Aloha Families of Pre-Kindergarten Applicants,

Applications are being accepted for high-quality public pre-kindergarten programs in selected public charter schools in Hawai‘i. Note: Enrollment is contingent upon the availability of funds.

Eighteen classrooms participated in the federal Preschool Development Grant to develop high-quality pre-K programs. The funding for this program ended in School Year 2018-2019. Though federal funding is ending this year, the State Public Charter School Commission is seeking funding from the state. The continuance of these pre-K programs is contingent upon our state funding.

Evidence shows that high-quality preschool helps prepare children for later success in school and in life. To ensure that your child has the opportunity to attend a preschool program, we are strongly encouraging families to apply their child in this AND at least one other program.

As families, you are your child’s first teacher and play a vital role in his or her education. The goal of this charter school pre-kindergarten program is to build on your child’s existing skills and strengthen your family’s ability to support your child’s learning. Your child’s attendance every day and your active participation are both needed to ensure success.

If this program is funded, the enrollment selection for a child to participate in this program is based upon:

1. Completion of the student’s application packet in full (see below);
2. Age eligibility – for school year 2019-2020, the child must have been born on or between August 1, 2014 and July 31, 2015; and
3. Income eligibility – to be determined by the State Legislature.
The following forms must be completed and turned in to the charter school’s office for your child to be considered for selection:

1. The charter school’s application form;
2. Your child’s birth certificate;
3. Income verification documents (2018 1040 Income Tax Returns, or paystubs for the previous 12 months, or proof of current TANF, SSI eligibility, or verification of homelessness), and the Attestation of Family Income form if the family is unable to provide income verification documents;
4. Proof of completion of all State Department of Health requirements on the completed Form 14, including:
   a. A current tuberculosis screening;
   b. A current physical exam with immunizations that are up-to-date based on child’s age, or, in the event that you are unable to complete this update of the physical exam in time, the scheduled appointment date when the health requirements shall be met; and
5. Completed Early Childhood Pre-K Health Record Supplement form (DHS 908).

Apply now – seats are limited!
First selections will take place on Friday, May 10, 2019 at 3:30 p.m.
If there are any vacancies thereafter, a second selection round will take place on Friday, June 7, 2019 at 3:30 p.m.
Note: A lottery system will be used if the number of complete applications exceeds the number of slots available. After June 7, 2019 selection will be made on a first come first served basis.

For more information, please contact the charter school, or call Deanne Goya at the Commission office at (808) 586-5227. Thank you for your interest, and we look forward to an exciting year filled with learning for all!

Best regards,

[Signature]

Sione Thompson
Executive Director
Hawai‘i State Public Charter Schools
Prekindergarten Application Packet Checklist
SY 2019-2020

Directions for Schools: Please attach this form as first page for all completed packets

School Name: ________________________________
Student Applicant’s Name: ________________________________
Date/Time Complete Packet Received by School: ________________________________

Complete packet must include the following documents completed in full (✓ to indicate that it was received):

☐ 1. Preschool Development Grant Application Packet Checklist (this completed form)
☐ 2. Student Application form
☐ 3. Copy of child’s birth certificate
☐ 4. Attestation Statement of Family Income form
☐ 5. Income documents
☐ 6. Student Health Record with updated PE, TB (dated 8/01/15 or later), immunizations and
☐ 7. Early Childhood Pre-K Health Record Supplement Form (DHS 908)

Date packet scanned/ emailed to Deanne @ deanne.goya@spcsc.hawaii.gov:

Note: If sending packet/documents via inter-office mail, email Deanne to notify of forthcoming packet.

School Office Staff contact name: __________________________ Email: __________________________ Phone: __________________________

Notes or comments:

If PE/TB is not up-to-date, indicate appointment date/time to meet this requirement: __________________________

Eligible? ☐ Yes ☐ No FPL ________%
Enrolled? ☐ Yes ☐ No
Waitlisted? ☐ Yes ☐ No

SPCSC confirmation date that packet has been received:

SPCSC will reply via email to confirm receipt of application packet. If email is not received by charter school within 48 hours identifying receipt of packet, please contact Deanne via email.

SPCSC PDG Form, revised 12/20/18
ATTESTATION STATEMENT OF FAMILY INCOME

School: 
School Year: 2019-2020

Directions: This document must be completed in full by all families.

