

# **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 Church of the Nazarene

## Hale Aloha Nazarene School

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

2026-27

### PRESCHOOL FEES:

YEARLY COMP. FEE: \$275.00

REGISTRATION FEE: \$50.00 (NEW STUDENTS ONLY)

### MONTHLY RATES:

2:30 Pickup.....\$875.00

5:30 Pickup.....\$925.00

Drop off time is any time after 6:45am

### Multi-Student Family Discounts:

1st Child Full Rate

2nd Child Pay 75%

3rd Child Pay 50%

4th Child Free

Please Note: We do not provide school lunches. You must prepare a home lunch for your child every day. We do provide morning and afternoon snacks.

HALE ALOHA NAZARENE SCHOOL  
APPLICATION FORM

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



FOR OFFICE USE ONLY  
Registration Fee \_\_\_\_\_  
Comprehensive Fee \_\_\_\_\_  
Health Card \_\_\_\_\_  
Date of Entry \_\_\_\_\_  
Emergency Form \_\_\_\_\_  
Handbook \_\_\_\_\_  
Scanned \_\_\_\_\_  
Birth Certificate \_\_\_\_\_

**A \$275.00 Comprehensive Fee must accompany this application for all students.**  
**A \$50.00 Registration Fee must accompany this application for new students.**  
**These fees are NOT REFUNDABLE.**

PICK UP TIME 2:30 \_\_\_ 5:30 \_\_\_

Name (Legal) \_\_\_\_\_ M \_\_\_ F \_\_\_  
Last First Middle Preferred Name  
Mailing Address \_\_\_\_\_ Phone \_\_\_\_\_  
Physical Address Street City Zip Code email address  
Street City Older Younger  
Birthdate \_\_\_\_\_ Birthplace \_\_\_\_\_ No. Siblings: Brothers \_\_\_\_\_  
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.

A legal birth certificate must accompany the completed application.

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 Benioff Medical Center, #932-3000; 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. Information 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

BACKGROUND HISTORY

We desire to be effective in relating to your child in every way possible while he./she is here in Hale Aloha School. You may greatly enhance our ability to do that by providing the following information. Please fill in the questionnaire as completely as possible. The information will be held in strictest confidence and will be used only to the extent that it benefits your child.

Name and address of the last school attended by this child:

---

Date Withdrawn \_\_\_\_\_

How does the child respond to other members of the family? Readily? \_\_\_\_\_ Reluctantly? \_\_\_\_\_

Which member of your family does the child relate to most often? \_\_\_\_\_

Are other people such as roomers, grandparents, etc. living in your home? \_\_\_\_\_

To what extent is your child exposed to extended family members? ie. grandparents, aunts, uncles, cousins, etc.

---

Does your child have a special adult friend? \_\_\_\_\_ If so, whom? \_\_\_\_\_

**PARENT CHILD RELATIONSHIPS**

In what way does your child relate to you as parents?

Very dependent \_\_\_\_\_ Comfortably \_\_\_\_\_ Very independent \_\_\_\_\_

Is there a noticeable difference in your child's relationship with each parent? \_\_\_\_\_ If so, please describe:

---

How much time in minutes or hours per day, does each parent spend with the child, other than meeting basic needs such as feeding, dressing:

Mother: Hrs. \_\_\_\_\_ Minutes \_\_\_\_\_ Father: Hrs. \_\_\_\_\_ Minutes \_\_\_\_\_

How would you evaluate your child's response to authority?

Rebellious \_\_\_\_\_ Reluctant \_\_\_\_\_ Acceptant \_\_\_\_\_ Compliant \_\_\_\_\_

Has your child experienced any tragedies such as death in the family or a fire, etc.? \_\_\_\_\_

---

What are some of the positive events in your child's life? \_\_\_\_\_

---

## **QUALITIES AND ATTITUDES**

What is your child's greatest fear? \_\_\_\_\_

Is your child used to being away from you? \_\_\_\_\_

Does your child accept separation when left with a sitter? \_\_\_\_\_

Is your child aware of what is acceptable behavior?

Yes \_\_\_\_\_ Usually \_\_\_\_\_ Sometimes \_\_\_\_\_ No \_\_\_\_\_

Does your child understand why some behavior is acceptable and some behavior is not acceptable?

