1's Cell Phone: _____ Parent #2's Cell Phone: _____

Parent #1 Speaks English: ____NO ____YES Parent #2 Speaks English: ____NO ____YES

*Has the student been tested for COVID-19? ____NO ____YES

If yes, please list the result_____

*Family must present documentation of student's negative test result before beginning Quarantine program. Testing is not required for the Emergency Contact and Off-Campus Housing programs.

Medical Insurance Information:

Company Name: _____Policy #: _____

Coverage Start Date: _____ Coverage End Date:_____

_____

Parent #1 - Signature Date (MM/DD/YYYY)

_____

Parent #2 – Signature Date (MM/DD/YYYY)

Student Health Advocates LLC
Parental Agreement & Contract for Services

I/We, the undersigned parents/guardians of (student name) _____ agree to complete the terms of the Student Health Advocates program and financial obligations prior to my/our student's arrival for the start of school or at the time of enrollment if the school academic year has begun.

I/We agree to provide SHA temporary adult authority over the best interests of my/our child during emergency situations and while my/our child is engaged in non-emergency services provided by SHA.

I/We agree to uphold our financial obligations for my/our student while enrolled in Student Health Advocates and abide the refund policy.

I/We agree that if our student does not gain entry in the United States due to US State Dept. travel restrictions that this contract will be void and that we will receive a refund of all payments made.

I/We agree to provide copies of all health insurance documents to Student Health Advocates prior to my/our student's arrival in the United States and upon any further request by Student Health Advocates.

I/We agree to immediately notify Student Health Advocates of any changes to my/our child's health insurance and/or coverage.

I/We agree that any additional medical expenses incurred in the US by my/our child is solely my/our responsibility and not that of Student Health Advocates or its agents, employees, and/or representatives (including host families).

I/We agree to notify Student Health Advocates of any changes to my/our contact details as soon as possible.

I/We agree that Student Health Advocates has the right to terminate this financial agreement should any Student Health Advocates policies be violated by the parents or the student, including but not limited to: nonresponse to SHA communication for more than three business days; student's gross violation as determined by SHA staff of the Student Code of Conduct while the student is engaged in SHA services off campus; parents' verbal or physical harassment, assault, or threat of violence toward any SHA employee, subcontracto, and any SHA-enrolled student; parents' acting on behalf of another SHA student without SHA's express consent; and false accusations, slander, or libel related to SHA employees, subcontractors, and SHA-enrolled students.

I/We agree to indemnify, defend, and hold harmless SHA, its agents, employees, and/or representatives from and against all actions, damages, liabilities, costs, and expenses; including reasonable attorneys' fees; arising as a result of any claim for bodily injury or damage to real personal property.

PARENTAL AGREEMENT CONT'D.

Program Fees & Services (check all that apply): *Once we receive completed forms and Enrollment Fee, we will send you a registration confirmation and begin organizing other services if required.*

- ☐ **Emergency Contact Program: Standard Enrollment – $2,000**
- ☐ Emergency Contact Program: Expedited Enrollment – $3,000
- ☐ Pre-campus Arrival Quarantine – billed separately
- ☐ Airport transportation service to/from school and/or quarantine site – billed separately

_____

Parent #1 - Signature Date

_____

Parent #2 - Signature (optional) Date (optional)

Student Health Advocates LLC

Parental Consent for Medical Care for a Minor

This medical consent form is necessary to authorize healthcare services for students who are under 18 years of age while participating in the Student Health Advocates program.

CONSENT TO MEDICAL TREATMENT

Date: _____

I/We _____and _____,
(Parent #1 Full Name) (Parent #2 Full Name)

of_____
(Residential Address)

are the parents/legal guardians of _____,
(Student's Full Name)

whose date of birth is _____ / _____ / _____.
(Month) (Day) (Year)

I/We hereby appoint agents, employees, and/or representatives of *Student Health Advocates*, and/or host families who are members of *Student Health Advocates*, to act on behalf of and in the best interest of our child concerning his/her medical treatment and to obtain any necessary medical treatment in the United States of America for my/our child while participating in the *Student Health Advocates* program.

In case of illness, accident, or injury, I/we authorize an agent/employee/representative of *Student Health Advocates* to seek treatment by qualified medical personnel, to consent on our

behalf to any emergency medical or dental treatment to be rendered to my/our child, and to release pertinent information to appropriate health care professionals.

I/We understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of *Student Health Advocates* to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed health care provider may deem advisable.

I/We, the undersigned, release anyone affiliated with Student Health Advocates, from any and all current and future claims, charges, costs and/or causes of action for loss of property, personal injury, illness, accident or death sustained by our student, regardless of insurance coverage. I/We further agree to indemnify Student Health Advocates for any and all liabilities, including liabilities to third parties, and accept full financial and legal responsibility for our student

EMERGENCY CONTACT

Parent #1

Home phone: _____ Work phone: _____
Mobile phone: _____

Parent #2

Home phone: _____ Work phone: _____
Mobile phone: _____

_____

Parent #1 - Signature Date (MM/DD/YYYY)

_____

Parent #2 - Signature Date (MM/DD/YYYY

_____

SHA Representative Acceptance Date (MM/DD/YYYY)

SHA
STUDENT HEALTH ADVOCATES

Student Health Advocates LLC

Consent for Release of Student Information

As parents, or legal guardians, of _____ born ____/___/___
(Student's Full Name) (DOB: MM/DD/YYYY)

I/We _____ and _____,
(Parent #1's Full Name) (Parent #2's Full Name)

of_____ hereby authorize
(Residential Address)

_____located at _____
(Name of School) (Address of School)

to release all necessary student records, including but not limited to student's health and academic records, to agents, employees, and/or representatives of *Student Health Advocates* upon request.

I/We understand that this information is considered a student education record. Further, I/we understand that by signing this release, we are waiving the right to keep this information confidential under the Family Educational Rights and Privacy Act (FERPA). I/We certify that consent for disclosure of this information is entirely voluntary. I/We understand this consent for disclosure of information can be revoked in writing at any time, but will not affect the information released under any previous consent. If I/we wish to make any changes to this consent for release, I understand that I will need to complete and file a new form.

☐ I/We wish to waive the right to confidentiality provided under FERPA, and release my/our child's information to *Student Health Advocates*. (Check box to consent)

_____

Parent #1 - Signature Date (MM/DD/YYYY)

_____

Parent #2 - Signature Date (MM/DD/YYYY)

Student Health Advocates – Payment Instructions

Banking Information

Wire Transfer Information: preferred method of payment

SWIFT Code: NRTHUS33XXX
Account Number: 4377545301
Routing Number: 011103093

TD Bank
319 North Main St.
West Hartford, CT 06117

Student Health Advocates
801 Farmington Ave.
West Hartford, CT 06119

Credit Card Authorization: subject to 5% service fee for all transactions

Required only for future services, as needed, to be billed at least 24 hours before services are rendered. Invoice will be sent detailing each additional service prior to billing credit card.

☐Visa ☐Mastercard ☐AMEX ☐Discover

_____
Name on Card

_____ _____
Student Name Relationship to Student

_____
Credit Card Number

____/____/____ _____
Expiration Date Validation Code

_____
Signature

**By singing you agree to all privacy terms and conditions, and authorize Student Health Advocates to charge above card for additional services as needed or required by card holder or individuals on their behalf.*