IMPORTANT NOTICE!

By the ***FIRST DAY OF SCHOOL***, all new students to any public or private school in the State of Hawai'i must have:

1) Tuberculosis (TB) clearance

AND

2) A completed Student Health Record (Form 14) including a physical examination and all required immunizations ***OR*** a signed statement or appointment card from your child's doctor.

Students missing either of these requirements will ***NOT*** be permitted to enter school on the first day.

The Health State

Hawai'i Department of Health
Immunization Program

Hilo **C**hurch of the **N**azarene

Hale **A**loha **N**azarene **S**chool

595 Kupulau Rd.
Hilo, HI 96720
959-4949 959-7020-fax

Richard A. Ragle
Pastor

Stacia Burton
Principal

. . . at the foot of the cross.

TUITION FEE SCHEDULE
SUMMER 2024

PRESCHOOL FEES:

REGISTRATION FEE: $50.00

MONTHLY RATES:

2:30........................$790.00
5:30.........................$840.00

Multi-Student Family Discounts:

1st Child	Full Rate
2nd Child	Pay 75%
3rd Child	Pay 50%
4th Child	Free

HALE ALOHA NAZARENE SCHOOL
APPLICATION FORM

595 KUPULAU RD
HILO, HI 96720
PHONE: 959-4949

2024 SUMMER PRESCHOOL

FOR OFFICE USE ONLY
Registration Fee ____________
Comprehensive Fee ____________
Health Card ____________
Date of Entry ____________
Emergency Form ____________
Handbook ____________

A $50.00 Summer Fee must accompany this application.

PICK UP TIME 2:30___ 5:30___

Name (Legal) ______________________________ M ____ F ____
Last First Middle Preferred Name

Mailing Address ______________________________ Phone ____________
Street City Zip Code

Physical Address ______________________________ email address ____________
Street City

Birthdate ____________ Birthplace ____________ No. Siblings: Brothers ____ (Older) ____ (Younger)
Sisters ____ ____

Requested Date of Entry ____________ Requested Class (3's or 4's) ____________
Language Spoken In The Home ____________

FATHER OR GUARDIAN

Name ______________________________ Living With Child: Yes ____ No ____

Racial Ancestry ____________ Deceased ____________ Divorced ____________

Occupation ____________ Business Phone ____________

Employer ____________ Pager/Cellular # ____________

Employer Address ____________

Church Membership: No _____ Yes _____ Where ____________

MOTHER OR GUARDIAN

Name ______________________________ Living With Child: Yes ____ No ____

Racial Ancestry ____________ Deceased ____________ Divorced ____________

Occupation ____________ Business Phone ____________

Employer ____________ Pager/Cellular # ____________

Employer Address ____________

Church Membership: No _____ Yes _____ Where ____________

MEDICAL INFORMATION

Name of Child's Doctor ____________ Phone ____________

Office Address ____________ Medical Insurance ____________

Allergies and Other Health Concerns ____________

PERSONS TO BE NOTIFIED IN AN EMERGENCY WHEN PARENTS CANNOT BE REACHED:

1. Name ______________________________ Relationship ______________

   Address ______________________________ Telephone ______________

2. Name ______________________________ Relationship ______________

   Address ______________________________ Telephone ______________

3. Name ______________________________ Relationship ______________

   Address ______________________________ Telephone ______________

HOW DID YOU HEAR ABOUT HALE ALOHA NAZARENE SCHOOL?

Friend/Relative _____ Newspaper _____ Yellow Pages _____ Other ____________________

POLICIES AND PERMISSION

I have read the HALE ALOHA NAZARENE SCHOOL Handbook and hereby agree to comply to all policies and procedures as stated, including:

POLICIES

My child must have a Health Card (Form 14) dated not more than three months prior to admission to school. An annual physical exam and dental certification is recommended.

My child will remain at home for all illnesses including fever, vomiting, diarrhea, impetigo, etc. A readmit slip is required from the doctor after childhood illnesses such as measles, mumps, chicken pox, etc. A label from medication will be required as proof of use in cases of "ukus" or head lice.

