

Attached are 2 forms required by the Department of Human Services Childcare Licensing Division.

\*\*\*PLEASE HAVE YOUR CHILD'S PHYSICIAN COMPLETE BOTH FORMS.

\*\*THESE FORMS ARE DUE BY your child's first day.

1. Student Health Record Form 14
2. Early Childhood PreK Health Record Supplement (Form908)

Hawaii State Law requires all students to meet the following health examination and immunization requirements:

- Tuberculosis (TB) clearance must be completed within one year. The certificate of TB examination must include date of administration, reading and results in millimeters.
- A physical examination must be completed within one year before first attending school in Hawaii and must be performed by a U.S. licensed physician, APRN, or PA. Physicals often happen at age 2, 3 & 4.

Recommended immunizations for attendance are:

- 4 DTaP/DTP/Td (diphtheria/tetanus/pertussis),
- 3 Polio,
- 1 MMR (measles, mumps, rubella),
- 3 Hepatitis B,
- 1 Varicella (chickenpox)  1 Hib (Haemophilus influenzae type b)

*Children may be exempt from immunization requirements for medical or religious reasons, if the appropriate documentation is presented to the school. A religious exemption form may be obtained and completed at the school that your child will attend. Medical exemptions must be obtained from your child's doctor (a U.S. licensed physician). No other exemptions are allowed by the State.*

**Fax the completed forms with  
immunization records TB test results to  
Ka Hana Pono Daycare & Preschool at  
808-638-2631**

# Department of Education STUDENT'S HEALTH RECORD

Student Address Label

Name \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial)

Birthdate \_\_\_\_\_  
 Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Parent's Name \_\_\_\_\_ (Mother/Legal Guardian) \_\_\_\_\_ (Father/Legal Guardian)

Please complete the following sections **(CHECK IF YES)**

Female  Male  Preschool:  Elementary:  Intermediate/Middle:  High:

Entry Date: / /  
 Entry Date: / /  
 Entry Date: / /  
 Entry Date: / /

Allergies: \_\_\_\_\_

**MEDICAL STATUS**

Allergy (type)     Cancer/L. leukemia     Hearing Problems     Hypertension     Seizures     Vision Problem  
 Asthma     Chronic Cough/Wheezing     Heart Disease     JRA Arthritis     Sickle Cell Anemia  
 Behavioral Problems     Diabetes     Hemophilia     Rheumatic Heart     Skin Problems

**PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE**

Date	Grade	Height	Weight	BMI	Blood Pressure	Vision			Hearing	Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
						R.	L.	L.																			
/ /																											
/ /																											
/ /																											

**TUBERCULOSIS EVALUATION**

Check one box below, complete date assessment, test or x-ray was administered. Physician, APRN, PA, Clinic

Negative	Date: / /	
TB Risk Assessment	Date: / /	
Negative test for TB infection	Date: / /	
Positive test, and negative chest x-ray	Date: / /	

**DENTAL EXAMINATION**

Dental Check-Up    Date: / /

Dental Check-Up    Date: / /

Dental Check-Up    Date: / /

**IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)**

	Type	Date	Type	Date	Type	Date	Type	Date	Type	Date	Type	Date	Type	Date	Type	Date	Type	Date	Type	Date	Type	Date	Type	Date	Type	Date	Type	Date
DTaP, DTP, DT, Tdap or Td	Date	/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /
Polio (IPV or OPV)	Date	/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /
Hib (Haemophilus influenzae type b)	Date	/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /
Pneumococcal Conjugate	Date	/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /
Hepatitis B	Date	/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /
Hepatitis A	Date	/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /
MMR	Date	/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /
HPV	Date	/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /
Other	Date	/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /

Physician, APRN, PA or Clinic \_\_\_\_\_

**Health History Comments: Include Referrals and Reports. Recommendation for significant findings.**  
(Please Print)

Date		Signature & Title	Date	Signature & Title

## Early Childhood Pre-K Health Record Supplement\*

<b>Name of Child:</b>		<b>Name of Child Care Facility:</b>	
<b>Child's DOB:</b>		<b>To Be Completed By The Physician</b>	
<b>1. Type Screening</b>	<b>2. Date Completed</b>	<b>3. Results</b>	<b>4. Recommendations/Follow up</b>
Head Circumference (up to 2yrs old)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Hgb/Hct		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Lead		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
BMI (≥ 2 years old)		<input type="checkbox"/> Normal <input type="checkbox"/> Counsel	
Developmental Screening Tool: <input type="checkbox"/> PEDS <input type="checkbox"/> ASQ <input type="checkbox"/> Other _____		<input type="checkbox"/> No Concern <input type="checkbox"/> Concern	
<b>5. Medical Conditions</b>		<b>6. Special Care Plan Needed</b>	<b>7. Recommendations</b>
<b>Allergies/Sensitivities</b> <input type="checkbox"/> None • <b>List:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
<b>Medications/Treatments</b> <input type="checkbox"/> None • <b>List:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
<b>Special Diet prescribed by physician</b> <input type="checkbox"/> None • <b>List:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
<b>Behavioral Issues/Social Emotional Concerns</b> <input type="checkbox"/> None • <b>List:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
<b>Medical Conditions/Related Surgeries</b> <input type="checkbox"/> None • <b>List:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
<b>9. Physician/NP/APRN/PA or Clinic Name, Address, Zip, Phone, Fax</b>		<b>11. I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood Provider</b>	
		_____ Early Childhood Provider Name	
<b>10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp)      Date</b>		<b>12. Parent/Guardian Name</b>	
		<b>13. Parent/Guardian Signature      Date</b>	