Child's name: ____________________________
Father’s Name: ____________________________ Mother’s Name: ____________________________

Check all areas that apply and provide the necessary documents to demonstrate eligibility:

☐ I am currently eligible for the Temporary Assistance for Needy Families (TANF) program.
☐ I am currently eligible for the Supplemental Security Income (SSI) program.
☐ The applying child is currently in foster care.
☐ My family is homeless.
☐ None apply.

Income verification documents must be submitted with the completed student application packet:
✓ 2018 1040 Income Tax Returns;
✓ Paystubs for past year or any part thereof; or
✓ Verification of current TANF, SSI, homeless or foster care status, if applicable.

Declaration of employment and income status for parent(s) living in household:

<table>
<thead>
<tr>
<th>Parent’s Name</th>
<th>Employer</th>
<th>Period of Employment for Past 12 months</th>
<th>Salary earned during past 12 months of employment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>TOTAL $</td>
</tr>
</tbody>
</table>

If applicable: I am unable to provide the required income documents because:

☐ I am unable to locate all of the documents.
☐ I did not file 2018 taxes to date.
☐ Other (explain): ____________________________________________________________

By signing below, I certify that the information provided above is true and correct to the best of my knowledge.

Signature: ____________________________ Printed Name: ____________________________
Contact phone number: ____________________________ Work phone number or alternate phone number: ____________________________

<table>
<thead>
<tr>
<th>Family Size (families please complete)</th>
<th>Date pkt. received in full</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Poverty Guidelines (FPG) (based on family size)</td>
<td>FPL ≤ 200%? Yes No</td>
</tr>
<tr>
<td>Family Income</td>
<td>DOB 8/14 - 7/31/15 Yes No</td>
</tr>
<tr>
<td>Federal Poverty Level (FPL) (Income/FPG)</td>
<td>At-Risk Yes No</td>
</tr>
<tr>
<td>%</td>
<td>Confirmed by:</td>
</tr>
</tbody>
</table>
School Name: Kamaile Academy PCS  

STUDENT ENROLLMENT FORM  SIS-10W (Revised)  

INSTRUCTIONS: PRINT YOUR ENTRIES LEGIBLY  

Legal Last Name:  
Legal First Name:  
Middle Initial:  
Suffix: Jr., II, III, etc.:  
Gender: M  F  
Grade Level:  
Birth Date:  
Verification of DOB:  

☐ Not Homeless  ☐ Homeless*  ☐ Completed MVA Packet  

**Homeless** means individuals who lack a fixed, regular and adequate nighttime residence (within the meaning of section 42 USC §11302(e)(1)) and includes:  

(i) children and youth who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason, are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement.  

(ii) children and youth who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of 42 USC §11302(e)(2)(C));  

(iii) children and youth who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations or similar settings; and  

(iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle.  

If you have any questions regarding the above, please call 1-866-927-7095  

PRESCHOOL EXPERIENCE  

Preschool Experience  
Yes  No  
If "Yes"—attended:  
☐ less than 6 months  ☐ 6 to 12 months  ☐ more than 1 year  
Program: (if applicable)  

LAST HAWAII PUBLIC SCHOOL ATTENDED  

Name:  
Last Grade Attended:  
Year:  

PRIOR SCHOOL ATTENDED (If not Hawaii Public School)  

Name:  
Address:  
U.S. Phone:  
U.S. Fax:  

CITIZENSHIP  

Country of Birth:  
If Country of Birth is other than US, give year of arrival:  
US Citizen: Yes ☐  No ☐  
If not US Citizen, indicate status: Refugee ☐ Immigrant ☐ Non-Immigrant ☐  

LANGUAGE INFORMATION  

Language Codes: (Select a letter from the list and fill in the blanks below)  
Language (Spoken) at Home  First (Acquired) Language  Language Most Used  
A - English  F - Cebuano/Visayan  K - Vietnamese  Q - Fijian  V - Pangasinan  L - Other (Specify):  
B - Cantonese  G - Hawaiian  M - Chukese  R - Hmong  W - Portuguese  
C - Mandarin  H - Japanese  N - Pohnpeian  S - Lao  X - Spanish  
D - Ilocano  I - Korean  O - Cambodian  T - Marshallese  Y - Thai  
E - Tagalog  J - Samoan  P - Chamorro  U - Pampango  Z - Tongan  

Continue on next page  
Page 1/4  SIS-10W Rev 12/16 SPAAB
Please complete ETHNICITY INFORMATION, RACE INFORMATION, and PRIMARY ETHNICITY/RACE INFORMATION

