School Information

Thank you for your interest in having your keiki attend our program!

We are located in Nānākuli at the Puʻuheleakala Recreation Center

Address: 87-169 Helelua Street, Waianae, HI 96792

Phone: 808-773-7171

Hours: 7:00AM-5:00PM

We accept children ages 2 through 5 years old in two mixed age range classrooms.

We operate year round from August to July with the following closures:

- All state and federal holidays
- One week in December between Christmas and New Years
- One week in March aligned with the nearest public school break
- The last week in July
- 4 Days for Professional Development with 30 days notice

Full Time Preschool:

Hours: 7:00AM - 5:00PM

Registration Fee: $150.00

Tuition: $1200.00

Part Time Preschool:

Hours: 7:00AM-1:30 PM

Registration Fee: $150.00

Tuition: $850.00

We accept the following subsidies: Child Care Connection, First to Work, Preschool Open Doors. PLease let us know if your ʻohana needs help applying for assistance.

Enrollment Checklist

Parent Checkbox	**All forms listed below must be received fully completed before your keiki is considered enrolled.** Preferred Start Date:	Office Checkbox
	Enrollment Application	
	Child Information	
	Medical Emergency Permissions	
	Authorized Pick-Up List	
	Consent to Release Information	
	Photo/Video Release	
	Form 14 Health Record signed by doctor and parent.	
	DHS 908: Supplemental Health Record signed by doctor and parent.	
	TB Clearance or Assessment	
	Birth Certificate	
	Tuition Agreement or Subsidy Confirmation	
	Additional Paperwork including TRO information or Custody Agreements.	

FOR OFFICE USE	
Date Received:	Received From:
Date Approved:	Start Date:
Funding Source:	
Notes:	

ENROLLMENT APPLICATION

Date:____________________ School Year: ______________________________

Child's First Name:________________ Middle:_______ Last:__________________________

Preferred Name:______________________ Date of Birth: ______________________

Race/Ethnicity: (Please check all that apply)

- o Chinese
- o Japanese
- o Hawaiian
- o Samoan
- o Tongan
- o African American
- o Native American
- o Filipino
- o Korean
- o Caucasian
- o Other:_______

Does your child have Special Needs or Medical Requirements? If yes, describe:

____

____

Does your child have food allergies? If yes, describe:

____

____

Family Information

Living Address: ____

City: _____________________________________ State: _________ Zip Code: ___________

Mailing Address:____

City:______________________________________ State:_________ Zip Code: ___________

Home Phone: ____________ Work Phone: _______________ Cell Phone: ______________

Email: ____

Primary Parent/Guardian

First Name: _______________ Middle: ______________ Last: ___________________

Date of Birth: _______ Best Contact #:_________________

Relationship to Child:_____________ Marital Status: ______________

Native Hawaiian? Yes/No Highest Education Completed: _________________________

Secondary Parent/Guardian

First Name: _______________ Middle: ______________ Last: ___________________

Date of Birth: _______ Best Contact #:_________________

Relationship to Child:_____________ Marital Status: ______________

Native Hawaiian? Yes/No Highest Education Completed: _________________________

Household Information

Does your family receive General Assistance (GA) or Temporary Assistance to Needy Families (TANF)? Yes/No

Please check the income level corresponding to the combined yearly income of the child's parents. This includes TANF and/or any other sources of income.

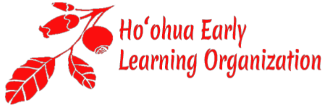
- o Less than 9,999
- o 10,000-24,999
- o 25,000-54,999
- o 55,0000-74,999
- o 75,000 and above

Number of adults in the household? _____ Number of children in the household? ____
Language most often spoken at home: ______________________
Please list the following information for every person living in the household including all adults and children not listed above.

Name	Gender	Age	Date of Birth	Relationship to Child

Emergency Contact Information (Please only list adults 18 years of age or older)
First Name: ________________________________ Last: ________________________________
Relationship to Child: __________ Home Phone: __________ Mobile Phone:___________
Work Phone: _________________

Secondary Emergency Contact
First Name: ________________________________ Last: ________________________________
Relationship to Child: __________ Home Phone: __________ Mobile Phone:___________
Work Phone: _____________________



CHILD INFORMATION

Parent/Guardian Name(s): ____

Child's Name: ______________________________ Birth Date: ____________

Previous School Experience (previous daycare or preschool): ______________________________

Support Services, Past or Present

Is your child currently or have they in the past received other support services (Infant Development Program, NICU, Early Intervention, Speech/Occupational/Behavioral Therapy)? Yes/No

If Yes, please explain below:

____

____

____

Child's Information

Health or Medical Problems during Pregnancy, Labor or Birth: Yes/No

If yes, please explain: ____

Hospitalizations? Yes/No

If yes, explain: ____

Birth Information: Full Term __________ Premature ___________ Needed Special Care _________

Explain: ____

History of: Ear Infections (#___) Asthma _____________ Chronic Issues ______________

Explain any health history if needed:

____

____

____

Medications your Child is currently taking:

____

____

____

Are there any health problems you know or suspect your child may have? ________________

____

____

____

Development

How many hours does your child sleep at night? ______________ Nap? ______________

At what age did you child first walk? ___________ Speak single words?_______________

What language(s) is spoken at home? ____

Are there any developmental problems you know or suspect your child may have?

