Kamehameha Schools Preschools Health Record Supplement

School Year _____

Name of Child:	Child's DOB:	Student ID:	Name of Preschool:

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	
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	Official 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

10. Physician/NP/ APRN/ PA or Clinic Signature **Review/Sign Date:**_____
(Signature or stamp)

11. ***By submitting this supplemental form you are providing authorization for our medical department to contact your healthcare provider for more information if needed (e.g., the development of a Special Care Plan).***

12. Parent/Guardian Name

13. Parent/Guardian Signature **Date**

*Supplement to the STATE OF HAWAIʻI, DEPARTMENT OF EDUCATION, FORM 14, Rev. 2010, RS 09-1051 (Rev. of RS 06-0698).
Providers: Instructions on how to complete the form can be found at https://humanservices.hawaii.gov/bessd/child-care-program/forms/.