Lahaina Spring Program 2019

1. Child's Name (Last, First, M.I.) ____________________

Grade______ Age______ Gender ______ Birth Date__________________ School____________________

2. Parents / Legal Guardians (AUTHORIZED TO PICK UP CHILD)

Parent's Name	HDL#	Work Phone	Cell/Home Phone
Parent's Name	HDL#	Work Phone	Cell/Home Phone

3. Email Address ____________________

4. Mailing Address____________________

City____________________ State__________ Zip__________

5. Medical Conditions/Allergies____________________

6. Doctor's Name____________________ Phone__________

Address____________________ City__________ State______ Zip__________

7. Medical Insurance____________________ Policy #____________________

8. Authorized Pick-Up & Emergency People (Other than parents / legal guardians):

Name	HDL#	Work Phone	Cell/Home Phone
Name	HDL#	Work Phone	Cell/Home Phone

SPONSOR

I hereby agree that, if Kama'aina Kids staff is unable to contact me or one of the persons listed as emergency contact, I hereby consent that if my child exhibits signs of illness or injury, that at the discretion of the Kama'aina Kids supervisor on duty, my child may be taken to the nearest medical facility and be given any examination or treatment that is deemed necessary by the personnel of the medical facility and, if permissible by medical facility, subsequently released to Kama'aina Kids Supervisor or staff-in-charge. I hereby give my child permission to attend and participate in the activities conducted by Kama'aina Kids' program. These activities include aquatics, off-property excursions, van transportation, and enrichment activities. I hereby authorize Kama'aina Kids to use my child's name and video or photograph at any time and in any manner in connection with its advertising, publicity, and public relations programs. The video-photo may only be used by Kama'aina Kids. No further cla

DISCIPLINE

Discipline is used to assure the safety and well being of all program participants. All children are expected to respect themselves, other people and their property. If a child is not following the guidelines of Kama'aina Kids staff consistent with these expectations, then the child will take a time out from the activity at the staff member's discretion. A child with consistent behavior problems will be sent to Kama'aina Kids' Program Site Coordinator who may contact the parents for the purpose of removing the child from the program. Kama'aina Kids reserves the right to refuse any child's future participation in its programs. I hereby authorize Kama'aina Kids and its employees to exercise these discipline policies in regard to my child.

Signature of Releasor ____________________ Date __________

Kama'aina Kids is an equal opportunity organization and does not deny enrollment or discriminate on the grounds of race, color, religion, gender, or national origin. Eligibility to participate in this program is dependent on verification of a child's ability to function safely in a 1:15 ratio.

March 18 - March 22

Lahaina Preschool

1. Spring Package

❑ 7am - 5:30pm

$145 for **Entire Session**

2. Program by the Day

❑ 7am - 5:30pm

$31 per day

March				
18	19	20	21	22

Use above calendar to select dates.

Breakfast, lunch and snacks included

Please make payments to **Kama'aina Kids** and submit to:

Lahaina Preschool
553 Wainee Street
Lahaina HI 96761
Questions? Call 446-0614 or 727-5593

Total 1 .... $ ________

Total 2 .... $ ________

Total Due .... $ ________

Payment Information Below

❑ Option 1 (Check/Money Order) # ____________________

❑ Option 2 (Credit/Debit Card- please choose type of card below)

❍ VISA ❍ MasterCard ❍ American Express

____
Name as it appears on the card

____
Card Number

__________ Expiration Date   __________ CVV (3 digit on back) $__________ Total to be charged

____
Signature   Date

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)

Vaccine							
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 ______________________________

Early **C**hildhood **P**re-K **H**ealth **R**ecord **S**upplement*

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. Early Childhood 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. 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)

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

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

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: i.e.: no peanut products allowed___________________________
____

Program modification: ____
____

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: ____________