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.

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 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

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.