

Paia Spring Program 2017

March 20 through March 24

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: _____

Paia Preschool



① Spring Package

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

② Program by the Day

7am - 5:30pm
\$31 per day

March				
20	21	22	23	24

Use above calendar to select dates.

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

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

Paia Preschool
401 Baldwin Avenue
Paia, HI 96779

Questions? Call 579-9185

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 _____

Total Amount to be Charged: \$ _____

Signature _____

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.

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	Date	Date	Date	Date	Date
DTaP, DTP, DT, Tdap or Td	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
Polio (IPV or OPV)	Type						
	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
Hib (<i>Haemophilus influenzae</i> 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 Childhood Pre-K Health Record Supplement*

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)		<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	
5. Medical Conditions		6. Special Care Plan Needed	7. Recommendations
Allergies/Sensitivities <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	8. EC Provider Use Only <input type="checkbox"/> Special Care Plan completed
Medications/Treatments <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
Special Diet prescribed by physician <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
Behavioral Issues/Social Emotional Concerns <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
Medical Conditions/Related Surgeries <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 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	
10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp) Date		12. Parent/Guardian Name	
		13. Parent/Guardian Signature Date	

*Supplement to the STATE OF HAWAII, DEPARTMENT OF EDUCATION, FORM 14, Rev. 2010, RS 09-1051 (Rev. of RS 06-0698)