School: _____
School Year: 2023-2024

ATTESTATION STATEMENT OF FAMILY INCOME

Directions: This document must be completed in full by <u>all</u> families.

Child's name: _____ **Family size:** _____

Father's Name: _____ **Mother's Name:** _____

Check all areas that apply and provide the necessary documents to demonstrate eligibility:

☐ I am currently eligible for the Temporary Assistance for Needy Families (TANF or previously known as welfare) program.
☐ I am currently eligible for the Supplemental Nutrition Assistance Program (SNAP or previously known as food stamps).
☐ The applying child is currently in foster care.
☐ My family is homeless.
☐ My child is and English Language Learner.
☐ My child has an IEP and is receiving special education services. Name the school providing SPED services_____
☐ None apply.

Income verification documents are encouraged to support the information provided on this page. This page MUST be signed and completed in full.

- ✓ 2022 1040 Income Tax Returns;
- ✓ Pay stubs for past 12 months or any part thereof; or
- ✓ Verification of current TANF, SNAP, homeless or foster care status, if applicable.

Declaration of employment and income status for parent(s) living in household:

Parent's Name	Employer	Period of Employment for Past 12 months	Salary earned during past 12 months of employment
			$
			$
			$
			$
			$
		TOTAL	**$**

If applicable: I am unable to provide the required income documents because:

☐ I am unable to locate all of the documents.
☐ I did not file 2022 taxes to date.
☐ Other (explain):

By signing below, I certify that the information provided above is true and correct to the best of my knowledge.

*Signature of Parent/Guardian **(required)***

Printed Name of Parent/Guardian

*Contact phone number **(required)***

Work phone number or alternate phone number

FOR OFFICE USE ONLY:

Family Size		**Date pkt. received in full**	
Federal Poverty Guidelines (FPG) (based on family size)		**FPL ≤ 300%?**	☐ **Yes** ☐ **No**
		DOB 8/01/18 - 7/31/20?	☐ **Yes** ☐ **No**
Family Income		**Priority?**	☐ **Yes** ☐ **No**
Federal Poverty Level (FPL) (Income/FPG)	**%**	**Confirmed by:**	

Reset Form Print Form

School Name: Complex Area:

STUDENT ENROLLMENT FORM SIS-10W *(Revised)*

Student ID No.	Entry Date	Entry Code	Room
	For school use only		

INSTRUCTIONS: PRINT YOUR ENTRIES LEGIBLY

Ethnicity/Race Observed: _____ Initial _____ Date

STUDENT PERSONAL DATA

Legal Last Name: _____ Gender: ☐ M ☐ F Grade Level: _____

Legal First Name: _____ Birth Date: _____

Middle Initial: _____ Suffix: (Jr, II, III, etc): _____ Verification of DOB: _____

☐ Not Homeless ☐ Homeless* ☐ Completed MVA Packet

_____ _____

DOE Representative Signature Parent/Legal Guardian Signature

*"Homeless" means individuals who lack a fixed, regular and adequate nighttime residence (within the meaning of section 42 USCS §11302(a)(1)) and includes:

(i) children and youth who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement.

(ii) children and youth who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of 42 USCS §11302(a)(2)(C));

(iii) children and youth who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations or similar settings; and

(iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle.

If you have any questions regarding the above, please call 1-866-927-7095

PRESCHOOL EXPERIENCE

Preschool Experience ☐ Yes ☐ No

If "Yes" – attended:
☐ less than 6 months
☐ between 6 and 12 months
☐ more than 1 year

Pre-School Program: (if applicable)
☐ EOEL
☐ KALO
☐ Charter School

LAST HAWAII PUBLIC SCHOOL ATTENDED

Name: _____

Last Grade Attended: _____ Year: _____

PRIOR SCHOOL ATTENDED (If not Hawaii Public School)

Name: _____ U.S. Phone: _____

Address: _____ U.S. Fax: _____

CITIZENSHIP

Country of Birth: _____ If Country of Birth is other than US, give year of arrival: _____

US Citizen: ☐ Yes ☐ No If not US Citizen, indicate status: Refugee ☐ Immigrant ☐ Non-Immigrant ☐

