NEW STUDENT (ELC - PreSchool)

SACRED HEARTS ACADEMY

3253 WAIALAE AVENUE • HONOLULU, HAWAII 96816 • 808-734-5058 • FAX 808-737-7867 • WWW.SACREDHEARTS.ORG

Aloha New Parent(s)/Guardian(s),

Congratulations and welcome to Sacred Hearts Academy.

The health and well-being of our students are of the utmost priority at Sacred Hearts Academy. The Academy is required by the State of Hawaii Department of Health to monitor and report immunization and physical examination requirements.

As of July 1, 2020, additional immunizations and tuberculosis clearance (TB) will be required for students entering childcare or pre-school, kindergarten, 7th grade, and post-secondary schools, and all students entering school in Hawaii for the first time, regardless of age. The updated immunization requirements conform with current national recommendations and reflect what occurs in healthcare provider offices and clinics in Hawaii as standard medical practices.

For incoming new **ELC - PreSchool** students, health requirements are:

PreSchool or Childcare

Diphtheria-Tetanus-Pertussis (DTaP)
Haemophilus influenzae type b (Hib)
Hepatitis A (Hep A)
Hepatitis B (Hep B)
Measles-Mumps-Rubella (MMR)
Pneumoccal Conjugate Vaccine (PCV)
Polio (IPV)
Varicella (Chickenpox)

Tuberculosis Clearance (TB)**

ALL students must show evidence of receiving these immunizations along with a completed physical examination and TB clearance prior to attending 1st day of school.
*****TB clearance required for school attendance, talk to your child's healthcare provider, or call the DOH Tuberculosis Control Branch at (808) 832-5731 or visit health.hawaii.gov/tb***

If any of these immunizations were not given to your daughter due to medical or religious reasons, you will need to provide the appropriate documentation *before* the 1st day of instruction for your daughter. Medical exemptions must be obtained from your daughter's doctor.

If you have questions or concerns, please email the Sacred Hearts Academy Health Room at healthroom@faculty.sacredhearts.org. We appreciate your cooperation in our efforts to keep Sacred Hearts Academy a healthy learning environment for all our students, faculty, and staff.

Sincerely,

Ms. Cheyanne Thompson
Health Coordinator, Sacred Hearts Academy

Sacred Hearts Academy
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)

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

SACRED HEARTS ACADEMY
ATHLETIC PARTICIPATION FORM

Valid for one school year from date of examination, subject to re-examination should there be evidence of physical deterioration or impairment during the school year.

Student Name: _____
Last First Middle

Birthdate: _____ Place of Birth: _____

Health/Accident Insurance: _____ Policy Number: _____

Grade: _____ Age: _____ Height: _____ Weight: _____ Blood Pressure: _____

Parent(s)/Guardian(s) Name(s): _____

Address: _____ Phone: _____

Significant past illness, injury or operations: _____

_____

_____

Eyes: _____ Vision: _____ Ears: _____ Hearing: _____ Mouth/Throat: _____

Lungs: _____ Heart: _____

Abdomen: _____ Musculo-Skeletal (scoliosis): _____ Neurological: _____

Skin: _____ Extremities (flatfeet): _____

Date of last tetanus booster: _____

Comments: _____

_____

_____

Sport(s) Participation Check List

Parent(s)/Guardian(s): please initial approved sport(s) in the column marked "P/G".
Examining physician: please "x" approved sport(s) in the column marked "DR".

P/G	DR	SPORT	P/G	DR	SPORT	P/G	DR	SPORT	P/G	DR	SPORT
		Air Riflery			Football			Softball			Water Polo
		Basketball			Golf			Swimming			Wrestling
		Bowling			Gymnastics			Tennis			Cheerleading
		Cross Country			Riflery			Track & Field			Kayaking
		Canoe Paddling			Soccer			Volleyball			Other:

Physician's Certification

I certify that I have, on this date, examined and found this student physically able to compete in the sport activity approved by the student's parent(s) or legal guardian(s) and have so indicated with an "x" by each sport.

_____
Examining Physician (print) Date

_____
Signature of examining physician Phone

_____
Street Address City/State/Zip

Student Application and Certification

I hereby request permission to compete in interscholastic athletics for Sacred Hearts Academy. I understand that participation is entirely voluntary on my part, and that I have not violated any of the eligibility rules and regulations of the Interscholastic League of Honolulu.

