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

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.

State of Hawaii
Department of Human Services

Benefit, Employment & Support Services Division

Early Childhood Pre-K Health Record Supplement*

Name of Child:	**Name of Child Care Facility:**
Child's DOB:	**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	
BMI (≥ 2 years old)		❑ Normal ❑ Counsel	
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. 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)

1. Type of Screening: Check all that apply.
- **Head Circumference, Hgb/Hct, Lead, BMI**
- **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**", "**Normal**" or "**Counsel**". If the box is marked abnormal, concern or counsel, please complete Box 4. Recommendations/Follow up.

4. Recommendations/Follow up
Please complete if abnormal, concern or counsel 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. 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.

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.

INSTRUCTIONS for the DHS 908

PURPOSE

The DHS 908 Early Childhood Pre-K Health Record Supplement (EC Pre-K HRS) form was created with the assistance of the Healthy Child Care Hawaii, a collaborative project of the University of Hawaii/School of Medicine - Department of Pediatrics, American Academy of Pediatrics - Hawaii Chapter, Department of Health/Children with Special Health Needs Branch. The purpose of the DHS 908 is to provide developmentally appropriate information on the child's health, growth and developmental status for entrance into a Pre-Kindergarten (Pre-K) program which includes an Infant and Toddler Child Care Center (IT), Group Child Care Center (GCC), and Group Child Care Home (GCH). The child's physician is requested to complete the DHS 908 in conjunction with the Department of Education (DOE) Form 14.

INSTRUCTIONS FOR THE CHILD CARE FACILITY:

1. A health record shall be required and obtained from the parent or guardian of each child entering a licensed child care facility such as a Family Child Care Home (FCC), GCC, GCH, or an IT and be kept on file at the facility in accordance with the applicable Hawaii Administrative Rules (HAR) §§17-891.1-20, 17-892.1-20, and 17-895-20.
2. The Department of Education (DOE) Student Health Record "Form 14" (F14) shall be used to comply with this requirement listed in #1, or a comparable writing (documentation) of a child's current immunizations, evidence of child's good health/physical examination results, and TB test/clearance results. The F14 (rev. 2010) is available and may be downloaded from the DOE website, http://doe.k12.hi.us/forms/index.htm.
3. In addition, the records of each child in a GCC, GCH, and IT shall include pertinent information about the health status (including Body Mass Index), developmental progress, and any special needs and efforts necessary to meet these needs in accordance with HAR §§17-892.1-20(c) and 17-895-20(c). The DHS 908 or comparable writing (document) shall be used to comply with the requirement listed in #2. The DHS 908 may be downloaded from the DHS Child Care Connection Hawaii website, http://humanservices.hawaii.gov/bessd/child-care-program/child-care-licensing/child-care-center-Licensing-forms/.
4. At the time of a facility's initial licensing visit, each child shall have a F14 and a DHS 908 on file.
5. At the time of a facility's annual licensing visit, new students enrolled for the school year who do not have a F14 on file shall, also, be required to have a DHS 908 on file.
6. Children entering new programs that were previously enrolled at a licensed child care program with a DHS 908 form that was signed by an approved

health care practitioner within 12 months of admission do not need to update their form;

7. Furthermore, providers shall issue the DHS 908 form (09/15) version to all families when families request the F14 on file to update their form due to an upcoming well-child visit or immunization scheduled with the health care practitioner. Providers shall instruct families to have the health care practitioner complete the DHS 908 form (09/15) to keep the program informed of the child's *on-going* growth and development while the child is enrolled in the program.
8. The facility's director shall document at least 2 attempts to obtain the DHS 908 from the parent. If after 2 attempts the DHS 908 is not returned, the child's health requirement shall be met as long as the F14 is on file.
9. If a child has a medical condition noted on the F14 or the physician has marked "Yes" in Box 6 of the DHS 908 that a Special Care Plan should be developed, the child care facility should develop a Special Care Plan for the child and kept on file at the facility. Please refer to the "Sample Special Care Plan" on page 4 of the DHS 908.
10. The DHS 908 is only recommended for entry into a FCC.
11. A FCC and GCH provider's own children who are enrolled in school and school-aged children enrolled in the FCC or GCH for before and after school care who satisfy health requirements for enrollment in school are not required to furnish evidence of the child's health.
12. Children enrolled in licensed before and after school child care facilities (BAS) are not required to furnish evidence of the child's health per HAR §17-896-19(a).