LANGUAGE INFORMATION

Language Codes: (Select a letter from the list and fill in the blanks below)

_____ Language (Spoken) at Home _____ First (Acquired) Language _____ Language Most Used

A – English	**F** – Cebuano/Visayan	**K** – Vietnamese	**Q** – Fijian	**V** – Pangasinan	**L** – Other (Specify):
B – Cantonese	**G** – Hawaiian	**M** – Chuukese	**R** – Hmong	**W** – Portuguese	_____
C – Mandarin	**H** – Japanese	**N** – Pohnpeian	**S** – Lao	**X** – Spanish	
D – Ilocano	**I** – Korean	**O** – Cambodian	**T** – Marshallese	**Y** – Thai	
E – Tagalog	**J** – Samoan	**P** – Chamorro	**U** – Pampango	**Z** - Tongan	

Continue on next page

Please complete ETHNICITY INFORMATION, RACE INFORMATION, and PRIMARY ETHNICITY/RACE INFORMATION

ETHNICITY INFORMATION

Are you **(J)** Hispanic (Ex. Cuban, Mexican, Puerto Rican, Spanish, Other Hispanic)? ☐ Yes ☐ No

RACE INFORMATION

Check all that apply:

- ☐ **A** – American Indian or Alaska Native
- ☐ **B** – Black
- ☐ **C** – Chinese
- ☐ **D** – Filipino
- ☐ **E** – Native Hawaiian
- ☐ **G** – Japanese
- ☐ **H** – Korean
- ☐ **I** – Portuguese
- ☐ **K** – Samoan
- ☐ **L** – White
- ☐ **N** – Indo-Chinese (Ex. Cambodian, Laotian, Vietnamese)
- ☐ **O** – Micronesian (Ex. Chuukese, Marshallese Pohnpeian,)
- ☐ **P** – Tongan
- ☐ **Q** – Guamanian/Chamorro
- ☐ **R** – Other Asian
- ☐ **S** – Other Pacific Islander

PRIMARY ETHNICITY/RACE INFORMATION

What is the student's primary race? (Select only ONE letter from either the ethnicity or race list and fill in the blank) _____

☐ I decline to provide ethnicity and race information. I understand that if I do not provide this information, a school representative will designate the ethnicity and race categories for my child.

LEGAL PARENT/GUARDIAN LIVING IN THE HOUSEHOLD WITH STUDENT

FIRST PARENT/GUARDIAN

Check one: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other (specify): _____ Relation: _____

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single Custody of Child: ☐ Yes ☐ No

Custody Documentation Submitted: ☐ Yes ☐ No Custody Type: ☐ Sole Custody ☐ Physical Custody ☐ Joint Legal

_____ _____
Legal Last Name Legal First Name

Home Address: _____ APT# _____ City _____ Zip _____

Mailing Address (if different from Home Address): _____

_____ _____ _____ _____
Home Phone # Cellular Phone # Pager # Work Phone # (include ext.)

Email Address: _____

Allow this person access to: *(check all that apply)* ☐ mailing ☐ portal (if applicable) ☐ messenger

EMERGENCY CONTACT: *(check one)* Call Sequence ☐ 1 ☐ 2

Is this parent/guardian a member of the Armed Services, National Guard or Reserves? ☐ Yes ☐ No

Military Status (check one): ☐ Traditional Reservist / M-Day ☐ Active Duty (Title 10) ☐ Federal Technician (Title 32)

Deployed? ☐ Yes ☐ No

Branch of Service (check one):

- ☐ Army
- ☐ Air Force
- ☐ Navy
- ☐ Marine
- ☐ Coast Guard
- ☐ Army National Guard
- ☐ Air National Guard
- ☐ Army Reserves
- ☐ Air Force Reserves
- ☐ Navy Reserves
- ☐ Marine Reserves
- ☐ Coast Guard Reserves

Does this person work for the Federal Government or work on Federal Property? ☐ Yes ☐ No

Continue on next page

LEGAL PARENT/GUARDIAN LIVING IN THE HOUSEHOLD WITH STUDENT

SECOND PARENT/GUARDIAN

Check one: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other (specify): _____ Relation: _____

