Holokai: Sustaining Voyaging Traditions

Holokai is a rigorous program requiring healthy learners. Please have the applicant's physician complete the Physician's Health Appraisal Certification portion of this form. If medical conditions change at anytime, please contact us to update your child's medical form.

1. Submit this application to Nā Kālai Wa'a, 65-1206 Māmalahoa Hwy, Suite 1-101, Kamuela, HI 96743
2. Enclose $35 ** non-refundable registration fee — cashier or personal check to Nā Kālai Wa'a
3. Complete and submit Physician Health Appraisal Certification — **due May 25**.

Scholarships are available for consideration of waiving registration fee. Please attach an additional form with a statement of need.

Student Information		
Last Name	First	Middle
Address:		Zip Code:
Date of Birth (mm/dd/yyyy):	Gender: M / F	Grade entering SY 2017-2018:
Last School Attended:	Homeroom Teacher:	Adult T-Shirt Size:
Specify your 1st and 2nd preference of session for your child to attend: ____ Session 1: June 27 - July 6 ___ Session 2: July 11 - July 20		

Parent / Legal Guardian Information	
Mother / Legal Guardian Name:	
Last	First
Address:	Zip Code:
Home Phone: ( ) -	Cell Phone: ( ) -
Business Phone: ( ) -	eMail address:
Father / Legal Guardian Name:	
Last	First
Address:	Zip Code:
Home Phone: ( ) -	Cell Phone: ( ) -
Business Phone: ( ) -	eMail address:

Adult Emergency Contact Information (other than parent or legal guardian)
If parent or legal guardian cannot be reached, please provide an adult emergency contact who may authorize emergency medical care for your child.

Emergency Contact Name: Relation to Child:

Last First

Home Phone: ( ) - Cell Phone: ( ) -

Business Phone: ( ) -

Physician Health Appraisal Certification - section to be completed by physician

Student Name (Last, First, Middle) Date of Birth (mm/dd/yyyy) Gender M / F

Date of most recent physical examination (mm/dd/yyyy): **Must be completed after June 1, 2016**

I certify that this child has no existing physical or mental disabilities and/or surgical conditions that may restrict, or impair his/her activities; require treatment or medication; or require special accommodation unless stated below (or attached):

Please list all medications including over-the-counter medications prescribed for this child. All medications must be labelled with child's name and rx.

Diagnosis	Medication:	Prescription (dosage and frequency):

Does child have any allergies (food, allergies, plants, bee stings, etc.)? Yes No

* If Yes, please list allergy and allergy reaction:

Physician Name (Print): Phone: ( ) -

Complete Mailing Address:

Physician Signature Date:

Student Name (Last, First, Middle)

Parent / Legal Guardian Release

Only medication that your child cannot go without for the duration of the program should be sent with him/her. All medications must be in the original dispensed container and labelled with child‘s name and dosage. Student must be able to administer his/her own medication as prescribed by a physician. I/We authorize the Medical Director or a designee to consult with or refer my/our child to such physician or facilities as they deem necessary or appropriate. My/Our preference in the event of such consultation or referral is as follows:

Physician Name:		
Phone: ( ) -	Hospital:	
I/We have a Medical Insurance Plan:	Yes	No
Subscriber‘s Name:	Relationship to Student:	
Medical Insurance Company:		

Permission for Treatment and Release

As the parent(s) of the above name applicant (my/our child) I/we understand that the ultimate responsibility for the medical treatment of my/our child rests with me/us and my/our family, and agree to the following:

Limited Emergency and Non-Emergency Medical Services: I/We understand that Nā Kālai Wa‘a offers limited student emergency and non-emergency medical services. I/We hereby authorize such emergency and non-emergency medical services for my/our child as may be deemed necessary or appropriate by the staff of Nā Kālai Wa‘a, and that Nā Kālai Wa‘a will make reasonable attempts to notify me/us as soon as possible of injury or illness to my/our child.

Referral and Consultation: I/We further authorize Nā Kālai Wa‘a to refer my/our child to, or consult with such physicians or facilities as Nā Kālai Wa‘a deems necessary or appropriate. My/Our preference (which is not mandatory) in the event of such referral or consultation is stated in this Medical Form. I/We understand that any charges for such referral and consultation shall be our sole responsibility.

Release: In consideration of my/our child‘s enrollment in Nā Kālai Wa‘a‘s program and on behalf of myself/ourselves, my/our personal representatives, my/our heirs, my/our assignees and my/our child, I/we **(**a) waive and release any and all claims against Nā Kālai Wa‘a and it‘s trustees officers, directors, agents, representatives, and employees, in both their personal and professional capacities (collectively also Nā Kālai Wa‘a) for injuries, liabilities, losses, and damages connected with or arising out of the rendering of medical treatment to my/our child and (b) we agree to indemnify, defend and forever hold harmless, Nā Kālai Wa‘a from and against any and all claims, proceedings, injuries, liabilities, losses, or damages, and expenses including reasonable attorneys fees and costs, relating to the rendering of medical treatment of my/our child.

I/WE HAVE READ AND UNDERSTAND THE CONTENTS OF THIS STATEMENT; UNDERSTAND THE NATURE OF THIS STATEMENT AS CONTRACTUAL NOT MERE RECITAL; CONFIRM THAT I/WE WERE GRANTED AN OPPORTUNITY TO ASK QUESTIONS ABOUT THIS STATEMENT; AND THAT I/WE ARE SIGNING THIS STATEMENT AS MY/OUR OWN FREE ACT.

Print Mother‘s / Legal Guardian‘s Name	Signature	Date
Print Father‘s / Legal Guardian‘s Name	Signature	Date

Signatures of both parents are required. If only one parent signs, or adult(s) other than parent(s), legal documentation must be submitted to Nā Kālai Wa‘a.

Student Name (Last, First, Middle)		
Nā Kālai Waʻa Official Use		
School:		
Grade:		
Medical:		
NKW Waiver & Release:	KS Waiver:	
Registration Fee:	School Coordinator:	