

**JOSH B. GREEN, M.D.**  
GOVERNOR



**MAKALAPUA ALENCASTRE**  
CHAIRPERSON

STATE OF HAWAII  
**STATE PUBLIC CHARTER SCHOOL COMMISSION**  
**('AHA KULA HO'ĀMANA)**  
<http://CharterCommission.Hawaii.Gov>  
1164 Bishop Street, Suite 1100, Honolulu, Hawaii 96813  
Tel: 808-586-3775 Fax: 808-586-3776

December 11, 2025

Aloha Families of Early Learning Applicants,

Mahalo for your interest in this program. The enrollment packet is being accepted for all families selected to participate in the program.

Evidence shows that high-quality preschool helps prepare children for later success in school and in life.

As families, you are your child's first and most influential teacher and play a vital role in his or her education. The goal of this early learning program is to build on your child's existing skills and strengthen your family's ability to maximize your child's learning. Your child's attendance every day and your active participation are both needed to ensure your child's success.

Families of selected children will have **FIVE BUSINESS DAYS** to submit this completed student enrollment packet to complete the application process. **If the forms are not received, your child's name will be placed back on the waitlist.**

The following forms **must be completed and turned into your charter school's office** for your child to be considered for enrollment:

1. The Student Enrollment form (SIS-10W);
2. Your child's birth certificate;
3. Income verification documents (2023 1040 Income Tax Returns (page one only) or proof of current TANF, SNAP eligibility, or verification of homelessness);
4. Attestation of Family Income form;

5. 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
  - c. Completed Early Childhood Pre-K Health Record Supplement form (DHS 908).

For more information, please contact the Waikiki Community Preschool. Mahalo for your interest, and we look forward to an exciting year filled with learning for all!

Best regards,

A handwritten signature in blue ink, appearing to read 'Ed Noh', followed by a long horizontal line extending to the right.

Ed H. Noh, Ed. D.

Executive Director

**Hawai'i State Public Charter Schools  
Early Learning Application Packet  
Checklist SY 2026-2027**

**For SPCSC office use only:**

☐ TSG entry

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

**School Name:** \_\_\_\_\_ Waikiki Community Preschool  
**Student Applicant's Name:** \_\_\_\_\_  
**Date/Time Complete Packet Received by School:** \_\_\_\_\_

**Complete packet must include the following documents completed in full (✓ to indicate it is complete):**

- ☐ 1. Early Learning 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 (page one of tax return or documentation of TANF, SNAP, or homelessness)
- ☐ 6. Student Health Record with updated PE, TB (dated 8/01/24 or later), immunizations and
- ☐ 7. Early Childhood Pre-K Health Record Supplement Form (DHS 908)

**TO BE COMPLETED BY SCHOOL:** Date/time completed packet received: \_\_\_\_\_

School Office Staff contact name: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

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

*Notes or comments:*

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.**

School: Waikiki Community Preschool  
School Year: 2026-2027

### ATTESTATION STATEMENT OF FAMILY INCOME

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

Child's name: \_\_\_\_\_ Family size: \_\_\_\_\_  
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 or previously known as welfare) program.  
☐ I am currently eligible for the Supplemental Nutrition Assistance Program (SNAP or previously known as food stamps).  
☐ The applying child is currently in foster care.  
☐ My family is homeless.  
☐ My child is and English Language Learner.  
☐ My child has an IEP and is receiving special education services. Name the school providing SPED services \_\_\_\_\_  
☐ None apply.

**Income verification documents are encouraged to support the information provided on this page. This page MUST be signed and completed in full.**

- ✓ 2025 1040 Income Tax Returns - page one onlyor
- ✓ Verification of current TANF, SNAP, homeless or foster care status, if applicable.

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

| Parent's Name | Employer | Period of Employment<br>for Past 12 months | Salary earned during past<br>12 months of employment |
|---------------|----------|--------------------------------------------|------------------------------------------------------|
|               |          |                                            | \$                                                   |
|               |          |                                            | \$                                                   |
|               |          |                                            | \$                                                   |
|               |          |                                            | \$                                                   |
|               |          |                                            | \$                                                   |
|               |          | <b>TOTAL</b>                               | <b>\$</b>                                            |

**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 2025 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 of Parent/Guardian (required)*

