IMPORTANT NOTICE!

By the ***FIRST DAY OF SCHOOL***, all new students to any public or private school in the State of Hawai'i must have the following:

1. Tuberculosis (TB) clearance
   (Current within 12 months' prior to enrollment)
2. A completed Student Health Record (Form 14) including a physical examination and all required immunizations OR a signed statement or appointment card from your child's doctor
3. A completed Health Record (Form 908) including signatures

Students missing any of these requirements will ***NOT*** be permitted to enter school on the first day.

The Health State
HAWAI'I DEPARTMENT OF HEALTH

State of Hawaii
Department of Human Services

Benefit, Employment & Support Services Division

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 HAWAI'I, DEPARTMENT OF EDUCATION, FORM 14, Rev. 2010, RS 09-1051 (Rev. of RS 06-0698)

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/Legal Guardian) _____ (Father/Legal 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 EVALUATION

Check one box below, complete date assessment, test or x-ray was administered.		Physician, APRN, PA, Clinic
☐ Negative TB Risk Assessment	Date: __/__/__	
☐ Negative test for TB infection	Date: __/__/__	
☐ Positive test, and negative chest x-ray	Date: __/__/__	

DENTAL EXAMINATION

Dental Check-Up	Date: __/__/__
Dental Check-Up	Date: __/__/__

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	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Hepatitis A	Type						
	Date	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
MMR	Type				**Varicella Date**		
	Date	__/__/__	__/__/__	__/__/__		__/__/__	__/__/__
HPV	Type				**Meningococcal Conjugate Date**		
	Date	__/__/__	__/__/__	__/__/__		__/__/__	__/__/__
Other	Type						
	Date	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__

Physician, APRN, PA or Clinic _____

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.

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

Date		Signature & Title	Date		Signature & Title

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.

REQUEST FOR EXEMPTION FROM VACCINATION ON RELIGIOUS GROUNDS

Student's Name:		Student's Date of Birth:	
Student's Home Address:		City	Zip
Name of Child Care Facility or School:	Street Address:	City	Zip

_____ I certify that immunization conflicts with my bona fide religious tenets and practices.
Initials

_____ I understand that if at any time there is, in the opinion of the Department of Health, danger of an outbreak or epidemic from any communicable disease for which immunization is required, this exemption from immunization shall not be recognized and my child will be excluded from school or his/her child care facility until the threat of an epidemic is over or he/she receives the proper immunization.
Initials

_____ I understand that a request for religious exemption based on objections to specific vaccines will not be granted.
Initials

I understand the benefits and risks of the vaccinations my child is required to have for school/child care facility attendance, the risk of my child contracting the diseases that vaccines prevent, and the risk of my child transmitting disease to others. I understand that this form may not be used for personal or philosophical reasons.

_____
Parent/Guardian Name (please print)

_____ Date: _____
Parent/Guardian Signature

HAWAII REVISED STATUTES: §302A-1156, §302A-1157, §325-34
HAWAII ADMINISTRATIVE RULES: §11-157-5

Medical Exemption Form

Instructions for completing Medical Exemption Form:
Section 1: Completed by parent/guardian or student (aged ≥18 years): Enter child care facility, school, or post-secondary school, and student information
Section 2: Completed by licensed health care provider (MD, DO, ND, APRN-Rx, PA): Check exempted vaccine, contraindication or precaution, or both, and complete duration of exemption

Section 1: Child Care Facility, School, Post-Secondary School, and Student Information

Student's Name:	Student's Date of Birth:		
Student's Home Address	City	State	Zip
Name of Child Care Facility, School, Post-Secondary School	Street Address	City	Zip

I understand that if at any time there is, in the opinion of the Department of Health, danger of an outbreak or epidemic from any communicable disease for which immunization is required, this exemption from immunization shall not be recognized and the student named above will be excluded from attending the child care facility, school, or post-secondary school until the Director of Health has determined that the presence of the outbreak no longer exists [HRS §302A-1157].

Parent/Guardian Name [if student <18 years]. (Please print): _____

Parent/Guardian OR Student (if aged ≥18 years) Signature: _____ Date: _____

Section 2: For Health Care Provider Use ONLY (MD, DO, ND, APRN-Rx, PA):

VACCINE	CONTRAINDICATIONS* (Check all that apply to this patient):	PRECAUTIONS* (Check all that apply to this patient)	FROM:	TO:
☐ **DTaP** ☐ **Tdap** ☐ **DT, Td**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ **DTaP/Tdap only:** Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose of DTP, DTaP, Tdap	☐ Guillain-Barre Syndrome <6 weeks after previous dose of tetanus-toxoid-containing vaccine ☐ History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid-containing or tetanus-toxoid-containing vaccine ☐ Moderate or severe acute illness with or without fever ☐ **DTaP/Tdap only:** Progressive or unstable neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy	/ /	/ /
☐ **Hib**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Age <6 weeks	☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ **Hep A**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ **Hep B**	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Hypersensitivity to yeast	☐ Moderate or severe acute illness with or without fever	/ /	/ /

*https://health.hawaii.gov/docd/files/2019/08/HAR11-157_EXHIBIT_B.pdf

Section 2: For Health Care Provider Use ONLY (MD, DO, ND, APRN-Rx, PA):				
VACCINE	CONTRAINDICATIONS* (Check all that apply to this Patient):	PRECAUTIONS* (Check all that apply to this patient)	FROM:	TO:
☐ HPV	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	☐ Pregnancy ☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ MMR	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Pregnancy ☐ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) ☐ Family history of altered immunocompetence	☐ Recent (<11 months) receipt of antibody-containing blood product ☐ History of thrombocytopenia or thrombocytopenic purpura ☐ Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing ☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ MCV	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ PCV	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose of PCV13 or any diphtheria-toxoid-containing vaccine or to a component of a vaccine (PCV13 or any diphtheria-toxoid-containing vaccine)	☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ IPV	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	☐ Pregnancy ☐ Moderate or severe acute illness with or without fever	/ /	/ /
☐ Varicella	☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component ☐ Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) ☐ Pregnancy ☐ Family history of altered immunocompetence	☐ Recent (<11 months) receipt of antibody-containing blood product ☐ Moderate or severe acute illness with or without fever ☐ Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination ☐ Use of aspirin or aspirin-containing products	/ /	/ /

I certify that in my medical judgement, due to the contraindication(s)/precaution(s) noted above, this student is exempt from the specific vaccine(s) named for the period indicated.

Health care provider's name/Title (Please Print): _____ License number: _____

Address: _____

Health care provider's signature: _____ Date: _____

DTaP=Diphtheria, Tetanus, acellular Pertussis, Tdap=Tetanus, diphtheria, acellular pertussis, DT=diphtheria, tetanus, Td=tetanus, diphtheria, Hib=*Haemophilus influenzae* type B, Hep A=hepatitis A, Hep B=hepatitis B, HPV=human papillomavirus, MMR=measles, mumps, rubella, MCV=meningococcal conjugate vaccine, PCV=pneumococcal conjugate vaccine, IPV=inactivated poliovirus vaccine

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: _____