Waikato University Tauranga Campus
Student Health – 101 Durham Street, Tauranga

TAURANGA CONSENT FORM

Legal Name *	(Title)	**Family Name***	**First Name(s)***	**Middle Name(s)**
Other Name(s) * (E.g: Maiden Name/Preferred Name) Please tick the name you prefer to be known as			**NHI (office Use only)**	**Student ID Number:**
Birth Details *		**Day/Month/Year of Birth***	**Place of Birth***	**Country of Birth***
Gender * (you would like to be identified as)	☐ Male ☐ Female ☐ Gender Diverse (please state) _____		**Sex** (at birth)	☐ Male ☐ Female ☐ Another Term _____
Occupation & Employer details				

Residential Address * (During Academic Year)	**House (or RAPID) Number and Street Name***	**Suburb/Rural Location***	**Town / City and Postcode***
Postal Address (if different from above)	**House Number and Street Name or PO Box Number**	**Suburb/Rural Delivery**	**Town / City and Postcode**

Contact Details	**Mobile Phone**	**Home Phone**	I agree to receiving Txt messages ☐ Yes ☐ No Email Address	
Emergency Contact/NOK	Name		Relationship	Mobile Phone (or other)

Community Services Card	☐ Yes	☐ No	**Expiry Day/Month/Year**	**Card Number**

Ethnicity Details *

Which ethnic group(s) do you belong to? (Tick multiple boxes if needed, including Iwi.)

☐ New Zealand European ☐ Māori, Iwi: _____

☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian

☐ Other (such as Dutch, Japanese, Tokelauan). Please state: _____

*Fields with * are compulsory*

Consent to Share Health Information with other Health Providers involved in my care: ☐ Yes ☐ No

Smoking is an important factor influencing health

If you are aged 15 and over, please tick the space that applies for you

☐ Currently smoke ☐ Recently quit ☐ Ex-smoker (over 1 year) ☐ Never smoked

Smoking has a hugely negative impact on your health. In most cases, you will immediately experience the benefits of quitting.

If you currently smoke, would like some help to quit? ☐ Yes ☐ No

Student Health Service (Tauranga) keeps records of the interactions that you have with the service.

Occasionally the nurse may need to discuss relevant health information with other members of Student Health Service or external health providers including Bay Counselling or your GP to ensure you are able to access the services you need. If the nurse is concerned about your safety or the safety of others, then the nurse may need to disclose relevant health information to other parties such as emergency services or student accommodation managers.

Consent to Share Information

I give consent for my information to be used for the assessment and care coordination of my treatment/support and acknowledge that I am entitled under the Privacy Act and Health Information Privacy Code to access any information and documentation that relates to me.

I understand that this consent form will be held by Student Health Service as a part of my clinical notes, and that, if I am referred to Bay Counselling, a copy of this consent will also be sent to Bay Counselling.

Please indicate whether you prefer to be given a hard copy or have this emailed to you.

☐ Hardcopy ☐ Email

Your consent to share personal health information is entirely voluntary and you may withdraw your consent at any time. Should you have any questions about this process or wish to withdraw your consent please contact: ***University of Waikato Tauranga Student Health Service*** at **022 013 9003.**

Student Name: _____

Signature: _____

Date: _____

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

Student Mental Health & Wellbeing Service Agreement Form

Applies to Mental Health Nurses, Counsellors, Alcohol and Other Drug Clinician, Social Worker, **Health Improvement Practitioners, Health Coaches and counselling, psychology/nursing placement students.**

I agree to receive free, short-term mental health & wellbeing support at Student Health, University of Waikato. Information that I provide will be used to inform care and support provided. Care provided adheres to the Code of Health & Disability Consumer Rights (1996) and Te Tiriti O Waitangi principles.

I agree to attend all booked appointments at the arranged time and if my circumstances change, I will cancel or reschedule prior to the appointment time.

There may be times where referral to external services and agencies is required; my clinician will discuss this with me if needed.

I understand that I may be asked if a placement student can be involved in my care. My prior consent will be obtained and I acknowledge that I can withdraw this at any time.

I understand that Student Health keeps records of interactions I have with the service. Clinicians involved in my care at Student Health Services are able to access these. There may be times where relevant health information is shared with other members of the Student Health team or external providers with the intent of improving coordination, safety and quality of care. If I am enrolled in the practice, and later decide to enrol with another practice, my entire file will be transferred including all mental health & wellbeing records. In accordance with the Privacy Act (2020) and the Health Information Privacy Code (1994), I am entitled to access health records that pertain to me.

I understand that if there are concerns for my safety or the safety of others, my clinician may have to disclose relevant information to other parties including other Student Health staff, my nominated next of kin and/or emergency services. My clinician will keep me well informed during this process and obtain informed consent where possible.

I understand that once I cease paying the student services fee, I am no longer eligible to access mental health & wellbeing support via Student Health Services. At this time, I will be supported to access other external support services as required.

I understand that this Service Agreement form will be held by Student Health as part of my health records.

Your consent to sharing personal health and wellbeing information is voluntary and you may withdraw consent at any time.

If you have any questions about this form, please contact Student Health on (07) 838 4037 OR speak with your clinician at your appointment.

By signing below, you are acknowledging you have read, understand, and agree to the above information.

STUDENT FULL NAME/ID	
SIGNATURE/ DATE	

Updated: March 2022