

Paia Summer Day Camps 2017

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

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 Releaser _____ 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.

Piilani Preschool

1 Summer Package

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

Online payment not available.

2 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.

3 Camp by the Day

7am-5:30pm

_____ days x \$45/day = \$ _____

Use calendars to select days.

May

		31	6	7
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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 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	Dates Given (Month/Day/Year)							
	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	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
Other	Date	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __

*OFFICE USE ONLY (Rev. 2010)

Physician, APRN, PA or Clinic _____

Early Childhood Pre-K Health Record Supplement*

Name of Child: Child's DOB:		Name of Child Care Facility: 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: <input type="checkbox"/> PEDS <input type="checkbox"/> ASQ <input type="checkbox"/> Other _____		No Concern Concern	
5. Medical Conditions		6. Special Care Plan Needed	7. Recommendations Use Only
Allergies/Sensitivities None • List:		YesNo	Special Care Plan completed
Medications/Treatments None • List:		YesNo	Special Care Plan completed
Special Diet prescribed by physician None • List:		YesNo	Special Care Plan completed
Behavioral Issues/Social Emotional Concerns None • List:		YesNo	Special Care Plan completed
Medical Conditions/Related Surgeries None • List:		YesNo	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)

Instructions for Completing the Early Childhood Pre-K Health Record Supplement

To Be Completed by the Physician (Please print)

<p>1. Type of Screening: Check all that apply.</p> <ul style="list-style-type: none"> • Head Circumference, Hgb/Hct, Lead, BMI • Developmental Screening: The screening tools listed are: <div style="margin-left: 20px;"> PEDS: Parent's Evaluation of Developmental Status ASQ: Ages and Stages Questionnaire Other: Print the name of screening tool used. </div> <p>2. Date Completed Write the date mm/dd/year the screening was performed. i.e., 06/01/2006.</p> <p>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.</p> <p>4. Recommendations/Follow up</p>	<p>7. Recommendations Write your recommendations, e.g., "Medications must be administered by the parent before or after school hours."</p> <p>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.</p> <p>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.</p> <p>10. Physician/NP/ APRN/ PA, of Clinic (Signature or Stamp) and Date: Physician, nurse practitioner, physician assistant must sign his/her name or</p>
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<p>Please complete if abnormal, concern or counsel is selected.</p> <p>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</p> <p>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.</p>	<p>stamp and write in the date of child's examination.</p> <p>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.</p> <p>12. Parent/Guardian Name Print the name of the Parent or Guardian</p> <p>13. Parent/Guardian Signature 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: 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: _____