KAMEHAMEHA SCHOOLS®

Kamehameha Schools Preschools Health Record

Name _____ (Last) _____ (First) _____ (Middle Initial) Female ❑ Male ❑ _____ Child's Birthdate Student ID: _____ Preschool Name: _____

Parent's Name: _____ (Mother/Guardian) _____ (Father/Guardian)

Home Phone: _____ Other Phone: _____

Allergies:

Medical Status

Allergy (type) ❑	Cancer/Leukemia ❑	Hearing Problems ❑	Hypertension ❑	Seizures ❑	Vision Problem ❑
Asthma ❑	Chronic Cough/Wheezing ❑	Heart Disease ❑	JRA Arthritis ❑	Sickle Cell Anemia ❑	**History of COVID-19:** ❑Yes ❑No
Behavioral Problems ❑	Diabetes ❑	Hemophilia ❑	Rheumatic Heart ❑	Skin Problems ❑	Date: _____ Severity: _____

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	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)

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	/ /	/ /
Other	Type						
	Date	/ /	/ /	/ /	/ /	/ /	/ /

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Physician, APRN, PA or Clinic _____

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

Date		Signature & Title	Date		Signature & Title