Yes \_\_\_\_\_ Vaguely \_\_\_\_\_ No \_\_\_\_\_

Describe your child's attitude toward coming to our school?

Eager \_\_\_\_\_ Desirous \_\_\_\_\_ Reluctant \_\_\_\_\_ Frightened \_\_\_\_\_

## **ACTIVITIES**

What activities does your child most enjoy? \_\_\_\_\_

Where does your child prefer playing? Indoors \_\_\_\_\_ Outdoors \_\_\_\_\_

What pets or animals do you have in the home? \_\_\_\_\_

Does your child fear animals? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what kind? \_\_\_\_\_

List your child's favorite toys: \_\_\_\_\_

List your child's responsibilities in the home: \_\_\_\_\_

About how much time per day does your child watch TV? Hrs. \_\_\_\_\_ Mins. \_\_\_\_\_

Has your child been exposed to organized group games? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your child ever received formal instruction? (swimming lessons, Sunday School, etc.)

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what type? \_\_\_\_\_

Has your child ever attended a nursery school before? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, where? \_\_\_\_\_ For how long? \_\_\_\_\_

**HABITS**

Does your child have any specific habits such as nail biting, bed wetting, teeth grinding, etc?

Habit (s) \_\_\_\_\_ Frequency: \_\_\_\_\_

Does your child take a nap? \_\_\_\_\_ How long? \_\_\_\_\_

What is your child's bedtime? \_\_\_\_\_ when does he/she waken? \_\_\_\_\_

Has your child achieved toilet control? Yes \_\_\_\_\_ No \_\_\_\_\_ An exception to this achievement might be

\_\_\_\_\_

Is your child right or left handed or ambidextrous? Please circle one.

**EXPERIENCES**

What has been your child's travel experiences? (visits, vacations, etc.)

Place

Year

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child experienced surgery, serious illness, hospitalization, or an accident? \_\_\_\_\_

\_\_\_\_\_

Is your child on any medication? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what are the medications and what are the medications and what are the side effects? \_\_\_\_\_

\_\_\_\_\_

Are there health factors to which the staff should be alerted? Such as allergies, seizures, diabetes, hearing or visual impairment, etc.? \_\_\_\_\_

\_\_\_\_\_

**COMMENTS**

Briefly share your reasons for enrolling your child in our school \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**GENERAL EVALUATIONS**

Please assess the following areas of your child's life and development at this time.

	Above Average	Average	Below Average
Mentally (memory, learning, etc.)	_____	_____	_____
Physical (strength, coordination)	_____	_____	_____
Socially (relationships w/others)	_____	_____	_____
Spiritually (awareness of God, God's love)	_____	_____	_____

**PEER RELATIONSHIPS**

Is your child developing relationships with other children? Yes \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ No \_\_\_\_\_

What is your child's preference concerning play?

Plays alone \_\_\_\_\_ Prefers to play with others \_\_\_\_\_ Equally happy \_\_\_\_\_

Describe your child's adjustment regarding:

	Hesitant	Ready	Eager
Small Groups	_____	_____	_____
Large Groups	_____	_____	_____
New Friends	_____	_____	_____
Familiar Friends	_____	_____	_____

Is there a particular child your child likes or dislikes ? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, what reason does your child give for liking or disliking that child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_