Student name (print) Date

Signature of student

Permission of Parent(s) or Legal Guardian(s)

I hereby give my consent for the above student to engage in athletic activities (sports) as a representative of Sacred Hearts Academy, including accompanying the team on its out-of-town trips, in the particular sport(s) which I have identified by signing my initials next to such sport(s) on the reverse side of this form. I understand that Sacred Hearts Academy will make all reasonable efforts to provide, whenever possible and as appropriate, transportation to and from off-campus athletic practices and contests by commercial or school-owned vehicle, and that circumstances may, from time-to-time, require transportation by alternate means (e.g. by coaches, other students, and other parents driving personal vehicles); I hereby consent to such primary and alternate transportation arrangements. I agree that a physician may treat the above student whenever necessary until other arrangements can be made, and that the coach or trainer may render first aid if so qualified.

I understand that there are inherent risks of personal injury and/or property damage in the student's participation in such sport(s). With full knowledge of such risks, whether foreseen or unforeseen, on behalf of myself, my heirs, my personal representatives, my assigns, and the minor child, I agree to: 1) assume any and all risks of injury, loss or damage which may arise out of such participation, including, but not limited to: a) the rendering of any medical treatment arising therefrom, and b) the primary or alternate transportation described above (collectively also, "participation"); 2) waive and release any and all claims against Sacred Hearts Academy and its trustees, employees, agents and representatives, both in their professional and personal capacities, for any and all injuries, losses or damages connected with, or arising out of such participation; and 3) indemnity and hold Sacred Hearts Academy forever harmless from and against any and all claims which may arise out of such participation.

I REPRESENT THAT I HAVE READ, AND I UNDERSTAND, THE CONTENT OF THIS STATEMENT; I UNDERSTAND THE NATURE OF THIS STATEMENT AS CONTRACTUAL AND NOT A MERE RECITAL; I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THIS STATEMENT; AND I HAVE EXECUTED THIS STATEMENT AS MY OWN FREE ACT.

I understand that Sacred Hearts Academy has allowed the above student to participate in the identified sport(s) in reliance upon my review and execution of this statement.

Father/Legal Guardian Signature Date

Mother/Legal Guardian Signature Date

NOTE: This form shall be valid for one school year from the date of examination, subject to written modification or revocation by any party hereto should there exist evidence of physical deterioration or impairment during the school year. The student will not be allowed to practice or compete in the approved sport(s) until this form has first been completed and executed by the student and by the student's parent(s) or legal guardian(s), and returned to the Sacred Hearts Academy Athletic Department.

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.

Hawai'i State Department of Health
TUBERCULOSIS
Control Program

Frequently Asked Questions (FAQ) about TB Testing for Students, Children and School/Child Care Employees — Hawaii Administrative Rules 11-164.2

Do all students need a TB test?

All students, over 12 months of age, enrolling for the first time in child care, school or college need to have a TB clearance, but not everyone will need a TB test. For childcare or school, a clearance on or after 12 months of age is valid and this clearance does not expire for school attendance K-12th grade. Students taking online or off campus classes only do not need a TB clearance.

Do school or child care employees need clearance? What about volunteers?

Child care employees need to have a TB clearance within 12 months before hire. They need a new clearance if they move to a new center. School and college employees need a TB clearance within 12 months before hire or after their 16th birthday. This clearance does not expire for school employment. All child care volunteers need a TB clearance, but only those school volunteers who will be working more than 30 days in a year will need clearance.

My child had a TB clearance when she first went to school. Does she need a new clearance for high school or college?

The clearance is still good for high school. However, she will need a new clearance for college in Hawaii. Also, if she takes college courses, on the college campus while enrolled in high school, she will need a new clearance on or after 16 years of age. This clearance does not expire and is good for later college attendance.

Who needs a TB test?

Persons who have spent time in countries where TB is more common, were exposed to someone with active TB disease, have a severely weakened immune system, have TB symptoms or children who have someone in their household from a country where TB is more common need to be tested. People with TB symptoms will also need a chest x-ray to check for active TB disease.

What countries have more TB?

