KROC KEIKI LEARNING CENTER

Enrollment Agreement • SY 2020–21

THE SALVATION ARMY RAY AND JOAN KROC CORPS COMMUNITY CENTER

ENROLLING CHILD (FIRST, MIDDLE, LAST)

ENROLLING PARENT/GUARDIAN (FIRST, MIDDLE, LAST)

RELIGIOUS INSTRUCTION CONSENT

I HEREBY GIVE MY CHILD PERMISSION TO PARTICIPATE IN THE SALVATION ARMY KROC KEIKI LEARNING CENTER (KKLC) CHRISTIAN INSTRUCTION CURRICULUM. THIS INCLUDES, BUT IS NOT LIMITED TO, LEARNING BIBLE STORIES, SINGING CHRISTIAN SONGS, ATTENDING CHAPEL SERVICES, AND PARTICIPATING IN HOLIDAY CELEBRATIONS FROM A BIBLICAL CHRISTIAN PERSPECTIVE.

FIELD TRIP RELEASE

I HEREBY GIVE CONSENT TO THE KKLC TO TAKE MY CHILD ON ALL EXCURSIONS OR FIELD TRIPS WHETHER ON FOOT OR BY OTHER MEANS OF TRANSPORTATION. I UNDERSTAND THAT ADVANCE INFORMATION INCLUDING DATE, TIMES, DESTINATION AND MODE OF TRANSPORTATION WILL BE PROVIDED WHENEVER POSSIBLE. HOWEVER, I REALIZE THAT SOME SHORTER TRIPS WITHIN KROC CENTER HAWAII PROPERTY MAY TAKE PLACE WITHOUT ADVANCE NOTICE.

FINANCIAL TERMS AND CONDITIONS

1. I HAVE PAID A ONE-TIME **APPLICATION FEE**, AS STATED BELOW, WHEN I TURNED IN MY APPLICATION.
2. I AGREE TO PAY A **DEPOSIT (REFUNDABLE AFTER PROPER NOTICE OF WITHDRAWAL GIVEN, CHILD EXITS OUR PROGRAM AND ALL OUTSTANDING BALANCES ARE PAID)**, AS STATED BELOW, AT ENROLLMENT, TO RESERVE MY CHILD'S SPACE IN THE CLASS.
3. I AGREE TO PAY AN **ANNUAL SUPPLY FEE**, AS STATED BELOW, AT THE TIME OF ENROLLMENT, AND THEN ANNUALLY THEREAFTER.
4. I AGREE TO PAY THE **MONTHLY TUITION FEE** AS STATED BELOW BY **AUTOMATIC MONTHLY PAYMENT** ON CREDIT CARD OR **ONE TIME PAYMENT**, WITH NO DEDUCTIONS FOR ABSENCES OR HOLIDAYS. IF TUITION IS NOT PAID PRIOR TO THE CLOSE OF BUSINESS ON THE **10TH DAY OF THE MONTH** OF ATTENDANCE, A **LATE PAYMENT FEE**, AS STATED BELOW, WILL BE ADDED TO MY CHILD'S TUITION.
5. I AGREE TO PAY A **RETURN CHECK FEE**, AS STATED BELOW. IF I HAVE A RETURNED CHECK, THE KKLC WILL THEN HAVE THE OPTION TO REFUSE FUTURE CHECKS.
6. I AGREE TO PAY A PER CHILD **LATE PICKUP FEE** FOR EACH INCREMENTAL PERIOD OF TIME IF MY CHILD IS PICKED UP AFTER THE KKLC'S CLOSING AS INDICATED IN FEE SCHEDULE BELOW.
7. I AGREE THAT THE KKLC ACCEPTS ONLY THE FOLLOWING PAYMENT METHODS: **CREDIT CARD, CASH PAYMENT ACCEPTED AT MEMBER SERVICES DESK, PERSONAL CHECKS, CASHIER CHECKS, SPECIFIC CREDIT CARDS OR MONEY ORDERS**.
8. IN CASE OF WITHDRAWAL OF MY CHILD FROM KKLC, I AGREE TO GIVE THE SCHOOL A WRITTEN NOTICE AT LEAST **60 DAYS PRIOR TO WITHDRAWAL**.
9. LEGAL AUTHORITIES MAY BE CONTACTED FOR CHILD(REN) LEFT AT KKLC WITHOUT NOTIFICATION FROM CHILD'S PRIMARY OR SECONDARY CONTACT FOR **MORE THAN ONE HOUR AFTER CLOSING TIME OF THE PRESCHOOL.**
10. THE TERMS OF THIS AGREEMENT ARE SUBJECT TO CHANGE IN WHOLE OR IN PART BY THE KKLC WITH TWO WEEKS' NOTICE.
11. IF TUITION REMAINS UNPAID BY THE 20TH OF THE MONTH, THE ADMINISTRATOR RESERVES THE RIGHT TO DISENROLL THE CHILD.
12. THIS AGREEMENT MAY BE TERMINATED BY THE KKLC AT ANY TIME. A CHILD MAY BE DISENROLLED BY THE KKLC WITHOUT PRIOR NOTICE IF, IN THE SOLE OPINION OF THE ADMINISTRATION, IT IS IN THE BEST INTERESTS OF THE CHILD OR THE KKLC TO DISENROLL THE CHILD.