# Hale Aloha Nazarene School

## Supply List

2026-2027

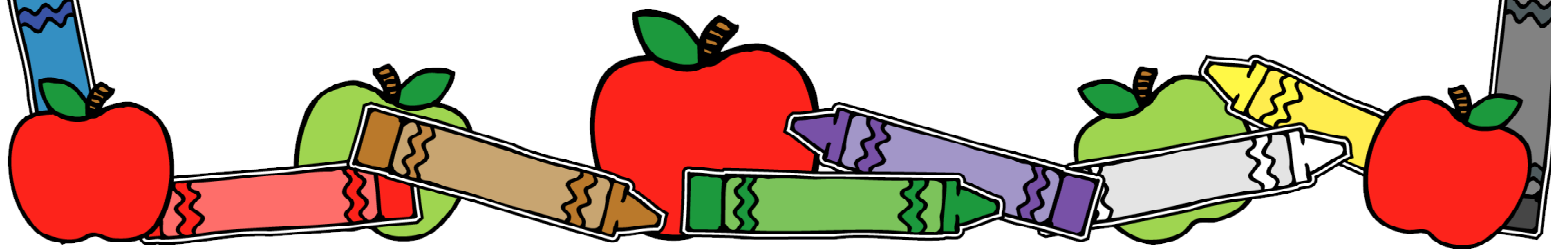


Please mark all items and clothing with your child's name

- 2 Clorox or Lysol Wipes
- 1 Small blanket for naps (no sleeping bags, please);  
small pillow optional. **MUST BE ABLE TO FIT IN CUBBY BASKET**
- 1 Twin Fitted Sheet
- 1 LARGE backpack labeled with child's name
- 1 Large ziplock bag with child's name on front and change of  
clothes (also labeled) inside
- 1 Pair rubber slippers labeled with child's name
- 1 Box of tissues - Shoe Box size 
- 4 8 oz. bottles antibacterial liquid soap (Softsoap, Equate, or Dial only)
- 1 Box Band Aids
- 2 Hand Wipes (Wet Ones)
- 2 Paper Towels
- 1 Pkg Napkins
- 2 Boxes of 2 gallon ziploc bags
- 1 Large Water Bottle - filled with water to last the day

ALL OTHER ITEMS WILL BE SUPPLIED BY THE SCHOOL

# BACK TO SCHOOL



### 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>
Allergies/Sensitivities <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
Medications/Treatments <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
Special Diet prescribed by physician <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
Behavioral Issues/Social Emotional Concerns <input type="checkbox"/> None • List:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Special Care Plan completed
Medical Conditions/Related Surgeries <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. List</b> 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>
--	---

Department of Education  
**STUDENT'S HEALTH RECORD**

Student Address Label

Name \_\_\_\_\_  
(Last) (First) (Middle Initial)

Female  Preschool: Entry Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Male  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) <input type="checkbox"/>	Cancer/Leukemia <input type="checkbox"/>	Hearing Problems <input type="checkbox"/>	Hypertension <input type="checkbox"/>	Seizures <input type="checkbox"/>	Vision Problem <input type="checkbox"/>		
Asthma <input type="checkbox"/>	Chronic Cough/Wheezing <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	JRA Arthritis <input type="checkbox"/>	Sickle Cell Anemia <input type="checkbox"/>			
Behavioral Problems <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Hemophilia <input type="checkbox"/>	Rheumatic Heart <input type="checkbox"/>	Skin Problems <input type="checkbox"/>			

PHYSICIAN'S EXAMINATION CODE: N-NORMAL; A-ABNORMAL; C-CORRECTED; R-RECEIVING CARE																												
Date	Grade	Height	Weight	BMI	Blood Pressure	Vision		Hearing		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	
						R.	L.	R.	L.																			
____/____/____																												
____/____/____																												

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)							
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						
	Date	____/____/____	____/____/____	____/____/____	____/____/____	Varicella Date ____/____/____	____/____/____
HPV	Type						
	Date	____/____/____	____/____/____	____/____/____	____/____/____	Meningococcal Conjugate Date ____/____/____	____/____/____
Other	Type						
	Date	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____

Physician, APRN, PA or Clinic \_\_\_\_\_





**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.

<b>Screening for schools, child care facilities or food handlers (TB Document A or E)</b>
<input type="checkbox"/> Negative TB risk assessment
<input type="checkbox"/> Negative test for TB infection
<input type="checkbox"/> Positive test for TB infection, and negative chest X-ray

<b>Initial Screening for health care facilities or residential care settings (TB Document B or C)</b>
<input type="checkbox"/> Negative test for TB infection (2-step)
<input type="checkbox"/> New positive test for TB infection, and negative chest X-ray
<input type="checkbox"/> Previous positive test for TB infection, negative CXR within previous 12 months, and negative symptom screen
<input type="checkbox"/> Previous positive test for TB infection, and negative CXR

<b>Annual Screening for Health care facilities or residential care settings (TB Document D)</b>
<input type="checkbox"/> Negative test for TB infection
<input type="checkbox"/> New positive test for TB infection, and negative chest X-ray
<input type="checkbox"/> Previous positive test for TB infection, and negative symptoms screen
<input type="checkbox"/> 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.