It is easier to list the areas where there isn't much TB disease; The United States, Canada, Australia, New Zealand, and Western and Northern Europe. All other countries are considered to have enough TB disease that spending a significant amount of time there might put a person at risk for getting TB infection.

Can I have a blood test instead of a TB skin test?

A blood test, commonly called an IGRA, can be substituted for the skin test in persons who need a TB test. Only one blood test is currently available in Hawaii, the Quantiferon Gold In-Tube test. These can be ordered through your doctor. However, these tests are not currently accepted for children under 2 years old and cannot be used for TB clearance in these children. This test can also be expensive and the Hawaii State Department of Health (DOH) will only be doing the TB skin tests for clearances.

How do I get a TB clearance?

You can contact your health care provider or you can go to one of the DOH clinics. The clinics and locations can be found on the DOH website at www.health.hawaii.gov/tb or by calling (808) 832-5731. All screening and testing is free and no appointment is needed. Please bring a photo ID and children under 18 years of age will need to come with a parent or guardian, or with a responsible adult and a note from the parent/guardian giving permission for testing. If your doctor is sending you to one of the DOH clinics, please bring the referral from your doctor.

Where can I get more information?

More information can be found on the DOH website at www.health.hawaii.gov/tb, or by calling the TB Control Branch at (808) 832-5731.

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 HAWAI'I, 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: _____

Program modification: i.e.: no peanut products allowed_____

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:_____

VACCINATION EXEMPTION PURSUANT TO THE

Hawaii Administrative Rules §11-157-5 & OFFICIAL CODE OF Haw. Rev. Stat. § 325-34

§11-157-5 Exemptions. (b) *A religious exemption shall be granted to a student whose parent, custodian, guardian, or other person in loco parentis certifies that the person's religious beliefs prohibit the practice of immunization. Requests for religious exemptions based on objections to specific immunizing agents will not be granted. Students who have reached the age of majority shall apply on their own behalf. The certification shall be retained in the student's health record. Reports of such exemptions shall be submitted to the department by each school.*

§ 325-34 *No person shall be subjected to vaccination, revaccination or immunization, who shall in writing object thereto on the grounds that the requirements are not in accordance with the religious tenets of an established church of which the person is a member or adherent, or, if the person is a minor or under guardianship, whose parent or guardian shall in writing object thereto on such grounds, but no objection shall be recognized when, in the opinion of the director of health, there is danger of an epidemic from any communicable disease.*

VACCINE EXEMPTION FORM

I,_____, as the parent, guardian or person in
(insert your name)
loco parentis of the child _____, hereby certify that the
(insert your child's name)
administration of any vaccine or other immunizing agents is contrary to our personal religious beliefs.

□ Diphtheria	□ Measles	□ Other
□ Tetanus	□ Mumps	□ ALL
□ Pertussis	□ Rubella	
□ Polio	□ Haemophilus influenzae type b	
□ Hepatitis B	□ Varicella	
□ Smallpox	□ Anthrax	

This is pursuant to my right to refuse vaccination on the grounds that vaccinations conflict with my religious beliefs. Pursuant to Hawaii statute I am providing a copy of this statement to our child's school administrator or operator of the group program pursuant to Hawaii Administrative Rules §11-157-5 and Haw. Rev. Stat. § 325-34.

Parent _____ Date _____

Parent _____ Date _____

Subscribed and Sworn before me this _____ day of _____, 20____.

_____
Notary's Signature and Seal

Making Informed Decisions

Your decision to vaccinate or not should be an informed decision. Vaccines can cause severe injuries such as seizures, death, anaphylaxis, brain damage and other reactions. The type and severity of reactions may vary from vaccine to vaccine and child to child. The effects of a vaccine injury may be temporary or permanent. If you notice any changes in your child's condition after receiving a vaccine, you should contact your doctor immediately or go to a hospital. Vaccines have never been proven to be safe or effective and your child may contract the disease even if he is vaccinated. What has been proven is that you can get the disease from the vaccine or from coming into contact with a recently vaccinated person. The polio vaccine is just one example. It is a known fact that most healthcare providers do not fully inform patients of the side effects a vaccine can have on the body, brain and immune system. Because of the highly toxic ingredients all vaccines contain, you should thoroughly research vaccines for yourself before making such an important decision. DO NOT allow someone else, even your healthcare provider, scare or force you into making this decision without being fully informed. Many healthcare providers have not researched vaccine history or toxicology and are not fully informed.