\_\_\_\_\_  
*Printed Name of Parent/Guardian*

\_\_\_\_\_  
*Contact phone number (required)*

\_\_\_\_\_  
*Work phone number or alternate phone number*

**FOR OFFICE USE ONLY:**

|                                                                    |          |                                   |                                                          |
|--------------------------------------------------------------------|----------|-----------------------------------|----------------------------------------------------------|
| <b>Family Size</b>                                                 |          | <b>Date pkt. received in full</b> |                                                          |
| <b>Federal Poverty Guidelines (FPG)<br/>(based on family size)</b> |          | <b>FPL ≤ 300%?</b>                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Family Income</b>                                               |          | <b>DOB 8/01/21 - 7/31/23?</b>     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Federal Poverty Level (FPL)<br/>(Income/FPG)</b>                | <b>%</b> | <b>Priority?</b>                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                                                    |          | <b>Confirmed by:</b>              |                                                          |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                         |                                                                         |                                       |      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------|------|
| School Name: Waikiki Community Preschool                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                         | Complex Area:                                                           |                                       |      |
| <b>STUDENT ENROLLMENT FORM</b> SIS-10W (Rev. 4/2023)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Student ID No.                                          | Entry Date                                                              | Entry Code                            | Room |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | For school use only                                     |                                                                         |                                       |      |
| <b>INSTRUCTIONS: PRINT YOUR ENTRIES LEGIBLY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Ethnicity/Race Observed: _____ Initial _____ Date _____ |                                                                         |                                       |      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Verification of DOB: _____                              |                                                                         |                                       |      |
| <b>STUDENT PERSONAL DATA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                         |                                                                         |                                       |      |
| Legal Last Name: _____ Legal First Name: _____ Middle Initial: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                         |                                                                         |                                       |      |
| Suffix: (Jr, II, III, etc): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Grade Level: _____ Birth Date (MM/DD/YYYY): _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                         |                                                                         |                                       |      |
| <input type="checkbox"/> Not Homeless <input type="checkbox"/> Homeless* <input type="checkbox"/> Completed MVA Packet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                         |                                                                         |                                       |      |
| _____<br>Parent/Legal Guardian Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                         |                                                                         | _____<br>DOE Representative Signature |      |
| <p>**"Homeless" means individuals who lack a fixed, regular and adequate nighttime residence (within the meaning of section 42 USCS §11302(a)(1)) and includes:</p> <ul style="list-style-type: none"> <li>(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; or are abandoned in hospitals;</li> <li>(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 USCS §11302(a)(2)(C));</li> <li>(iii) children and youth who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations or similar settings; and</li> <li>(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.</li> </ul> <p>Please contact the Community Homeless Concerns Liaison (CHCL) in your area with questions: <a href="https://bit.ly/HILiaisons">bit.ly/HILiaisons</a> or call (808) 305-9868.</p> |                                                         |                                                                         |                                       |      |
| <b>PRESCHOOL EXPERIENCE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                         |                                                                         |                                       |      |
| Preschool Experience <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                         |                                                                         |                                       |      |
| If "Yes" – attended:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                         | Preschool Program: (if applicable)                                      |                                       |      |
| <input type="checkbox"/> less than 6 months<br><input type="checkbox"/> between 6 and 12 months<br><input type="checkbox"/> more than 1 year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                         | <input type="checkbox"/> EOEL<br><input type="checkbox"/> Charter Pre-K |                                       |      |
| *Incoming Kindergarten students must complete the Supplemental Kindergarten Enrollment Form                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                         |                                                                         |                                       |      |
| <b>LAST HAWAII PUBLIC SCHOOL ATTENDED</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                         |                                                                         |                                       |      |
| Name: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                         |                                                                         |                                       |      |
| Last Grade Attended: _____ Year: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                         |                                                                         |                                       |      |
| <b>PRIOR SCHOOL ATTENDED (If not Hawaii Public School)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                         |                                                                         |                                       |      |
| Name: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                         |                                                                         | Phone: _____                          |      |
| Address: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                         |                                                                         | Fax: _____                            |      |
| <b>ADDITIONAL INFORMATION *</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                         |                                                                         |                                       |      |
| Country of Birth: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                         | Date First Entered U.S. School: _____<br>(MM/DD/YYYY)                   |                                       |      |
| * Providing this information is not required and will only be used to determine whether the child may be eligible for programs offered in the district that provide enhanced instructional opportunities for immigrant children and youth.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                         |                                                                         |                                       |      |