**ETHNICITY INFORMATION**

Are you (J) Hispanic (Ex. Cuban, Mexican, Puerto Rican, Spanish, Other Hispanic)? □ Yes □ No

**RACE INFORMATION**

Check all that apply:

- □ A – American Indian or Alaska Native
- □ B – Black
- □ C – Chinese
- □ D – Filipino
- □ E – Native Hawaiian
- □ F – Other Asian
- □ G – Japanese
- □ H – Korean
- □ I – Portuguese
- □ J – Indo-Chinese (Ex. Cambodian, Lao, Vietnamese)
- □ K – Samoan
- □ L – White
- □ M – Micronesian (Ex. Chuukese, Marshallese, Pohnpeian)
- □ N – Other Pacific Islander
- □ O – Guamanian/Chamorro
- □ P – Tongan

**PRIMARY ETHNICITY/RACE INFORMATION**

What is the student’s primary race? (Select only ONE letter from either the ethnicity or race list and fill in the blank) ____________

☐ I decline to provide ethnicity and race information. I understand that if I do not provide this information, a school representative will designate the ethnicity and race categories for my child.

---

**LEGAL PARENT/GUARDIAN LIVING IN THE HOUSEHOLD WITH STUDENT**

Check one: □ Mr. □ Mrs. □ Ms. □ Other (specify): ____________ Relation: ____________

Marital Status: □ Married □ Divorced □ Separated □ Single

Custody Documentation Submitted: □ Yes □ No

Custody Type: □ Sole Custody □ Physical Custody □ Joint Legal

Custody of Child: □ Yes □ No

Legal Last Name: ____________ Legal First Name: ____________

Home Address: ____________ APT# ____________ City: ____________ Zip: ____________

Mailing Address (if different from Home Address): ____________

Home Phone #: ____________ Cellular Phone #: ____________ Pager #: ____________ Work Phone #: (include ext.) ____________

Email Address: ____________

Allow this person access to: (circle all that apply) ____________ mailing / portal (if applicable) / messenger

EMERGENCY CONTACT: (circle one) □Call Sequence 1 □Call Sequence 2

Is this parent/guardian a member of the Armed Services, National Guard or Reserves? □ Yes □ No

Military Status (check one): □ Traditional Reservist / M-Day □ Active Duty (Title 10) □ Federal Technician (Title 32)

Deployed? □ Yes □ No

Branch of Service (check one):

- □ Army
- □ Air Force
- □ Navy
- □ Marine
- □ Coast Guard
- □ Air National Guard
- □ Army Reserves
- □ Marine Reserves
- □ Coast Guard Reserves

Does this person work for the Federal Government or work on Federal Property? □ Yes □ No
**LEGAL PARENT/GUARDIAN NOT LIVING WITH STUDENT (cont.)**

- Is this parent/guardian a member of the Armed Services, National Guard or Reserves?  
  - Yes  
  - No
- Military Status (check one):  
  - Traditional Reservist / M-Day  
  - Active Duty (Title 10)  
  - Federal Technician (Title 32)
- Deployed?  
  - Yes  
  - No
- Branch of Service (check one):  
  - Army  
  - Marine  
  - Air National Guard  
  - Navy Reserves  
  - Air Force  
  - Coast Guard  
  - Army Reserves  
  - Marine Reserves  
  - Air Force Reserves  
  - Coast Guard Reserves
- Does the person work for the Federal Government or work on Federal Property?  
  - Yes  
  - No

**EMERGENCY CONTACT INFORMATION**

(Person To Notify In Case Of Emergency Other than First or Second Parent/Guardian Contact)

<table>
<thead>
<tr>
<th>Check one:</th>
<th>Mr.</th>
<th>Ms.</th>
<th>Other (specify):</th>
<th>Relation:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone #</th>
<th>Cellular Phone #</th>
<th>Pager #</th>
<th>Work Phone # (include ext.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SCHOOL SUPPLEMENTARY INFORMATION**

<table>
<thead>
<tr>
<th>Other Children In HIDOE Schools:</th>
<th>Legal First, Middle Initial &amp; Last Name</th>
<th>HIDOE School Attending</th>
<th>DOB</th>
<th>Grade</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Parent/Legal Guardian Signature: ________________________  Date: __________

FOR SCHOOL USE:
QUESTIONNAIRE TO DETERMINE ELIGIBILITY

MV1

McKinney-Vento Homeless Assistance Act (MVA)

Student’s Name ______________________________ School ____________________________

Section 1: ☐ Student/Parent/Legal Guardian IS NOT in a homeless situation
   (includes living with friends or family due to personal choice)
   (If Section 1 is checked, STOP and complete Parent/Legal Guardian’s signature below; form is complete.)