Always provide a detailed history of your child's health to your doctor. Make sure they know of allergies, neurological problems, nutritional deficiencies, any immune system disorder and skin diseases such as eczema. Most physicians and nurses do not warn parents that if their child's health is compromised in any way, such as having a common cold or previous reaction to a vaccine, they should not receive vaccines.

Benefits of Non-Vaccination

When you choose to not vaccinate your child, you have the responsibility to educate yourself on how to maintain the well-being of not only their body but also their mind and spirit as well. Childhood diseases can result in minor symptoms to severe complication or death depending on the child's immune system and treatment protocols followed. The stronger the immune system, the less severe are the symptoms of the disease. A child that goes through the full expression of the disease (i.e. fever and skin eruptions, without suppressing any of these symptoms) usually acquires immunity from that disease for life. Good nutrition and cleanliness play a major role. The risk of contracting various diseases can vary over time or locality. Symptoms or complications of these diseases may be treatable by alternative methods or may resolve without treatment. Educate yourself on childhood diseases from informed alternative sources. Fear of these diseases comes from not being properly informed.

For More Information

To make a truly informed decision there are numerous sources of information on the risks of vaccines and the risks and benefits of childhood diseases. Sources of information to determine if the risks associated with vaccines outweigh any perceived benefits include: vaccine package inserts, the Physicians Desk Reference, the U.S. Center for Disease Control and Prevention, public and medical libraries or state and local health agencies. (NOTE: These sources do not give complete and total information on vaccine ingredients and their toxicity, nor do they provide accurate statistics.)
Vaccination Liberation – www.vaclib.org or (888) 249-1421
National Vaccine Information Center – www.909shot.com or (800) 909-SHOT / (703) 938-0324
(NOTE: The two websites above, Vaccination Liberation and the National Vaccine Information Center, have proven to be excellent sources for extensive vaccine information.)

Reporting Reactions

If you do decide to vaccinate, report vaccine reactions to the Vaccine Adverse Event Reporting System (800) 822-7969. Always get the vaccine name, vaccine manufacturer and lot number. Keep records of day to day reactions from the time of vaccination for at least 6 months to 2 years, no matter how slight the reactions. Long-term effects of vaccines have not been well documented by the allopathic community and are just now being researched. If your child has been injured by a vaccine, he may be eligible for compensation under the National Vaccine Injury Compensation Program.

Revised 2/06 Source: Vaccination Liberation, P.O. Box 457, Spirit Lake, ID 83869
This form may be reproduced

IMPORTANT NOTICE TO PARENTS

State of Hawai'i
Department of Health
Immunization Branch

SCHOOL HEALTH REQUIREMENTS, EFFECTIVE: JULY 1, 2020

What does Hawai'i State Law require for childcare facility and school attendance?

Hawai'i State Law requires all students to meet physical examination, immunization, and tuberculosis clearance requirements before they may attend a childcare facility, preschool, or public/private school in the State.

Are exemptions allowed?

Children may be exempt from immunization requirements for medical or religious reasons, if the appropriate documentation is presented to the childcare facility or school. Religious exemption forms may be completed at the childcare facility or school that your child will attend. Medical exemptions must be obtained from your child's healthcare provider. No other exemptions are allowed by the State.

What are the health requirements?

1 Physical Examination:
- Must be completed within one year before:
  - First date of attendance at a childcare facility, preschool, or school in Hawai'i; and
  - First date of attendance in the seventh grade.
- Must be performed by a U.S. licensed physician, APRN or PA.

2 Immunizations:
Immunizations are required for childcare facility and school attendance. Required immunizations depend on the age of the child (childcare or preschool) or grade of the student. All immunizations must meet minimum age and interval requirements between vaccine doses.

3 Tuberculosis (TB) Clearance:
For information regarding TB clearance requirements for school attendance, talk to your child's healthcare provider or contact the Department of Health Tuberculosis Control Branch:

call: (808) 832-5731

web: health.hawaii.gov/tb

What is required by the first day of school?

By the first day of school, all students entering childcare, preschool, or school in Hawai'i for the first time must have:

1

A completed health record form to document that a physical examination was performed within one year before childcare facility or school entrance, and that all immunization requirements have been met.