SPECIAL CARE PLAN FOR A CHILD WITH ALLERGY

CHILD'S NAME:_____ Date of Birth: _____

FACILITY NAME: _____

Parent(s) or Guardian(s) Name: _____

Emergency Phone Numbers: Mother _____ Father _____

Primary Health Provider Name: _____ Emergency Phone: _____

Specialist's Name (if any): _____ Emergency Phone: _____

Description of Allergy: _____

_____

Describe what signs/or symptom look like:_____

_____

Describe known triggers: _____

_____

Describe treatment:_____

_____

Possible side effects: i.e.: no peanut products allowed_____

_____

Program modification: _____

_____

When to call parent/health provider regarding symptoms or failure to respond to treatment:

_____

When to consider what condition requires urgent care or reassessment: _____

_____

Physician's Name: _____

Physician's Signature: _____ Date:_____

You can get a copy of the "Student's Health Record" (Form 14) from the childcare facility or school where your child will be enrolled or from your child's healthcare provider.

WHAT IF MY CHILD IS TRANSFERRING FROM ANOTHER STATE OR TERRITORY OF THE U.S.?

You will need to show proof that the health requirements have been met prior to childcare facility or school entry. The childcare facility or school will accept out-of-state records that meet the State of Hawai'i requirements for physical examination, immunizations, and tuberculosis clearance.

WHICH IMMUNIZATIONS ARE REQUIRED?

Immunizations are required for all students entering childcare or preschool, kindergarten, and seventh grade, and for those students entering school in Hawai'i for the first time, regardless of age.

Childcare or Preschool	Kindergarten - Grade 12	Grade 7
Diphtheria-Tetanus-Pertussis (DTaP)	Diphtheria-Tetanus-Pertussis (DTaP)	Human Papillomavirus (HPV)
Haemophilus influenzae type b (Hib)	Hepatitis A (Hep A)	Meningococcal Conjugate (MCV)
Hepatitis A (Hep A)	Hepatitis B (Hep B)	Tetanus-diphtheria-pertussis (Tdap)
Hepatitis B (Hep B)	Human Papillomavirus (HPV)*	
Measles-Mumps-Rubella (MMR)	Meningococcal Conjugate (MCV)*	
Pneumococcal Conjugate Vaccine (PCV)	Measles-Mumps-Rubella (MMR)	
Polio (IPV)	Polio (IPV)	
Varicella (chickenpox)	Tetanus-diphtheria-pertussis (Tdap)*	
	Varicella (chickenpox)	

*All students must show evidence of receiving these immunizations prior to attendance in 7th grade or higher.

ARE EXEMPTIONS ALLOWED?

Children may be exempt from immunization requirements for medical or religious reasons, if the appropriate documentation is presented to the childcare facility or school. Religious exemption forms may be completed at the childcare facility or school that your child will attend. Medical exemptions must be obtained from your child's healthcare provider. No other exemptions are allowed by the State.

WHAT ARE THE HEALTH REQUIREMENTS FOR POST-SECONDARY SCHOOL ATTENDANCE IN HAWAII?

LMSM Excursion Release Form

I (parent/guardian) _____ give permission to allow my child_____ , to attend the excursions planned by LMSM. My child is allowed to ride a bus or other transportation provided by LMSM to these excursions.

Signing this form gives consent to allow LMSM staff/volunteers to make any medical decisions, 911 calls, administer first/aid or emergency procedures necessary if an emergency were to arise. LMSM is able to release any medical, confidential, and important information about my child to the proper individuals in case of an emergency.

Signature_____
Date:_____

LITTLE MONK SEAL MONTESSORI Consent for Medical and/or Emergency Treatment**

I, _____, hereby voluntarily consent to the rendering of care, and medical treatment by the staff of Little Monk Seal Montessori as may in their professional judgement be necessary to provide for the medical, or emergency care of my CHILD

_____.

Child 's Full Name Full Name

I further give my consent to LITTLE MONK SEAL MONTESSORI STAFF who will be caring for my child for the period _____ through _____, to arrange for routine or emergency medical and/or dental care and treatment necessary to preserve the health of my child. I also allow them to **release any health or medical or important information** about my child to any other emergency responder, DR. nurse. caregiver, etc. in the event that my child is injured or ill while under the care of the Little Monk Seal, I hereby give permission to the caregiver to provide first aid for the child and to take the appropriate measures, including contacting the Emergency Medical Service (EMS) system and arranging for transportation to the nearest emergency medical facility.

In making medical decisions on my behalf for the benefit of my dependent, I direct that the caregiver attempt to contact me. However, if medical care becomes essential, I give permission to the caregiver (Little Monk Seal Montessori) to make such decisions regarding such treatment as deemed appropriate by the medical doctor, hospital or their authorized designee. In furtherance of any treatment decisions to be made by the caregiver on my behalf for the benefit of my dependent, I authorize the caregiver to request, obtain, review and inspect any and all information bearing upon my child's health and relevant to any such decisions to be made respecting such treatment.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of my dependent and that I am responsible for all reasonable charges in connection with the care and treatment rendered to my dependent during this period.