Section 2: Student/Parent/Legal Guardian: (Check the box ☑ that applies)

☐ Lives with friends or family due to economic hardship, such as loss of housing or income
☐ Lives on the beach, at a campground, in a park, or in a hotel
☐ Lives in a tent, car, bus or other non-permanent structure
☐ Lives in a domestic violence shelter
☐ Lives in an emergency or transitional shelter (Please circle, or write in name if not listed.)
   ☐ Kauai: Kauai Economic Opportunity: Manaolana, Lihue Court, Other: ________________
   ☐ Hawaii: Kihei Pua, Beyond Shelter, Na Kahua Hale of Ulu Wini-Kaloko Transitional, Other: ________________
   ☐ Maui: Ka Hale A Ke Ola: Central/Westside, Other: ________________
   ☐ Oahu: Family Promise, Institute for Human Services (IHS), Loliaina, Ohana Ola O Kahumana, Maili Land, Vancouver House, Nakolea, Seawinds, Palolul Kaialulu (Wai’anae Civic Center), Weinberg Village Waimanalo, Ulu Ke Kukui, Ka Ohu Hou O Manoa, Family Assessment Center, Other: ________________

☐ Has no regular place to stay at night
☐ Is an unaccompanied youth

Parent/Legal Guardian’s Signature ___________________________ Print Name ___________________________ Date ________________

When any box in Section 2 above is checked, the student may be eligible to receive MVA services including meals and transportation to and from school of origin. School personnel will assist the Parent/Legal Guardian or unaccompanied youth to complete the reverse side of this form and any remaining MVA forms.

This questionnaire is intended to address the McKinney-Vento Act (42 U.S.C. 11434a(2)).

All collected information will only be used for the purposes of providing educational services pursuant to the McKinney-Vento Act and is protected by federal and state laws.

RS 17-1506, June 2017 (Rev. of RS 16-1399)
Section 3:
Name of School ____________________________

School of Origin
(last school attended or last school attended with a permanent residence)
________________________________________

Student's Name ___________________________________________ ☐ Male ☐ Female

Date of Birth _______/______/_______ Grade ________

Siblings, including children aged 0-5:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>School</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section 4: Contact Information

Address ____________________________ City ____________ Telephone ________

Emergency Contacts:

Name ______________________ Relationship ________ Telephone ________ Email ________

Name ______________________ Relationship ________ Telephone ________ Email ________

Section 5: Student is applying for the following:

☐ Free/Reduced-Price Meals  ☐ Transportation to and from school of origin  ☐ Other ______________________

Note: Services will be comparable to those provided to all other students attending this school.

Section 6: Parent/Legal Guardian

I understand and agree that the Homeless Concerns Liaison may contact me.

Parent/Legal Guardian's Signature ____________________________ Telephone ________ Date ________

Section 7: For School Use Only

Student ID #  — — — — — — — — —

Student Enrolled As:

☐ Home School (school within the geographic area of student's current residence)
☐ School of Origin (school attended when permanently housed/last school attended)
☐ Geographic Exception (GE)
☐ Other __________________________________________

PRINT Name of School Administrator ____________________________ Title ________

Signature of School Administrator ____________________________ Date ________

By signing above, the school representative acknowledges that the parent/legal guardian has been provided with MVA information and a copy of this form.
# Student's Health Record

**Department of Education**

**STUDENT’S HEALTH RECORD**

<table>
<thead>
<tr>
<th>Name</th>
<th>(Last)</th>
<th>(First)</th>
<th>(Middle Initial)</th>
<th>Female</th>
<th>Preschool</th>
<th>Entry Date</th>
<th>Elementary</th>
<th>Entry Date</th>
<th>Intermediate/Middle</th>
<th>Entry Date</th>
<th>High</th>
<th>Entry Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parent’s Name</th>
<th>(Mother/Guardian)</th>
<th></th>
<th>(Father/Guardian)</th>
<th>Allergies</th>
</tr>
</thead>
</table>

Please complete the following sections (CHECK IF YES)

