

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

<b>Name of Child:</b>		<b>DOB:</b>	
<b>Name of Child Care Facility:</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	
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	<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>12. Parent/Guardian Name</b>			
<b>10. Physician/NP/ APRN/ PA or Clinic Signature (Signature or stamp)</b>		<b>13. Parent/Guardian Signature</b>	<b>Date</b>

\*Supplement to the STATE OF HAWAII, DEPARTMENT OF EDUCATION, FORM 14, Rev. 4/10, RS 10-1369 (Rev. of RS 09-1051)  
DHS 908 (09/11)

**Instructions for the Physician (Please print)**

<p><b>1. Type of Screening:</b> Check all that apply.</p> <ul style="list-style-type: none"><li>• <b>Head Circumference, Hgb/Hct, Lead</b></li><li>• <b>Developmental Screening:</b> The screening tools listed are: <b>PEDS:</b> Parent's Evaluation of Developmental Status <b>ASQ:</b> Ages and Stages Questionnaire <b>Other:</b> Print the name of screening tool used.</li></ul> <p><b>2. Date Completed</b> Write the date <b>mm/dd/year</b> the screening was performed. i.e., 06/01/2006.</p> <p><b>3. Results</b> Mark (X) to indicate "<b>Normal</b>" or "<b>Abnormal</b>", "<b>No Concern</b>" or "<b>Concern</b>". If the box is marked abnormal or concern, please complete Box 4. Recommendations/Follow up.</p> <p><b>4. Recommendations/Follow up</b> Please complete if abnormal or concerned is selected.</p> <p><b>5. Medical Conditions</b> Mark (X) "<b>None</b>" box for each item if the child has no <b>Allergies/Sensitivities, Medications/Treatments, Special Diet prescribed by physician, Behavioral Issues/Social Emotional Concerns, Medical Conditions/ Related Surgeries.</b> List type of medical condition, e.g., <b>Medical Condition/Related Surgeries List:</b> Asthma</p> <p><b>6. Special Care Plan Needed</b> If child has a medical condition and the Early Childhood Provider should develop a special care plan, mark (X) <b>Yes</b>, next to the appropriate category. If child does not need a special care plan, mark (X) <b>No</b>.</p>	<p><b>7. Recommendations</b> Write your recommendations, e.g., "Medications must be administered by the parent before or after school hours."</p> <p><b>8. Early Childhood Provider Use Only</b> This section is designated for the early childhood provider to complete if physician has marked (X) Yes in Box 6. A sample form of a Special Care Plan is located on the DHS 908A Instructions for the DHS 908 Early Childhood Pre-K Health Record Supplement form which can be downloaded from the Department of Human Service website: <a href="http://hawaii.gov/dhs/self-sufficiency/childcare/licensing/forms/">http://hawaii.gov/dhs/self-sufficiency/childcare/licensing/forms/</a></p> <p><b>9. Physician/NP/APRN/PA or Clinic Name</b> Type or print legibly physician, nurse practitioner, advanced practiced registered nurse, physician assistant or clinic name, address, zip, phone, and fax.</p> <p><b>10. Physician/NP/ APRN/ PA, of Clinic (Signature or Stamp) and Date:</b> Physician, nurse practitioner, physician assistant must sign his/her name or stamp and write in the date of child's examination.</p> <p><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> The Early Childhood program is encouraged to type, print legibly, or stamp the program name here prior to parent signature.</p> <p><b>12. Parent/Guardian Name</b> Print the name of the Parent or Guardian</p> <p><b>13. Parent/Guardian Signature</b> The Parent or Guardian must sign his/her name and write the date signed.</p>
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