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.

INSTRUCTIONS for the DHS 908

PURPOSE

The DHS 908 Early Childhood Pre-K Health Record Supplement (EC Pre-K HRS) form was created with the assistance of the Healthy Child Care Hawaii, a collaborative project of the University of Hawaii/School of Medicine - Department of Pediatrics, American Academy of Pediatrics - Hawaii Chapter, Department of Health/Children with Special Health Needs Branch. The purpose of the DHS 908 is to provide developmentally appropriate information on the child's health, growth and developmental status for entrance into a Pre-Kindergarten (Pre-K) program which includes an Infant and Toddler Child Care Center (IT), Group Child Care Center (GCC), and Group Child Care Home (GCH). The child's physician is requested to complete the DHS 908 in conjunction with the Department of Education (DOE) Form 14.

INSTRUCTIONS FOR THE CHILD CARE FACILITY:

1. A health record shall be required and obtained from the parent or guardian of each child entering a licensed child care facility such as a Family Child Care Home (FCC), GCC, GCH, or an IT and be kept on file at the facility in accordance with the applicable Hawaii Administrative Rules (HAR) §§17-891.1-20, 17-892.1-20, and 17-895-20.
2. The Department of Education (DOE) Student Health Record "Form 14" (F14) shall be used to comply with this requirement listed in #1, or a comparable writing (documentation) of a child's current immunizations, evidence of child's good health/physical examination results, and TB test/clearance results. The F14 (rev. 2010) is available and may be downloaded from the DOE website, http://doe.k12.hi.us/forms/index.htm.
3. In addition, the records of each child in a GCC, GCH, and IT shall include pertinent information about the health status (including Body Mass Index), developmental progress, and any special needs and efforts necessary to meet these needs in accordance with HAR §§17-892.1-20(c) and 17-895-20(c). The DHS 908 or comparable writing (document) shall be used to comply with the requirement listed in #2. The DHS 908 may be downloaded from the DHS Child Care Connection Hawaii website, http://humanservices.hawaii.gov/bessd/child-care-program/child-care-licensing/child-care-center-Licensing-forms/.
4. At the time of a facility's initial licensing visit, each child shall have a F14 and a DHS 908 on file.
5. At the time of a facility's annual licensing visit, new students enrolled for the school year who do not have a F14 on file shall, also, be required to have a DHS 908 on file.
6. Children entering new programs that were previously enrolled at a licensed child care program with a DHS 908 form that was signed by an approved

health care practitioner within 12 months of admission do not need to update their form;

7. Furthermore, providers shall issue the DHS 908 form (10/14) version to all families when families request the F14 on file to update their form due to an upcoming well-child visit or immunization scheduled with the health care practitioner. Providers shall instruct families to have the health care practitioner complete the DHS 908 form (10/14) to keep the program informed of the child's *on-going* growth and development while the child is enrolled in the program; and
8. HCCH recommends as best practice that a separate DHS 908 form (10/14) be completed and attached to the F14 at the same time the health record is updated.
9. The facility's director shall document at least 2 attempts to obtain the DHS 908 from the parent. If after 2 attempts the DHS 908 is not returned, the child's health requirement shall be met as long as the F14 is on file.
10. If a child has a medical condition noted on the F14 or the physician has marked "Yes" in Box 6 of the DHS 908 that a Special Care Plan should be developed, the child care facility should develop a Special Care Plan for the child and kept on file at the facility. Please refer to the Sample Special Care Plan on Page 2 of the DHS 908A.
11. The DHS 908 is only recommended for entry into a FCC.
12. A FCC and GCH provider's own children who are enrolled in school and school-aged children enrolled in the FCC or GCH for before and after school care who satisfy health requirements for enrollment in school are not required to furnish evidence of the child's health.
13. Children enrolled in licensed before and after school child care facilities (BAS) are not required to furnish evidence of the child's health per HAR §17-896-19(a).

State of Hawaii
Department of Human Services

Benefit, Employment & Support Services Division

Early Childhood Pre-K Health Record Supplement*

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. EC 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)

DHS 908 (10/14)

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
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**.

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 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.

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: _____

Program modification: i.e.: no peanut products allowed _____

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:_____