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,

Ed H. Noh, Ed. D.
Executive Director

For SPCSC office use only:
☐ TSG entry

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

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

School Name: _____

Student Applicant's Name: _____

Date/Time Complete Packet Received by School: _____

Complete packet must include the following documents completed in full (√ to indicate 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: _____
School Year: 2026-2027

ATTESTATION STATEMENT OF FAMILY INCOME

Directions: This document must be completed in full by <u>all</u> 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 for Past 12 months	Salary earned during past 12 months of employment
			$
			$
			$
			$
			$
		TOTAL	**$**

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:

Family Size		**Date pkt. received in full**	
Federal Poverty Guidelines (FPG) (based on family size)		**FPL ≤ 300%?**	☐ **Yes** ☐ **No**
		DOB 8/01/21 - 7/31/23?	☐ **Yes** ☐ **No**
Family Income		**Priority?**	☐ **Yes** ☐ **No**
Federal Poverty Level (FPL) (Income/FPG)	**%**	**Confirmed by:**	

Reset Form

Print Form

School Name: Complex Area:

STUDENT ENROLLMENT FORM SIS-10W *(Rev. 4/2023)*

Student ID No.	Entry Date	Entry Code	Room
	For school use only		

INSTRUCTIONS: PRINT YOUR ENTRIES LEGIBLY

Ethnicity/Race Observed: _____ Initial _____ Date

Verification of DOB: _____

STUDENT PERSONAL DATA

Legal Last Name: _____ Legal First Name: _____ Middle Initial: _____

Suffix: (Jr, II, III, etc): _____ Gender: ☐ M ☐ F Grade Level: _____ Birth Date *(MM/DD/YYY)*: _____

☐ Not Homeless ☐ Homeless* ☐ Completed MVA Packet

_____ _____

Parent/Legal Guardian Signature DOE Representative Signature

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

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

(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));

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

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

Please contact the Community Homeless Concerns Liaison (CHCL) in your area with questions: bit.ly/HILiaisons or call (808) 305-9868.

PRESCHOOL EXPERIENCE

Preschool Experience ☐ Yes ☐ No

If "Yes" – attended:

☐ less than 6 months
☐ between 6 and 12 months
☐ more than 1 year

Preschool Program: (if applicable)

☐ EOEL
☐ Charter Pre-K

*Incoming Kindergarten students must complete the Supplemental Kindergarten Enrollment Form

LAST HAWAII PUBLIC SCHOOL ATTENDED

Name: _____

Last Grade Attended: _____ Year: _____

PRIOR SCHOOL ATTENDED (If not Hawaii Public School)

Name: _____ Phone: _____

Address: _____ Fax: _____

ADDITIONAL INFORMATION *

Country of Birth: _____ Date First Entered U.S. School: _____

(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.

Continue on next page

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:

- ☐ **A** – American Indian or Alaska Native
- ☐ **B** – Black
- ☐ **C** – Chinese
- ☐ **D** – Filipino
- ☐ **E** – Native Hawaiian
- ☐ **G** – Japanese
- ☐ **H** – Korean
- ☐ **I** – Portuguese
- ☐ **K** – Samoan
- ☐ **L** – White
- ☐ **N** – Indo-Chinese (Ex. Cambodian, Laotian, Vietnamese)
- ☐ **O** – Micronesian (Ex. Chuukese, Marshallese Pohnpeian,)
- ☐ **P** – Tongan
- ☐ **Q** – Guamanian/Chamorro
- ☐ **R** – Other Asian
- ☐ **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

FIRST 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

Continue on next page

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):	Military Status (check one):	Deployed?
☐ Air Force ☐ Army ☐ Coast Guard ☐ Marine Corps	☐ Active Duty ☐ Title 10 Orders	☐ Yes
☐ Navy ☐ Space Force ☐ NOAA ☐ USPHS	☐ National Guard ☐ Reserve	☐ 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

Continue on next page

LEGAL PARENT/GUARDIAN NOT LIVING WITH STUDENT (cont.)