____

____

____

Temperament *Please Circle All Of The Following That Apply To Your Child*
Very shy   Fearless   Aggressive   Easily goes to strangers   Slow to warm up to strangers
Does not separate well from parents   Cries when parent returns   Runs to parent upon parent's return   Keeps playing upon parent's return. Hard to console when upset. Easy to console when upset.

Behavior. *Please Circle All Of The Following That Apply To Your Child*
Very quiet. Watches others play from a distance.   Plays alone even if other children are around. Engages others in play. Plays with others for long periods without incident. Allows others to play with him/her. Does not play well with others. Hard to handle behavior. Does not follow rules. Stays with a task more than 10 minutes. Stays with a task fewer than 10 minutes. Does not finish activities. Shows off activities when finished. Goes from activity to activity without showing real interest in any. Has a few favorite activities. Repeats same activity over and over.

Vision. *Please Circle All Of The Following That Apply To Your Child*
Appears to see fine things that are near. Appears to see fine things that are far. Blinks or rubs eyes frequently. Squints or frowns to see. Holds things too close or too far to look at them. Does not point at, comment on, things that are far.

Hearing, Speech and Language. *Please Circle All Of The Following That Apply*
History of ear infections. Needs to have sentences repeated. Wants T.V. or radio on loudly. Seems inattentive to directions. Tilts head to listen. Speaks loudly Needs to watch speaker's face/mouth. Hard to understand my child's words.   Stutters. Voice sounds unusual. Mispronounces many words. Does not pick-up new words or ideas easily.   Has difficulty: expressing him/herself, following directions, routines, or remembering directions or routines.

Movement. *Please Circle All Of The Following That Apply To Your Child*
Mostly has control of body. Clumsy. Difficulty hopping or jumping. Difficulty throwing or catching a ball. Difficulty using: scissors, writing utensils, building blocks, or 2 hands together.

Please, on the line continuum below, mark with an X how active you think your child is
|____|
Often Still   Very Active

Child's Home Life
- ☐ Two parents in a longtime, stable relationship, living in the same home with child
- ☐ Parental disparity (Separated, divorced, often fighting, violence, other _________)
- ☐ Recent death, major illness, incarceration, etc. of a loved one
- ☐ Change in the environment (address, schedule, routine, others moving in or out)
- ☐ Exposure to a traumatic event (serious accident, injury, death, natural disaster, etc.)
- ☐ Other: ____

Parent's Observations and Concerns, *please attach additional pages if necessary*
____
____
____
____

MEDICAL AND EMERGENCY PERMISSIONS

Parent/Guardian Name: ______________________________ **Phone:** ____________

Parent/Guardian Name: ______________________________ **Phone:** ____________

I give permission to Hoʻohua Early Learning Organization (HELO) to refer my child (name) ________________________________ to for all necessary medical/dental examinations, tests, and developmental screenings thought significant to my child's healthy growth and progress. In addition, if I cannot be reached in case of an emergency caused by my child's illness or injury, I authorize HELO to contact the following persons, who are each at least 18 years old and authorized to have medical information about my child and to make healthcare decisions for my child on my behalf:

Primary Authorized Contact
Name: ____ Relationship: _____________
Phone #: ____________________ Cell #: ________________

Secondary Authorized Contact
Name: ____ Relationship: _____________
Phone #: ____________________ Cell #: ________________

My Child's Pediatrician (for treatment when needed)
Doctor's Name: ___________________________ Phone #: ____________________

If that physician is not available, take my child to (Doctor, Hospital, Urgent Care):

____

____

____

My insurance company is: __________________ My group/policy # is: ___________
List any known health problems:

____

____

____

In case of an extreme emergency, I understand that HELO staff will either call an ambulance or accompany my child to the Waianae Comprehensive Health Center's Emergency Room, or the closest source of medical aid at the discretion of the Emergency Medical Personnel or other staff member in charge.

I assume all responsibility for the medical/dental care for my child and will comply with all health requirements set forth by HELO policy.

Parent/Guardian Signature: ___________________________ Date: ______________

Parent/Guardian Signature: ___________________________ Date: ______________

AUTHORIZED PICK-UP LIST

Child's Name:____

1. ____
Name Telephone #

2. ____
Name Telephone #

3. ____
Name Telephone #

4. ____
Name Telephone #

5. ____
Name Telephone #

6. ____
Name Telephone #

7. ____
Name Telephone #

8. ____
Name Telephone #

9. ____
Name Telephone #

10. ____
Name Telephone #

My signature on this form signifies that I understand that if I am not the person picking-up my keiki, the staff at HELO will only release my keiki to those listed on this form. The people I have designated above are each at least 18 years old, and will show identification to staff when requested. I also understand that in case of emergency, if the persons listed as emergency contacts are not available, HELO will contact those listed above in the order they are listed.

