



## CASUAL ENROLMENT FORM

<b>Legal Name *</b>	(Title)	<b>Family Name*</b>	<b>First Name(s)*</b>	<b>Middle Name(s)</b>
<b>Other Name(s) *</b> (E.g: Maiden Name/Preferred Name) Please tick the name you prefer to be known as			<b>NHI</b> (office Use only)	<b>Student ID Number:</b>
<b>Birth Details *</b>	<b>Day/Month/Year of Birth*</b>	<b>Place of Birth*</b>		<b>Country of Birth*</b>
<b>Gender *</b> (you would like to be identified as)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse (please state) _____		<b>Sex</b> (at birth)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Another Term _____
<b>Residential Address During Academic Year. *</b>	<input type="checkbox"/> Student Village <input type="checkbox"/> College Hall <input type="checkbox"/> Orchard Park <input type="checkbox"/> Bryant Hall <input type="checkbox"/> Silverdale Apartments (Please tick which one applies if living in the halls)			
	<b>House (or RAPID) Number and Street Name*</b>	<b>Suburb/Rural Location*</b>	<b>Town / City and Postcode*</b>	
<b>Postal Address</b> (if different from above)	<b>House Number and Street Name or PO Box Number</b>	<b>Suburb/Rural Delivery</b>	<b>Town / City and Postcode</b>	
<b>Contact Details</b>	<b>Mobile Phone</b>	<b>Home Phone</b>	I agree to receiving Txt messages <input type="checkbox"/> Yes <input type="checkbox"/> No	
			<b>Email Address</b>	
<b>Emergency Contact/NOK</b>	<b>Name</b>		<b>Relationship</b>	<b>Mobile Phone (or other)</b>
<b>NZAID/Manaaki Student</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Permanent Resident</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Ethnicity Details *</b>				
Which ethnic group(s) do you belong to? (Tick multiple boxes if needed, including Iwi.)				
<input type="checkbox"/> New Zealand European <input type="checkbox"/> Māori, Iwi: _____				
<input type="checkbox"/> Samoan <input type="checkbox"/> Cook Island Māori <input type="checkbox"/> Tongan <input type="checkbox"/> Niuean <input type="checkbox"/> Chinese <input type="checkbox"/> Indian				
<input type="checkbox"/> 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



### **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 & 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, if I 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 my 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.**

<b>STUDENT FULL NAME/ID</b>	
<b>SIGNATURE/ DATE</b>	