Paia Summer Day Camps 2017

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 ____________ LIC# ____________ Work Phone ____________ Cell Phone

   ____________ Parent's Name ____________ LIC# ____________ Work Phone ____________ Cell Phone

3. Mailing Address____________________

   City____________________ State____________ Zip____________________

4. Medical Conditions/Allergies____________________

5. Doctor's Name____________________ Phone____________________

   Address____________________ City____________________ State_______ Zip____________

6. Medical Insurance____________________ Policy #____________________

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

   ____________ Name ____________ LIC# ____________ Work Phone ____________ Cell Phone

   ____________ Name ____________ LIC# ____________ Work Phone ____________ Cell 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 claims will be made by me.

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 ____________

Stay in contact with Kama'aina Kids Programs for keiki of all ages! Sign-up to receive our notifications on programs and specials!

✔ Email: ____________________ First/Last Name:____________________

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.

May 31 through July 21 • No Program 6/12, 7/4

Paia Preschool

Online payment not available.

❶ Summer Package

❑ 7am-5:30pm, $950 for **Entire Session**

❷ Camp by the Week

❑ 7am-5:30pm $95 for wk 1

❑ 7am-5:30pm $125/wk for wks 3 & 6

❑ 7am-5:30pm $150/wk for wks 2, 4, 5, 7 & 8

Check off the weeks needed							
5/31	6/5	6/13	6/19	6/26	7/3	7/10	7/17
1							
		3			6		
	2		4	5		7	8

Use above calendar to select weeks.

❸ Camp by the Day

❑ 7am-5:30pm

_____days x $45/day = $_________

Use calendars to select days.

May				
3	4	31	6	7

June				
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30

July				
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21

Breakfast, Lunch & Snacks included

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

Paia Preschool
401 Baldwin Avenue
Paia, HI 96779

Questions? Call 446-4642

Totals 1, 2 . . . .$________

***Late Fee ($25)** . . . .$________

Total Due . . . .$__________

$30 Withdrawal Fee • $25 Late Fee • $10 Program Changes • $25 Return Check Fee

If family is on state assistance of any kind, program payments need to be paid upfront, and are then reimbursed by the state.

Payment Information Below

____________________ Person responsible for payment

❑ **Option 1** (Check or Money Order) #_______________

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

❐ VISA ❐ MasterCard ❐ Discover ❐ Amex

____________________ Name as it appears on the card

____________________ Card Number Exp.Date CVV#

Total Amount 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		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	/ /

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

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	/ /	/ /	/ /	/ /	/ /	/ /

Physician, APRN, PA or Clinic ______

State of Hawaii
Department of Human Services

Benefit, Employment & Support Services Division

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 HAWAI'I, 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

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**.	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.

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: 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: ____________