Please complete ETHNICITY INFORMATION, RACE INFORMATION, and PRIMARY RACE INFORMATION

ETHNICITY INFORMATION

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

RACE INFORMATION

Check all that apply:

- |                                                               |                                              |                                                                                 |                                                     |
|---------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> A – American Indian or Alaska Native | <input type="checkbox"/> E – Native Hawaiian | <input type="checkbox"/> K – Samoan                                             | <input type="checkbox"/> P – Tongan                 |
| <input type="checkbox"/> B – Black                            | <input type="checkbox"/> G – Japanese        | <input type="checkbox"/> L – White                                              | <input type="checkbox"/> Q – Guamanian/Chamorro     |
| <input type="checkbox"/> C – Chinese                          | <input type="checkbox"/> H – Korean          | <input type="checkbox"/> N – Indo-Chinese (Ex. Cambodian, Laotian, Vietnamese)  | <input type="checkbox"/> R – Other Asian            |
| <input type="checkbox"/> D – Filipino                         | <input type="checkbox"/> I – Portuguese      | <input type="checkbox"/> O – Micronesian (Ex. Chuukese, Marshallese Pohnpeian,) | <input type="checkbox"/> S – Other Pacific Islander |

PRIMARY RACE INFORMATION

What is the student's primary race? (Select only ONE letter from the Race Information section 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

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/  
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D  
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A  
N

Check one: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other (specify): \_\_\_\_\_ Relation: \_\_\_\_\_

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single Custody of Child: ☐ Yes ☐ No

Custody Documentation Submitted: ☐ Yes ☐ No Custody Type: ☐ Sole Custody ☐ Physical Custody ☐ Joint Legal

Legal Last Name \_\_\_\_\_ Legal First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Birth Date (MM/DD/YYYY) \_\_\_\_\_

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: (check all that apply) ☐ mailing ☐ portal (if applicable) ☐ messenger

EMERGENCY CONTACT: (check one) Call Sequence ☐ 1 ☐ 2

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

Branch of Service (check one):

- |                                    |                                      |                                      |                                       |
|------------------------------------|--------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Air Force | <input type="checkbox"/> Army        | <input type="checkbox"/> Coast Guard | <input type="checkbox"/> Marine Corps |
| <input type="checkbox"/> Navy      | <input type="checkbox"/> Space Force | <input type="checkbox"/> NOAA        | <input type="checkbox"/> USPHS        |

Military Status (check one):

- |                                         |                                          |
|-----------------------------------------|------------------------------------------|
| <input type="checkbox"/> Active Duty    | <input type="checkbox"/> Title 10 Orders |
| <input type="checkbox"/> National Guard | <input type="checkbox"/> Reserve         |

Deployed?

- ☐ Yes  
☐ No

Does this person work for the Federal Government or work on Federal Property? ☐ Yes ☐ No

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

SECOND PARENT / GUARDIAN

Check one: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other (specify): \_\_\_\_\_ Relation: \_\_\_\_\_  
Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single Custody of Child: ☐ Yes ☐ No  
Custody Documentation Submitted: ☐ Yes ☐ No Custody Type: ☐ Sole Custody ☐ Physical Custody ☐ Joint Legal

Legal Last Name \_\_\_\_\_ Legal First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Birth Date (MM/DD/YYYY) \_\_\_\_\_

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: (check all that apply) ☐ mailing ☐ portal (if applicable) ☐ messenger

EMERGENCY CONTACT: (check one) Call Sequence ☐ 1 ☐ 2

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

Branch of Service (check one):

☐ Air Force ☐ Army ☐ Coast Guard ☐ Marine Corps  
☐ Navy ☐ Space Force ☐ NOAA ☐ USPHS

Military Status (check one):

☐ Active Duty ☐ Title 10 Orders  
☐ National Guard ☐ Reserve

Deployed?

