

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

| To Be Completed By The Physician                                                                                                    |                   |                                                                      |                                                                                                                                                                                         |                                                      |             |
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| 1. Type Screening                                                                                                                   | 2. Date Completed | 3. Results                                                           | 4. Recommendations/Follow up                                                                                                                                                            |                                                      |             |
| 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<br>Tool: <input type="checkbox"/> PEDS <input type="checkbox"/> ASQ<br><input type="checkbox"/> Other _____ |                   | <input type="checkbox"/> No Concern <input type="checkbox"/> Concern |                                                                                                                                                                                         |                                                      |             |
| 5. Medical Conditions                                                                                                               |                   | 6. Special Care Plan Needed                                          | 7. Recommendations                                                                                                                                                                      | 8. EC Provider Use Only                              |             |
| <b>Allergies/Sensitivities</b> <input type="checkbox"/> None<br>• <b>List:</b>                                                      |                   | <input type="checkbox"/> Yes <input type="checkbox"/> No             |                                                                                                                                                                                         | <input type="checkbox"/> Special Care Plan completed |             |
| <b>Medications/Treatments</b> <input type="checkbox"/> None<br>• <b>List:</b>                                                       |                   | <input type="checkbox"/> Yes <input type="checkbox"/> No             |                                                                                                                                                                                         | <input type="checkbox"/> Special Care Plan completed |             |
| <b>Special Diet prescribed by physician</b> <input type="checkbox"/> None<br>• <b>List:</b>                                         |                   | <input type="checkbox"/> Yes <input type="checkbox"/> No             |                                                                                                                                                                                         | <input type="checkbox"/> Special Care Plan completed |             |
| <b>Behavioral Issues/Social Emotional Concerns</b> <input type="checkbox"/> None<br>• <b>List:</b>                                  |                   | <input type="checkbox"/> Yes <input type="checkbox"/> No             |                                                                                                                                                                                         | <input type="checkbox"/> Special Care Plan completed |             |
| <b>Medical Conditions/Related Surgeries</b> <input type="checkbox"/> None<br>• <b>List:</b>                                         |                   | <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><br><br>_____<br>_____<br>_____                              |                   |                                                                      | <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><br><br>_____<br>Early Childhood Provider Name |                                                      |             |
|                                                                                                                                     |                   |                                                                      | <b>12. Parent/Guardian Name</b><br><br>_____                                                                                                                                            |                                                      |             |
| <b>10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp)</b>                                                          |                   | <b>Date</b>                                                          | <b>13. Parent/Guardian Signature</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)**

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| <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:<br/><b>PEDS:</b> Parent's Evaluation of Developmental Status<br/><b>ASQ:</b> Ages and Stages Questionnaire<br/><b>Other:</b> Print the name of screening tool used.</li></ul> <p><b>2. Date Completed</b><br/>Write the date <b>mm/dd/year</b> the screening was performed. i.e., 06/01/2006.</p> <p><b>3. Results</b><br/>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><br/>Please complete if abnormal, concern or counsel is selected.</p> <p><b>5. Medical Conditions</b><br/>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><br/>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><br/>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><br/>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><br/>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><br/>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><br/>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><br/>Print the name of the Parent or Guardian</p> <p><b>13. Parent/Guardian Signature</b><br/>The Parent or Guardian must sign his/her name and write the date signed.</p> |
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**To be used as part of a cover letter to the preschool, parent or physician.**

The purpose of the Hawaii Department of Human Services (DHS) Early Childhood Pre-K Health Record Supplement (EC-Pre-K HRS) is to provide developmentally appropriate information on the child's health, growth and developmental status for (Pre) school entry. The EC-Pre-K HRS is to be used in conjunction with the Hawaii Department of Education (DOE), Student's Health Record Form 14 2010.

The DHS EC Pre-K Health Record can be downloaded from the Hawaii Department of Human Services website, <http://humanservices.hawaii.gov/> and search for Form 908. The DOE Student Health Record Form 14 can be downloaded at Department of Education website: <http://www.hawaiipublicschools.org/Pages/home.aspx>, click on Parents and Students, click on Enrolling in School, click on How to Enroll, look for Related Downloads and click on Student Health Record.

The child's physician is requested to complete the DOE Student Health Record Form 14 and DHS EC Pre-K Health Record Supplement. The following are directions for completing the DHS EC Pre-K Health Record Supplement.

## 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: \_\_\_\_\_