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single Custody of Child: ☐ Yes ☐ No

Custody Documentation Submitted: ☐ Yes ☐ No Custody Type: ☐ Sole Custody ☐ Physical Custody ☐ Joint Legal

_____ _____
Legal Last Name Legal First Name

Home Address: _____ APT# _____ City _____ Zip _____

Mailing Address (if different from Home Address): _____

_____ _____ _____ _____
Home Phone # Cellular Phone # Pager # Work Phone # (include ext.)

Email Address: _____ Allow

this person access to: *(check all that apply)* ☐ mailing ☐ portal (if applicable) ☐ messenger

EMERGENCY CONTACT: *(check one)* Call Sequence ☐ 1 ☐ 2

Is this parent/guardian a member of the Armed Services, National Guard or Reserves? ☐ Yes ☐ No

Military Status (check one): ☐ Traditional Reservist / M-Day ☐ Active Duty (Title 10) ☐ Federal Technician (Title 32)

Deployed? ☐ Yes ☐ No

Branch of Service (check one):

☐ Army	☐ Marine	☐ Air National Guard	☐ Navy Reserves
☐ Air Force	☐ Coast Guard	☐ Army Reserves	☐ Marine Reserves
☐ Navy	☐ Army National Guard	☐ Air Force Reserves	☐ Coast Guard Reserves

Does this person work for the Federal Government or work on Federal Property? ☐ Yes ☐ No

PARENT/GUARDIAN NOT LIVING WITH STUDENT

PARENT/GUARDIAN

Check one: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other (specify): _____ Relation: _____

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single Custody of Child: ☐ Yes ☐ No

_____ _____
Legal Last Name Legal First Name

Home Address: _____ APT# _____ City _____ Zip _____

Mailing Address (if different from Home Address): _____

_____ _____ _____ _____
Home Phone # Cellular Phone # Pager # Work Phone # (include ext.)

Email Address: _____ Allow

this person access to: *(check all that apply)* ☐ mailing ☐ portal (if applicable) ☐ messenger

EMERGENCY CONTACT: *(check one)* Sequence ☐ 1 ☐ 2 ☐ 3

Continue on next page

LEGAL PARENT/GUARDIAN NOT LIVING WITH STUDENT (cont.)

GUARDIAN

Is this parent/guardian a member of the Armed Services, National Guard or Reserves? ☐ Yes ☐ No

Military Status (check one): ☐ Traditional Reservist / M-Day ☐ Active Duty (Title 10) ☐ Federal Technician (Title 32)

Deployed? ☐ Yes ☐ No

Branch of Service (check one):

☐ Army	☐ Marine	☐ Air National Guard	☐ Navy Reserves
☐ Air Force	☐ Coast Guard	☐ Army Reserves	☐ Marine Reserves
☐ Navy	☐ Army National Guard	☐ Air Force Reserves	☐ Coast Guard Reserves

Does this person work for the Federal Government or work on Federal Property? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

FIRST

(Person To Notify In Case Of Emergency Other than First or Second Parent/Guardian Contact)

Check one: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other (specify): _____ Relation: _____

Last Name _____ First Name _____ Email Address _____

Home Phone # _____ Cellular Phone # _____ Pager # _____ Work Phone # (include ext.) _____

EMERGENCY CONTACT: *(check one)* Call Sequence ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

SECOND

(Person To Notify In Case Of Emergency Other than First or Second Parent/Guardian Contact)

Check one: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other (specify): _____ Relation: _____

Last Name _____ First Name _____ Email Address _____

Home Phone # _____ Cellular Phone # _____ Pager # _____ Work Phone # (include ext.) _____

EMERGENCY CONTACT: *(check one)* Call Sequence ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

SCHOOL SUPPLEMENTARY INFORMATION

Other Children In HIDOE Schools:

	Legal First, Middle Initial & Last Name	HIDOE School Attending	DOB	Grade	Relationship
1.					
2.					
3.					
4.					

