

# Paia Fall Program 2017

October 9 through October 13

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

Grade \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Birth Date \_\_\_\_\_ School \_\_\_\_\_

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

\_\_\_\_\_ Father's Name \_\_\_\_\_ LIC# \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

\_\_\_\_\_ Mother'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.

## Lahaina Preschool

### ❶ Fall Package

7am-5:30pm, \$145 for Entire Session

### ❷ Program by the Day

7am-5:30pm  
\$30 per day



\*\*Use above calendar to select dates.\*\*

**\*\*Breakfast, Lunch & Snacks included\*\***

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

Paia Preschool  
401 Baldwin Ave.  
Paia HI 96779

Questions? Call 446-4646

Totals 1 .....\$ \_\_\_\_\_

Totals 2 .....\$ \_\_\_\_\_

Total Due .....\$ \_\_\_\_\_

## 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 (3 digits on back of card) \_\_\_\_\_

Total Amount to be Charged: \$ \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



# Department of Education STUDENT'S HEALTH RECORD

Student Address Label

Name \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial)

Female  Preschool: Entry Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Male  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) <input type="checkbox"/>	Cancer/Leukemia <input type="checkbox"/>	Hearing Problems <input type="checkbox"/>	Hypertension <input type="checkbox"/>	Seizures <input type="checkbox"/>	Vision Problem <input type="checkbox"/>		
Asthma <input type="checkbox"/>	Chronic Cough/Wheezing <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	JRA Arthritis <input type="checkbox"/>	Sickle Cell Anemia <input type="checkbox"/>			
Behavioral Problems <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Hemophilia <input type="checkbox"/>	Rheumatic Heart <input type="checkbox"/>	Skin Problems <input type="checkbox"/>			

**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	__ / __ / __
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**IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)**

Vaccine	Type	Date Given			
	DTaP, DTP, DT, Tdap or Td	Date	__ / __ / __	__ / __ / __	__ / __ / __
Polio (IPV or OPV)	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
Hib ( <i>Haemophilus influenzae</i> type b)	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
Pneumococcal Conjugate	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
Hepatitis B	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
MMR	Date	__ / __ / __	__ / __ / __	__ / __ / __	Varicella __ / __ / __
Hepatitis A	Date	__ / __ / __	__ / __ / __		
Other	Type				
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
Other	Type				
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __

\*OFFICE USE ONLY (Rev. 2010)

Physician, APRN, PA or Clinic \_\_\_\_\_

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

<b>Name of Child:</b>		<b>Name of Child Care Facility:</b>	
<b>Child's DOB:</b>		<b>To Be Completed By The Physician</b>	
<b>1. Type Screening</b>	<b>2. Date Completed</b>	<b>3. Results</b>	<b>4. Recommendations/Follow up</b>
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 Tool: <input type="checkbox"/> PEDS <input type="checkbox"/> ASQ <input type="checkbox"/> Other _____		<input type="checkbox"/> No Concern <input type="checkbox"/> Concern	
<b>5. Medical Conditions</b>		<b>6. Special Care Plan Needed</b>	<b>7. Recommendations</b>
<b>Allergies/Sensitivities</b> <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>8. EC Provider Use Only</b> <input type="checkbox"/> Special Care Plan completed
<b>Medications/Treatments</b> <input type="checkbox"/> None • List:		<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 • List:		<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 • List:		<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 • List:		<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>		<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> _____	
		Early Childhood Provider Name	
<b>10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp)</b> <b>Date</b>		<b>12. Parent/Guardian Name</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)