Parent/Guardian Name: __________________________

Parent/Guardian Signature: __________________________

Date: __________________________

Date: __________________________

CONSENT TO RELEASE INFORMATION

This release is meant to facilitate the sharing of information about your child's progress at school with people who pick her/him up, or in the case of divorced/separated parents if the non-custodial parent requests the information in our records.

I, ___________________________, hereby declare that I am the parent/legal guardian of ____________________________________ and give my permission to Hoʻohua Early Learning Organization (HELO) and/or my child's teachers at HELO to release information from their school records, except for records I originally provided HELO, e.g. medical records, to the following family members, friends, and/or agencies:

____

____

____

I expressly deny permission to release information to the following (when naming a non-custodial parent, please provide legal documentation verifying your right to enforce such restrictions); in the case of a TRO please submit a photo of the person named in the order.

____

____

____

HELO guarantees that the child's information will only be released to those named above. Disclosure to any other person or agency will require a separate release. ____

Parent/Legal Guardian Signature: __________________________ Date: __________________

STATEMENT OF CONSENT AND WAIVER OF PHOTOGRAPHS

Child's Name: ____

I hereby consent to the staff of Hoohua Early Learning Organization (HELO) taking photographs, electronic/digital images, audiovisual and sound recordings of my child, or the minor for whom I am a guardian, release any rights I may have to them, and acknowledge that HELO, and not the staff, is the sole owner and copyright holder of them.

I also consent to HELO using the photographs, digital images, audiovisual or sound recordings, for any purpose deemed appropriate and ethical by HELO including, but not limited to classroom postings, school newsletters, educational materials, books, DVDs or other digital media, teacher's professional portfolios, the Program's professional portfolio, photographic exhibits connected with the school, advertising for the school, brochures for the school, etc. I waive any right to inspect/approve the photographs, electronic/digital images, audiovisual, or sound recordings, and any right to approve HELO's use of them.

I understand and acknowledge that HELO is not obligated to use any of the photographs, electronic/digital images, audiovisual, or sound recordings.

Please initial next to any form of media you give consent for us to post on:

_____Banners _____Newspaper _____Instagram _____Facebook ____Website
____. Other Print

____ ____________________________
Parent's/Legal Guardian's Signature Date

OCT2021

Department of Education

STUDENT'S HEALTH RECORD

Student Address Label

Name ______________________________ (Last) (First) (Middle Initial)

Female ❑ Male ❑

Preschool: Entry Date __/__/__
Elementary: Entry Date __/__/__
Intermediate/Middle: Entry Date __/__/__
High: Entry Date __/__/__

Birthdate ☐☐■☐☐■☐☐☐☐ Month Day Year

Parent's Name ______________ (Mother/Legal Guardian) ______________ (Father/Legal Guardian)

Allergies: ______________________________

Please complete the following sections **(CHECK IF YES)**

MEDICAL STATUS

Allergy (type) ❑	Cancer/Leukemia ❑	Hearing Problems ❑	Hypertension ❑	Seizures ❑	Vision Problem ❑
Asthma ❑	Chronic Cough/Wheezing ❑	Heart Disease ❑	JRA Arthritis ❑	Sickle Cell Anemia ❑	
Behavioral Problems ❑	Diabetes ❑	Hemophilia ❑	Rheumatic Heart ❑	Skin Problems ❑	

PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE

Date	Grade	Height	Weight	BMI	Blood Pressure	Vision R.	Vision L.	Hearing R.	Hearing L.	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
/ /																							/ /				
/ /																							/ /				

TUBERCULOSIS EVALUATION

	Check one box below, complete date assessment, test or x-ray was administered.		Physician, APRN, PA,Clinic
☐	Negative TB Risk Assessment	Date: / /	
☐	Negative test for TB infection	Date: / /	
☐	Positive test, and negative chest x-ray	Date: / /	

DENTAL EXAMINATION

Dental Check-Up	Date: / /
Dental Check-Up	Date: / /

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)

Vaccine							
DTaP, DTP, DT, Tdap or Td	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Polio (IPV or OPV)	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Hib *(Haemophilus influenzae* type b)	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Pneumococcal Conjugate	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis B	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
Hepatitis A	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /
MMR	Type				**Varicella Date**		
	Date	/ /	/ /	/ /		/ /	/ /
HPV	Type				**Meningococcal Conjugate Date**		
	Date	/ /	/ /	/ /		/ /	/ /
Other	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /

Physician, APRN, PA or Clinic ______________________________

Health History Comments: Include Referrals and Reports. Recommendation for significant findings.
(Please Print)

Date		Signature & Title	Date		Signature & Title

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)		❑ 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* **Hoohua Early Learning Organization** 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 HAWAIʻI, 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)

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.

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: ___________________

SAMPLE