Parent/Legal Guardian Signature: _____ **Date:** _____

FOR SCHOOL USE:

State of Hawaii • Department of Education
OFFICE OF STUDENT SUPPORT SERVICES

475 22nd Avenue
Honolulu, Hawaii 96816
Telephone: 808-305-9869
Toll Free: 1-866-927-7095

QUESTIONNAIRE TO DETERMINE ELIGIBILITY MV1

This form is intended to address the McKinney-Vento Act (MVA) and must be completed for each student

Questionnaires are filed for one (1) year for all students and seven (7) years for any student identified as living in unstable housing.

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____

_____

Student's current residence such as address, cross streets, landmarks, etc.

Primary Contact Name: _____ Relationship: _____ Phone: _____

Alternate Contact Name: _____ Relationship: _____ Phone: _____

CHECK ONE BOX	STUDENT'S CURRENT LIVING ARRANGEMENT	MVA CODE
☐	**Unsheltered** *Campground, car, beach/park, abandoned building, street or any other inadequate living space*	06
☐	**Shelter** *Emergency, transitional or domestic violence shelter, name of shelter:* _____	04
☐	**Hotel/Motel** *Due to lack of other suitable housing, **excludes** temporary lodging for military persons awaiting housing*	02
☐	**Doubled Up** *Temporarily with family or other person due to loss of housing or as a result of economic hardship*	03
☐	**Permanent Housing** *Student who is living in a fixed, regular, and adequate housing situation* STOP **If this box is checked, stop here and sign below; form is complete**	07

If the student is NOT in the physical custody of a parent or legal guardian, also check below:

☐	**Unaccompanied Youth**	05

List all siblings living in the same arrangement, including children 0-5 years of age:

Name	Age	School	Grade

The information you provide above will determine what services you or your child may be eligible to receive under the **McKinney-Vento Homeless Assistance Act - 42 U.S.C. §11434a(2)**. If eligible under the Act, you or your child are entitled to immediate enrollment in school and free school meals. Transportation may be provided to and from school of origin. This questionnaire allows a Homeless Concerns Liaison to contact you for additional support. By signing, you grant permission to share/release pertinent information among shelter and school personnel, to support school enrollment and full participation.

_____ _____ _____

Parent/Legal Guardian/Unaccompanied Youth Signature **Print Name** **Date**

For School Use Only: *School designee to complete this page if the student is identified as living in unstable housing.*

NOTE: The McKinney-Vento Act requires immediate enrollment for students living in unstable housing, even if the student is unable to provide documents, such as school records, immunization records and other health records, proof of residency, or other documents. 42 U.S.C. §11432(g)(3)(C).

* "Enrolled" means attending classes and participating fully in school activities. 42 U.S.C. §11434a(1)

Student ID #: __ __ __ __ __ __ __ __ __ __ Date Student Enrolled: ____ / ____ / ____

Student Enrolled As:

☐ Home School (school within the geographic area of student's current residence)

☐ School of Origin (school attended when permanently housed/last school attended)

☐ Geographic Exception (GE)

☐ Other: _____

By acknowledging below, the school designee agrees that the form is complete and the parent/legal guardian/ unaccompanied youth has been provided MVA information and a copy of this form.

Designee Signature	Print Name	Date

By signing below, the principal indicates that he/she has reviewed this form and understands the school's responsibility under the **McKinney-Vento Homeless Assistance Act.**

The school principal determines the student as:

☐ Eligible under McKinney-Vento Act

☐ Not eligible under McKinney-Vento Act Reason: _____

MV2 Initiated: ☐ Yes ☐ No Date MV2 Initiated: ____ / ____ / ____

Principal Signature	Print Name	Date

Notes/Updates:

Date	Action Taken	Remarks	Initials

Note*: Please forward a copy of this form to your Homeless Concerns Liaison within 3 business days.*

INSERT BIRTH CERTIFICATE

HERE

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/Guardian) _____ (Father/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	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__

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

Physician, APRN, PA or Clinic _____

State of Hawaii
Department of Human Services

Benefit, Employment & Support Services Division

Early Childhood Pre-K Health Record Supplement*

Name of Child: **DOB:**

Name of Child Care Facility:

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	
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. 4/10, RS 10-1369 (Rev. of RS 09-1051)

DHS 908 (09/11)

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

Date		Signature & Title	Date		Signature & Title