☐ Yes  
☐ No

Does this person work for the Federal Government or work on Federal Property? ☐ Yes ☐ No

**PARENT/GUARDIAN NOT LIVING WITH STUDENT**

PARENT / GUARDIAN

Check one: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other (specify): \_\_\_\_\_ Relation: \_\_\_\_\_  
Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single Custody of Child: ☐ Yes ☐ No

Legal Last Name \_\_\_\_\_ Legal First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Birth Date (MM/DD/YYYY): \_\_\_\_\_

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: (check all that apply) ☐ mailing ☐ portal (if applicable) ☐ messenger

EMERGENCY CONTACT: (check one) Sequence ☐ 1 ☐ 2 ☐ 3

**LEGAL PARENT/GUARDIAN NOT LIVING WITH STUDENT (cont.)****G  
U  
A  
R  
D  
I  
A  
N**Is this parent/guardian a member of the Armed Services, National Guard or Reserves? ☐ Yes ☐ No

Branch of Service (check one):

☐ Air Force ☐ Army ☐ Coast Guard ☐ Marine Corps  
☐ Navy ☐ Space Force ☐ NOAA ☐ USPHS

Military Status (check one):

☐ Active Duty ☐ Title 10 Orders  
☐ National Guard ☐ Reserve

Deployed?

☐ Yes  
☐ NoDoes this person work for the Federal Government or work on Federal Property? ☐ Yes ☐ No**EMERGENCY CONTACT INFORMATION****F  
I  
R  
S  
T**

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

Check one: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other (specify): \_\_\_\_\_ Relation: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Email Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cellular Phone # \_\_\_\_\_ Pager # \_\_\_\_\_ Work Phone # (include ext.) \_\_\_\_\_

EMERGENCY CONTACT: (*check one*) Call Sequence ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5**S  
E  
C  
O  
N  
D**

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

Check one: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other (specify): \_\_\_\_\_ Relation: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Email Address \_\_\_\_\_

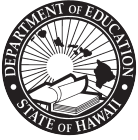
Home Phone # \_\_\_\_\_ Cellular Phone # \_\_\_\_\_ Pager # \_\_\_\_\_ Work Phone # (include ext.) \_\_\_\_\_

EMERGENCY CONTACT: (*check one*) Call Sequence ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5**SCHOOL SUPPLEMENTARY INFORMATION**Other  
Children  
In  
HIDOE  
Schools:

| Legal First, Middle Initial & Last Name | HIDOE School Attending | DOB   | Grade | Relationship |
|-----------------------------------------|------------------------|-------|-------|--------------|
| 1. _____                                | _____                  | _____ | _____ | _____        |
| 2. _____                                | _____                  | _____ | _____ | _____        |
| 3. _____                                | _____                  | _____ | _____ | _____        |
| 4. _____                                | _____                  | _____ | _____ | _____        |

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FOR SCHOOL USE:



## QUESTIONNAIRE TO DETERMINE ELIGIBILITY MV1

This form is intended to address the McKinney-Vento  
Act (MVA) and must be completed for each student

Questionnaires are  
filed for one (1) year  
for all students and  
seven (7) years for  
any student  
identified as living in  
unstable housing.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Waikiki Community Preschool \_\_\_\_\_ Grade: \_\_\_\_\_

Student's current residence such as address, cross streets, landmarks, etc.

Primary Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Alternate Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

CHECK  
ONE BOX

### STUDENT'S CURRENT LIVING ARRANGEMENT

MVA  
CODE

☐

**Unsheltered**

*Campground, car, beach/park, abandoned building, street or any other inadequate living space*

06

☐

**Shelter**

*Emergency, transitional or domestic violence shelter, name of shelter: \_\_\_\_\_*

04

☐

**Hotel/Motel**

*Due to lack of other suitable housing, **excludes** temporary lodging for military persons awaiting housing*

02

☐

**Doubled Up**

*Temporarily with family or other persons due to loss of housing or as a result of economic hardship*

03

☐

**Permanent Housing**

*Student who is living in a fixed, regular, and adequate housing situation  
including youth in foster care*



If this box is checked, stop here  
and sign below; form is complete

07

If the student is NOT in the physical custody of a parent or legal guardian, also check below:

☐

**Unaccompanied Youth**

05

List all siblings living in the same arrangement, including children 0-5 years of age:

| Name  | Date of Birth | School | Grade |
|-------|---------------|--------|-------|
| _____ | _____         | _____  | _____ |
| _____ | _____         | _____  | _____ |
| _____ | _____         | _____  | _____ |
| _____ | _____         | _____  | _____ |

The information you provide above will determine what services you or your child may be eligible to receive under the **McKinney-Vento Homeless Assistance Act - 42 U.S.C. §11434a(2)**. If eligible under the Act, you or your child are entitled to immediate enrollment in school and free school meals. Transportation may be provided to and from school of origin. This questionnaire allows a Homeless Concerns Liaison to contact you for additional support. By signing, you grant permission to share/release pertinent information among service providers, shelter, and school personnel to support immediate school enrollment and full participation.