PARENT/GUARDIAN NAME (PRINT)

PARENT/GUARDIAN NAME (SIGNATURE) DATE

(CONTINUED ON FOLLOWING PAGE)

KROC KEIKI LEARNING CENTER

Payment Information

THE SALVATION ARMY RAY AND JOAN KROC CORPS COMMUNITY CENTER

INTERNAL USE: ATTACH RECEIPT

CREDIT CARD PAYMENT AUTHORIZATION

The goal of The Salvation Army Ray and Joan Kroc Corps Community Center is to offer convenient payment methods. Please choose between the options listed below.

☐ I PREFER MONTHLY PAYMENTS

AUTOMATIC MONTHLY ON CREDIT CARD

I authorize The Salvation Army Ray and Joan Kroc Corps Community Center ("Kroc Center Hawaii") to charge my credit card monthly indicated below. This is an automatic withdrawal system where payment of dues are regularly charged around the 20th of each month for the next month's tuition of

☐ $1,150.00 (3-5 year old class) ☐ $1,250.00 (2-year old class & 3-year old class not potty trained)

If payment is declined, 2nd attempt will be made 1–3 days after 20th.

☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER

NAME (AS IT APPEARS ON CARD)

SIGNATURE

For security purposes, you must complete ***Credit Card Payment Authorization Form.***

☐ I CHOOSE A ONE-TIME PAYMENT

I authorize The Salvation Army Ray and Joan Kroc Corps Community Center ("Kroc Center Hawaii") to make a one-time debit to my credit card indicated below for the tuition amount of $13,800 or $15,000 (2-year-old class & 3-year old class not potty trained). This is permission for a single transaction only and does not provide authorization for any additional unrelated debits or credits to your account.

One-time payments are non-refundable. **PARENT/GUARDIAN INITIALS: _____**

☐ CASH

☐ MONEY ORDER (MAKE PAYABLE TO THE SALVATION ARMY KROC CENTER) __

☐ CHECK CHECK #

OR ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER

NAME (AS IT APPEARS ON CARD)

SIGNATURE

For security purposes, you must complete ***Credit Card Payment Authorization Form.***

MAKE A DONATION & JOIN KROC CARES

Your tax-deductible donation matters! An unrestricted gift supports programs & services available at Kroc Center Hawaii. Or help a deserving individual in the community reach their potential by donating to the Kroc Center Hawaii Scholarship Program.

☐ YES, I WANT TO HELP. I WOULD LIKE TO MAKE A ONE-TIME DONATION OF

$_____ ☐ UNRESTRICTED

☐ SCHOLARSHIP

☐ YES, I WANT TO HELP WITH A RECURRING MONTHLY DONATION OF

$_____ ☐ UNRESTRICTED

☐ SCHOLARSHIP

☐ NO, I DO NOT WANT TO PARTICIPATE AT THIS TIME.