When my child becomes ill during a school day, I will take my child home as soon as possible when notified by the school.

I will notify the school between 7:00 and 8:00 AM if my child will be absent from school.

All tuition is due on the first day of the month and payable within the first ten (10) days of each month. A late fee will be charged after the tenth of the month. All tuition, registration fee and comprehensive fee are nonrefundable. A fee will be charged for checks returned by the bank. ***If applicable, the Registrar will give you an attached memo for payment schedule.**

I will notify the school of any changes in my telephone number, address or place of employment.

I will notify the school office in writing at least two weeks in advance or pay two weeks tuition when disenrolling my child.

If my child is in Preschool Program, and he/she is not picked up by 5:30 PM, a late fee will be charged.

My child will be picked up by (please list at least one person other than parents):

1. Name ______________________ Relationship ______________
   Address ______________________ Telephone ______________
2. Name ______________________ Relationship ______________
   Address ______________________ Telephone ______________
3. Name ______________________ Relationship ______________
   Address ______________________ Telephone ______________
4. Name ______________________ Relationship ______________
   Address ______________________ Telephone ______________
5. Name ______________________ Relationship ______________
   Address ______________________ Telephone ______________

I will contact the school when authorizing someone else to pick up my child. Positive identification of persons picking up my child will be required.

In the event that my child becomes ill or sustains an injury while in the care of HALE ALOHA NAZARENE SCHOOL I give my permission to those in charge to take the steps necessary to stop any bleeding. I understand the school will follow the Emergency Procedure: 1) Notify the parents/guardians; 2) Call the child's emergency contact persons; 3) Contact the child's doctor; 4) Call Hilo Medical Center, #974-4700; 5) Call #911 for all urgent situations. I understand a teacher, teacher assistant, or staff member will accompany my child and remain with my child until I can reach the treatment facility.

If it is not possible to reach the doctor named above or to receive my instruction for my child's care, consent is given to any licensed physician and/or surgeon called upon to administer treatment, drugs or medications, and perform such surgical procedures as he shall think the emergency requires for the relief of pain and to preserve his/her life and health. I will be responsible for all expenses incurred by such an illness or injury.

I agree that classroom, playground, Chapel, and field trip activities provide very effective learning experiences. My child, ______________________ , has full approval to participate in any and all
(Child's Name)

activities planned for his/her class while enrolled at HALE ALOHA NAZARENE SCHOOL.

I fully understand that the teachers and staff will do their very best to supervise my child for his/her welfare and well-being; however, I am also aware of unforeseen incidents which may occur. I hereby agree to waive all responsibility of the teachers, staff and school in the event of such happenings.

We do take special note of the birth of our Savior, Jesus Christ. Our students have opportunity to celebrate this joyous event through special services and/or programs. Every student is required to participate in all general programs of the school.

Permission to Release Information to the Hilo Church of the Nazarene

HALE ALOHA NAZARENE SCHOOL is a ministry of the Hilo Church of the Nazarene. I fully realize that by signing this registration/application form, I am authorizing and consenting to the disclosure of my name, address, and telephone information to the staff of Hilo Church of the Nazarene.

Photo Release and Consent

I hereby grant permission to HALE ALOHA NAZARENE SCHOOL to use any or all photographs taken of my child while attending HANS or participating in any of the school's sponsored activities. These photos may be used for classroom and yearbook purposes. I fully realize that by signing this registration/application form, I am authorizing and consenting to the use of photos for these purposes.

Access, Confidentiality and Disclosure of Student Records

HANS, in compliance with the Family Educational Rights and Privacy Act, provides that with the exception of directory information, all student records are confidential and available only to the student.

Under the FERPA Act, parental access to student records may be granted if the student is under 21 years of age and the parent certifies in writing that the student is a dependent as defined by the IRS. In the case of divorce either parent (custodial or noncustodial) has access to the record of a dependent student. In formation will be released to a third party by written permission only.