GUARDIAN

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

EMERGENCY CONTACT INFORMATION

FIRST

(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]

SECOND

(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:

State of Hawaii • Department of Education
OFFICE OF STUDENT SUPPORT SERVICES

475 22nd Avenue
Honolulu, Hawaii 96816
bit.ly/HILiaisons

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: _____ 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* STOP **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: _____
(Last) (First) (Middle Initial)

Sex: ☐M ☐F
DOB: ____/____/____

Entry dates
Pre-K: ____/____/____
Elem.: ____/____/____
Int./Middle: ____/____/____
High: ____/____/____

Student Address Label

Parent/Legal Guardian Names:
1. _____ 2. _____

Medical Conditions

☐Allergies	☐Asthma	☐Chronic Cough/Wheezing	☐Hearing Problems	☐Seizures	Other
☐Bees	☐Blood Disorders	☐Diabetes Type I	☐Heart Condition	☐Skin Problems	_____
☐Food	☐Bone/Joint Disorders	☐Diabetes Type II	☐High Blood Pressure	☐Vision Problems	_____
☐Medication	☐Cancer/Leukemia	☐Genetic Condition	☐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
☐Negative TB Risk Assessment	____/____/____
☐Negative test for TB infection	____/____/____
☐Positive test & negative chest x-ray	____/____/____

Dental Examination

Dental Check-Up	____/____/____
Dental Check-Up	____/____/____

Vision and Hearing

Visual Acuity ☐Color Vision Deficient R 20 /____ L 20 /____ ☐ Corrected ☐Corrected	____/____/____
Hearing Thresholds 500 1000 2000 4000 R _____|_____|_____|_____ L _____|_____|_____|_____	____/____/____

Signature or Stamp of Healthcare Provider or Clinic:

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	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____

STATE OF HAWAII, DEPARTMENT OF EDUCATION, FORM 14, February 2022
*If recommended/required based on screening/EPSDT requirements.

6-8A

RS 22-1004 (Rev. of RS 18-0811) May 2022

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

Date	Comments	Signature & Title	Date	Comments	Signature & Title

Early Childhood Pre-K Health Record Supplement*

Name of Child:	**Name of Child Care Facility:**
Child's DOB:	**To Be Completed By The Physician**

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

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

9. Physician/NP/APRN/PA or Clinic Name, Address, Zip, Phone, Fax	11. *I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood Provider* _____ Early Childhood Provider Name
	12. Parent/Guardian Name
10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp) **Date**	**13. Parent/Guardian Signature** **Date**

*Supplement to the STATE OF HAWAIʻI, DEPARTMENT OF EDUCATION, FORM 14, Rev. 2010, RS 09-1051 (Rev. of RS 06-0698)

Instructions for Completing the Early Childhood Pre-K Health Record Supplement

To Be Completed by the Physician (Please print)

1. Type of Screening: Check all that apply.

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

2. Date Completed

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

3. Results

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

4. Recommendations/Follow up

Please complete if abnormal, concern or counsel is selected.

5. Medical Conditions

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

6. Special Care Plan Needed

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

7. Recommendations

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

8. Early Childhood Provider Use Only

This section is designated for the early childhood provider to complete if physician has marked (X) Yes in Box 6. Sample forms of the Special Care Plans can be requested from Department of Human Service (DHS) office, phone or downloaded from the Department of Human Service website.

9. Physician/NP/APRN/PA or Clinic Name

Type or print legibly physician, nurse practitioner, advanced practiced registered nurse, physician assistant or clinic name, address, zip, phone, and fax.

10. Physician/NP/ APRN/ PA, of Clinic (Signature or Stamp) and Date:

Physician, nurse practitioner, physician assistant must sign his/her name or stamp and write in the date of child's examination.

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

The Early Childhood program is encouraged to type, print legibly, or stamp the program name here prior to parent signature.

12. Parent/Guardian Name

Print the name of the Parent or Guardian

13. Parent/Guardian Signature

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

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 <u>ONLY IF</u> 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: _____