Tuition fees and dues are non-refundable. I understand my first automatic payment is on: July 20, 2020 **PARENT/GUARDIAN INITIALS: _____**

Changes to automatic payment must be submitted by the 10th of the month to be effective for the following month's auto payment.

PARENT/GUARDIAN INITIALS: _____

CERTIFICATION

I CERTIFY THAT I HAVE RECEIVED, READ, AND UNDERSTAND THE INFORMATION CONTAINED IN THE APPLICATION FOR ENROLLMENT FORM AND IN THIS ENROLLMENT AGREEMENT, AND AGREE TO THE TERMS AND CONDITIONS SET FORTH THEREIN, INCLUDING THE FINANCIAL TERMS AND CONDITIONS AND FEE SCHEDULE SET FORTH IN THIS AGREEMENT.

SIGNATURE OF PARENT/GUARDIAN DATE

FOR INTERNAL USE ONLY: ACCEPTED BY

ENTERED BY **DATE**

INITIAL PAYMENT:

$

KROC KEIKI LEARNING CENTER

Credit Card Payment Authorization Form

THE SALVATION ARMY RAY AND JOAN KROC CORPS COMMUNITY CENTER

Sign and complete this form to authorize The Salvation Army Ray & Joan Kroc Corps Community Center ("Kroc Center Hawaii") to make a one time debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date.

PLEASE COMPLETE THE INFORMATION BELOW

I _____ authorize The Salvation Army Kroc Center Hawaii to charge my credit card
CARDHOLDER NAME (AS IT APPEARS ON THE CARD)

account on file indicated below for _____ on or after _____. This payment is for
AMOUNT DATE

Tuition
_____.
DESCRIPTION OF GOODS/SERVICES

- ○ This is a **ONE-TIME AUTHORIZATION ONLY.** **INITIAL: _____**
- ○ This is **MONTHLY RECURRING CHARGES ON OR AROUND THE 20TH OF EACH MONTH.** **INITIAL: _____**

BILLING ADDRESS CITY, STATE, ZIP

PHONE NUMBER EMAIL

SIGNATURE DATE

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

(BOTTOM SECTION WILL BE SHREDDED)

CARD INFORMATION

ACCOUNT TYPE ○ VISA ○ MASTERCARD ○ AMEX ○ DISCOVER

CARDHOLDER NAME

ACCOUNT NUMBER EXPIRATION DATE

CVV2 (3 DIGIT NUMBER ON BACK OF VISA/MC, 4 DIGITS ON FRONT OF AMEX)

KROC KEIKI LEARNING CENTER

OFFICE USE ONLY CHILD'S LAST NAME CLASS

Emergency Contact Authorization SY 2020–21

THE SALVATION ARMY RAY AND JOAN KROC CORPS COMMUNITY CENTER

THE SALVATION ARMY KROC CENTER HAWAII

Please provide us with the following information to enable us to care for your child.