\*Supplement to the STATE OF HAWAII, DEPARTMENT OF EDUCATION, FORM 14, Rev. 2010, RS 09-1051 (Rev. of RS 06-0698)

**Instructions for Completing the Early Childhood Pre-K Health Record Supplement**

**To Be Completed by the Physician (Please print)**

<p><b>1. Type of Screening:</b> Check all that apply.</p> <ul style="list-style-type: none"><li>• <b>Head Circumference, Hgb/Hct, Lead, BMI</b></li><li>• <b>Developmental Screening:</b> The screening tools listed are: <b>PEDS:</b> Parent's Evaluation of Developmental Status <b>ASQ:</b> Ages and Stages Questionnaire <b>Other:</b> Print the name of screening tool used.</li></ul> <p><b>2. Date Completed</b> Write the date <b>mm/dd/year</b> the screening was performed. i.e., 06/01/2006.</p> <p><b>3. Results</b> Mark (X) to indicate "<b>Normal</b>" or "<b>Abnormal</b>", "<b>No Concern</b>" or "<b>Concern</b>", "<b>Normal</b>" or "<b>Counsel</b>". If the box is marked abnormal, concern or counsel, please complete Box 4. Recommendations/Follow up.</p> <p><b>4. Recommendations/Follow up</b> Please complete if abnormal, concern or counsel is selected.</p> <p><b>5. Medical Conditions</b> Mark (X) "<b>None</b>" box for each item if the child has no <b>Allergies/Sensitivities, Medications/Treatments, Special Diet prescribed by physician, Behavioral Issues/Social Emotional Concerns, Medical Conditions/ Related Surgeries. List</b> type of medical condition, e.g., <b>Medical Condition/Related Surgeries List:</b> Asthma</p> <p><b>6. Special Care Plan Needed</b> If child has a medical condition and the Early Childhood Provider should develop a special care plan, mark (X) <b>Yes</b>, next to the appropriate category. If child does not need a special care plan, mark (X) <b>No</b>.</p>	<p><b>7. Recommendations</b> Write your recommendations, e.g., "Medications must be administered by the parent before or after school hours."</p> <p><b>8. Early Childhood Provider Use Only</b> This section is designated for the early childhood provider to complete if physician has marked (X) Yes in Box 6. Sample forms of the Special Care Plans can be requested from Department of Human Service (DHS) office, phone or downloaded from the Department of Human Service website.</p> <p><b>9. Physician/NP/APRN/PA or Clinic Name</b> Type or print legibly physician, nurse practitioner, advanced practiced registered nurse, physician assistant or clinic name, address, zip, phone, and fax.</p> <p><b>10. Physician/NP/ APRN/ PA, of Clinic (Signature or Stamp) and Date:</b> Physician, nurse practitioner, physician assistant must sign his/her name or stamp and write in the date of child's examination.</p> <p><b>11. "I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood provider."</b> The Early Childhood program is encouraged to type, print legibly, or stamp the program name here prior to parent signature.</p> <p><b>12. Parent/Guardian Name</b> Print the name of the Parent or Guardian</p> <p><b>13. Parent/Guardian Signature</b> The Parent or Guardian must sign his/her name and write the date signed.</p>
--	---

**To be used as part of a cover letter to the preschool, parent or physician.**

The purpose of the Hawaii Department of Human Services (DHS) Early Childhood Pre-K Health Record Supplement (EC-Pre-K HRS) is to provide developmentally appropriate information on the child's health, growth and developmental status for (Pre) school entry. The EC-Pre-K HRS is to be used in conjunction with the Hawaii Department of Education (DOE), Student's Health Record Form 14 2010.

The DHS EC Pre-K Health Record can be downloaded from the Hawaii Department of Human Services website, <http://humanservices.hawaii.gov/> and search for Form 908. The DOE Student Health Record Form 14 can be downloaded at Department of Education website: <http://www.hawaiipublicschools.org/Pages/home.aspx>, click on Parents and Students, click on Enrolling in School, click on How to Enroll, look for Related Downloads and click on Student Health Record.

The child's physician is requested to complete the DOE Student Health Record Form 14 and DHS EC Pre-K Health Record Supplement. The following are directions for completing the DHS EC Pre-K Health Record Supplement.