

Honolulu Community Action Program, Inc.

A Non-Profit Human Service Agency

1109 Maunakea Street, 2nd Floor • Honolulu, Hawaii 96817-5156

Telephone (808) 521-4531 • Fax (808) 521-4538

H C A P



Ruby L. Hargrave
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Amy T. Chun
Controller

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Chad Buchanan
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Vice-Chairperson

Felipe P. Abinsay, Jr.
Secretary-Treasurer

LOCATIONS

CENTRAL
99-102 Kalaloa Street
Aiea, Hawaii 96701-3801
Phone: 488-6834

KALIHI-PALAMA
1555 Haka Drive, #2408
Honolulu, Hawaii 96817-5800
Phone: 847-0804

LEAHI
1915 Palolo Avenue
Honolulu, Hawaii 96816-2928
Phone: 732-7755

LEEWARD
85-555 Farrington Hwy.
Waianae, Hawaii 96792-2354
Phone: 696-4261

WINDWARD
47-232 Waihee Road
Kaneohe, Hawaii 96744-4947
Phone: 239-5754

KAPALAMA HEAD START
5 Sand Island Access Road,
Bldg. 921
Honolulu, Hawaii 96819-4905
Phone: 847-2400

KUNIA HEAD START
Old Kunia School
Kunia Drive
Kunia, Hawaii 96759-0246
Phone: 621-5099

Oahu Head Start Program

March 19, 2003

Dear Dr. Danilo S. Perlas:

Your patient/client Ronela Pasucal DOB 12-28-01 is an applicant/enrollee at Center: HB EHS in the HCAP/Oahu Head Start Program. Parent's name Dela Pasucal has given consent to release diagnostic information that will help us confirm a special need and assist us in developing an individualized plan for this child. Please send any current diagnostic reports and other pertinent information, which would be helpful to our planning for service. **(This is a 2nd request for this report, please send back ASAP, Thank you for your time.)**

Please complete the following:

- 1. Diagnostic/Condition:

Date of diagnosis:

- 2. Summary of Condition:

(attach additional sheets if necessary)

- 3. Treatment Plan and Recommendations including any emergency procedures:

(attach additional sheets if necessary)

4. Are there any activity restrictions or precautions that need to be addressed in the classroom, during outdoor play, and/or on field trips?

Yes No If yes, please describe:

5. Any special equipment, adaptations or modifications?

6. Medication and dosage:

a) When is medication administered?

b) What are possible side effects?

Signature of Diagnostician:

Date: _____

Name and Title:

Are you available to participate in this child's Individualized Education Program (IEP) planning process/Individualized Family Service Plan (IFSP) development process?

Yes No If yes, how would you like to be involved?

Please return to: HCAP/Oahu Head Start Program
1109 Maunakea Street, Second Floor
Honolulu, Hawaii 96817
Attn: Disabilities Program – Jo Ann Chinn

If you have any questions, please call one of our special educators, speech pathologists, audiologists, or our disabilities coordinator, at 847-2400; or Early Head Start special educator at 843-2530. Thank you for your cooperation.

Honolulu Community Action Program, Inc.
Oahu Head Start Program
1120 Maunakea Street, Suite 280
Honolulu, HI 96817
Phone: 847-2400

**CONSENT FOR RELEASE OF INFORMATION
DISABILITIES PROGRAM**

Dr.

To: Danilo S. Perlas Phone: 622-5556
Address: 302 California Ave. suite #208 Wahiawa, HI 96786
Re: Ronela Pasucal 12-28-01 HRB EHS
Child's Name DOB Center

This child is being considered for placement in the Oahu Head Start Disabilities Program. Information is being requested to assist in determining the existence of the following disabling condition(s):

Condition(s) and/or diagnosis: Failure to thrive

Mark all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Orthopedic impairment |
| <input type="checkbox"/> Emotional/behavioral disorder | <input type="checkbox"/> Speech or language impairment |
| <input type="checkbox"/> Health impairment | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Hearing impairment including deafness | <input type="checkbox"/> Visual impairment including blindness |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Developmental delays |
| <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Other impairment: (e.g. DOE Services)
(include eligibility report and/or Individualized Education Program) |

Please include diagnostic information and any restrictions, precautions, medications, recommendations, and any modifications or adaptations.

Please provide name/position of additional service provider(s) who have worked with this child (e.g. surgeon, psychologist, audiologist, speech/language pathologist, etc.): _____

Send information to: Honolulu Community Action Program, Inc.
Oahu Head Start Program
1120 Maunakea Street, Suite 280
Honolulu, HI 96817
Attn.: Disabilities Recruitment (Jo chin)

I, Dela Pasucal the undersigned, authorize and request the release of the above information to complete the Head Start records and to determine appropriate educational, health and social services planning for the above-named child.

Dela Pasucal
Signature of Parent/Legal Guardian Date

[Signature] 1/24/03
Head Start Staff Date

White - Physician

Yellow - Main File

Honolulu Community Action Program, Inc.
Oahu Head Start Program
1120 Maunakea Street, Suite 280
Honolulu, HI 96817
Phone: 847-2400

CONSENT FOR RELEASE OF INFORMATION
DISABILITIES PROGRAM

To: Dr. Perlas, Danilo Phone: 622-5556
Address: 302 California Ave #208, Wahiawa HI 96786
Re: Pascual, Ronela 12-28-01 EHS HB IV
Child's Name DOB Center

This child is being considered for placement in the Oahu Head Start Disabilities Program. Information is being requested to assist in determining the existence of the following disabling condition(s):

Condition(s) and/or diagnosis: Failure-to-Thrive and other developmental delays
Mark all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Orthopedic impairment |
| <input type="checkbox"/> Emotional/behavioral disorder | <input type="checkbox"/> Speech or language impairment |
| <input type="checkbox"/> Health impairment | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Hearing impairment including deafness | <input type="checkbox"/> Visual impairment including blindness |
| <input type="checkbox"/> Learning disability | <input checked="" type="checkbox"/> Developmental delays |
| <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Other impairment: (e.g. DOE Services)
(include eligibility report and/or Individualized Education Program) |

Please include diagnostic information and any restrictions, precautions, medications, recommendations, and any modifications or adaptations.

Please provide name/position of additional service provider(s) who have worked with this child (e.g. surgeon, psychologist, audiologist, speech/language pathologist, etc.): _____

Send information to: Honolulu Community Action Program, Inc.
Oahu Head Start Program
1120 Maunakea Street, Suite 280
Honolulu, HI 96817
Attn.: Disabilities Recruitment - Joanne Quon

I, Dela Pascual the undersigned, authorize and request the release of the above information to complete the Head Start records and to determine appropriate educational, health and social services planning for the above-named child.

Dela Pascual 3/6/03
Signature of Parent/Legal Guardian Date

A. Grillo 3/6/03 A. Grillo
Head Start Staff Date

White - Physician

Yellow - Main File