STUDENT INFORMATION

CHILD'S FIRST NAME | LAST NAME | MIDDLE INITIAL | PREFERRED NAME

RESIDENCE STREET ADDRESS | CITY | STATE | ZIP

DATE OF BIRTH | BIRTHPLACE | SEX | PRIMARY LANGUAGE

HEIGHT | WEIGHT | HAIR COLOR | EYE COLOR

DISTINGUISHING MARKS | POTTY TRAINED ☐ YES ☐ NO

ALLERGIES (FOOD, MEDICATION, ETC.) *ANY ALLERGY MUST BE STATED IN DHS FORM 908

CHRONIC HEALTH CONDITIONS

CHILD'S PHYSICIAN | TELEPHONE NUMBER

HEALTH INSURANCE COMPANY | PLAN NUMBER | PREFERRED MEDICAL FACILITY

PARENT/GUARDIAN INFORMATION

PRIMARY CONTACT? ☐ YES ☐ NO | RELATIONSHIP TO CHILD? ☐ MOTHER ☐ FATHER ☐ LEGAL GUARDIAN

PARENT'S STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PARENT/GUARDIAN FIRST NAME | MIDDLE NAME | LAST NAME

HOME PHONE | CELL PHONE | WORK PHONE

EMPLOYER | JOB TITLE/POSITION

PERMISSION TO PICK UP CHILD? ☐ YES ☐ NO | EMAIL ADDRESS

LIVES WITH CHILD? ☐ YES ☐ NO | CONTACT IN EMERGENCY? ☐ YES ☐ NO

DOES PARENT HAVE LEGAL RESTRICTIONS TO PARENTAL CUSTODY? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN

PARENT/GUARDIAN INFORMATION

PRIMARY CONTACT? ☐ YES ☐ NO | RELATIONSHIP TO CHILD? ☐ MOTHER ☐ FATHER ☐ LEGAL GUARDIAN

PARENT'S STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PARENT/GUARDIAN FIRST NAME | MIDDLE NAME | LAST NAME

HOME PHONE | CELL PHONE | WORK PHONE

EMPLOYER | JOB TITLE/POSITION

PERMISSION TO PICK UP CHILD? ☐ YES ☐ NO | EMAIL ADDRESS

LIVES WITH CHILD? ☐ YES ☐ NO | CONTACT IN EMERGENCY? ☐ YES ☐ NO

DOES PARENT HAVE LEGAL RESTRICTIONS TO PARENTAL CUSTODY? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN

OTHER CONTACT: Family MUST provide at least one (1) Emergency Contact Personnel other than Parent/Guardian

Authorized as emergency contacts if primary contact(s) are not available. Complete for additional persons authorized to pick up child, or as required by law. Must be over 18 years old and show picture ID to a KKLC staff member.

#1 RELATIONSHIP ☐ FRIEND ☐ OTHER (SPECIFY)

FIRST NAME | MIDDLE NAME | LAST NAME

ADDRESS | CITY | STATE | ZIP

EMPLOYER

PERMISSION TO PICK UP CHILD? ☐ YES ☐ NO | CONTACT NUMBER

LIVES WITH CHILD? ☐ YES ☐ NO | CONTACT IN EMERGENCY? ☐ YES ☐ NO

#2 RELATIONSHIP ☐ FRIEND ☐ OTHER (SPECIFY)

FIRST NAME MIDDLE NAME LAST NAME

ADDRESS CITY STATE ZIP

EMPLOYER

PERMISSION TO PICK UP CHILD? ☐ YES ☐ NO CONTACT NUMBER

LIVES WITH CHILD? ☐ YES ☐ NO CONTACT IN EMERGENCY? ☐ YES ☐ NO

#3 RELATIONSHIP ☐ FRIEND ☐ OTHER (SPECIFY)

FIRST NAME MIDDLE NAME LAST NAME

ADDRESS CITY STATE ZIP

EMPLOYER

PERMISSION TO PICK UP CHILD? ☐ YES ☐ NO CONTACT NUMBER

LIVES WITH CHILD? ☐ YES ☐ NO CONTACT IN EMERGENCY? ☐ YES ☐ NO

#4 RELATIONSHIP ☐ FRIEND ☐ OTHER (SPECIFY)

FIRST NAME MIDDLE NAME LAST NAME

ADDRESS CITY STATE ZIP

EMPLOYER

PERMISSION TO PICK UP CHILD? ☐ YES ☐ NO CONTACT NUMBER

LIVES WITH CHILD? ☐ YES ☐ NO CONTACT IN EMERGENCY? ☐ YES ☐ NO

#5 RELATIONSHIP ☐ FRIEND ☐ OTHER (SPECIFY)

FIRST NAME MIDDLE NAME LAST NAME

ADDRESS CITY STATE ZIP

EMPLOYER

PERMISSION TO PICK UP CHILD? ☐ YES ☐ NO CONTACT NUMBER

LIVES WITH CHILD? ☐ YES ☐ NO CONTACT IN EMERGENCY? ☐ YES ☐ NO

KROC KEIKI LEARNING CENTER

Medical Information

THE SALVATION ARMY RAY AND JOAN KROC CORPS COMMUNITY CENTER

MEDICAL INFORMATION

The information provided below will assist our staff in providing the best care for your child. Check if applicable or allergic. If your child needs medicine administered during school time, a “Request for the Administration of Medication" form must be completed by your child's physician.