_____

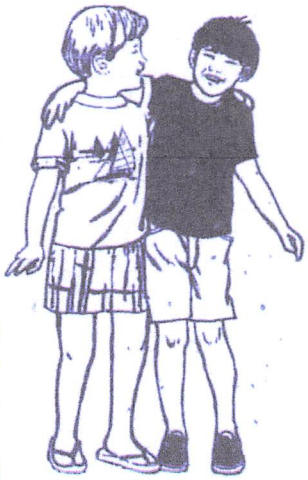
Date

_____

Signature of legal guardian

What if my child is transferring from another state or territory of the U.S.?

You will need to show proof that the health requirements have been met prior to school entry. The school will accept out-of-state records that meet the State of Hawai`i requirements for the physical examination, tuberculosis examination, and immunizations.



Which immunizations are required and how many doses does my child need?

Immunizations are required for all students entering preschool, kindergarten, and 7th grade, and for those students entering school in Hawai`i for the first time, regardless of age. See the tables on the following pages for the specific vaccines and number of doses required.

REQUIRED IMMUNIZATIONS - PRESCHOOL

BY THIS AGE:	CHILDREN ARE REQUIRED TO HAVE:
3 months	1 DTaP* + 1 Polio + 1 Hep B + Hib*
5 months	2 DTaP* + 2 Polio + 2 Hep B + Hib*
7 months	3 DTaP* + 2 Polio + 2 Hep B + Hib*
16 months	3 DTaP* + 2 Polio + 2 Hep B + 1 MMR♦ + Hib*
19 months	4 DTaP* + 3 Polio + 3 Hep B + 1 MMR♦ + Hib* + 1 varicella♥

TB

Vaccine abbreviations: DTaP=Diphtheria-Tetanus-Acellular Pertussis, Polio=IPV (Inactivated poliovirus vaccine) or OPV (Oral poliovirus vaccine); MMR=Measles-Mumps-Rubella; Hib=*Haemophilus influenzae* type b; Hep B=Hepatitis B vaccine; Varicella=chickenpox

★ DTP may be used in place of DTaP.

* More than one dose of Hib is recommended for children less than 15 months of age to be fully protected against *Haemophilus influenzae* type b. For preschool entry, children must have received at least one dose of Hib on or after 12 months of age.

♥ Effective July 1, 2002.
A documented history of varicella (chickenpox), signed by a U.S. licensed MD, DO, APRN, or PA, may be substituted for the varicella vaccine requirement.

♦ MMR #1 and varicella #1 must have been received on or after 12 months of age.

All immunizations must meet the minimum ages and intervals between vaccine doses.

Getting to know your little one

Please help us to know your child better by filling in the following information.

Child's Name_____

1. Areas of strength:

2. Areas for growth:

3. Interaction with peers and siblings:

4. Goals for this experience:

5. Separation concerns:

6. Describe how your child spends his/ her time at home:

7. Please explain your philosophy for discipline at home:

8. List any known allergies and precautions:

9. Additional information you would like to share

Additional Medical Information

Child's
Name_____

Doctor_____Phone_____
Address_____
Dentist_____Phone_____
Address_____

Do we have permission to contact your doctor or dentist in an emergency?
Yes_____ No_____

REQUEST FOR EXEMPTION FROM VACCINATION ON RELIGIOUS GROUNDS

Student's Name:		Student's Date of Birth:	
Student's Home Address:		City	Zip
Name of Child Care Facility or School:	Street Address:	City	Zip

_____ Initials — I certify that immunization conflicts with my bona fide religious tenets and practices.

_____ Initials — I understand that if at any time there is, in the opinion of the Department of Health, danger of an outbreak or epidemic from any communicable disease for which immunization is required, this exemption from immunization shall not be recognized and my child will be excluded from school or his/her child care facility until the threat of an epidemic is over or he/she receives the proper immunization.

_____ Initials — I understand that a request for religious exemption based on objections to specific vaccines will not be granted.

I understand the benefits and risks of the vaccinations my child is required to have for school/child care facility attendance, the risk of my child contracting the diseases that vaccines prevent, and the risk of my child transmitting disease to others. I understand that this form may not be used for personal or philosophical reasons.

_____
Parent/Guardian Name (please print)

_____ Date: _____
Parent/Guardian Signature

HAWAII REVISED STATUTES: §302A-1156, §302A-1157, §325-34
HAWAII ADMINISTRATIVE RULES: §11-157-5