THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

Pinnacle Incorporated

INTERNATIONAL STUDENT ENROLMENT 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 _____
Residential Address During Academic Year. *	☐ **Student Village** ☐ **College Hall** ☐ **Orchard Park** ☐ **Bryant Hall** ☐ **Silverdale Apartments** (Please tick which one applies if living in the halls)				
	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)
NZAID/Manaaki Student	☐ Yes	☐ No	**Permanent Resident**	☐ Yes	☐ No

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

Name of Insurance Provider: _____

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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 share 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

Studentsafe Direct Billing Application Form

New Enrolment – Student to complete

Under your Studentsafe Inbound University Policy the majority of treatments at the campus healthcare centre and related prescriptions can be billed directly to Allianz Global Assistance. This form must be completed if you wish to apply to use direct billing to pay for treatments.

By completing this form and using direct billing you confirm you accept that Allianz Global Assistance can request diagnosis and treatment details related to your healthcare visits, and you are: -

- the authorised Studentsafe Inbound University Policy holder or you are insured under a couple or family policy; and are
- aware of the policy terms, conditions, limits and direct billing exclusions such as: -
- Policy limits exclude health screening, immigration procedures, treatment for weight loss, misuse of alcohol, contraception, and pregnancy. Please read the policy working for further details.
- Direct billing excludes pre-existing medical conditions, alternative medical treatment(s), treatment or testing for sexually transmitted diseases.

If your condition cannot be direct-billed, but you believe you are entitled to claim for your treatment to be paid, you can go to www.insurancesafenz.com/claims Make a claim and download a claim form. The completed form can be emailed to claims@insurancesafenz.co.nz or posted to PO Box 112316 Penrose Auckland, 1642. If you require assistance or further advice, call 0800 486 004.

Date _____ Policy Holder's Student ID _____

Policy Holder's Name _____

Policy Holder's Signature _____

If you are not the policy holder, but are covered by a couple or family policy, please also list your details below.

Name _____

Student ID _____

Signature _____