## Medical Status

<table>
<thead>
<tr>
<th>Allergy (type)</th>
<th>Cancer/Lymphoma</th>
<th>Chronic Cough/Whooping Cough</th>
<th>Heart Disease</th>
<th>Hypertension</th>
<th>JRA Arthritis</th>
<th>Seizures</th>
<th>Sickle Cell Anemia</th>
<th>Rheumatic Heart</th>
<th>Skin Problems</th>
</tr>
</thead>
</table>

| Behavioral Problems | Disabili... | | | | | | | | |

## Physician’s Examination Code: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE

| Date | Grade | Height | Weight | BMI | Blood Pressure | Vision | Hearing | R | L | R | L | Ear | Nose | Throat | Teeth | Heart | Liver | Stomach | Spleen | Extremities | Nutrition | Vorlactes Immunity to Diphtheria | Pertussis Immunity (DPT) | Polio Immunity (IPV or OPV) | Hepatitis B | MMR | Hepatitis A | Other | Other | Other |
|------|-------|--------|-------|-----|----------------|--------|---------|---|---|---|---|-----|------|--------|------|------|------|--------|-------|-------------|-----------------|-------------------|-------------------|-----------------|--------|-----------|-------|-------|-------|

## Tuberculosis Examination

**MANToux Test (INTRADERMAL)**

<table>
<thead>
<tr>
<th>Date Given</th>
<th>Date Read</th>
<th>Results (mm)</th>
<th>Physician, APRN, PA, or Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
</tr>
</tbody>
</table>

## Chest X-ray

<table>
<thead>
<tr>
<th>Date</th>
<th>Results</th>
<th>Location</th>
</tr>
</thead>
</table>

## Dental Examination

<table>
<thead>
<tr>
<th>Dental Check-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ / / /</td>
</tr>
</tbody>
</table>

## Immunizations (Vaccines, Dates Given: Month/Day/Year)

<table>
<thead>
<tr>
<th>Type</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP, DTP, DT, TdS or Td</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
</tr>
<tr>
<td>Polio (IPV or OPV)</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
</tr>
<tr>
<td>Hib (Haemophilus influenza type b)</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
</tr>
<tr>
<td>Pneumococcal Conjugate</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
</tr>
<tr>
<td>MMR</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
</tr>
<tr>
<td>Other</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
</tr>
<tr>
<td>Other</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
</tr>
<tr>
<td>Other</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
<td>/ / / /</td>
</tr>
</tbody>
</table>

*OFFICE USE ONLY (Rev. 2010)*

Physician, APRN, PA or Clinic

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature &amp; Title</th>
<th>Date</th>
<th>Signature &amp; Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

STATE OF HAWAII DEPARTMENT OF EDUCATION FORM 14 Rev 4/10 RS 10-1220 (Rev of RS 05-1051)
Early Childhood Pre-K Health Record Supplement*

<table>
<thead>
<tr>
<th>Name of Child:</th>
<th>DOB:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Child Care Facility:</th>
<th>To Be Completed By The Physician</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>1. Type Screening</th>
<th>2. Date Completed</th>
<th>3. Results</th>
<th>4. Recommendations/Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head Circumference (up to 2 yrs old)</td>
<td></td>
<td>Normal □ Abnormal □</td>
<td></td>
</tr>
<tr>
<td>Hgb/Hct</td>
<td></td>
<td>Normal □ Abnormal □</td>
<td></td>
</tr>
<tr>
<td>Lead</td>
<td></td>
<td>Normal □ Abnormal □</td>
<td></td>
</tr>
<tr>
<td>Developmental Screening</td>
<td></td>
<td>Normal □ Abnormal □</td>
<td></td>
</tr>
<tr>
<td>Tool: □ PEDS □ ASQ</td>
<td></td>
<td>No Concern □ Concern □</td>
<td></td>
</tr>
<tr>
<td>□ Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Medical Conditions</th>
<th>6. Special Care Plan Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Allergies/Sensitivities □ None</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>* List:</td>
<td></td>
</tr>
<tr>
<td>□ Medications/Treatments □ None</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>* List:</td>
<td></td>
</tr>
<tr>
<td>□ Special Diet prescribed by physician □ None</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>* List:</td>
<td></td>
</tr>
<tr>
<td>□ Behavioral Issues/Social Emotional Concerns □ None</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>* List:</td>
<td></td>
</tr>
<tr>
<td>□ Medical Conditions/Related Surgeries □ None</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>* List:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Physician/NP/APRN/PA or Clinic Name, Address, Zip, Phone, Fax</th>
<th>11. I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Childhood Provider Name</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp)</th>
<th>Date</th>
<th>12. Parent/Guardian Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13. Parent/Guardian Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

*Supplement to the STATE OF HAWAII, 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/](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.