Department of Education

STUDENT'S HEALTH RECORD

Student Address Label

Name _____ (Last) _____ (First) _____ (Middle Initial)

Female ☐ Male ☐

Preschool: Entry Date __/__/__

Elementary: Entry Date __/__/__

Intermediate/Middle: Entry Date __/__/__

High: Entry Date __/__/__

Birthdate __/__/__ (Month / Day / Year)

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

Allergies: _____

Please complete the following sections **(CHECK IF YES)**

MEDICAL STATUS

Allergy (type) ☐	Cancer/Leukemia ☐	Hearing Problems ☐	Hypertension ☐	Seizures ☐	Vision Problem ☐
Asthma ☐	Chronic Cough/Wheezing ☐	Heart Disease ☐	JRA Arthritis ☐	Sickle Cell Anemia ☐	
Behavioral Problems ☐	Diabetes ☐	Hemophilia ☐	Rheumatic Heart ☐	Skin Problems ☐	

PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE

Date	Grade	Height	Weight	BMI	Blood Pressure	Vision R.	Vision L.	Hearing R.	Hearing L.	Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Nervous System	Skin	Scoliosis	Extremities	Nutrition	Varicella Immunity Secondary to Disease (DATE)	Reviewed Immunization Record (Check if Yes)	Completed PPD Screening (Check if Yes) See Results Below	Provider's Signature	Provider's Stamp or Printed Name
__/__/__																											
__/__/__																											

TUBERCULOSIS 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	__/__/__	__/__/__	__/__/__	**Varicella**	__/__/__	__/__/__
Hepatitis A	Date	__/__/__	__/__/__				
Other	Type						
	Date	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Other	Type						
	Date	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__

Physician, APRN, PA or Clinic _____

***OFFICE USE ONLY** (Rev. 2010)

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

Date		Signature & Title	Date		Signature & Title

State of Hawaii
Department of Human Services

Benefit, Employment & Support Services Division

Early Childhood Pre-K Health Record Supplement*

Name of Child: **DOB:**

Name of Child Care Facility: Waikoloa Baptist KeiKiland

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	
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

10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp) **Date**

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

13. Parent/Guardian Signature **Date**

*Supplement to the STATE OF HAWAI'I, DEPARTMENT OF EDUCATION, FORM 14, Rev. 4/10, RS 10-1369 (Rev. of RS 09-1051)

DHS 908 (09/11)

Instructions for the Physician (Please print)

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

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

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

4. Recommendations/Follow up
Please complete if abnormal or concerned is selected.

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

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

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

8. Early Childhood Provider Use Only
This section is designated for the early childhood provider to complete if physician has marked (X) Yes in Box 6. A sample form of a Special Care Plan is located on the DHS 908A Instructions for the DHS 908 Early Childhood Pre-K Health Record Supplement form which can be downloaded from the Department of Human Service website: http://hawaii.gov/dhs/self-sufficiency/childcare/licensing/forms/

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.

TB Document F: State of Hawaii TB Clearance Form

Hawaii State Department of Health
Tuberculosis Control Program

Patient Name	DOB	TB Screening Date

I have evaluated the individual named above using the process set out in the DOH TB Clearance Manual dated 2/10/17 and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawaii Administrative Rules.

Screening for schools, child care facilities or food handlers *(TB Document A or E)*
☐ Negative TB risk assessment
☐ Negative test for TB infection
☐ Positive test for TB infection, and negative chest X-ray

Initial Screening for health care facilities or residential care settings *(TB Document B or C)*
☐ Negative test for TB infection (2-step)
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, negative CXR within previous 12 months, and negative symptom screen
☐ Previous positive test for TB infection, and negative CXR

Annual Screening for Health care facilities or residential care settings *(TB Document D)*
☐ Negative test for TB infection
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, and negative symptoms screen
☐ Previous positive test for TB infection, and negative CXR

Signature or Unique Stamp of Practitioner: _____

Printed Name of Practitioner: _____

Healthcare Facility: _____

This TB clearance provides a reasonable assurance that the individual listed on this form was free from tuberculosis disease at the time of the exam. This form does not imply any guarantee or protection from future tuberculosis risk for the individual listed.

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.

☐ Yes ☐ No	**Does this person have significant TB symptoms?** Significant symptoms include cough for 3 weeks or more, plus at least one of the following: ☐ Coughing up blood ☐ Fever ☐ Night sweats ☐ Unexplained weight loss ☐ Unusual weakness ☐ 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

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

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