OR

An appointment notice from a healthcare provider for your child to complete the physical examination or immunization requirements.

AND

2

A completed TB clearance form.

More on Back

Students who have not completed the above requirements by the first day of school will not be allowed to attend school until these requirements are met.



Where do I get the "Student's Health Record" form?

You can get a copy of the "Student's Health Record" (Form 14) from the childcare facility or school where your child will be enrolled or from your child's healthcare provider.

What if my child is transferring from another state or territory of the U.S.?

You will need to show proof that the health requirements have been met prior to childcare facility or school entry. The childcare facility or school will accept out-of-state records that meet the State of Hawai'i requirements for physical examination, immunizations, and tuberculosis clearance.

Which immunizations are required?

Immunizations are required for all students entering childcare or preschool, kindergarten, and seventh grade, and for those students entering school in Hawai'i for the first time, regardless of age.

Childcare or Preschool
- Diphtheria-Tetanus-Pertussis (DTaP)
- *Haemophilus influenzae* type b (Hib)
- Hepatitis A (Hep A)
- Hepatitis B (Hep B)
- Measles-Mumps-Rubella (MMR)
- Pneumococcal Conjugate Vaccine (PCV)
- Polio (IPV)
- Varicella (chickenpox)

Kindergarten – 12th Grade
- DTaP
- Hep A
- Hep B
- Human Papillomavirus (HPV)*
- Meningococcal Conjugate (MCV)*
- MMR
- IPV
- Tetanus-diphtheria-pertussis (Tdap)*
- Varicella

7th Grade
- HPV
- MCV
- Tdap

**All students entering school in Hawai'i for the first time in 7th grade or higher must show evidence of receiving these immunizations prior to school attendance.*

Questions?

Hawai'i Department of Health Immunization Branch

Web: health.hawaii.gov/docd/vaccines-immunizations/school-health-requirements/
Email: immunization@doh.hawaii.gov
Call: (808) 586-8332 or 1 (800) 933-4832

Hawai'i Department of Health Tuberculosis Control Branch

Web: health.hawaii.gov/tb
Call: (808) 832-5731

Nondiscrimination in Services. We provide access to our activities without regard to race, color, national origin (including language), age, sex, religion, or disability. Write or call the Hawai'i Department of Health Immunization Branch or our departmental Affirmative Action Officer at P.O. Box 3378, Honolulu, Hawai'i 96801-3378 or at (808) 586-4616 (voice/tty) within 180 days of a problem.

August 2019

Sacred Hearts Academy

Emergency Information

Please print legibly in black ink and return this completed form to your homeroom teacher.

Student's Name: _____ **Entering Grade:** ____
First *Middle* *Last*

Home Address: _____

_____ _____ _____
City State Zip Code

Home Phone #: _____ Date of Birth: _____

Ethnic Background: _____

Religion: _____ If Catholic, please list parish: _____

School attended last school year: _____

If any relative is a graduate of Sacred Hearts Academy, please list below:

Name _____ Relationship to Student _____
Name _____ Relationship to Student _____
Name _____ Relationship to Student _____

Emergency Contact other than parents and/or guardians:

Name: _____ Relationship to Student: _____

Home #: _____ Cell #: _____ Work #: _____

PARENT/GUARDIAN INFORMATION

(Please provide a copy of legal documentation if only one parent has custody rights.)

Male Parent/Guardian:

Name: _____

Relationship to Student: _____

Receive mail & report cards: ☐ Yes ☐ No

Student lives with this parent: ☐ Yes ☐ Part-time ☐ No

Mailing Address (if different from above):

_____

_____
City State Zip Code

Home #: _____ Work #: _____

Pager #: _____ Cell #: _____

E-mail: _____

Employer: _____

Occupation: _____

Female Parent/Guardian:

Name: _____

Relationship to Student: _____

Receive mail & report cards: ☐ Yes ☐ No

Student lives with this parent: ☐ Yes ☐ Part-time ☐ No

Mailing Address (if different from above):

_____

_____
City State Zip Code

Home #: _____ Work #: _____

Pager #: _____ Cell #: _____

E-mail: _____

Employer: _____

Occupation: _____