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:

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	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. 4/10, RS 10-1369 (Rev. of RS 09-1051)

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

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

Physician, APRN, PA or Clinic ______________

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: ____

Program modification: i.e.: no peanut products allowed_________________________

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:____________