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 childs 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)

Female ❑ Male ❑

Preschool: Entry Date ___/___/___

Elementary: Entry Date ___/___/___

Intermediate/Middle: Entry Date ___/___/___

High: Entry Date ___/___/___

Birthdate ☐☐ Month ☐☐ Day ☐☐☐☐ Year

Parent's Name _____ (Mother/Legal Guardian) _____ (Father/Legal Guardian)

Allergies: _____

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

MEDICAL STATUS

Allergy (type)	❑	Cancer/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 R.	Vision L.	Hearing R.	Hearing L.	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
/ /																							/ /				
/ /																							/ /				

TUBERCULOSIS EVALUATION

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

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

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

State of Hawaii
Department of Human Services

Benefit, Employment & Support Services Division

Early Childhood Pre-K Health Record Supplement*

Name of Child: **DOB:**

Name of Child Care Facility:

To Be Completed By The Physician

1. Type Screening	2. Date Completed	3. Results	4. Recommendations/Follow up
Head Circumference (up to 2yrs old)		❑ Normal ❑ Abnormal	
Hgb/Hct		❑ Normal ❑ Abnormal	
Lead		❑ Normal ❑ Abnormal	
Developmental Screening Tool: ☐ PEDS ☐ ASQ ☐ Other _____		❑ No Concern ❑ Concern	

5. Medical Conditions	6. Special Care Plan Needed	7. Recommendations	8. EC Provider Use Only
Allergies/Sensitivities ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed
Medications/Treatments ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed
Special Diet prescribed by physician ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed
Behavioral Issues/Social Emotional Concerns ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed
Medical Conditions/Related Surgeries ❑ None • **List:**	❑ Yes ❑ No		❑ Special Care Plan completed

9. Physician/NP/APRN/PA or Clinic Name, Address, Zip, Phone, Fax

11. ***I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood Provider***

_____
Early Childhood Provider Name

12. Parent/Guardian Name

10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp) **Date**

13. Parent/Guardian Signature **Date**

*Supplement to the STATE OF HAWAI'I, DEPARTMENT OF EDUCATION, FORM 14, Rev. 4/10, RS 10-1369 (Rev. of RS 09-1051)

DHS 908 (09/11)

Instructions for the Physician (Please print)

1. Type of Screening: Check all that apply.
- **Head Circumference, Hgb/Hct, Lead**
- **Developmental Screening:** The screening tools listed are:
  PEDS: Parent's Evaluation of Developmental Status
  ASQ: Ages and Stages Questionnaire
  Other: Print the name of screening tool used.

2. Date Completed
Write the date **mm/dd/year** the screening was performed. i.e., 06/01/2006.

3. Results
Mark (X) to indicate "**Normal"** or "**Abnormal", "No Concern"** or **"Concern".** If the box is marked abnormal or concern, please complete Box 4. Recommendations/Follow up.

4. Recommendations/Follow up
Please complete if abnormal or concerned is selected.

5. Medical Conditions
Mark (X) **"None**" box for each item if the child has no **Allergies/Sensitivities**, **Medications/Treatments**, **Special Diet prescribed by physician**, **Behavioral Issues/Social Emotional Concerns**, **Medical Conditions/ Related Surgeries**. **List** type of medical condition, e.g., **Medical Condition/Related Surgeries List**: Asthma

6. Special Care Plan Needed
If child has a medical condition and the Early Childhood Provider should develop a special care plan, mark (X) **Yes**, next to the appropriate category. If child does not need a special care plan, mark (X) **No**.

7. Recommendations
Write your recommendations, e.g., "Medications must be administered by the parent before or after school hours."

8. Early Childhood Provider Use Only
This section is designated for the early childhood provider to complete if physician has marked (X) Yes in Box 6. A sample form of a Special Care Plan is located on the DHS 908A Instructions for the DHS 908 Early Childhood Pre-K Health Record Supplement form which can be downloaded from the Department of Human Service website: http://hawaii.gov/dhs/self-sufficiency/childcare/licensing/forms/

9. Physician/NP/APRN/PA or Clinic Name
Type or print legibly physician, nurse practitioner, advanced practiced registered nurse, physician assistant or clinic name, address, zip, phone, and fax.

10. Physician/NP/ APRN/ PA, of Clinic (Signature or Stamp) and Date:
Physician, nurse practitioner, physician assistant must sign his/her name or stamp and write in the date of child's examination.

11. *"I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood provider."*
The Early Childhood program is encouraged to type, print legibly, or stamp the program name here prior to parent signature.

12. Parent/Guardian Name
Print the name of the Parent or Guardian

13. Parent/Guardian Signature
The Parent or Guardian must sign his/her name and write the date signed.