

Department of Education  
STUDENT'S HEALTH RECORD

Name (Last) (First) (Middle Initial)

Female ☐ Preschool: / /

Male ☐ Elementary: / /

Intermediate/Middle: / /

High: / /

Birthdate

Month Day Year

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

Allergies:

Student Address Label

MEDICAL STATUS											
Allergy (type)	<input type="checkbox"/> Cancer/Leukemia	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Seizures	<input type="checkbox"/> Vision Problem						
Asthma	<input type="checkbox"/> Chronic Cough/Wheezing	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> JRA Arthritis	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/>						
Behavioral Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Rheumatic Heart	<input type="checkbox"/> Skin Problems	<input type="checkbox"/>						

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
/ /																					/ /					
/ /																					/ /					

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	Date	/	/	/	/	/	/	/	/	/
HPV	Type	Date	/	/	/	/	/	/	/	/	/
Other	Type	Date	/	/	/	/	/	/	/	/	/

Physician, APRN, PA or Clinic

**Health History Comments:** Include Referrals and Reports. Recommendation for significant findings.

[illegible]

**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.



## 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)		<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"/> Abnormal	
Developmental Screening		<input type="checkbox"/> Normal <input type="checkbox"/> Counsel	
Tool: <input type="checkbox"/> PEDS <input type="checkbox"/> ASQ <input type="checkbox"/> Other _____		<input type="checkbox"/> No Concern <input type="checkbox"/> Concern	
5. Medical Conditions		6. Special Care Plan Needed	7. Recommendations
Allergies/Sensitivities <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	8. EC Provider Use Only <input type="checkbox"/> Special Care Plan completed
Medications/Treatments <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
Special Diet prescribed by physician <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
Behavioral Issues/Social Emotional Concerns <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
Medical Conditions/Related Surgeries <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 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	
		12. Parent/Guardian Name	
		Early Childhood Provider Name	
10. Physician/NP/APRN/PA or Clinic Signature (Signature or stamp)		13. Parent/Guardian Signature	
Date		Date	

\*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 "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.</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) "None" 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.</b> List 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>
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## 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).

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)
<i>Haemophilus influenzae</i> 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 7<sup>th</sup> 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?



## 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*

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.