Parent/Legal Guardian/Unaccompanied Youth Signature

Print Name

Date

**For School Use Only:** *School designee to complete this page if the student is identified as living in unstable housing.*

**NOTE:** The McKinney-Vento Act requires immediate enrollment for students living in unstable housing, even if the student is unable to provide documents, such as school records, immunization records and other health records, proof of residency, or other documents. 42 U.S.C. §11432(g)(3)(C).

\* "Enrolled" means attending classes and participating fully in school activities. 42 U.S.C. §11434a(1)

Student ID #: \_\_\_\_\_

Date Student Enrolled: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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: \_\_\_\_\_

By acknowledging below, the school designee agrees that the form is complete and the parent/legal guardian/unaccompanied youth has been provided MVA information and a copy of this form.

\_\_\_\_\_  
Designee Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

By signing below, the principal indicates that he/she has reviewed this form and understands the school's responsibility under the **McKinney-Vento Homeless Assistance Act**.

The school principal determines the student as:

- ☐ Eligible under McKinney-Vento Act
- ☐ Not eligible under McKinney-Vento Act Reason: \_\_\_\_\_
- MV2 Initiated: ☐ Yes ☐ No Date MV2 Initiated: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Principal Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**Notes/Updates:**

| Date | Action Taken | Remarks | Initials |
|------|--------------|---------|----------|
|      |              |         |          |
|      |              |         |          |
|      |              |         |          |
|      |              |         |          |

**Note:** Please forward a copy of this form to your Homeless Concerns Liaison within 3 business days.

INSERT BIRTH CERTIFICATE  
HERE

**Department of Education  
Student's Health Record**

| Student Information                                           |  |                                                                                   |                                                                                                                             |
|---------------------------------------------------------------|--|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| Name: _____<br><small>(Last) (First) (Middle Initial)</small> |  | Sex: <input type="checkbox"/> M <input type="checkbox"/> F<br>DOB: ____/____/____ | <b>Entry dates</b><br>Pre-K: ____/____/____<br>Elem.: ____/____/____<br>Int./Middle: ____/____/____<br>High: ____/____/____ |
| Parent/Legal Guardian Names:<br>1. _____ 2. _____             |  |                                                                                   |                                                                                                                             |

| Medical Conditions                  |                                               |                                                 |                                              |                                          |                               |  |
|-------------------------------------|-----------------------------------------------|-------------------------------------------------|----------------------------------------------|------------------------------------------|-------------------------------|--|
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Chronic Cough/Wheezing | <input type="checkbox"/> Hearing Problems    | <input type="checkbox"/> Seizures        | Other _____<br>_____<br>_____ |  |
| <input type="checkbox"/> Bees       | <input type="checkbox"/> Blood Disorders      | <input type="checkbox"/> Diabetes Type I        | <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Skin Problems   |                               |  |
| <input type="checkbox"/> Food       | <input type="checkbox"/> Bone/Joint Disorders | <input type="checkbox"/> Diabetes Type II       | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vision Problems |                               |  |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Cancer/Leukemia      | <input type="checkbox"/> Genetic Condition      | <input type="checkbox"/> Metabolic Disorder  |                                          |                               |  |

| Physical Examination (N - Normal, A - Abnormal, R - Receiving Care) |        |        |     |             |                |      |      |      |        |       |       |       |         |                |      |           |             |           |                      |              |
|---------------------------------------------------------------------|--------|--------|-----|-------------|----------------|------|------|------|--------|-------|-------|-------|---------|----------------|------|-----------|-------------|-----------|----------------------|--------------|
| Date                                                                | Height | Weight | BMI | *Blood Lead | Blood Pressure | Eyes | Ears | Nose | Throat | Teeth | Heart | Lungs | Abdomen | Nervous System | Skin | Scoliosis | Extremities | Nutrition | Provider's Signature | Printed Name |
| ____/____/____                                                      |        |        |     |             |                |      |      |      |        |       |       |       |         |                |      |           |             |           |                      |              |
| ____/____/____                                                      |        |        |     |             |                |      |      |      |        |       |       |       |         |                |      |           |             |           |                      |              |

