

# Department of Education STUDENT'S HEALTH RECORD

Student Address Label

Name \_\_\_\_\_  
(Last) (First) (Middle Initial)

Female  Preschool: Entry Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Male  Elementary: Entry Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Intermediate/Middle: Entry Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 High: Entry Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Birthdate 

<small>Month</small>	<small>Day</small>	<small>Year</small>					

Parent's Name \_\_\_\_\_  
(Mother/Guardian) (Father/Guardian)

Allergies: \_\_\_\_\_

Please complete the following sections (CHECK IF YES)

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

PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE																												
Date	Grade	Height	Weight	BMI	Blood Pressure	Vision		Hearing		Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name	
						R	L	R	L																			
____/____/____																												
____/____/____																												

TUBERCULOSIS EXAMINATION MANTOUX TEST (INTRADERMAL)			
Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic
____/____/____	____/____/____		
____/____/____	____/____/____		

  

CHEST X-RAY		
Date	Results	Location
____/____/____		

  

DENTAL EXAMINATION	
Dental Check-Up	____/____/____

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)							
DTaP, DTP, DT, Tdap or Td	Type						
	Date	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Polio (IPV or OPV)	Type						
	Date	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Hib (Haemophilus influenzae type b)	Type						
	Date	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Pneumococcal Conjugate	Type						
	Date	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Hepatitis B	Type						
	Date	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
MMR	Date	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Hepatitis A	Date	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Other	Type						
	Date	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Other	Type						
	Date	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____

\*OFFICE USE ONLY (Rev. 2010)

Physician, APRN, PA or Clinic \_\_\_\_\_



## Early Childhood Pre-K Health Record Supplement\*

<b>Name of Child:</b>		<b>Name of Child Care Facility:</b> Waikoloa Baptist Keikiland	
<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 Tool: <input type="checkbox"/> PEDS <input type="checkbox"/> ASQ <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>
Allergies/Sensitivities <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>8. EC Provider Use Only</b> <input type="checkbox"/> Special Care Plan completed
Medications/Treatments <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
Special Diet prescribed by physician <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
Behavioral Issues/Social Emotional Concerns <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
Medical Conditions/Related Surgeries <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
<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>	
		_____ Early Childhood Provider Name	
<b>10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp)</b>		<b>12. Parent/Guardian Name</b>	
		<b>13. Parent/Guardian Signature</b>	
<b>Date</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: <b>PEDS:</b> Parent's Evaluation of Developmental Status <b>ASQ:</b> Ages and Stages Questionnaire <b>Other:</b> Print the name of screening tool used.</li></ul> <p><b>2. Date Completed</b> Write the date <b>mm/dd/year</b> the screening was performed. i.e., 06/01/2006.</p> <p><b>3. Results</b> Mark (X) to indicate "<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> Please complete if abnormal, concern or counsel is selected.</p> <p><b>5. Medical Conditions</b> 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.</b> List type of medical condition, e.g., <b>Medical Condition/Related Surgeries List:</b> Asthma</p> <p><b>6. Special Care Plan Needed</b> If child has a medical condition and the Early Childhood Provider should develop a special care plan, mark (X) <b>Yes</b>, next to the appropriate category. If child does not need a special care plan, mark (X) <b>No</b>.</p>	<p><b>7. Recommendations</b> Write your recommendations, e.g., "Medications must be administered by the parent before or after school hours."</p> <p><b>8. Early Childhood Provider Use Only</b> This section is designated for the early childhood provider to complete if physician has marked (X) Yes in Box 6. Sample forms of the Special Care Plans can be requested from Department of Human Service (DHS) office, phone or downloaded from the Department of Human Service website.</p> <p><b>9. Physician/NP/APRN/PA or Clinic Name</b> Type or print legibly physician, nurse practitioner, advanced practiced registered nurse, physician assistant or clinic name, address, zip, phone, and fax.</p> <p><b>10. Physician/NP/ APRN/ PA, of Clinic (Signature or Stamp) and Date:</b> Physician, nurse practitioner, physician assistant must sign his/her name or stamp and write in the date of child's examination.</p> <p><b>11. "I give my consent for my child's Health Care Provider to discuss the information on this form with my Early Childhood provider."</b> The Early Childhood program is encouraged to type, print legibly, or stamp the program name here prior to parent signature.</p> <p><b>12. Parent/Guardian Name</b> Print the name of the Parent or Guardian</p> <p><b>13. Parent/Guardian Signature</b> The Parent or Guardian must sign his/her name and write the date signed.</p>
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**TB Document G: State of Hawaii TB Risk Assessment for Adults and Children**  
 Hawaii State Department of Health  
 Tuberculosis Control Program

**1. Check for TB symptoms**

- If there are significant TB symptoms, then further testing (including a chest x-ray) is required for TB clearance.
- If significant symptoms are absent, proceed to TB Risk Factor questions.

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does this person have significant TB symptoms?</b> Significant symptoms include <u>cough for 3 weeks or more</u> , plus at least one of the following:
	<input type="checkbox"/> Coughing up blood <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Unusual weakness <input type="checkbox"/> Fatigue

**2. Check for TB Risk Factors**

- If any "Yes" box below is checked, then TB testing is required for TB clearance
- If all boxes below are checked "No", then TB clearance can be issued without testing

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Was this person born in a country with an elevated TB rate?</b> Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Has this person traveled to (or lived in) a country with an elevated TB rate for four weeks or longer?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>At any time has this person been in contact with someone with <i>infectious TB disease</i>?</b> (Do not check "Yes" if exposed only to someone with latent TB)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the individual have a health problem that affects the immune system, or is medical treatment planned that may affect the immune system?</b> (Includes HIV/AIDS, organ transplant recipient, treatment with TNF-alpha antagonist, or steroid medication for a month or longer)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>For persons under age 16 only: Is someone in the child's household from a country with an elevated TB rate?</b>

<b>Provider Name with Licensure/Degree:</b>  <b>Assessment Date:</b>	<b>Person's Name and DOB:</b>  <b>Name and Relationship of Person Providing Information (if not the above-named person):</b>
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