☐ DIABETES ☐ ASTHMA ☐ CARRIES EPI-PEN ☐ ALLERGIC TO PENICILLIN

☐ EPILEPSY ☐ CARRIES INHALER ☐ ALLERGIC TO INSECT STINGS ☐ BEHAVIORAL CHALLENGES

OTHER/PLEASE DESCRIBE ANY CONDITION

DIETARY RESTRICTIONS

PLEASE LIST ANY ACTIVITY RESTRICTIONS

NAME AND PURPOSE OF ANY MEDICATIONS

PLEASE LIST ANYTHING ELSE THAT MAY AFFECT YOUR CHILD’S EXPERIENCE AT SCHOOL (IE. MOVING, DIVORCE, ETC)

HEALTH INSURANCE

HEALTH INSURANCE ☐ YES ☐ NO COMPANY

POLICY # FAMILY DOCTOR

DOC PHONE # DOCTORS ADDRESS

PREFERRED MEDICAL FACILITY

MEDICAL RELEASE & CONSENT

I hereby give my consent for The Salvation Army Kroc Keiki Learning Center to contact my family physician for medical and/or surgical care for my child where such service is required. If my family physician is not available, I hereby give my consent to have my child treated by a physician chosen by the Kroc Keiki Learning Center. I understand that whenever possible, the staff will have my child taken to the medical facility preferred by the family and listed on my child’s record. I hereby grant the Kroc Keiki Learning Center staff permission to transport or have transported my child to the nearest hospital emergency room or call another physician in the event that the listed physician, the emergency contacts, or I cannot be contacted. I/We will not hold The Salvation Army financially responsible for calling any emergency agency required to care for my child. Furthermore, in the event of an emergency, I hereby consent for medical and surgical care for my child at any hospital, clinic, or other medical facility at the discretion of the Kroc Keiki Learning Center staff.

I hereby release The Salvation Army Kroc Keiki Learning Center, members and staff or other agencies acting for the said program, from responsibility in the event of an accident or from any other liability which might be incurred while receiving services from the Kroc Keiki Learning Center both at the facility as well as on outings outside of the Kroc Center. It is clearly understood that a conscientious effort will be made to notify me or my spouse before any action is taken EXCEPT in the event of an emergency when any such action might delay medical care and threaten the health and/or well-being of my child. In the event of an emergency, a member of the Kroc Keiki Learning Center staff will contact me as soon as possible. I will accept full responsibility for any and all expenses related to the medical and/or surgical care of my child including transportation to a medical facility, if required.

SIGNATURE OF PARENT/GUARDIAN DATE

SIGNATURE OF PARENT/GUARDIAN DATE

KROC KEIKI LEARNING CENTER

Liability Waiver

THE SALVATION ARMY RAY AND JOAN KROC CORPS COMMUNITY CENTER

LIABILITY WAIVER

By signing this document I (we) agree to the following terms: In case of illness or accident The Salvation Army Ray and Joan Kroc Corps Community Center ("Kroc Center Hawaii") is authorized to secure emergency medical treatment at my expense. Kroc Center Hawaii reserves the right to dismiss any participant who does not show respect for the facility, including but not limited to: property, equipment, policies, other members and staff. Members who are dismissed will not be given a refund of fees paid. Kroc Center Hawaii assumes no responsibility for personal property that is either in or out of lockers. By signing this Enrollment Form, I (we) hereby waive any and all claims against Kroc Center Hawaii. I understand that use of the facilities and equipment at Kroc Center Hawaii, including the transportation to and from The Salvation Army for field trip or program purposes, may involve risk of bodily injury or property damage and I agree to assume any such risks. I understand that it is up to me to consult physicians and other professionals to make sure that my child can safely participate in activities and events at Kroc Center Hawaii. I also understand and agree that by signing this Agreement, I am giving up my (or the minor for whom I sign) right to make any claim against The Salvation Army, its agents, employees and volunteers, including the right to sue them, for bodily injury or property damage or any other loss that I might suffer while using Kroc Center Hawaii facilities and services, except as limited by law.

