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 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 _____

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

| Date | | Signature & Title | Date | | Signature & Title |
|---|---|---|---|---|---|
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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:** CORNERSTONE EARLY EDUCATION CENTER (CEEC)

## 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<br>Tool: ☐ PEDS ☐ ASQ<br>☐ Other _____ | | ❑ No Concern ❑ Concern | |

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

CORNERSTONE EARLY EDUCATION CENTER (CEEC)
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)
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.