FERPA affords students certain rights with respect to their educational records. These rights include:

Access- The right to inspect and review the student's education records within 45 days of the day HANS receives a request for access. The right to request the amendment of the student's education records that the student believes are inaccurate or misleading.

Right to file a complaint-A complaint may be filed with the U.S. Department of Education concerning alleged failures by the school to comply with the requirements of FERPA.

Confidentiality and Disclosure

The right to consent to disclosures of personally identifiable information contained in the student's education records, except to the extent that FERPA authorizes disclosure without consent. One exception which permits disclosure without consent is disclosure to school officials with legitimate educational interests. A school official has a legitimate educational interest if the official needs to review an education record in order to fulfill his or her professional responsibility. Upon request, the school may disclose education records without consent to officials of another school in which a student seeks or intends to enroll. Finally, "public information" may be released freely unless the student files the appropriate form requesting that certain public information not be released.

In accordance with Federal law and U. S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326W, Whitten Building, 1400 Independence Ave., SW, Washington, D. C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

______________________________ ______________

Signature of Father or Guardian Date

______________________________ ______________

Signature of Mother or Guardian Date

State of Hawaii
Department of Human Services

Benefit, Employment & Support Services Division

Early Childhood Pre-K Health Record Supplement*

Name of Child: **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	
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. 4/10, RS 10-1369 (Rev. of RS 09-1051)

DHS 908 (09/11)

Instructions for the Physician (Please print)

1. Type of Screening: Check all that apply.

- **Head Circumference, Hgb/Hct, Lead**
- **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".** If the box is marked abnormal or concern, please complete Box 4. Recommendations/Follow up.

4. Recommendations/Follow up

Please complete if abnormal or concerned 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. 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: http://hawaii.gov/dhs/self-sufficiency/childcare/licensing/forms/

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.

Department of Education

STUDENT'S HEALTH RECORD

Student Address Label

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

Female ❑ Male ❑

Birthdate [|] [|] [| | |] Month Day Year

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

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		
	Date	/ /	/ /	/ /	Conjugate 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

TB Document F: State of Hawaii TB Clearance Form

Hawaii State Department of Health
Tuberculosis Control Program

Patient Name	DOB	TB Screening Date

I have evaluated the individual named above using the process set out in the DOH TB Clearance Manual dated 2/10/17 and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawaii Administrative Rules.

Screening for schools, child care facilities or food handlers *(TB Document A or E)*
☐ Negative TB risk assessment
☐ Negative test for TB infection
☐ Positive test for TB infection, and negative chest X-ray

Initial Screening for health care facilities or residential care settings *(TB Document B or C)*
☐ Negative test for TB infection (2-step)
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, negative CXR within previous 12 months, and negative symptom screen
☐ Previous positive test for TB infection, and negative CXR

Annual Screening for Health care facilities or residential care settings *(TB Document D)*
☐ Negative test for TB infection
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, and negative symptoms screen
☐ Previous positive test for TB infection, and negative CXR

Signature or Unique Stamp of Practitioner: ______________________________

Printed Name of Practitioner: ______________________________

Healthcare Facility: ______________________________

This TB clearance provides a reasonable assurance that the individual listed on this form was free from tuberculosis disease at the time of the exam. This form does not imply any guarantee or protection from future tuberculosis risk for the individual listed.

Hale Aloha Nazarene School

Preschool Supply List

Please mark everything with your child's name

1	Mat/blanket for naps (small pillow optional) MUST be able to fit in backpack & cubby/basket
1	Large Backpack
1	Set of extra clothes in a ziploc bag with child's name on it
1	Set of Water Play clothes and towel marked with child's name
1	Pair of rubber slippers marked with child's name
2	Boxes of gallon size Ziploc bags
3	Bottles hand soap (Dial, Equate,etc.)
1	Package napkins
2	Boxes Kleenex tissue
1	Twin fitted sheet