NOTICE - In order to promote a safe and secure environment, Kroc Center Hawaii has placed video cameras in various locations. As part of our commitment to the safety of children and vulnerable persons, Kroc Center Hawaii reserves the right to consult public sources to determine whether any member or guest of any member poses an unreasonable risk of harm to its patrons, staff, or visitors. Kroc Center Hawaii may use the Kroc Keiki Learning Center student's photo for promotional purposes.

I hereby irrevocably grant to Kroc Center Hawaii, its successors and assigns, its agents and those by whom it is commissioned, the absolute, unrestricted and unlimited license, right, permission, and consent to use and reuse, disseminate, copyright, print, reproduce, publish and republish, for any and all trade purposes or commercial or other advertising or public purposes, and in any and all advertising, publicity, display, publication or media, my child/dependent's name, signature and likeness, and any portraits, pictures, photographic prints, video, multimedia or other representations of my child/dependent, or in which he/she may appear, or any reproductions or sketches thereof or parts thereof, photographic or otherwise, with such additions, deletions, alterations or changes therein as you in your discretion may make, either separately or together with my name or a fictitious name, or the name of another person, with or without any statements or testimonials made by me, or authorized by me which you may, in your discretion, prepare for use in connection therewith. I warrant that I have not limited or restricted the use of my child/dependent's name or photograph to the use of any organization or person.

I hereby grant unrestricted use of audio tracks or text by The Salvation Army for such purposes as The Salvation Army may deem appropriate.

I hereby release and discharge The Salvation Army, its successors, assigns and agents from any and all claims and demands arising out of or in connection with the use of any of the foregoing, including any claims for defamation, invasion of privacy or violation of any statutory right.

PARENT/GUARDIAN NAME, PLEASE PRINT DATE

PARENT/GUARDIAN SIGNATURE

KROC KEIKI LEARNING CENTER

Child Profile

THE SALVATION ARMY RAY AND JOAN KROC CORPS COMMUNITY CENTER

CHILD'S NAME AGE

NICKNAME(S) / PREFERRED NAME

IS YOUR CHILD POTTY-TRAINED ☐ YES ☐ NO

IF NO, PLEASE STATE WHAT HELP THEY NEED

SLEEPING HABITS

WHAT TIME DOES YOUR CHILD GO TO BED EACH NIGHT? WAKE UP?

HOW DOES YOUR CHILD FALL ASLEEP AT NIGHT/NAP?

TYPICAL NAP TIME FOR YOUR CHILD EACH DAY? TO

DOES YOUR CHILD SLEEP WELL? ☐ YES ☐ NO

WORDS & LANGUAGE

LANGUAGE SPOKEN AT HOME

WHAT WORD(S) DOES YOUR CHILD USE FOR THE FOLLOWING:

DRINK

BATHROOM

BOWEL MOVEMENT

URINATION

CHILD PREFERENCES

FOODS YOUR CHILD LIKES

FOODS YOUR CHILD DISLIKES

STRONG FEARS/DISLIKES

DESCRIBE YOUR CHILD'S PERSONALITY:

LIST 3 FAVORITE ACTIVITIES/THINGS YOUR CHILD LIKES:

HOW WELL DOES YOUR CHILD GET ALONG WITH OTHER CHILDREN?

HOW MUCH TELEVISION/ELECTRONICS DOES YOUR CHILD WATCH/PLAY DAILY?

CHILD/FAMILY HISTORY

ANY PREVIOUS GROUP CARE OR PRESCHOOL EXPERIENCES? (SCHOOL NAME, DATES ATTENDED, REASON FOR LEAVING)

AGES AND NAMES OF SIBLINGS

PETS AT HOME

MEDICAL CHARACTERISTICS (ALLERGIES, ILLNESSES, ETC.) *ANY ALLERGIES MUST BE STATED IN DHS FORM 908

FAMILY TRADITIONS

ARE THERE ANY HOLIDAYS OR CULTURAL ACTIVITIES THAT YOUR CHILD/FAMILY DOES NOT CELEBRATE? IF YES, PLEASE LIST

OTHER INFO

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 the following:

1. Tuberculosis (TB) clearance
   (Current within 12 months' prior to enrollment)
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
3. A completed Health Record (Form 908) including signatures

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

The Health State
HAWAI'I DEPARTMENT OF HEALTH

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* _____ 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.