| Tuberculosis Evaluation                                               |                |
|-----------------------------------------------------------------------|----------------|
| Check appropriate box                                                 | Date           |
| <input type="checkbox"/> Negative TB Risk Assessment                  | ____/____/____ |
| <input type="checkbox"/> Negative test for TB infection               | ____/____/____ |
| <input type="checkbox"/> Positive test & negative chest x-ray         | ____/____/____ |
| Dental Examination                                                    |                |
| Dental Check-Up                                                       | ____/____/____ |
| Dental Check-Up                                                       | ____/____/____ |
| Vision and Hearing                                                    |                |
| Visual Acuity <input type="checkbox"/> Color Vision Deficient         |                |
| R <u>20</u> / _____ L <u>20</u> / _____                               |                |
| <input type="checkbox"/> Corrected <input type="checkbox"/> Corrected | ____/____/____ |
| Hearing Thresholds                                                    |                |
| 500 1000 2000 4000                                                    |                |
| R _____                                                               |                |
| L _____                                                               | ____/____/____ |

| Immunizations                       |      |                |                |                |                |                                                |
|-------------------------------------|------|----------------|----------------|----------------|----------------|------------------------------------------------|
| DTaP, DTP, DT or Td                 | Type |                |                |                |                |                                                |
|                                     | Date | ____/____/____ | ____/____/____ | ____/____/____ | ____/____/____ |                                                |
| Polio (IPV or OPV)                  | Type |                |                |                |                |                                                |
|                                     | Date | ____/____/____ | ____/____/____ | ____/____/____ |                | ____/____/____                                 |
| Hib (Haemophilus influenzae tybe b) | Type |                |                |                |                |                                                |
|                                     | Date | ____/____/____ | ____/____/____ | ____/____/____ |                |                                                |
| Pneumococcal Conjugate              | Type |                |                |                |                |                                                |
|                                     | Date | ____/____/____ | ____/____/____ | ____/____/____ |                |                                                |
| Hepatitis B                         | Type |                |                |                |                | Varicella immunity secondary to disease (date) |
|                                     | Date | ____/____/____ | ____/____/____ | ____/____/____ |                |                                                |
| Hepatitis A                         | Type |                |                | Varicella      |                |                                                |
|                                     | Date | ____/____/____ | ____/____/____ | Date           | ____/____/____ |                                                |
| MMR                                 | Type |                |                |                | MCV            |                                                |
|                                     | Date | ____/____/____ | ____/____/____ |                | Date           |                                                |
| HPV                                 | Type |                |                |                | Tdap           |                                                |
|                                     | Date | ____/____/____ | ____/____/____ | ____/____/____ | Date           |                                                |
| Other                               | Type |                |                |                |                |                                                |
|                                     | Date | ____/____/____ | ____/____/____ | ____/____/____ | ____/____/____ |                                                |

Signature or Stamp of Healthcare Provider or Clinic: \_\_\_\_\_

**Health History Comments:** Include referrals and reports. Recommendation for significant findings. (Please print)

[illegible][illegible]

## 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<br>Tool: <input type="checkbox"/> PEDS <input type="checkbox"/> ASQ<br><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<br>• <b>List:</b>                                                      |                          | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                            | <b>8. EC Provider Use Only</b><br><input type="checkbox"/> Special Care Plan completed |
| <b>Medications/Treatments</b> <input type="checkbox"/> None<br>• <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<br>• <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<br>• <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<br>• <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><br>_____<br>Early Childhood Provider Name |                                                                                        |
|                                                                                                                                     |                          | <b>12. Parent/Guardian Name</b><br>_____                                                                                                                                            |                                                                                        |
| <b>10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp)</b> <b>Date</b>                                              |                          | <b>13. Parent/Guardian Signature</b> <b>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:<br/><b>PEDS:</b> Parent's Evaluation of Developmental Status<br/><b>ASQ:</b> Ages and Stages Questionnaire<br/><b>Other:</b> Print the name of screening tool used.</li></ul> <p><b>2. Date Completed</b><br/>Write the date <b>mm/dd/year</b> the screening was performed. i.e., 06/01/2006.</p> <p><b>3. Results</b><br/>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><br/>Please complete if abnormal, concern or counsel is selected.</p> <p><b>5. Medical Conditions</b><br/>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><br/>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><br/>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><br/>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><br/>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><br/>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><br/>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><br/>Print the name of the Parent or Guardian</p> <p><b>13. Parent/Guardian Signature</b><br/>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.

**Please complete the following document ONLY IF your child has an allergy that has been diagnosed by a physician.**

## 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: \_\_\_\_\_