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		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 EXAMINATION
MANTOUX TEST (INTRADERMAL)

Date Given	Date Read	Results (mm)	Physician, APRN, PA, or Clinic
___/___/___	___/___/___		
___/___/___	___/___/___		

CHEST X-RAY

Date	Results	Location

DENTAL EXAMINATION

Dental Check-Up	___/___/___

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	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
MMR	Date	___/___/___	___/___/___	___/___/___	**Varicella**	___/___/___	___/___/___
Hepatitis A	Date	___/___/___	___/___/___				
Other	Type						
	Date	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Other	Type						
	Date	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

Physician, APRN, PA or Clinic _____

***OFFICE USE ONLY** (Rev. 2010)

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

Date		Signature & Title	Date		Signature & Title

KROC KEIKI LEARNING CENTER

Special Care Plan

THE SALVATION ARMY RAY AND JOAN KROC CORPS COMMUNITY CENTER

Special Care Plan is required for children who have medical conditions, allergies, sensitivities, special diets, treaments, behavior issues and/or social emotional concerns. This is to be completed and signed by your child's doctor.

FAMILY/CHILD INFORMATION

CHILD'S NAME _____ DATE OF BIRTH _____

CLASSROOM NAME _____

PARENT(S) OR GUARDIAN(S) NAME _____ EMERGENCY PHONE _____

PRIMARY HEALTH PROVIDER _____ EMERGENCY PHONE _____

SPECIALIST'S NAME (IF ANY) _____ EMERGENCY PHONE _____

ALLERGY OR DIETARY RESTRICTION

DESCRIPTION OF ALLERGY OR DIETARY RESTRICTION

DESCRIBE SIGNS OR SYMPTOMS IF CHILD EATS OR IS EXPOSED TO

DESCRIBE KNOWN TRIGGERS AND/OR REACTION

TREATMENT DESCRIPTION*

*ANY MEDICATION MUST BE ACCOMPANIED BY A REQUEST FOR THE ADMINISTRATION OF MEDICATION.

DESCRIBE TREATMENT/MEDICATION

POSSIBLE SIDE EFFECTS

TEMPORARY PROGRAM ADAPTATION

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 _____

KROC KEIKI LEARNING CENTER

Request for the Administration of Medication

THE SALVATION ARMY RAY AND JOAN KROC CORPS COMMUNITY CENTER

Request for the Administration of Medication is required for children who require to have medication administered during school care or for emergency treatments.

PHYSICIAN'S INSTRUCTIONS

_____ is under my care and should receive _____ _____, as follows:
NAME OF CHILD NAME OF MEDICINE DOSAGE

SPECIFIC INSTRUCTIONS FOR ADMINISTRATION

POSSIBLE SIDE EFFECTS TO WATCH FOR

EXPIRATION DATE _____ *WE WILL NOT ADMINISTER EXPIRED MEDICATION OR ANY MEDICATION WITHOUT PHYSICIAN'S SIGNATURE
MM/DD/YY

SIGNATURE OF PHYSICIAN DATE OF SIGNATURE PHONE NUMBER

RX NUMBER PHARMACY

STREET ADDRESS PHONE NUMBER

PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICINE, VITAMIN, FOOD SUPPLEMENT, SUNSCREEN OR INSECT REPELLANT

I hereby request and give permission for the staff at the Kroc Keiki Learning Center, to administer the following to my child. I understand that the Kroc Keiki Learning Center is not responsible for missing times and/or dosage of medication.

NAME OF CHILD NAME OF MEDICATION

DOSAGE TIME(S) TO BE GIVEN

SIGNATURE OF PARENT DATE OF SIGNATURE

MEDICATION GIVEN BY THE SALVATION ARMY KROC KEIKI LEARNING CENTER

_____ was given _____ _____, at the following time(s) and date(s):
NAME OF CHILD NAME OF MEDICINE DOSAGE

DATE OF DOSAGE	AMOUNT OF DOSAGE	SIGNATURE

CREATED 06/10/15 REVISED 04/04/18

DATE OF DOSAGE	AMOUNT OF DOSAGE	SIGNATURE

CREATED 06/10/15 REVISED 04/04/18